As Introduced

134th General Assembly

Regular Session **H. B. No. 125**

2021-2022

Representatives Crossman, Lightbody

Cosponsors: Representatives West, Miller, J., Smith, M., Galonski, Brent, Miranda, Troy, Weinstein, Smith, K., Lepore-Hagan, Skindell, Howse, Robinson, Boggs, Liston, Sweeney, Sheehy, Sobecki, Russo, Hicks-Hudson, Miller, A., Kelly, Blackshear, Upchurch, Brown, Denson, Crawley, O'Brien, Jarrells, Leland, Ingram, Boyd, Sykes

A BILL

To amend sections 1731.03, 1731.04, 1731.05, 1731.09, 1739.05, 1751.01, 1751.06, 1751.12, 1751.16, 1751.18, 1751.58, 1751.69, 3901.381, 3922.01, 3923.122, 3923.57, 3923.571, 3923.85, 3924.01, 3924.02, 3924.03, 3924.033, 3924.06, 3924.51, and 3924.73; to enact sections 3902.40, 3902.41, 3902.42, 3902.43, and 3902.44; and to repeal sections 1751.15, 3923.58, 3923.581, 3923.582, 3923.59, 3924.07, 3924.08, 3924.09, 3924.10, 3924.11, 3924.111, 3924.12, 3924.13, and 3924.14 of the Revised Code regarding health insurance premiums and benefits.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 1731.03, 1731.04, 1731.05, 1731.09, 1739.05, 1751.01, 1751.06, 1751.12, 1751.16, 1751.18, 1751.58, 1751.69, 3901.381, 3922.01, 3923.122, 3923.57, 3923.571, 3923.85, 3924.01, 3924.02, 3924.03, 3924.033, 3924.06,

3924.51, and 3924.73 be amended and sections 3902.40, 3902.41, 3902.42, 3902.43, and 3902.44 of the Revised Code be enacted to read as follows:

Sec. 1731.03. (A) A small employer health care alliance may do any of the following:

(1) Negotiate and enter into agreements with one or more insurers for the insurers to offer and provide one or more health benefit plans to small employers for their employees and retirees, and the dependents and members of the families of such employees and retirees, which coverage may be made available to enrolled small employers without regard to industrial, rating, or other classifications among the enrolled small employers under an alliance program, except as otherwise provided under the alliance program, and for the alliance to perform, or contract with others for the performance of, functions under or with respect to the alliance program;

(2) Contract with another alliance for the inclusion of the small employer members of one in the alliance program of the other;

(3) Provide or cause to be provided to small employers information concerning the availability, coverage, benefits, premiums, and other information regarding an alliance program and promote the alliance program;

(4) Provide, or contract with others to provide, enrollment, record keeping, information, premium billing, collection and transmittal, and other services under an alliance program;

(5) Receive reports and information from the insurer and negotiate and enter into agreements with respect to inspection

and audit of the books and records of the insurer;

(6) Provide services to and on behalf of an alliance program sponsored by another alliance, including entering into an agreement described in division (B) of section 1731.01 of the Revised Code on behalf of the other alliance;

(7) If it is a nonprofit corporation created under Chapter 1702. of the Revised Code, exercise all powers and authority of such corporations under the laws of the state, or, if otherwise constituted, exercise such powers and authority as apply to it under the applicable laws, and its articles, regulations, constitution, bylaws, or other relevant governing instruments.

(B) A small employer health care alliance is not and shall not be regarded for any purpose of law as an insurer, an offeror or seller of any insurance, a partner of or joint venturer with any insurer, an agent of, or solicitor for an agent of, or representative of, an insurer or an offeror or seller of any insurance, an adjuster of claims, or a third-party administrator, and will not be liable under or by reason of any insurance coverage or other health benefit plan provided or not provided by any insurer or by reason of any conditions or restrictions on eligibility or benefits under an alliance program or any insurance or other health benefit plan provided under an alliance program or by reason of the application of those conditions or restrictions.

(C) The promotion of an alliance program by an alliance or by an insurer is not and shall not be regarded for any purpose of law as the offer, solicitation, or sale of insurance.

(D)(1) No alliance shall adopt, impose, or enforce medical underwriting rules or underwriting rules requiring a small

employer to have more than a minimum number of employees for the purpose of determining whether an alliance member is eligible to purchase a policy, contract, or plan of health insurance or health benefits from any insurer in connection with the alliance health care program.

(2) No alliance shall reject any applicant for membership in the alliance based on the health status of the applicant's employees or their dependents or because the small employer does not have more than a minimum number of employees.

(3) A violation of division (D)(1) or (2) of this section is deemed to be an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

(4) Nothing in division (D)(1) or (2) of this section shall be construed as inhibiting or preventing an alliance from adopting, imposing, and enforcing rules, conditions, limitations, or restrictions that are based on factors other than the health status of employees or their dependents or the size of the small employer for the purpose of determining whether a small employer is eligible to become a member of the alliance. Division (D)(1) of this section does not apply to an insurer that sells health coverage to an alliance member under an alliance health care program.

(E) Except as otherwise specified in section 1731.09 of the Revised Code, health benefit plans offered and sold to alliance members that are small employers as defined in section 3924.01 of the Revised Code are subject to sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code.

(F) Any person who represents an alliance in bargaining or

negotiating a health benefit plan with an insurer shall disclose to the governing board of the alliance any direct or indirect financial relationship the person has or had during the past two years with the insurer.

Sec. 1731.04. (A) An agreement between an alliance and an insurer referred to in division (B) of section 1731.01 of the Revised Code shall contain at least the following:

(1) A provision requiring the insurer to offer and sell to small employers served or to be served by an alliance one or more health benefit plan options for coverage of their eligible employees and the eligible dependents and members of the families of the eligible employees and, if applicable, such members' eligible retirees and the eligible dependents and members of the families of the retirees, subject to such conditions and restrictions as may be set forth or incorporated into the agreement;

(2) A brief description of each type of health benefit plan option that is to be so offered and the conditions for the modification, continuation, and termination of the coverage and benefits thereunder;

(3) A statement of the eligibility requirements that an employee or retiree must meet in order for the employee or retiree to be eligible to obtain and retain coverage under any health benefit plan option so offered and, if one of such requirements is that an employee must regularly work for a minimum number of hours per week, a statement of such minimum number of hours, which minimum shall not exceed twenty-five hours per week;

(4) ~~A description of any pre-existing condition and~~

~~waiting period rules;~~

~~(5)~~ A statement of the premium rates or other charges that apply to each health benefit plan option or a formula or method of determining the rates or charges;

~~(6)~~ (5) A provision prescribing the minimum employer contribution toward premiums or other charges required in order to permit a small employer to obtain coverage under a health benefit plan option offered under an alliance program;

~~(7)~~ (6) A provision requiring that each health benefit plan under the alliance program must provide for the continuation of coverage of participants of an enrolled small employer so long as the small employer determines that such person is a qualified beneficiary entitled to such coverage pursuant to Part 6 of Title I of the "Federal Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, and the laws of this state, and regulations or rulings interpreting such provisions. Such coverage provided by the insurer under the plan to participants shall comply with the "Federal Employee Retirement Income Security Act of 1974" and the relevant statutes, regulations, and rulings interpreting that act, including provisions regarding types of coverage to be provided, apportionments of limitations on coverage, apportionments of deductibles, and the rights of qualified beneficiaries to elect coverage options relating to types of coverage and otherwise.

(B) An agreement between an alliance and an insurer referred to in division (B) of section 1731.01 of the Revised Code may contain provisions relating to, but not limited to, any of the following:

(1) The application and enrollment process for a small employer and related provisions pertaining to historical experience, health statements, and underwriting standards;

(2) The minimum number of those employees eligible to be participants that are required to participate in order to permit a small employer to obtain coverage under a health benefit plan option offered under the alliance program, which may vary with the number of employees or those eligible to be participants in respect of the small employer;

(3) A procedure for allowing an enrolled small employer to change from one plan option to another under the alliance program, subject to qualifying by size or otherwise under the alliance program;

(4) The application of any risk-related pooling or grouping programs and related premiums, conditions, reviews, and alternatives offered by the insurer;

(5) The availability of a medicare supplement coverage option for eligible participants who are covered by Parts A and B of medicare, Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301;

(6) Relevant experience periods, enrollment periods, and contract periods;

(7) Effective dates for coverage of eligible participants;

(8) Conditions under which denial or withdrawal of coverage of participants or small employers and their employees may occur by reason of falsification or misrepresentation of material facts or criminal conduct toward the insurer, small employer, or alliance under the program;

(9) Premium rate structures, which may be uniform or make provision for age-specific rates, differentials based on number of participants of an enrolled small employer, products and plan options selected, and other factors, rate adjustments based on consumer price indices, utilization, or other relevant factors, notification of rate adjustments, and arbitration;

(10) Any responsibilities of the alliance for billing, collection, and transmittal of premiums;

(11) Inclusion under the alliance program of small employers that are members of other organizations described in division (A)(1) of section 1731.01 of the Revised Code that contract with the alliance for this purpose, and conditions pertaining to those small employer members and to their employees and retirees, and dependents and family members of those employees or retirees, as applicable under the alliance program;

(12) The agreement of the insurer to offer and sell one or more health benefit plans to small employer members of another small employer health care alliance that contracts with the alliance for this purpose;

(13) Use of the health benefit plan options of the insurer in the alliance program and use of the names of the alliance and the insurer;

(14) Indemnification from claims and liability by reason of acts or omissions of others;

(15) Ownership, use, availability, and maintenance of confidentiality of data and records relating to the alliance program;

(16) Utilization reports to be provided to the alliance by

the insurer;

(17) Such other provisions as may be agreed upon by the alliance and the insurer to better provide for the articulation, promotion, financing, and operation of the alliance program or a health benefit plan under the program in furtherance of the public purposes stated in section 1731.02 of the Revised Code.

(C) Neither an alliance program nor an agreement between an alliance and an insurer is itself a policy or contract of insurance, or a certificate, indorsement, rider, or application forming any part of a policy, contract, or certificate of insurance. Chapters 3905., 3933., and 3959. of the Revised Code do not apply to an alliance program or to an agreement between an alliance and an insurer thereunder, as such, or to the functions of the alliance under an alliance program.

Sec. 1731.05. If a qualified alliance, or an alliance that, based upon evidence of interest satisfactory to the superintendent of insurance, will be a qualified alliance within a reasonable time, submits a request for a proposal on a health benefit plan to at least three insurers and does not receive at least one reasonably responsive proposal within ninety days from the date the last such request is submitted, the superintendent, at the request of such alliance, may require that insurers offer proposals to such alliance for health benefit plans for the small employers within such alliance. Such proposals shall include such coverage and benefits for such premiums, as shall take into account the functions provided by the alliance and the economies of scale, and have other terms and provisions as are approved by the superintendent, consistent with the purposes and standards set forth in section 1731.02 of the Revised Code. ~~In making the determination as to which insurers shall be asked to~~

~~submit proposals under this section, the superintendent shall apply the standards set forth in division (G)(4)(a) of section 3924.11 of the Revised Code.~~ Any insurer that does not submit a proposal when required to do so by the superintendent hereunder, shall be deemed to be in violation of section 3901.20 of the Revised Code and shall be subject to all of the provisions of section 3901.22 of the Revised Code, including division (D)(1) of section 3901.22 of the Revised Code as if it provided that the superintendent may suspend or revoke an insurer's license to engage in the business of insurance.

Nothing in this section shall be construed as requiring an insurer to enter into an agreement with an alliance under contractual terms that are not acceptable to the insurer or to authorize the superintendent to require an insurer to enter into an agreement with an alliance under contractual terms that are not acceptable to the insurer.

This section applies beginning eighteen months after its effective date.

Sec. 1731.09. (A) Nothing contained in this chapter is intended to or shall inhibit or prevent the application of the provisions of Chapter 3924. of the Revised Code to any health benefit plan or insurer to which they would otherwise apply in the absence of this chapter, except as otherwise specified in divisions (B) and (C) of this section or unless such application conflicts with the provisions of section 1731.05 of the Revised Code.

(B) An insurer may establish one or more separate classes of business solely comprised of one or more alliances. All of the following shall apply to health plans covering small employers in each class of business established pursuant to this

division:

(1) The premium rate limitations set forth in section 3924.04 of the Revised Code apply to each class of business separate and apart from the insurer's other business;

(2) For purposes of applying sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code to a class of business, the base premium rate and midpoint rate shall be determined with respect to each class of business separate and apart from the insurer's other business.

(3) The midpoint rate for a class of business shall not exceed the midpoint rate for any other class of business or the insurer's non-alliance business by more than fifteen per cent.

(4) The insurer annually shall file with the superintendent of insurance an actuarial certification consistent with section 3924.06 of the Revised Code for each class of business demonstrating that the underwriting and rating methods of the insurer do all of the following:

(a) Comply with accepted actuarial practices;

(b) Are uniformly applied to health benefit plans covering small employers within the class of business;

(c) Comply with the applicable provisions of this section and sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code.

(5) An insurer shall apply sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code to the insurer's non-alliance business and coverage sold through alliances not established as a separate class of business.

(6) An insurer shall file with the superintendent a notification identifying any alliance or alliances to be treated

as a separate class of business at least sixty days prior to the date the rates for that class of business take effect.

(7) Any application for a certificate of authority filed pursuant to section 1731.021 of the Revised Code shall include a disclosure as to whether the alliance will be underwritten or rated as part of a separate class of business.

(C) As used in this section:

(1) "Class of business" means a group of small employers, as defined in section 3924.01 of the Revised Code, that are enrolled employers in one or more alliances.

(2) "Actuarial certification," "base premium rate," and "midpoint rate" have the same meanings as in section 3924.01 of the Revised Code.

Sec. 1739.05. (A) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program may be established only if any of the following applies:

(1) The arrangement has and maintains a minimum enrollment of three hundred employees of two or more employers.

(2) The arrangement has and maintains a minimum enrollment of three hundred self-employed individuals.

(3) The arrangement has and maintains a minimum enrollment of three hundred employees or self-employed individuals in any combination of divisions (A)(1) and (2) of this section.

(B) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program shall comply with all laws applicable to self-funded programs in this

state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 3901.491, 3902.01 to 3902.14, 3923.041, 3923.24, 3923.282, 3923.30, 3923.301, 3923.38, ~~3923.581,~~ 3923.602, 3923.63, 3923.80, 3923.84, 3923.85, 3923.851, 3923.86, 3923.87, 3923.89, 3923.90, 3924.031, 3924.032, and 3924.27 of the Revised Code.

(C) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall solicit enrollments only through agents or solicitors licensed pursuant to Chapter 3905. of the Revised Code to sell or solicit sickness and accident insurance.

(D) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall provide benefits only to individuals who are members, employees of members, or the dependents of members or employees, or are eligible for continuation of coverage under section 1751.53 or 3923.38 of the Revised Code or under Title X of the "Consolidated Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 U.S.C.A. 1161, as amended.

(E) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code is subject to, and shall comply with, sections 3903.81 to 3903.93 of the Revised Code in the same manner as other life or health insurers, as defined in section 3903.81 of the Revised Code.

Sec. 1751.01. As used in this chapter:

(A)(1) "Basic health care services" means the following services when medically necessary and, except for health care plans offered in the large group market, the essential health benefits identified in division (B)(1) of section 3902.43 of the

Revised Code:

(a) Physician's services, except when such services are supplemental under division (B) of this section;

(b) Inpatient hospital services;

(c) Outpatient medical services;

(d) Emergency health services;

(e) Urgent care services;

(f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;

(g) Diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses;

(h) Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care;

(i) Routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Revised Code.

"Basic health care services" does not include experimental procedures.

Except as provided by divisions (A)(2) and (3) of this section in connection with the offering of coverage for diagnostic and treatment services for biologically based mental illnesses, a health insuring corporation shall not offer coverage for a health care service, defined as a basic health care service by this division, unless it offers coverage for all

listed basic health care services. However, this requirement does not apply to the coverage of beneficiaries enrolled in medicare pursuant to a medicare contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage of medicaid recipients, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services.

(2) A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses without offering coverage for all other basic health care services. A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses alone or in combination with one or more supplemental health care services. However, a health insuring corporation that offers coverage for any other basic health care service shall offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services.

(3) A health insuring corporation that offers coverage for basic health care services is not required to offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services if all of the following apply:

(a) The health insuring corporation submits documentation certified by an independent member of the American academy of

actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(b) The health insuring corporation submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (A)(3)(a) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(c) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (A)(3)(a) and (b) of this section:

(i) Incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

Any determination made by the superintendent under this

division is subject to Chapter 119. of the Revised Code.

(B)(1) "Supplemental health care services" means any health care services other than basic health care services that a health insuring corporation may offer, alone or in combination with either basic health care services or other supplemental health care services, and includes:

(a) Services of facilities for intermediate or long-term care, or both;

(b) Dental care services;

(c) Vision care and optometric services including lenses and frames;

(d) Podiatric care or foot care services;

(e) Mental health services, excluding diagnostic and treatment services for biologically based mental illnesses;

(f) Short-term outpatient evaluative and crisis-intervention mental health services;

(g) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction;

(h) Home health services;

(i) Prescription drug services;

(j) Nursing services;

(k) Services of a dietitian licensed under Chapter 4759. of the Revised Code;

(l) Physical therapy services;

(m) Chiropractic services;

(n) Any other category of services approved by the superintendent of insurance.

(2) If a health insuring corporation offers prescription drug services under this division, the coverage shall include prescription drug services for the treatment of biologically based mental illnesses on the same terms and conditions as other physical diseases and disorders.

(C) "Specialty health care services" means one of the supplemental health care services listed in division (B) of this section, when provided by a health insuring corporation on an outpatient-only basis and not in combination with other supplemental health care services.

(D) "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

(E) "Closed panel plan" means a health care plan that requires enrollees to use participating providers.

(F) "Compensation" means remuneration for the provision of health care services, determined on other than a fee-for-service or discounted-fee-for-service basis.

(G) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation.

(H) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of

another state.

(I) "Emergency health services" means those health care services that must be available on a seven-days-per-week, twenty-four-hours-per-day basis in order to prevent jeopardy to an enrollee's health status that would occur if such services were not received as soon as possible, and includes, where appropriate, provisions for transportation and indemnity payments or service agreements for out-of-area coverage.

(J) "Enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation.

(K) "Evidence of coverage" means any certificate, agreement, policy, or contract issued to a subscriber that sets out the coverage and other rights to which such person is entitled under a health care plan.

(L) "Health care facility" means any facility, except a health care practitioner's office, that provides preventive, diagnostic, therapeutic, acute convalescent, rehabilitation, mental health, intellectual disability, intermediate care, or skilled nursing services.

(M) "Health care services" means basic, supplemental, and specialty health care services.

(N) "Health delivery network" means any group of providers or health care facilities, or both, or any representative thereof, that have entered into an agreement to offer health care services in a panel rather than on an individual basis.

(O) "Health insuring corporation" means a corporation, as defined in division (H) of this section, that, pursuant to a policy, contract, certificate, or agreement, pays for,

reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.

"Health insuring corporation" does not include a limited liability company formed pursuant to Chapter 1705. or 1706. of the Revised Code, an insurer licensed under Title XXXIX of the Revised Code if that insurer offers only open panel plans under which all providers and health care facilities participating receive their compensation directly from the insurer, a corporation formed by or on behalf of a political subdivision or a department, office, or institution of the state, or a public entity formed by or on behalf of a board of county commissioners, a county board of developmental disabilities, an alcohol and drug addiction services board, a board of alcohol, drug addiction, and mental health services, or a community mental health board, as those terms are used in Chapters 340. and 5126. of the Revised Code. Except as provided by division (D) of section 1751.02 of the Revised Code, or as otherwise provided by law, no board, commission, agency, or other entity under the control of a political subdivision may accept insurance risk in providing for health care services. However, nothing in this division shall be construed as prohibiting such entities from purchasing the services of a health insuring corporation or a third-party administrator licensed under Chapter 3959. of the Revised Code.

(P) "Intermediary organization" means a health delivery network or other entity that contracts with licensed health

insuring corporations or self-insured employers, or both, to provide health care services, and that enters into contractual arrangements with other entities for the provision of health care services for the purpose of fulfilling the terms of its contracts with the health insuring corporations and self-insured employers.

(Q) "Intermediate care" means residential care above the level of room and board for patients who require personal assistance and health-related services, but who do not require skilled nursing care.

(R) "Medical record" means the personal information that relates to an individual's physical or mental condition, medical history, or medical treatment.

(S)(1) "Open panel plan" means a health care plan that provides incentives for enrollees to use participating providers and that also allows enrollees to use providers that are not participating providers.

(2) No health insuring corporation may offer an open panel plan, unless the health insuring corporation is also licensed as an insurer under Title XXXIX of the Revised Code, the health insuring corporation, on June 4, 1997, holds a certificate of authority or license to operate under Chapter 1736. or 1740. of the Revised Code, or an insurer licensed under Title XXXIX of the Revised Code is responsible for the out-of-network risk as evidenced by both an evidence of coverage filing under section 1751.11 of the Revised Code and a policy and certificate filing under section 3923.02 of the Revised Code.

(T) "Osteopathic hospital" means a hospital registered under section 3701.07 of the Revised Code that advocates

osteopathic principles and the practice and perpetuation of osteopathic medicine by doing any of the following:

(1) Maintaining a department or service of osteopathic medicine or a committee on the utilization of osteopathic principles and methods, under the supervision of an osteopathic physician;

(2) Maintaining an active medical staff, the majority of which is comprised of osteopathic physicians;

(3) Maintaining a medical staff executive committee that has osteopathic physicians as a majority of its members.

(U) "Panel" means a group of providers or health care facilities that have joined together to deliver health care services through a contractual arrangement with a health insuring corporation, employer group, or other payor.

(V) "Person" has the same meaning as in section 1.59 of the Revised Code, and, unless the context otherwise requires, includes any insurance company holding a certificate of authority under Title XXXIX of the Revised Code, any subsidiary and affiliate of an insurance company, and any government agency.

(W) "Premium rate" means any set fee regularly paid by a subscriber to a health insuring corporation. A "premium rate" does not include a one-time membership fee, an annual administrative fee, or a nominal access fee, paid to a managed health care system under which the recipient of health care services remains solely responsible for any charges accessed for those services by the provider or health care facility.

(X) "Primary care provider" means a provider that is designated by a health insuring corporation to supervise,

coordinate, or provide initial care or continuing care to an enrollee, and that may be required by the health insuring corporation to initiate a referral for specialty care and to maintain supervision of the health care services rendered to the enrollee.

(Y) "Provider" means any natural person or partnership of natural persons who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services, or any professional association organized under Chapter 1785. of the Revised Code, provided that nothing in this chapter or other provisions of law shall be construed to preclude a health insuring corporation, health care practitioner, or organized health care group associated with a health insuring corporation from employing certified nurse practitioners, certified nurse anesthetists, clinical nurse specialists, certified nurse-midwives, pharmacists, dietitians, physician assistants, dental assistants, dental hygienists, optometric technicians, or other allied health personnel who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services.

(Z) "Provider sponsored organization" means a corporation, as defined in division (H) of this section, that is at least eighty per cent owned or controlled by one or more hospitals, as defined in section 3727.01 of the Revised Code, or one or more physicians licensed to practice medicine or surgery or osteopathic medicine and surgery under Chapter 4731. of the Revised Code, or any combination of such physicians and hospitals. Such control is presumed to exist if at least eighty per cent of the voting rights or governance rights of a provider sponsored organization are directly or indirectly owned, controlled, or otherwise held by any combination of the

physicians and hospitals described in this division.

(AA) "Solicitation document" means the written materials provided to prospective subscribers or enrollees, or both, and used for advertising and marketing to induce enrollment in the health care plans of a health insuring corporation.

(BB) "Subscriber" means a person who is responsible for making payments to a health insuring corporation for participation in a health care plan, or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health insuring corporation.

(CC) "Urgent care services" means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may include such health care services provided out of the health insuring corporation's approved service area pursuant to indemnity payments or service agreements.

Sec. 1751.06. Upon obtaining a certificate of authority as required under this chapter, a health insuring corporation may do all of the following:

(A) Enroll individuals and their dependents in either of the following circumstances:

(1) The individual resides or lives in the approved service area.

(2) The individual's place of employment is located in the approved service area.

(B) Contract with providers and health care facilities for

the health care services to which enrollees are entitled under the terms of the health insuring corporation's health care contracts;

(C) Contract with insurance companies authorized to do business in this state for insurance, indemnity, or reimbursement against the cost of providing emergency and nonemergency health care services for enrollees, subject to the provisions set forth in this chapter and the limitations set forth in the Revised Code;

(D) Contract with any person pursuant to the requirements of division (A)(18) of section 1751.03 of the Revised Code for managerial or administrative services, or for data processing, actuarial analysis, billing services, or any other services authorized by the superintendent of insurance. However, a health insuring corporation shall not enter into a contract for any of the services listed in this division with an insurance company that is not authorized to engage in the business of insurance in this state.

(E) Accept from governmental agencies, private agencies, corporations, associations, groups, individuals, or other persons, payments covering all or part of the costs of planning, development, construction, and the provision of health care services;

(F) Purchase, lease, construct, renovate, operate, or maintain health care facilities, and their ancillary equipment, and any property necessary in the transaction of the business of the health insuring corporation;

(G) In the employer group market, impose an affiliation period of not more than sixty days, or for late enrollees an

affiliation period of not more than ninety days, which period begins on the individual's date of enrollment and runs concurrently with any waiting period imposed under the coverage. For purposes of this division, "affiliation period" means a period of time which, under the terms of the coverage offered, must expire before the coverage becomes effective. No health care services or benefits need to be provided during an affiliation period, and no periodic prepayments can be charged for any coverage during that period.

(H) If a health insuring corporation offers coverage in the small employer group market through a network plan, limit or deny the coverage in accordance with section 3924.031 of the Revised Code;

(I) Refuse to issue coverage in the small employer group market pursuant to section 3924.032 of the Revised Code;

(J) Establish employer contribution rules or group participation rules for the offering of coverage in connection with a group contract in the small employer group market, as provided in division ~~(E)~~ (D)(1) of section 3924.03 of the Revised Code.

Nothing in this section shall be construed as prohibiting a health insuring corporation without other commercial enrollment from contracting solely with federal health care programs regulated by federal regulatory bodies.

Nothing in this section shall be construed to limit the authority of a health insuring corporation to perform those functions not otherwise prohibited by law.

Sec. 1751.12. (A)(1) No contractual periodic prepayment and no premium rate for nongroup and conversion policies for

health care services, or any amendment to them, may be used by any health insuring corporation at any time until the contractual periodic prepayment and premium rate, or amendment, have been filed with the superintendent of insurance, and shall not be effective until the expiration of sixty days after their filing unless the superintendent sooner gives approval. The filing shall be accompanied by an actuarial certification in the form prescribed by the superintendent. The superintendent shall disapprove the filing, if the superintendent determines within the sixty-day period that the contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees. The superintendent shall notify the health insuring corporation of the disapproval, and it shall thereafter be unlawful for the health insuring corporation to use the contractual periodic prepayment or premium rate, or amendment.

(2) No contractual periodic prepayment for group policies for health care services shall be used until the contractual periodic prepayment has been filed with the superintendent. The filing shall be accompanied by an actuarial certification in the form prescribed by the superintendent. The superintendent may reject a filing made under division (A)(2) of this section at any time, with at least thirty days' written notice to a health insuring corporation, if the contractual periodic prepayment is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees.

(3) At any time, the superintendent, upon at least thirty days' written notice to a health insuring corporation, may withdraw the approval given under division (A)(1) of this

section, deemed or actual, of any contractual periodic prepayment or premium rate, or amendment, based on information that either of the following applies:

(a) The contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles.

(b) The contractual periodic prepayment or premium rate, or amendment, is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees.

(4) Any disapproval under division (A)(1) of this section, any rejection of a filing made under division (A)(2) of this section, or any withdrawal of approval under division (A)(3) of this section, shall be effected by a written notice, which shall state the specific basis for the disapproval, rejection, or withdrawal and shall be issued in accordance with Chapter 119. of the Revised Code.

(B) Notwithstanding division (A) of this section, a health insuring corporation may use a contractual periodic prepayment or premium rate for policies used for the coverage of beneficiaries enrolled in medicare pursuant to a medicare risk contract or medicare cost contract, or for policies used for the coverage of beneficiaries enrolled in the federal employees health benefits program pursuant to 5 U.S.C.A. 8905, or for policies used for the coverage of medicaid recipients, or for policies used for the coverage of beneficiaries under any other federal health care program regulated by a federal regulatory body, or for policies used for the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative

services, if both of the following apply:

(1) The contractual periodic prepayment or premium rate has been approved by the United States department of health and human services, the United States office of personnel management, the department of medicaid, or the department of administrative services.

(2) The contractual periodic prepayment or premium rate is filed with the superintendent prior to use and is accompanied by documentation of approval from the United States department of health and human services, the United States office of personnel management, the department of medicaid, or the department of administrative services.

(C) The administrative expense portion of all contractual periodic prepayment or premium rate filings submitted to the superintendent for review must reflect the actual cost of administering the product. The superintendent may require that the administrative expense portion of the filings be itemized and supported.

(D)(1) Copayments, cost sharing, and deductibles must be reasonable and must not be a barrier to the necessary utilization of services by enrollees.

(2) A health insuring corporation, in order to ensure that copayments, cost sharing, and deductibles are reasonable and not a barrier to the necessary utilization of basic health care services by enrollees shall impose copayment charges, cost sharing, and deductible charges that annually do not exceed forty per cent of the total annual cost to the health insuring corporation of providing all covered health care services when applied to a standard population expected to be covered under

the filed product in question. The total annual cost of providing a health care service is the cost to the health insuring corporation of providing the health care service to its enrollees as reduced by any applicable provider discount. This requirement shall be demonstrated by an actuary who is a member of the American academy of actuaries and qualified to provide such certifications as described in the United States qualification standards promulgated by the American academy of actuaries pursuant to the code of professional conduct.

(3) For purposes of division (D) of this section, all of the following apply:

(a) Copayments imposed by health insuring corporations in connection with a high deductible health plan that is linked to a health savings account are reasonable and are not a barrier to the necessary utilization of services by enrollees.

(b) Division (D)(2) of this section does not apply to a high deductible health plan that is linked to a health savings account.

(c) Catastrophic-only plans, as described in division (D)(2) of section 3902.43 of the Revised Code and defined under the "Patient Protection and Affordable Care Act," 124 Stat. 119, 42 U.S.C. 18022 and any related regulations, are not subject to the limits prescribed in division (D) of this section, provided that such plans meet all applicable minimum federal requirements.

(E) A health insuring corporation shall not impose lifetime maximums on basic health care services. However, a health insuring corporation may establish a benefit limit for inpatient hospital services that are provided pursuant to a policy, contract, certificate, or agreement for supplemental

health care services.

(F) The superintendent may adopt rules allowing different copayment, cost sharing, and deductible amounts for plans with a medical savings account, health reimbursement arrangement, flexible spending account, or similar account;

(G) A health insuring corporation may impose higher copayment, cost sharing, and deductible charges under health plans if requested by the group contract, policy, certificate, or agreement holder, or an individual seeking coverage under an individual health plan. This shall not be construed as requiring the health insuring corporation to create customized health plans for group contract holders or individuals.

(H) As used in this section, "health savings account" and "high deductible health plan" have the same meanings as in the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 223, as amended.

Sec. 1751.16. (A) Except as provided in division (F) of this section, every group contract issued by a health insuring corporation shall provide an option for conversion to an individual contract issued on a direct-payment basis to any subscriber covered by the group contract who terminates employment or membership in the group, unless:

(1) Termination of the conversion option or contract is based upon nonpayment of premium after reasonable notice in writing has been given by the health insuring corporation to the subscriber.

(2) The subscriber is, or is eligible to be, covered for benefits at least comparable to the group contract under any of the following:

(a) Medicare;

(b) Any act of congress or law under this or any other state of the United States providing coverage at least comparable to the benefits under division (A)(2)(a) of this section;

(c) Any policy of insurance or health care plan providing coverage at least comparable to the benefits under division (A)(2)(a) of this section.

(B) ~~(1) The direct payment contract offered by the health insuring corporation pursuant to division (A) of this section shall provide the following:~~

~~(a) In the case of an individual who is not a federally eligible individual, benefits comparable to benefits in any of the individual contracts then being issued to individual subscribers by the health insuring corporation;~~

~~(b) In the case of a federally eligible individual, a basic and standard plan established under section 3924.10 of the Revised Code or plans substantially similar to the basic and standard plan in benefit design and scope of covered services. For purposes of division (B)(1)(b) of this section, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services. The contractual periodic prepayments charged for such plans may not exceed the amounts specified below:~~

~~(i) For calendar years 2010 and 2011, an amount that is two times the base rate charged any other individual of a group to which the organization is currently accepting new business and for which similar copayments and deductibles are applied;~~

~~(ii) For calendar year 2012 and every calendar year thereafter, an amount that is one and one-half times the base rate charged any other individual of a group to which the health insuring corporation is currently accepting new business and for which similar copayments and deductibles are applied, unless the superintendent of insurance determines that the amendments by this act to sections 3923.58 and 3923.581 of the Revised Code, have resulted in the market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase by more than five and one quarter percentage points during calendar year 2010. If the superintendent makes that determination, the premium limit established by division (B)(1)(b)(i) of this section shall remain in effect.~~

~~(2)~~ The direct payment contract offered pursuant to division (A) of this section may include a coordination of benefits provision as approved by the superintendent.

~~(3) For purposes of division (B) of this section:~~

~~(a) "Federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.~~

~~(b) "Base rate" means, as to any health benefit plan that is issued by a health insuring corporation, the lowest premium rate for new or existing business prescribed by the health insuring corporation for the same or similar coverage under a plan or arrangement covering any individual in a group with similar case characteristics.~~

(C) The option for conversion shall be available:

(1) Upon the death of the subscriber, to the surviving spouse with respect to such of the spouse and dependents as are

then covered by the group contract;

(2) To a child solely with respect to the child upon the child's attaining the limiting age of coverage under the group contract while covered as a dependent under the contract;

(3) Upon the divorce, dissolution, or annulment of the marriage of the subscriber, to the divorced spouse, or, in the event of annulment, to the former spouse of the subscriber.

(D) No health insuring corporation shall use age or health status as the basis for refusing to renew a converted contract.

(E) Written notice of the conversion option provided by this section shall be given to the subscriber by the health insuring corporation by mail. The notice shall be sent to the subscriber's address in the records of the employer upon receipt of notice from the employer of the event giving rise to the conversion option. If the subscriber has not received notice of the conversion privilege at least fifteen days prior to the expiration of the thirty-day conversion period, then the subscriber shall have an additional period within which to exercise the privilege. This additional period shall expire fifteen days after the subscriber receives notice, but in no event shall the period extend beyond sixty days after the expiration of the thirty-day conversion period.

(F) This section does not apply to any group contract offering only supplemental health care services or specialty health care services.

Sec. 1751.18. (A)(1) No health insuring corporation shall cancel or fail to renew the coverage of a subscriber or enrollee because of any health status-related factor in relation to the subscriber or enrollee, the subscriber's or enrollee's

requirements for health care services, or for any other reason designated under rules adopted by the superintendent of insurance.

(2) Unless otherwise required by state or federal law, no health insuring corporation, or health care facility or provider through which the health insuring corporation has made arrangements to provide health care services, shall discriminate against any individual with regard to enrollment, disenrollment, or the quality of health care services rendered, on the basis of the individual's race, color, sex, age, religion, military status as defined in section 4112.01 of the Revised Code, or status as a recipient of medicare or medicaid, or any health status-related factor in relation to the individual. However, a health insuring corporation shall not be required to accept a recipient of medicare or medical assistance, if an agreement has not been reached on appropriate payment mechanisms between the health insuring corporation and the governmental agency administering these programs. ~~Further, except for open enrollment coverage under sections 3923.58 and 3923.581 of the Revised Code and except as provided in section 1751.65 of the Revised Code, a health insuring corporation may reject an applicant for nongroup enrollment on the basis of any health status-related factor in relation to the applicant.~~

(B) A health insuring corporation may cancel or decide not to renew the coverage of an enrollee if the enrollee has performed an act or practice that constitutes fraud or intentional misrepresentation of material fact under the terms of the coverage and if the cancellation or nonrenewal is not based, either directly or indirectly, on any health status-related factor in relation to the enrollee.

(C) An enrollee may appeal any action or decision of a health insuring corporation taken pursuant to section 2742(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-42, as amended. To appeal, the enrollee may submit a written complaint to the health insuring corporation pursuant to section 1751.19 of the Revised Code. The enrollee may, within thirty days after receiving a written response from the health insuring corporation, appeal the health insuring corporation's action or decision to the superintendent.

(D) As used in this section, "health status-related factor" means any of the following:

(1) Health status;

(2) Medical condition, including both physical and mental illnesses;

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

(7) Evidence of insurability, including conditions arising out of acts of domestic violence;

(8) Disability.

Sec. 1751.58. Except as otherwise provided in section 2721 of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-21, as amended, the following conditions apply to all group health insuring corporation contracts that are sold in

connection with an employment-related group health care plan and that are not subject to section 3924.03 of the Revised Code:

(A)(1) Except as provided in section 2712(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," if a health insuring corporation offers coverage in the small or large group market in connection with a group contract, the corporation shall renew or continue in force such coverage at the option of the contract holder.

(2) A health insuring corporation may cancel or decide not to renew the coverage of any eligible employee or of a dependent of an eligible employee under the group contract in accordance with division (B) of section 1751.18 of the Revised Code.

(B) Such group contracts are subject to ~~division (A)(3) of section 3924.03 and~~ sections 3924.033 and 3924.27 of the Revised Code.

(C) Such group contracts shall provide for the special enrollment periods described in section 2701(f) of the "Health Insurance Portability and Accountability Act of 1996."

(D) At least once in every twelve-month period, a health insuring corporation shall provide to all late enrollees, as defined in section 3924.01 of the Revised Code, who are identified by the contract holder, the option to enroll in the group contract. The enrollment option shall be provided for a minimum period of thirty consecutive days. All delays of coverage imposed under the group contract, including any affiliation period, shall begin on the date the health insuring corporation receives notice of the late enrollee's application or request for coverage, and shall run concurrently with each other.

Sec. 1751.69. (A) As used in this section, "cost sharing" means the cost to an individual insured under an individual or group health insuring corporation policy, contract, or agreement according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the policy, contract, or agreement.

(B) Notwithstanding section 3901.71 of the Revised Code and subject to division (D) of this section, no individual or group health insuring corporation policy, contract, or agreement providing basic health care services or prescription drug services that is delivered, issued for delivery, or renewed in this state, if the policy, contract, or agreement provides coverage for cancer chemotherapy treatment, shall fail to comply with either of the following:

(1) The policy, contract, or agreement shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intraveneously administered or injected cancer medications.

(2) The policy, contract, or agreement shall not comply with division (B)(1) of this section by imposing an increase in cost sharing solely for orally administered, intravenously administered, or injected cancer medications.

(C) Notwithstanding any provision of this section to the contrary, an individual or group health insuring corporation policy, contract, or agreement shall be deemed to be in compliance with this section if the cost sharing imposed under such a policy, contract, or agreement for orally administered cancer treatments does not exceed one hundred dollars per prescription fill. The cost -sharing limit of one hundred

dollars per prescription fill shall apply to a high deductible plan, as defined in 26 U.S.C. 223, or a catastrophic plan, as described in division (D)(2) of section 3902.43 of the Revised Code and defined in 42 U.S.C. 18022, only after the deductible has been met.

(D) The prohibitions in division (B) of this section do not preclude an individual or group health insuring corporation policy, contract, or agreement from requiring an enrollee to obtain prior authorization before orally administered cancer medication is dispensed to the enrollee.

(E) A health insuring corporation that offers coverage for basic health care services is not required to comply with division (B) of this section if all of the following apply:

(1) The health insuring corporation submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that compliance with division (B)(1) of this section for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(2) The health insuring corporation submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (E)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(3)(a) The superintendent of insurance makes the following

determinations from the documentation and opinion submitted pursuant to divisions (E)(1) and (2) of this section:

(i) Compliance with division (B)(1) of this section for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(b) Any determination made by the superintendent under division (E)(3) of this section is subject to Chapter 119. of the Revised Code.

Sec. 3901.381. (A) Except as provided in sections 3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.

(B)(1) Unless division (B)(2) or (3) of this section applies, when a third-party payer receives from a provider or beneficiary a claim on the standard claim form prescribed in rules adopted by the superintendent of insurance under section 3902.22 of the Revised Code, the third-party payer shall pay or deny the claim not later than thirty days after receipt of the claim. When a third-party payer denies a claim, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim.

(2)(a) Unless division (B)(3) of this section applies, when a provider or beneficiary has used the standard claim form, but the third-party payer determines that reasonable supporting documentation is needed to establish the third-party payer's responsibility to make payment, the third-party payer shall pay or deny the claim not later than forty-five days after receipt of the claim. Supporting documentation includes the verification of employer and beneficiary coverage under a benefits contract, confirmation of premium payment, medical information regarding the beneficiary and the services provided, information on the responsibility of another third-party payer to make payment or confirmation of the amount of payment by another third-party payer, and information that is needed to correct material deficiencies in the claim related to a diagnosis or treatment or the provider's identification.

Not later than thirty days after receipt of the claim, the third-party payer shall notify all relevant external sources that the supporting documentation is needed. All such notices shall state, with specificity, the supporting documentation needed. If the notice was not provided in writing, the provider, beneficiary, or third-party payer may request the third-party payer to provide the notice in writing, and the third-party payer shall then provide the notice in writing. If any of the supporting documentation is under the control of the beneficiary, the beneficiary shall provide the supporting documentation to the third-party payer.

The number of days that elapse between the third-party payer's last request for supporting documentation within the thirty-day period and the third-party payer's receipt of all of the supporting documentation that was requested shall not be counted for purposes of determining the third-party payer's

compliance with the time period of not more than forty-five days for payment or denial of a claim. ~~Except as provided in division (B)(2)(b) of this section, if~~ If the third-party payer requests additional supporting documentation after receiving the initially requested documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days.

(b) ~~If a third-party payer determines, after receiving initially requested documentation, that it needs additional supporting documentation pertaining to a beneficiary's preexisting condition, which condition was unknown to the third-party payer and about which it was reasonable for the third-party payer to have no knowledge at the time of its initial request for documentation, and the third-party payer subsequently requests this additional supporting documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall not be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days.~~

~~(c)~~ When a third-party payer denies a claim, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim.

~~(d)~~ (c) If a third-party payer determines that supporting documentation related to medical information is routinely necessary to process a claim for payment of a particular health care service, the third-party payer shall establish a

description of the supporting documentation that is routinely necessary and make the description available to providers in a readily accessible format.

Third-party payers and providers shall, in connection with a claim, use the most current CPT code in effect, as published by the American medical association, the most current ICD-10 code in effect, as published by the United States department of health and human services, the most current CDT code in effect, as published by the American dental association, or the most current HCPCS code in effect, as published by the United States centers for medicare and medicaid services.

(3) When a provider or beneficiary submits a claim by using the standard claim form prescribed in the superintendent's rules, but the information provided in the claim is materially deficient, the third-party payer shall notify the provider or beneficiary not later than fifteen days after receipt of the claim. The notice shall state, with specificity, the information needed to correct all material deficiencies. Once the material deficiencies are corrected, the third-party payer shall proceed in accordance with division (B)(1) or (2) of this section.

It is not a violation of the notification time period of not more than fifteen days if a third-party payer fails to notify a provider or beneficiary of material deficiencies in the claim related to a diagnosis or treatment or the provider's identification. A third-party payer may request the information necessary to correct these deficiencies after the end of the notification time period. Requests for such information shall be made as requests for supporting documentation under division (B)(2) of this section, and payment or denial of the claim is subject to the time periods specified in that division.

(C) For purposes of this section, if a dispute exists between a provider and a third-party payer as to the day a claim form was received by the third-party payer, both of the following apply:

(1) If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer by mail and retains a record of the day the claim was mailed, there exists a rebuttable presumption that the claim was received by the third-party payer on the fifth business day after the day the claim was mailed, unless it can be proven otherwise.

(2) If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer electronically, there exists a rebuttable presumption that the claim was received by the third-party payer twenty-four hours after the claim was submitted, unless it can be proven otherwise.

(D) Nothing in this section requires a third-party payer to provide more than one notice to an employer whose premium for coverage of employees under a benefits contract has not been received by the third-party payer.

(E) Compliance with the provisions of division (B)(3) of this section shall be determined separately from compliance with the provisions of divisions (B)(1) and (2) of this section.

(F) A third-party payer shall transmit electronically any payment with respect to claims that the third-party payer receives electronically and pays to a contracted provider under this section and under sections 3901.383, 3901.384, and 3901.386 of the Revised Code. A provider shall not refuse to accept a payment made under this section or sections 3901.383, 3901.384,

and 3901.386 of the Revised Code on the basis that the payment was transmitted electronically.

Sec. 3902.40. As used in sections 3902.40 to 3902.44 of the Revised Code:

(A) "Cost sharing" means the cost to a covered person under a health benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirement.

(B) "Covered person," "health care provider" or "provider," "health care services," and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.

(C) "Health benefit plan" has the same meaning as in section 3922.01 of the Revised Code, but does not include a limited benefit plan.

(E) "Preexisting condition exclusion" means, with respect to a health benefit plan, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment in the plan, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. "Condition" does not include genetic information in the absence of a diagnosis of the condition related to such information.

Sec. 3902.41. (A) With respect to the premium rate charged by a health plan issuer for a health benefit plan offered in the individual or small group market, all of the following apply:

(1) The premium rate shall vary with respect to the health benefit plan involved only by the following:

(a) Whether the health benefit plan covers an individual or family;

(b) Rating area, as established in accordance with division (C)(1) of this section;

(c) Age, except that such rate shall not vary by more than three to one for adults;

(d) Tobacco use, except that such rate shall not vary by more than one and one-half to one.

(2) The premium rate shall not vary with respect to the health benefit plan involved by any other factor not described in division (A) of this section.

(B) With respect to family coverage under a health benefit plan, the rating variations permitted under divisions (A)(1)(c) and (d) of this section shall be applied based on the portion of the premium that is attributable to each family member covered under the health benefit plan.

(C) The superintendent of insurance shall adopt rules to do the following:

(1) Establish one or more rating areas within the state;

(2) Define the permissible age bands for rating purposes under division (A)(1)(c) of this section.

(D) A health plan issuer shall not establish lifetime or annual limits on the dollar value of benefits described in section 3902.43 of the Revised Code for any covered person.

Sec. 3902.42. (A) Every individual health benefit plan shall accept every individual in this state who applies for coverage and every group health benefit plan shall accept every

employer in this state that applies for coverage, regardless of whether any individual or employee has a preexisting condition. A health benefit plan may restrict enrollment in coverage to open or special enrollment periods under division (C) of this section.

(B) A health plan issuer shall not impose any preexisting condition exclusion on any person.

(C)(1) The superintendent of insurance shall adopt rules to ensure that each individual health benefit plan has open enrollment during a statewide open enrollment period to allow individuals, including individuals who are not covered persons, to enroll in the health benefit plan.

(2) A health plan issuer shall provide special enrollment periods for individuals who lose coverage as a result of a qualifying event under 26 U.S.C. 9801(f) or 29 U.S.C. 1163.

Sec. 3902.43. (A) For purposes of this section, "essential health benefits package" means, with respect to a health benefit plan, coverage that does all of the following:

(1) Provides for the essential health benefits defined by the superintendent of insurance under division (B) of this section;

(2) Limits cost sharing for such coverage in accordance with division (C) of this section;

(3) Provides the level of coverage described in division (D) of this section.

(B)(1) Subject to division (B)(2) of this section, the superintendent shall define the essential health benefits, except that such benefits shall include at least the following

general categories and the items and services covered within the categories:

(a) Ambulatory patient services;

(b) Emergency services;

(c) Hospitalization;

(d) Maternity and newborn care;

(e) Mental health and substance use disorder services, including behavioral health treatment;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and chronic disease management;

(j) Pediatric services, including oral and vision care.

(2)(a) The superintendent shall ensure that the scope of the essential health benefits under division (B)(1) of this section is equal to the scope of benefits provided under a typical employer plan, as determined by the superintendent. To inform this determination, the superintendent shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multi-employer plans.

(b) In defining the essential health benefits described in division (B)(1) of this section, and in revising the benefits under division (B)(3)(g) of this section, the superintendent shall submit a report to the general assembly containing a certification that such essential health benefits meet the requirements described in division (B)(2)(a) of this section.

(3) In defining the essential health benefits under division (B)(1) of this section, the superintendent shall do all of the following:

(a) Ensure that such essential health benefits reflect an appropriate balance among the categories described in division (B)(1) of this section, so that benefits are not unduly weighted toward any category;

(b) Not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(c) Take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(d) Ensure that benefits established as essential health benefits not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(e) Provide that a qualified health benefit plan shall not be treated as providing coverage for the essential health benefits described in division (B)(1) of this section unless the plan does both of the following:

(i) Provides that coverage for emergency services, as defined in section 3923.65 of the Revised Code, will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is

more restrictive than the requirements or limitations that apply to emergency services received from providers who do have such a contractual relationship with the plan;

(ii) Provides that if emergency services are provided out-of-network, the cost-sharing requirement is the same requirement that would apply if such services were provided in-network.

(f) Periodically review the essential health benefits under division (B)(1) of this section and provide a report to the general assembly and the public that contains all of the following:

(i) An assessment of whether covered persons are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) An assessment of whether the essential health benefits need to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) Information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) An assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet the requirements of division (B)(2)(a) of this section.

(g) Periodically update the essential health benefits under division (B)(1) of this section to address any gaps in access to coverage or changes in the evidence base the superintendent identifies in the review conducted under division (B)(3)(f) of this section.

(4) Nothing in this section shall be construed to prohibit a health benefit plan from providing benefits in excess of the essential health benefits described in this section.

(5) A health benefit plan shall not offer coverage for an essential health benefit identified in division (B)(1) of this section unless it offers coverage for all listed essential health benefits identified in that division.

(C)(1) A health plan issuer shall not require cost sharing in an amount greater than eight thousand one hundred fifty dollars for self-only coverage and sixteen thousand three hundred dollars for other than self-only coverage for plan years beginning in 2021.

(2) For plan years beginning in a calendar year after 2021, the cost-sharing limit shall be as follows:

(a) In the case of self-only coverage, be equal to the dollar amount in division (C)(1) of this section, increased by the product of that amount and the premium adjustment percentage under division (C)(3) of this section for the calendar year;

(b) In the case of other than self-only coverage, twice the amount in effect under division (C)(2)(a) of this section. If the amount of any increase under division (C)(2)(a) of this section is not a multiple of fifty dollars, such increase shall be rounded to the next lowest multiple of fifty dollars.

(3) The premium adjustment percentage for any calendar year shall be the percentage by which the average per capita premium for health benefit plans in this state for the preceding calendar year, as estimated by the superintendent not later than the first day of October of such preceding calendar year, exceeds such average per capita premium for 2019, as determined

by the superintendent.

(D)(1)(a) Except as provided in division (D)(2) of this section, a health benefit plan shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to at least sixty per cent of the full actuarial value of the benefits provided under the plan.

(b) Under rules issued by the superintendent, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in division (B)(1) of this section shall be provided to a standard population, without regard to the population the plan may actually provide benefits to.

(2) A health benefit plan that does not provide the level of coverage described in division (D)(1) of this section shall be considered as meeting the requirements of that division with respect to any plan year if both of the following apply:

(a) An individual is only eligible to enroll in the health benefit plan if the individual meets either of the following conditions:

(i) The individual has not attained the age of thirty before the beginning of the plan year.

(ii) The individual meets a hardship exemption as determined by the superintendent.

(b) The health benefit plan provides both of the following:

(i) Except as provided in division (D)(2)(b)(ii) of this section, the essential health benefits listed in division (B)(1) of this section, except that the health benefit plan provides no

benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under division (C) of this section for the plan year except as provided for in section 3902.44 of the Revised Code;

(ii) Coverage for at least three primary care visits.

(3) If a health plan issuer offers a health benefit plan described in division (D)(2) of this section, the issuer shall only offer the plan in the individual market.

(E) The requirements of this section do not apply to health benefit plans offered in the large group market.

(F) Nothing in this section is subject to the requirements of section 3901.71 of the Revised Code.

Sec. 3902.44. (A) A health benefit plan shall provide coverage for and shall not impose any cost-sharing requirements for the following:

(1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States preventive services task force;

(2) Immunizations that have in effect a recommendation from the advisory committee on immunization practices of the United States centers for disease control and prevention with respect to the individual involved;

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the United States health resources and services administration;

(4) With respect to women, such additional preventive care

and screenings not described in division (A)(1) of this section as provided for in comprehensive guidelines supported by the United States health resources and services administration.

(B) The superintendent shall adopt rules to implement sections 3902.40 to 3902.44 of the Revised Code.

Sec. 3922.01. As used in this chapter:

(A) "Adverse benefit determination" means a decision by a health plan issuer:

(1) To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:

(a) A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;

(b) A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a nonemployer group, to participate in a plan or health insurance coverage;

(c) A determination that a health care service is not a covered benefit;

(d) The imposition of an exclusion, including exclusions for ~~pre-existing conditions,~~ source of injury, network, or any other limitation on benefits that would otherwise be covered.

(2) Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a nonemployer group;

(3) To rescind coverage on a health benefit plan.

(B) "Ambulatory review" has the same meaning as in section 1751.77 of the Revised Code.

(C) "Authorized representative" means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

(1) A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;

(2) A person authorized by law to provide substituted consent for a covered individual;

(3) A family member or a treating health care professional, but only when the covered person is unable to provide consent.

(D) "Best evidence" means evidence based on all of the following sources, listed according to priority, as they are available:

(1) Randomized clinical trials;

(2) Cohort studies or case-control studies;

(3) Case series;

(4) Expert opinion.

(E) "Covered person" means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "Covered person" does include the covered person's authorized representative with regard to an internal appeal or

external review in accordance with division (C) of this section. "Covered person" does not include the covered person's representative in any other context.

(F) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(G) "Emergency medical condition" has the same meaning as in section 1753.28 of the Revised Code.

(H) "Emergency services" has the same meaning as in section 1753.28 of the Revised Code.

(I) "Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence, based on a systematic review of the relevant research, in making decisions about the care of individuals.

(J) "Facility" means an institution providing health care services, or a health care setting, including hospitals and other licensed inpatient centers, ambulatory, surgical, treatment, skilled nursing, residential treatment, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

(K) "Final adverse benefit determination" means an adverse benefit determination that is upheld at the completion of a health plan issuer's internal appeals process.

(L) "Health benefit plan" means a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including benefit plans marketed in the individual or group market by all associations, whether bona fide or non-bona fide. "Health benefit plan" also means a

limited benefit plan, except as follows. "Health benefit plan" does not mean any of the following types of coverage: a policy, contract, certificate, or agreement that covers only a specified accident, accident only, credit, dental, disability income, long-term care, hospital indemnity, supplemental coverage, as described in section 3923.37 of the Revised Code, specified disease, or vision care; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; a medicare supplement policy of insurance, as defined by the superintendent of insurance by rule, coverage under a plan through medicare, medicaid, or the federal employees benefit program; any coverage issued under Chapter 55 of Title 10 of the United States Code and any coverage issued as a supplement to that coverage.

(M) "Health care professional" means a physician, psychologist, nurse practitioner, or other health care practitioner licensed, accredited, or certified to perform health care services consistent with state law.

(N) "Health care provider" or "provider" means a health care professional or facility.

(O) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(P) "Health plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts,

or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health plan issuer" includes a third party administrator licensed under Chapter 3959. of the Revised Code to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.

(Q) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to all of the following:

(1) The past, present, or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family;

(2) The provision of health care services or health-related benefits to a covered person;

(3) Payment for the provision of health care services to or for a covered person.

(R) "Independent review organization" means an entity that is accredited to conduct independent external reviews of adverse benefit determinations pursuant to section 3922.13 of the Revised Code.

(S) "Medical or scientific evidence" means evidence found in any of the following sources:

(1) Peer-reviewed scientific studies published in, or

accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the national institutes of health's library of medicine for indexing in index medicus and elsevier science ltd. for indexing in excerpta medicus;

(3) Medical journals recognized by the secretary of health and human services under section 1861(t)(2) of the federal social security act;

(4) The following standard reference compendia:

(a) The American hospital formulary service drug information;

(b) Drug facts and comparisons;

(c) The American dental association accepted dental therapeutics;

(d) The United States pharmacopoeia drug information.

(5) Findings, studies or research conducted by or under the auspices of a federal government agency or nationally recognized federal research institute, including any of the following:

(a) The federal agency for health care research and quality;

(b) The national institutes of health;

(c) The national cancer institute;

(d) The national academy of sciences;

(e) The centers for medicare and medicaid services;

(f) The federal food and drug administration;

(g) Any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services.

(6) Any other medical or scientific evidence that is comparable.

(T) "Person" has the same meaning as in section 3901.19 of the Revised Code.

(U) "Protected health information" means health information related to the identity of an individual, or information that could reasonably be used to determine the identity of an individual.

(V) "Rescind" means to retroactively cancel or discontinue coverage. "Rescind" does not include canceling or discontinuing coverage that only has a prospective effect or canceling or discontinuing coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(W) "Retrospective review" means a review conducted after services have been provided to a covered person.

(X) "Superintendent" means the superintendent of insurance.

(Y) "Utilization review" has the same meaning as in

section 1751.77 of the Revised Code.

(Z) "Utilization review organization" has the same meaning as in section 1751.77 of the Revised Code.

Sec. 3923.122. (A) Every policy of group sickness and accident insurance providing hospital, surgical, or medical expense coverage for other than specific diseases or accidents only, and delivered, issued for delivery, or renewed in this state on or after January 1, 1976, shall include a provision giving each insured the option to convert to ~~the following:~~

~~(1) In the case of an individual who is not a federally eligible individual,~~ any of the individual policies of hospital, surgical, or medical expense insurance then being issued by the insurer with benefit limits not to exceed those in effect under the group policy~~;~~

~~(2) In the case of a federally eligible individual, a basic or standard plan established in accordance with section 3924.10 of the Revised Code or plans substantially similar to the basic and standard plan in benefit design and scope of covered services. For purposes of division (A)(2) of this section, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services~~.

(B) An option for conversion to an individual policy shall be available without evidence of insurability to every insured, including any person eligible under division (D) of this section, who terminates employment or membership in the group holding the policy after having been continuously insured thereunder for at least one year.

Upon receipt of the insured's written application and upon

payment of at least the first quarterly premium not later than thirty-one days after the termination of coverage under the group policy, the insurer shall issue a converted policy on a form then available for conversion. The premium shall be in accordance with the insurer's table of premium rates in effect on the later of the following dates:

(1) The effective date of the converted policy;

(2) The date of application therefor; and shall be applicable to the class of risk to which each person covered belongs and to the form and amount of the policy at the person's then attained age. ~~However, premiums charged federally eligible individuals may not exceed the amounts specified below:~~

~~(a) For calendar years 2010 and 2011, an amount that is two times the base rate charged any other individual of a group to which the insurer is currently accepting new business and for which similar copayments and deductibles are applied;~~

~~(b) For calendar year 2012 and every year thereafter, an amount that is one and one-half times the base rate charged any other individual of a group to which the insurer is currently accepting new business and for which similar copayments and deductibles are applied, unless the superintendent of insurance determines that the amendments by this act to sections 3923.58 and 3923.581 of the Revised Code, have resulted in the market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase by more than five and one-quarter percentage points during calendar year 2010. If the superintendent makes that determination, the premium limit established by division (B)(2)(a) of this section shall remain in effect.~~

At the election of the insurer, a separate converted policy may be issued to cover any dependent of an employee or member of the group.

Except as provided in division (H) of this section, any converted policy shall become effective as of the day following the date of termination of insurance under the group policy.

Any probationary or waiting period set forth in the converted policy is deemed to commence on the effective date of the insured's coverage under the group policy.

(C) No insurer shall be required to issue a converted policy to any person who is, or is eligible to be, covered for benefits at least comparable to the group policy under:

(1) Title XVIII of the Social Security Act, as amended or superseded;

(2) Any act of congress or law under this or any other state of the United States that duplicates coverage offered under division (C)(1) of this section;

(3) Any policy that duplicates coverage offered under division (C)(1) of this section;

(4) Any other group sickness and accident insurance providing hospital, surgical, or medical expense coverage for other than specific diseases or accidents only.

(D) The option for conversion shall be available:

(1) Upon the death of the employee or member, to the surviving spouse with respect to such of the spouse and dependents as are then covered by the group policy;

(2) To a child solely with respect to the child upon

attaining the limiting age of coverage under the group policy while covered as a dependent thereunder;

(3) Upon the divorce, dissolution, or annulment of the marriage of the employee or member, to the divorced spouse, or former spouse in the event of annulment, of such employee or member, or upon the legal separation of the spouse from such employee or member, to the spouse.

Persons possessing the option for conversion pursuant to this division shall be considered members for the purposes of division (H) of this section.

(E) If coverage is continued under a group policy on an employee following retirement prior to the time the employee is, or is eligible to be, covered by Title XVIII of the Social Security Act, the employee may elect, in lieu of the continuance of group insurance, to have the same conversion rights as would apply had the employee's insurance terminated at retirement by reason of termination of employment.

(F) If the insurer and the group policyholder agree upon one or more additional plans of benefits to be available for converted policies, the applicant for the converted policy may elect such a plan in lieu of a converted policy.

(G) The converted policy may contain provisions for avoiding duplication of benefits provided pursuant to divisions (C)(1), (2), (3), and (4) of this section or provided under any other insured or noninsured plan or program.

(H) If an employee or member becomes entitled to obtain a converted policy pursuant to this section, and if the employee or member has not received notice of the conversion privilege at least fifteen days prior to the expiration of the thirty-one-day

conversion period provided in division (B) of this section, then the employee or member has an additional period within which to exercise the privilege. This additional period shall expire fifteen days after the employee or member receives notice, but in no event shall the period extend beyond sixty days after the expiration of the thirty-one-day conversion period.

Written notice presented to the employee or member, or mailed by the policyholder to the last known address of the employee or member as indicated on its records, constitutes notice for the purpose of this division. In the case of a person who is eligible for a converted policy under division (D)(2) or (D)(3) of this section, a policyholder shall not be responsible for presenting or mailing such notice, unless such policyholder has actual knowledge of the person's eligibility for a converted policy.

If an additional period is allowed by an employee or member for the exercise of a conversion privilege, and if written application for the converted policy, accompanied by at least the first quarterly premium, is made after the expiration of the thirty-one-day conversion period, but within the additional period allowed an employee or member in accordance with this division, the effective date of the converted policy shall be the date of application.

(I) The converted policy may provide that any hospital, surgical, or medical expense benefits otherwise payable with respect to any person may be reduced by the amount of any such benefits payable under the group policy for the same loss after termination of coverage.

(J) The converted policy may contain:

(1) Any exclusion, reduction, or limitation contained in the group policy or customarily used in individual policies issued by the insurer;

(2) Any provision permitted in this section;

(3) Any other provision not prohibited by law.

Any provision required or permitted in this section may be made a part of any converted policy by means of an endorsement or rider.

(K) The time limit specified in a converted policy for certain defenses with respect to any person who was covered by a group policy shall commence on the effective date of such person's coverage under the group policy.

(L) No insurer shall use deterioration of health as the basis for refusing to renew a converted policy.

(M) No insurer shall use age or health status as the basis for refusing to renew a converted policy.

(N) A converted policy made available pursuant to this section shall, if delivery of the policy is to be made in this state, comply with this section. If delivery of a converted policy is to be made in another state, it may be on a form offered by the insurer in the jurisdiction where the delivery is to be made and which provides benefits substantially in compliance with those required in a policy delivered in this state.

~~(O) As used in this section:~~

~~(1) "Base rate" means, as to any health benefit plan that is issued by an insurer in the individual market, the lowest premium rate for new or existing business prescribed by the~~

~~insurer for the same or similar coverage under a plan or arrangement covering any individual of a group with similar case characteristics.~~

~~(2) "Federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.~~

Sec. 3923.57. Notwithstanding any provision of this chapter, every individual policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state is subject to the following conditions, as applicable:

(A) ~~Pre-existing conditions provisions shall not exclude or limit coverage for a period beyond twelve months following the policyholder's effective date of coverage and may only relate to conditions during the six months immediately preceding the effective date of coverage.~~

~~(B) In determining whether a pre-existing conditions provision applies to a policyholder or dependent, each policy shall credit the time the policyholder or dependent was covered under a previous policy, contract, or plan if the previous coverage was continuous to a date not more than thirty days prior to the effective date of the new coverage, exclusive of any applicable service waiting period under the policy.~~

~~(C)~~ (1) Except as otherwise provided in division ~~(C)~~ (A) of this section, an insurer that provides an individual sickness and accident insurance policy to an individual shall renew or continue in force such coverage at the option of the individual.

(2) An insurer may nonrenew or discontinue coverage of an individual in the individual market based only on one or more of the following reasons:

(a) The individual failed to pay premiums or contributions in accordance with the terms of the policy or the insurer has not received timely premium payments.

(b) The individual performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the policy.

(c) The insurer is ceasing to offer coverage in the individual market in accordance with division ~~(D)~~ (B) of this section and the applicable laws of this state.

(d) If the insurer offers coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area, or in an area for which the insurer is authorized to do business; provided, however, that such coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(e) If the coverage is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association, on the basis of which the coverage is provided, ceases; provided, however, that such coverage is terminated under division ~~(C)~~ (A)(2)(e) of this section uniformly without regard to any health status-related factor of covered individuals.

~~An insurer offering coverage to individuals solely through membership in a bona fide association shall not be deemed, by virtue of that offering, to be in the individual market for purposes of sections 3923.58 and 3923.581 of the Revised Code. Such an insurer shall not be required to accept applicants for coverage in the individual market pursuant to sections 3923.58 and 3923.581 of the Revised Code unless the insurer also offers~~

~~coverage to individuals other than through bona fide associations.~~

(3) An insurer may cancel or decide not to renew the coverage of a dependent of an individual if the dependent has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage and if the cancellation or nonrenewal is not based, either directly or indirectly, on any health status-related factor in relation to the dependent.

~~(D)~~ (B)(1) If an insurer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the insurer if the insurer does all of the following:

(a) Provides notice to each individual provided coverage of this type in such market of the discontinuation at least ninety days prior to the date of the discontinuation of the coverage;

(b) Offers to each individual provided coverage of this type in such market, the option to purchase any other individual health insurance coverage currently being offered by the insurer for individuals in that market;

(c) In exercising the option to discontinue coverage of this type and in offering the option of coverage under division ~~(D)~~ (B)(1)(b) of this section, acts uniformly without regard to any health status-related factor of covered individuals or of individuals who may become eligible for such coverage.

(2) If an insurer elects to discontinue offering all health insurance coverage in the individual market in this state, health insurance coverage may be discontinued by the

insurer only if both of the following apply:

(a) The insurer provides notice to the department of insurance and to each individual of the discontinuation at least one hundred eighty days prior to the date of the expiration of the coverage.

(b) All health insurance delivered or issued for delivery in this state in such market is discontinued and coverage under that health insurance in that market is not renewed.

(3) In the event of a discontinuation under division ~~(D)~~ (B)(2) of this section in the individual market, the insurer shall not provide for the issuance of any health insurance coverage in the market and this state during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

~~(E)~~ (C) Notwithstanding divisions ~~(C)~~ (A) and ~~(D)~~ (B) of this section, an insurer may, at the time of coverage renewal, modify the health insurance coverage for a policy form offered to individuals in the individual market if the modification is consistent with the law of this state and effective on a uniform basis among all individuals with that policy form.

~~(F)~~ (D) Such policies are subject to sections 2743 and 2747 of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-43 and 300gg-47, as amended.

~~(G)~~ (E) Sections 3924.031 and 3924.032 of the Revised Code shall apply to sickness and accident insurance policies offered in the individual market in the same manner as they apply to health benefit plans offered in the small employer market.

In accordance with 45 C.F.R. 148.102, divisions ~~(C)~~ (A) to

~~(G)~~ (E) of this section also apply to all group sickness and accident insurance policies that are not sold in connection with an employment-related group health plan and that provide more than short-term, limited duration coverage.

In applying divisions ~~(C)~~ (A) to ~~(G)~~ (E) of this section with respect to health insurance coverage that is made available by an insurer in the individual market to individuals only through one or more associations, the term "individual" includes the association of which the individual is a member.

For purposes of this section, any policy issued pursuant to division (C) of section 3923.13 of the Revised Code in connection with a public or private college or university student health insurance program is considered to be issued to a bona fide association.

As used in this section, "bona fide association" has the same meaning as in section 3924.03 of the Revised Code, and "health status-related factor" and "network plan" have the same meanings as in section 3924.031 of the Revised Code.

This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy that is less than twelve months, or other policy that offers only supplemental benefits.

Sec. 3923.571. Except as otherwise provided in section 2721 of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-21, as amended, the following conditions apply to all group policies of sickness and accident insurance that are sold

in connection with an employment-related group health plan and that are not subject to section 3924.03 of the Revised Code:

(A) Any such policy shall comply with the requirements of ~~division (A) of section 3924.03 and~~ section 3924.033 of the Revised Code.

(B)(1) Except as provided in section 2712(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," if an insurer offers coverage in the small or large group market in connection with a group policy, the insurer shall renew or continue in force such coverage at the option of the policyholder.

(2) An insurer may cancel or decide not to renew the coverage of an employee or of a dependent of an employee if the employee or dependent, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage and if the cancellation or nonrenewal is not based, either directly or indirectly, on any health status-related factor in relation to the employee or dependent.

As used in division (B)(2) of this section, "health status-related factor" has the same meaning as in section 3924.031 of the Revised Code.

(C)(1) No such policy, or insurer offering health insurance coverage in connection with such a policy, shall require any individual, as a condition of coverage or continued coverage under the policy, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual covered under the policy on the basis of any health status-related factor in relation to the individual or to

an individual covered under the policy as a dependent of the individual.

(2) Nothing in division (C)(1) of this section shall be construed to restrict the amount that an employer may be charged for coverage under a group policy, or to prevent a group policy, and an insurer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(D) Such policies shall provide for the special enrollment periods described in section 2701(f) of the "Health Insurance Portability and Accountability Act of 1996."

(E) At least once in every twelve-month period, an insurer shall provide to all late enrollees, as defined in section 3924.01 of the Revised Code, who are identified by the policyholder, the option to enroll in the group policy. The enrollment option shall be provided for a minimum period of thirty consecutive days. All delays of coverage imposed under the group policy, including any ~~pre-existing condition exclusion period or~~ service waiting period, shall begin on the date the insurer receives notice of the late enrollee's application or request for coverage, and shall run concurrently with each other.

Sec. 3923.85. (A) As used in this section, "cost sharing" means the cost to an individual insured under an individual or group policy of sickness and accident insurance or a public employee benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the policy or plan.

(B) Notwithstanding section 3901.71 of the Revised Code and subject to division (D) of this section, no individual or group policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state and no public employee benefit plan that is established or modified in this state shall fail to comply with either of the following:

(1) The policy or plan shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intraveneously administered or injected cancer medications.

(2) The policy or plan shall not comply with division (B)(1) of this section by imposing an increase in cost sharing solely for orally administered, intravenously administered, or injected cancer medications.

(C) Notwithstanding any provision of this section to the contrary, a policy or plan shall be deemed to be in compliance with this section if the cost sharing imposed under such a policy or plan for orally administered cancer treatments does not exceed one hundred dollars per prescription fill. The cost -sharing limit of one hundred dollars per prescription fill shall apply to a high deductible plan, as defined in 26 U.S.C. 223, or a catastrophic plan, described in division (D)(2) of section 3902.43 of the Revised Code and as defined in 42 U.S.C. 18022, only after the deductible has been met.

(D)(1) The prohibitions in division (B) of this section do not preclude an individual or group policy of sickness and accident insurance or public employee benefit plan from requiring an insured or plan member to obtain prior authorization before orally administered cancer medication is

dispensed to the insured or plan member.

(2) Division (B) of this section does not apply to the offer or renewal of any individual or group policy of sickness and accident insurance that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, disability income, or other policy that offers only supplemental benefits.

(E) An insurer that offers any sickness and accident insurance or any public employee benefit plan that offers coverage for basic health care services is not required to comply with division (B) of this section if all of the following apply:

(1) The insurer or plan submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that compliance with division (B)(1) of this section for a period of at least six months independently caused the insurer or plan's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(2) The insurer or plan submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (E)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the insurer or plan for the coverage of basic health care services.

(3)(a) The superintendent of insurance makes the following determinations from the documentation and opinion submitted

pursuant to divisions (E)(1) and (2) of this section:

(i) Compliance with division (B)(1) of this section for a period of at least six months independently caused the insurer or plan's costs for claims and administrative expenses for the coverage of basic health care services to increase more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the insurer or plan for the coverage of basic health care services.

(b) Any determination made by the superintendent under division (E)(3) of this section is subject to Chapter 119. of the Revised Code.

Sec. 3924.01. As used in sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code:

(A) "Actuarial certification" means a written statement prepared by a member of the American academy of actuaries, or by any other person acceptable to the superintendent of insurance, that states that, based upon the person's examination, a carrier offering health benefit plans to small employers is in compliance with sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code. "Actuarial certification" shall include a review of the appropriate records of, and the actuarial assumptions and methods used by, the carrier relative to establishing premium rates for the health benefit plans.

(B) ~~"Adjusted average market premium price" means the average market premium price as determined by the board of directors of the Ohio health reinsurance program either on the basis of the arithmetic mean of all carriers' premium rates for~~

~~an OHC plan sold to groups with similar case characteristics by all carriers selling OHC plans in the state, or on any other equitable basis determined by the board.~~

~~(C)~~ "Base premium rate" means, as to any health benefit plan that is issued by a carrier and that covers at least two but no more than fifty employees of a small employer, the lowest premium rate for a new or existing business prescribed by the carrier for the same or similar coverage under a plan or arrangement covering any small employer with similar case characteristics.

~~(D)~~ (C) "Carrier" means any sickness and accident insurance company or health insuring corporation authorized to issue health benefit plans in this state or a MEWA. A sickness and accident insurance company that owns or operates a health insuring corporation, either as a separate corporation or as a line of business, shall be considered as a separate carrier from that health insuring corporation for purposes of sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code.

~~(E)~~ (D) "Case characteristics" means, with respect to a small employer, the geographic area in which the employees work; the age and sex of the individual employees and their dependents; the appropriate industry classification as determined by the carrier; the number of employees and dependents; and such other objective criteria as may be established by the carrier. "Case characteristics" does not include claims experience, health status, or duration of coverage from the date of issue.

~~(F)~~ (E) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefits plan covering the employee.

~~(G)~~ (F) "Eligible employee" means an employee who works a normal work week of thirty or more hours. "Eligible employee" does not include a temporary or substitute employee, or a seasonal employee who works only part of the calendar year on the basis of natural or suitable times or circumstances.

~~(H)~~ (G) "Health benefit plan" means any hospital or medical expense policy or certificate or any health plan provided by a carrier, that is delivered, issued for delivery, renewed, or used in this state on or after the date occurring six months after November 24, 1995. "Health benefit plan" does not include policies covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, or vision care; coverage under a one-time-limited-duration policy that is less than twelve months; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

~~(I)~~ (H) "Late enrollee" means an eligible employee or dependent who enrolls in a small employer's health benefit plan other than during the first period in which the employee or dependent is eligible to enroll under the plan or during a special enrollment period described in section 2701(f) of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg, as amended.

~~(J)~~ (I) "MEWA" means any "multiple employer welfare arrangement" as defined in section 3 of the "Federal Employee

Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended, except for any arrangement which is fully insured as defined in division (b)(6)(D) of section 514 of that act.

~~(K)~~ (J) "Midpoint rate" means, for small employers with similar case characteristics and plan designs and as determined by the applicable carrier for a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

~~(L) "Pre-existing conditions provision" means a policy provision that excludes or limits coverage for charges or expenses incurred during a specified period following the insured's enrollment date as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the enrollment date. Genetic information shall not be treated as such a condition in the absence of a diagnosis of the condition related to such information.~~

~~For purposes of this division, "enrollment date" means, with respect to an individual covered under a group health benefit plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.~~

~~(M)~~ (K) "Service waiting period" means the period of time after employment begins before an employee is eligible to be covered for benefits under the terms of any applicable health benefit plan offered by the small employer.

~~(N)~~ (L)(1) "Small employer" means, in connection with a group health benefit plan and with respect to a calendar year

and a plan year, an employer who employed an average of at least two but no more than fifty eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

(2) For purposes of division (N)(1) of this section, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be considered one employer. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected the employer will employ on business days in the current calendar year. Any reference in division (N) of this section to an "employer" includes any predecessor of the employer. Except as otherwise specifically provided, provisions of sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code that apply to a small employer that has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this division.

~~(O) "OHC plan" means an Ohio health care plan, which is the basic, standard, or carrier reimbursement plan for small employers and individuals established in accordance with section 3924.10 of the Revised Code.~~

Sec. 3924.02. (A) An individual or group health benefit plan is subject to sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code if it provides health care benefits covering at least two but no more than fifty employees of a small employer, and if it meets either of the following conditions:

(1) Any portion of the premium or benefits is paid by a small employer, or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium.

(2) The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for purposes of section 106 or 162 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.

(B) Notwithstanding division (A) of this section, divisions ~~(D)~~ (C), ~~(E)~~ (D)(2), ~~(F)~~ (E), and ~~(G)~~ (F) of section 3924.03 of the Revised Code and section 3924.04 of the Revised Code do not apply to health benefit policies that are not sold to owners of small businesses as an employment benefit plan. Such policies shall clearly state that they are not being sold as an employment benefit plan and that the owner of the business is not responsible, either directly or indirectly, for paying the premium or benefits.

(C) Every health benefit plan offered or delivered by a carrier, other than a health insuring corporation, to a small employer is subject to sections 3923.23, 3923.231, 3923.232, 3923.233, and 3923.234 of the Revised Code and any other provision of the Revised Code that requires the reimbursement, utilization, or consideration of a specific category of a licensed or certified health care practitioner.

(D) Except as expressly provided in sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code, no health benefit plan offered to a small employer is subject to any of the following:

(1) Any law that would inhibit any carrier from contracting with providers or groups of providers with respect

to health care services or benefits;

(2) Any law that would impose any restriction on the ability to negotiate with providers regarding the level or method of reimbursing care or services provided under the health benefit plan;

(3) Any law that would require any carrier to either include a specific provider or class of provider when contracting for health care services or benefits, or to exclude any class of provider that is generally authorized by statute to provide such care.

Sec. 3924.03. Except as otherwise provided in section 2721 of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-21, as amended, health benefit plans covering small employers are subject to the following conditions, as applicable:

(A)(1) ~~Pre-existing conditions provisions shall not exclude or limit coverage for a period beyond twelve months, or eighteen months in the case of a late enrollee, following the individual's enrollment date and may only relate to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six months immediately preceding the enrollment date.~~

~~Division (A)(1) of this section is subject to the exceptions set forth in section 2701(d) of the "Health Insurance Portability and Accountability Act of 1996."~~

~~(2) The period of any such pre-existing condition exclusion shall be reduced by the aggregate of the periods of creditable coverage, if any, applicable to the employee or~~

~~dependent as of the enrollment date.~~

~~(3) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health benefit plan, if, after that period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage. Subsections (c)(2) to (4) and (e) of section 2701 of the "Health Insurance Portability and Accountability Act of 1996" apply with respect to crediting previous coverage.~~

~~(4) As used in division (A) of this section:~~

~~(a) "Creditable coverage" has the same meaning as in section 2701(c)(1) of the "Health Insurance Portability and Accountability Act of 1996."~~

~~(b) "Enrollment date" means, with respect to an individual covered under a group health benefit plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.~~

~~(B)(1)~~ Except as provided in section 2712(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," if a carrier offers coverage in the small employer market in connection with a group health benefit plan, the carrier shall renew or continue in force such coverage at the option of the plan sponsor of the plan.

(2) A carrier may cancel or decide not to renew the coverage of any eligible employee or of a dependent of an eligible employee if the employee or dependent, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage and if the cancellation or nonrenewal is

not based, either directly or indirectly, on any health status-related factor in relation to the employee or dependent.

As used in division ~~(B)~~ (A)(2) of this section, "health status-related factor" has the same meaning as in section 3924.031 of the Revised Code.

~~(C)~~ (B) A carrier shall not exclude any eligible employee or dependent, who would otherwise be covered under a health benefit plan, on the basis of any actual or expected health condition of the employee or dependent.

If, prior to November 24, 1995, a carrier excluded an eligible employee or dependent, other than a late enrollee, on the basis of an actual or expected health condition, the carrier shall, upon the initial renewal of the coverage on or after that date, extend coverage to the employee or dependent if all other eligibility requirements are met.

~~(D)~~ (C) No health benefit plan issued by a carrier shall limit or exclude, by use of a rider or amendment applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident~~, except for pre-existing conditions as permitted under division (A) of this section~~. If a health benefit plan that is delivered or issued for delivery prior to April 14, 1993, contains such limitations or exclusions, by use of a rider or amendment applicable to a specific individual, the plan shall eliminate the use of such riders or amendments within eighteen months after April 14, 1993.

~~(E)~~ (D)(1) Except as provided in sections 3924.031 and 3924.032 of the Revised Code, and subject to such rules as may be adopted by the superintendent of insurance in accordance with

Chapter 119. of the Revised Code, a carrier shall offer and make available every health benefit plan that it is actively marketing to every small employer that applies to the carrier for such coverage.

Division ~~(E)~~ (D)(1) of this section does not apply to a health benefit plan that a carrier makes available in the small employer market only through one or more bona fide associations.

Division ~~(E)~~ (D)(1) of this section shall not be construed to preclude a carrier from establishing employer contribution rules or group participation rules for the offering of coverage in connection with a group health benefit plan in the small employer market, as allowed under the law of this state. As used in division ~~(E)~~ (D)(1) of this section, "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of employees and dependents and "group participation rule" means a requirement relating to the minimum number of employees or dependents that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(2) Each health benefit plan, at the time of initial group enrollment, shall make coverage available to all the eligible employees of a small employer without a service waiting period. The decision of whether to impose a service waiting period shall be made by the small employer. Such waiting periods shall not be greater than ninety days.

(3) Each health benefit plan shall provide for the special enrollment periods described in section 2701(f) of the "Health Insurance Portability and Accountability Act of 1996."

(4) At least once in every twelve-month period, a carrier shall provide to all late enrollees who are identified by the small employer, the option to enroll in the health benefit plan. The enrollment option shall be provided for a minimum period of thirty consecutive days. All delays of coverage imposed under the health benefit plan, including any ~~pre-existing condition exclusion period,~~ affiliation period~~,~~ or service waiting period, shall begin on the date the carrier receives notice of the late enrollee's application or request for coverage, and shall run concurrently with each other.

~~(F)~~ (E) The benefit structure of any health benefit plan may, at the time of coverage renewal, be changed by the carrier to make it consistent with the benefit structure contained in health benefit plans being marketed to new small employer groups. If the health benefit plan is available in the small employer market other than only through one or more bona fide associations, the modification must be consistent with the law of this state and effective on a uniform basis among small employer group plans.

~~(G)~~ (F) A carrier may obtain any facts and information necessary to apply this section, or supply those facts and information to any other third-party payer, without the consent of the beneficiary. Each person claiming benefits under a health benefit plan shall provide any facts and information necessary to apply this section.

For purposes of this section, "bona fide association" means an association that has been actively in existence for at least five years; has been formed and maintained in good faith for purposes other than obtaining insurance; does not condition membership in the association on any health status-related

factor, as defined in section 3924.031 of the Revised Code, relating to an individual, including an employee or dependent; makes health insurance coverage offered through the association available to all members regardless of any health status-related factor, as defined in section 3924.031 of the Revised Code, relating to such members or to individuals eligible for coverage through a member; does not make health insurance coverage offered through the association available other than in connection with a member of the association; and meets any other requirement imposed by the superintendent. To maintain its status as a "bona fide association," each association shall annually certify to the superintendent that it meets the requirements of this paragraph.

Sec. 3924.033. (A) Each carrier, in connection with the offering of a health benefit plan to a small employer, shall disclose to the employer, as part of its solicitation and sales materials, the following information:

(1) The provisions of the plan concerning the carrier's right to change premium rates and the factors that may affect changes in premium rates;

(2) The provisions of the plan relating to renewability of coverage;

(3) ~~The provisions of the plan relating to any pre-existing condition exclusion;~~

~~(4)~~ The benefits and premiums available under all health benefit plans for which the employer is qualified.

(B) The information described in division (A) of this section shall be provided in a manner determined to be understandable by the average small employer, and in a manner

sufficient to reasonably inform a small employer regarding the employer's rights and obligations under the health benefit plan.

(C) Nothing in this section requires a carrier to disclose any information that is by law proprietary and trade secret information.

Sec. 3924.06. (A) Compliance with the underwriting and rating requirements contained in sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code shall be demonstrated through actuarial certification. Carriers offering health benefit plans to small employers shall file annually with the superintendent of insurance an actuarial certification stating that the underwriting and rating methods of the carrier do all of the following:

(1) Comply with accepted actuarial practices;

(2) Are uniformly applied to health benefit plans covering small employers;

(3) Comply with the applicable provisions of sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code.

(B) If a carrier has established a separate class of business for one or more small employer health care alliances in accordance with section 1731.09 of the Revised Code, this section shall apply in accordance with section 1731.09 of the Revised Code.

(C) Carriers offering health benefit plans to small employers shall file premium rates with the superintendent in accordance with section 3923.02 of the Revised Code with respect to the carrier's sickness and accident insurance policies sold to small employers and in accordance with section 1751.12 of the Revised Code with respect to the carrier's health insuring

corporation policies sold to small employers.

Sec. 3924.51. (A) As used in this section:

(1) "Child" means, in connection with any adoption or placement for adoption of the child, an individual who has not attained age eighteen as of the date of the adoption or placement for adoption.

(2) "Health insurer" has the same meaning as in section 3924.41 of the Revised Code.

(3) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of that legal obligation.

(B) If an individual or group health plan of a health insurer makes coverage available for dependent children of participants or beneficiaries, the plan shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, irrespective of whether the adoption has become final.

~~(C) A health plan described in division (B) of this section shall not restrict coverage under the plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a pre-existing condition of the child at the time that the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage~~

~~under the plan.~~

Sec. 3924.73. (A) As used in this section:

(1) "Health care insurer" means any person legally engaged in the business of providing sickness and accident insurance contracts in this state, a health insuring corporation organized under Chapter 1751. of the Revised Code, or any legal entity that is self-insured and provides health care benefits to its employees or members.

(2) "Small employer" has the same meaning as in section 3924.01 of the Revised Code.

(B)(1) Subject to division (B)(2) of this section, nothing in sections 3924.61 to 3924.74 of the Revised Code shall be construed to limit the rights, privileges, or protections of employees or small employers under sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code.

(2) If any account holder enrolls or applies to enroll in a policy or contract offered by a health care insurer providing sickness and accident coverage that is more comprehensive than, and has a deductible amount that is less than, the coverage and deductible amount of the policy under which the account holder currently is enrolled, the health care insurer to which the account holder applies may subject the account holder to the same medical review, waiting periods, and underwriting requirements to which the health care insurer generally subjects other enrollees or applicants, unless the account holder enrolls or applies to enroll during a designated period of open enrollment.

Section 2. That existing sections 1731.03, 1731.04, 1731.05, 1731.09, 1739.05, 1751.01, 1751.06, 1751.12, 1751.16,

1751.18, 1751.58, 1751.69, 3901.381, 3922.01, 3923.122, 3923.57, 3923.571, 3923.85, 3924.01, 3924.02, 3924.03, 3924.033, 3924.06, 3924.51, and 3924.73 of the Revised Code are hereby repealed.

Section 3. That sections 1751.15, 3923.58, 3923.581, 3923.582, 3923.59, 3924.07, 3924.08, 3924.09, 3924.10, 3924.11, 3924.111, 3924.12, 3924.13, and 3924.14 of the Revised Code are hereby repealed.

Section 4. The amendments to sections 1751.16 and 3923.122 of the Revised Code in Section 1 of this act, which were suspended by Section 3 of Sub. S.B. 9 of the 130th General Assembly and which suspension was extended by Section 610.53 of Am. Sub. H.B. 49 of the 132nd General Assembly, do not affect the suspension of those sections. If either or both sections 1751.16 and 3923.122 of the Revised Code become operational, they will be so in either their form as amended by this act or as they are later amended.

Section 5. This act applies to health benefit plans, as defined in section 3922.01 of the Revised Code, delivered, issued for delivery, modified, or renewed on or after the effective date of this section.

Section 6. Section 1751.12 of the Revised Code is presented in this act as a composite of the section as amended by both H.B. 59 and H.B. 3 of the 130th General Assembly. The General Assembly, applying the principle stated in division (B) of section 1.52 of the Revised Code that amendments are to be harmonized if reasonably capable of simultaneous operation, finds that the composite is the resulting version of the section in effect prior to the effective date of the section as presented in this act.