

As Introduced

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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, Sobbecki, 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, 1
1731.09, 1739.05, 1751.01, 1751.06, 1751.12, 2
1751.16, 1751.18, 1751.58, 1751.69, 3901.381, 3
3922.01, 3923.122, 3923.57, 3923.571, 3923.85, 4
3924.01, 3924.02, 3924.03, 3924.033, 3924.06, 5
3924.51, and 3924.73; to enact sections 3902.40, 6
3902.41, 3902.42, 3902.43, and 3902.44; and to 7
repeal sections 1751.15, 3923.58, 3923.581, 8
3923.582, 3923.59, 3924.07, 3924.08, 3924.09, 9
3924.10, 3924.11, 3924.111, 3924.12, 3924.13, 10
and 3924.14 of the Revised Code regarding health 11
insurance premiums and benefits. 12

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

Section 1. That sections 1731.03, 1731.04, 1731.05, 13
1731.09, 1739.05, 1751.01, 1751.06, 1751.12, 1751.16, 1751.18, 14
1751.58, 1751.69, 3901.381, 3922.01, 3923.122, 3923.57, 15
3923.571, 3923.85, 3924.01, 3924.02, 3924.03, 3924.033, 3924.06, 16

3924.51, and 3924.73 be amended and sections 3902.40, 3902.41, 17
3902.42, 3902.43, and 3902.44 of the Revised Code be enacted to 18
read as follows: 19

Sec. 1731.03. (A) A small employer health care alliance 20
may do any of the following: 21

(1) Negotiate and enter into agreements with one or more 22
insurers for the insurers to offer and provide one or more 23
health benefit plans to small employers for their employees and 24
retirees, and the dependents and members of the families of such 25
employees and retirees, which coverage may be made available to 26
enrolled small employers without regard to industrial, rating, 27
or other classifications among the enrolled small employers 28
under an alliance program, except as otherwise provided under 29
the alliance program, and for the alliance to perform, or 30
contract with others for the performance of, functions under or 31
with respect to the alliance program; 32

(2) Contract with another alliance for the inclusion of 33
the small employer members of one in the alliance program of the 34
other; 35

(3) Provide or cause to be provided to small employers 36
information concerning the availability, coverage, benefits, 37
premiums, and other information regarding an alliance program 38
and promote the alliance program; 39

(4) Provide, or contract with others to provide, 40
enrollment, record keeping, information, premium billing, 41
collection and transmittal, and other services under an alliance 42
program; 43

(5) Receive reports and information from the insurer and 44
negotiate and enter into agreements with respect to inspection 45

and audit of the books and records of the insurer; 46

(6) Provide services to and on behalf of an alliance 47
program sponsored by another alliance, including entering into 48
an agreement described in division (B) of section 1731.01 of the 49
Revised Code on behalf of the other alliance; 50

(7) If it is a nonprofit corporation created under Chapter 51
1702. of the Revised Code, exercise all powers and authority of 52
such corporations under the laws of the state, or, if otherwise 53
constituted, exercise such powers and authority as apply to it 54
under the applicable laws, and its articles, regulations, 55
constitution, bylaws, or other relevant governing instruments. 56

(B) A small employer health care alliance is not and shall 57
not be regarded for any purpose of law as an insurer, an offeror 58
or seller of any insurance, a partner of or joint venturer with 59
any insurer, an agent of, or solicitor for an agent of, or 60
representative of, an insurer or an offeror or seller of any 61
insurance, an adjuster of claims, or a third-party 62
administrator, and will not be liable under or by reason of any 63
insurance coverage or other health benefit plan provided or not 64
provided by any insurer or by reason of any conditions or 65
restrictions on eligibility or benefits under an alliance 66
program or any insurance or other health benefit plan provided 67
under an alliance program or by reason of the application of 68
those conditions or restrictions. 69

(C) The promotion of an alliance program by an alliance or 70
by an insurer is not and shall not be regarded for any purpose 71
of law as the offer, solicitation, or sale of insurance. 72

(D) (1) No alliance shall adopt, impose, or enforce medical 73
underwriting rules or underwriting rules requiring a small 74

employer to have more than a minimum number of employees for the 75
purpose of determining whether an alliance member is eligible to 76
purchase a policy, contract, or plan of health insurance or 77
health benefits from any insurer in connection with the alliance 78
health care program. 79

(2) No alliance shall reject any applicant for membership 80
in the alliance based on the health status of the applicant's 81
employees or their dependents or because the small employer does 82
not have more than a minimum number of employees. 83

(3) A violation of division (D)(1) or (2) of this section 84
is deemed to be an unfair and deceptive act or practice in the 85
business of insurance under sections 3901.19 to 3901.26 of the 86
Revised Code. 87

(4) Nothing in division (D)(1) or (2) of this section 88
shall be construed as inhibiting or preventing an alliance from 89
adopting, imposing, and enforcing rules, conditions, 90
limitations, or restrictions that are based on factors other 91
than the health status of employees or their dependents or the 92
size of the small employer for the purpose of determining 93
whether a small employer is eligible to become a member of the 94
alliance. Division (D)(1) of this section does not apply to an 95
insurer that sells health coverage to an alliance member under 96
an alliance health care program. 97

(E) Except as otherwise specified in section 1731.09 of 98
the Revised Code, health benefit plans offered and sold to 99
alliance members that are small employers as defined in section 100
3924.01 of the Revised Code are subject to sections 3924.01 to 101
~~3924.14~~ 3924.06 of the Revised Code. 102

(F) Any person who represents an alliance in bargaining or 103

negotiating a health benefit plan with an insurer shall disclose 104
to the governing board of the alliance any direct or indirect 105
financial relationship the person has or had during the past two 106
years with the insurer. 107

Sec. 1731.04. (A) An agreement between an alliance and an 108
insurer referred to in division (B) of section 1731.01 of the 109
Revised Code shall contain at least the following: 110

(1) A provision requiring the insurer to offer and sell to 111
small employers served or to be served by an alliance one or 112
more health benefit plan options for coverage of their eligible 113
employees and the eligible dependents and members of the 114
families of the eligible employees and, if applicable, such 115
members' eligible retirees and the eligible dependents and 116
members of the families of the retirees, subject to such 117
conditions and restrictions as may be set forth or incorporated 118
into the agreement; 119

(2) A brief description of each type of health benefit 120
plan option that is to be so offered and the conditions for the 121
modification, continuation, and termination of the coverage and 122
benefits thereunder; 123

(3) A statement of the eligibility requirements that an 124
employee or retiree must meet in order for the employee or 125
retiree to be eligible to obtain and retain coverage under any 126
health benefit plan option so offered and, if one of such 127
requirements is that an employee must regularly work for a 128
minimum number of hours per week, a statement of such minimum 129
number of hours, which minimum shall not exceed twenty-five 130
hours per week; 131

~~(4) A description of any pre-existing condition and~~ 132

waiting period rules;	133
(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;	134 135 136
(6) — <u>(5)</u> 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;	137 138 139 140
(7) — <u>(6)</u> 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.	141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157
(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:	158 159 160 161

(1) The application and enrollment process for a small employer and related provisions pertaining to historical experience, health statements, and underwriting standards;	162 163 164
(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;	165 166 167 168 169 170
(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;	171 172 173 174
(4) The application of any risk-related pooling or grouping programs and related premiums, conditions, reviews, and alternatives offered by the insurer;	175 176 177
(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;	178 179 180 181
(6) Relevant experience periods, enrollment periods, and contract periods;	182 183
(7) Effective dates for coverage of eligible participants;	184
(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;	185 186 187 188 189

(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;	190 191 192 193 194 195
(10) Any responsibilities of the alliance for billing, collection, and transmittal of premiums;	196 197
(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;	198 199 200 201 202 203 204 205
(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;	206 207 208 209
(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;	210 211 212
(14) Indemnification from claims and liability by reason of acts or omissions of others;	213 214
(15) Ownership, use, availability, and maintenance of confidentiality of data and records relating to the alliance program;	215 216 217
(16) Utilization reports to be provided to the alliance by	218

the insurer;	219
(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.	220 221 222 223 224
(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.	225 226 227 228 229 230 231 232
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	233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248

~~submit proposals under this section, the superintendent shall~~ 249
~~apply the standards set forth in division (G) (4) (a) of section~~ 250
~~3924.11 of the Revised Code.~~ Any insurer that does not submit a 251
proposal when required to do so by the superintendent hereunder, 252
shall be deemed to be in violation of section 3901.20 of the 253
Revised Code and shall be subject to all of the provisions of 254
section 3901.22 of the Revised Code, including division (D) (1) 255
of section 3901.22 of the Revised Code as if it provided that 256
the superintendent may suspend or revoke an insurer's license to 257
engage in the business of insurance. 258

Nothing in this section shall be construed as requiring an 259
insurer to enter into an agreement with an alliance under 260
contractual terms that are not acceptable to the insurer or to 261
authorize the superintendent to require an insurer to enter into 262
an agreement with an alliance under contractual terms that are 263
not acceptable to the insurer. 264

This section applies beginning eighteen months after its 265
effective date. 266

Sec. 1731.09. (A) Nothing contained in this chapter is 267
intended to or shall inhibit or prevent the application of the 268
provisions of Chapter 3924. of the Revised Code to any health 269
benefit plan or insurer to which they would otherwise apply in 270
the absence of this chapter, except as otherwise specified in 271
divisions (B) and (C) of this section or unless such application 272
conflicts with the provisions of section 1731.05 of the Revised 273
Code. 274

(B) An insurer may establish one or more separate classes 275
of business solely comprised of one or more alliances. All of 276
the following shall apply to health plans covering small 277
employers in each class of business established pursuant to this 278

division:	279
(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;	280 281 282
(2) For purposes of applying sections 3924.01 to 3924.14 <u>3924.06</u> 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.	283 284 285 286 287
(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.	288 289 290
(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:	291 292 293 294 295
(a) Comply with accepted actuarial practices;	296
(b) Are uniformly applied to health benefit plans covering small employers within the class of business;	297 298
(c) Comply with the applicable provisions of this section and sections 3924.01 to 3924.14 <u>3924.06</u> of the Revised Code.	299 300
(5) An insurer shall apply sections 3924.01 to 3924.14 <u>3924.06</u> of the Revised Code to the insurer's non-alliance business and coverage sold through alliances not established as a separate class of business.	301 302 303 304
(6) An insurer shall file with the superintendent a notification identifying any alliance or alliances to be treated	305 306

as a separate class of business at least sixty days prior to the 307
date the rates for that class of business take effect. 308

(7) Any application for a certificate of authority filed 309
pursuant to section 1731.021 of the Revised Code shall include a 310
disclosure as to whether the alliance will be underwritten or 311
rated as part of a separate class of business. 312

(C) As used in this section: 313

(1) "Class of business" means a group of small employers, 314
as defined in section 3924.01 of the Revised Code, that are 315
enrolled employers in one or more alliances. 316

(2) "Actuarial certification," "base premium rate," and 317
"midpoint rate" have the same meanings as in section 3924.01 of 318
the Revised Code. 319

Sec. 1739.05. (A) A multiple employer welfare arrangement 320
that is created pursuant to sections 1739.01 to 1739.22 of the 321
Revised Code and that operates a group self-insurance program 322
may be established only if any of the following applies: 323

(1) The arrangement has and maintains a minimum enrollment 324
of three hundred employees of two or more employers. 325

(2) The arrangement has and maintains a minimum enrollment 326
of three hundred self-employed individuals. 327

(3) The arrangement has and maintains a minimum enrollment 328
of three hundred employees or self-employed individuals in any 329
combination of divisions (A) (1) and (2) of this section. 330

(B) A multiple employer welfare arrangement that is 331
created pursuant to sections 1739.01 to 1739.22 of the Revised 332
Code and that operates a group self-insurance program shall 333
comply with all laws applicable to self-funded programs in this 334

state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 335
3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 336
3901.491, 3902.01 to 3902.14, 3923.041, 3923.24, 3923.282, 337
3923.30, 3923.301, 3923.38, ~~3923.581~~, 3923.602, 3923.63, 338
3923.80, 3923.84, 3923.85, 3923.851, 3923.86, 3923.87, 3923.89, 339
3923.90, 3924.031, 3924.032, and 3924.27 of the Revised Code. 340

(C) A multiple employer welfare arrangement created 341
pursuant to sections 1739.01 to 1739.22 of the Revised Code 342
shall solicit enrollments only through agents or solicitors 343
licensed pursuant to Chapter 3905. of the Revised Code to sell 344
or solicit sickness and accident insurance. 345

(D) A multiple employer welfare arrangement created 346
pursuant to sections 1739.01 to 1739.22 of the Revised Code 347
shall provide benefits only to individuals who are members, 348
employees of members, or the dependents of members or employees, 349
or are eligible for continuation of coverage under section 350
1751.53 or 3923.38 of the Revised Code or under Title X of the 351
"Consolidated Omnibus Budget Reconciliation Act of 1985," 100 352
Stat. 227, 29 U.S.C.A. 1161, as amended. 353

(E) A multiple employer welfare arrangement created 354
pursuant to sections 1739.01 to 1739.22 of the Revised Code is 355
subject to, and shall comply with, sections 3903.81 to 3903.93 356
of the Revised Code in the same manner as other life or health 357
insurers, as defined in section 3903.81 of the Revised Code. 358

Sec. 1751.01. As used in this chapter: 359

(A) (1) "Basic health care services" means the following 360
services when medically necessary and, except for health care 361
plans offered in the large group market, the essential health 362
benefits identified in division (B) (1) of section 3902.43 of the 363

<u>Revised Code:</u>	364
(a) Physician's services, except when such services are supplemental under division (B) of this section;	365 366
(b) Inpatient hospital services;	367
(c) Outpatient medical services;	368
(d) Emergency health services;	369
(e) Urgent care services;	370
(f) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;	371 372
(g) Diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses;	373 374 375
(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;	376 377 378 379
(i) Routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to section 3923.80 of the Revised Code.	380 381 382
"Basic health care services" does not include experimental procedures.	383 384
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	385 386 387 388 389 390

listed basic health care services. However, this requirement 391
does not apply to the coverage of beneficiaries enrolled in 392
medicare pursuant to a medicare contract, or to the coverage of 393
beneficiaries enrolled in the federal employee health benefits 394
program pursuant to 5 U.S.C.A. 8905, or to the coverage of 395
medicaid recipients, or to the coverage of beneficiaries under 396
any federal health care program regulated by a federal 397
regulatory body, or to the coverage of beneficiaries under any 398
contract covering officers or employees of the state that has 399
been entered into by the department of administrative services. 400

(2) A health insuring corporation may offer coverage for 401
diagnostic and treatment services for biologically based mental 402
illnesses without offering coverage for all other basic health 403
care services. A health insuring corporation may offer coverage 404
for diagnostic and treatment services for biologically based 405
mental illnesses alone or in combination with one or more 406
supplemental health care services. However, a health insuring 407
corporation that offers coverage for any other basic health care 408
service shall offer coverage for diagnostic and treatment 409
services for biologically based mental illnesses in combination 410
with the offer of coverage for all other listed basic health 411
care services. 412

(3) A health insuring corporation that offers coverage for 413
basic health care services is not required to offer coverage for 414
diagnostic and treatment services for biologically based mental 415
illnesses in combination with the offer of coverage for all 416
other listed basic health care services if all of the following 417
apply: 418

(a) The health insuring corporation submits documentation 419
certified by an independent member of the American academy of 420

actuaries to the superintendent of insurance showing that 421
incurred claims for diagnostic and treatment services for 422
biologically based mental illnesses for a period of at least six 423
months independently caused the health insuring corporation's 424
costs for claims and administrative expenses for the coverage of 425
basic health care services to increase by more than one per cent 426
per year. 427

(b) The health insuring corporation submits a signed 428
letter from an independent member of the American academy of 429
actuaries to the superintendent of insurance opining that the 430
increase in costs described in division (A) (3) (a) of this 431
section could reasonably justify an increase of more than one 432
per cent in the annual premiums or rates charged by the health 433
insuring corporation for the coverage of basic health care 434
services. 435

(c) The superintendent of insurance makes the following 436
determinations from the documentation and opinion submitted 437
pursuant to divisions (A) (3) (a) and (b) of this section: 438

(i) Incurred claims for diagnostic and treatment services 439
for biologically based mental illnesses for a period of at least 440
six months independently caused the health insuring 441
corporation's costs for claims and administrative expenses for 442
the coverage of basic health care services to increase by more 443
than one per cent per year. 444

(ii) The increase in costs reasonably justifies an 445
increase of more than one per cent in the annual premiums or 446
rates charged by the health insuring corporation for the 447
coverage of basic health care services. 448

Any determination made by the superintendent under this 449

division is subject to Chapter 119. of the Revised Code.	450
(B) (1) "Supplemental health care services" means any	451
health care services other than basic health care services that	452
a health insuring corporation may offer, alone or in combination	453
with either basic health care services or other supplemental	454
health care services, and includes:	455
(a) Services of facilities for intermediate or long-term	456
care, or both;	457
(b) Dental care services;	458
(c) Vision care and optometric services including lenses	459
and frames;	460
(d) Podiatric care or foot care services;	461
(e) Mental health services, excluding diagnostic and	462
treatment services for biologically based mental illnesses;	463
(f) Short-term outpatient evaluative and crisis-	464
intervention mental health services;	465
(g) Medical or psychological treatment and referral	466
services for alcohol and drug abuse or addiction;	467
(h) Home health services;	468
(i) Prescription drug services;	469
(j) Nursing services;	470
(k) Services of a dietitian licensed under Chapter 4759.	471
of the Revised Code;	472
(l) Physical therapy services;	473
(m) Chiropractic services;	474

(n) Any other category of services approved by the superintendent of insurance.	475 476
(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.	477 478 479 480 481
(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.	482 483 484 485 486
(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.	487 488 489 490 491 492 493
(E) "Closed panel plan" means a health care plan that requires enrollees to use participating providers.	494 495
(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.	496 497 498
(G) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation.	499 500 501
(H) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of	502 503

another state. 504

(I) "Emergency health services" means those health care 505
services that must be available on a seven-days-per-week, 506
twenty-four-hours-per-day basis in order to prevent jeopardy to 507
an enrollee's health status that would occur if such services 508
were not received as soon as possible, and includes, where 509
appropriate, provisions for transportation and indemnity 510
payments or service agreements for out-of-area coverage. 511

(J) "Enrollee" means any natural person who is entitled to 512
receive health care benefits provided by a health insuring 513
corporation. 514

(K) "Evidence of coverage" means any certificate, 515
agreement, policy, or contract issued to a subscriber that sets 516
out the coverage and other rights to which such person is 517
entitled under a health care plan. 518

(L) "Health care facility" means any facility, except a 519
health care practitioner's office, that provides preventive, 520
diagnostic, therapeutic, acute convalescent, rehabilitation, 521
mental health, intellectual disability, intermediate care, or 522
skilled nursing services. 523

(M) "Health care services" means basic, supplemental, and 524
specialty health care services. 525

(N) "Health delivery network" means any group of providers 526
or health care facilities, or both, or any representative 527
thereof, that have entered into an agreement to offer health 528
care services in a panel rather than on an individual basis. 529

(O) "Health insuring corporation" means a corporation, as 530
defined in division (H) of this section, that, pursuant to a 531
policy, contract, certificate, or agreement, pays for, 532

reimburses, or provides, delivers, arranges for, or otherwise 533
makes available, basic health care services, supplemental health 534
care services, or specialty health care services, or a 535
combination of basic health care services and either 536
supplemental health care services or specialty health care 537
services, through either an open panel plan or a closed panel 538
plan. 539

"Health insuring corporation" does not include a limited 540
liability company formed pursuant to Chapter 1705. or 1706. of 541
the Revised Code, an insurer licensed under Title XXXIX of the 542
Revised Code if that insurer offers only open panel plans under 543
which all providers and health care facilities participating 544
receive their compensation directly from the insurer, a 545
corporation formed by or on behalf of a political subdivision or 546
a department, office, or institution of the state, or a public 547
entity formed by or on behalf of a board of county 548
commissioners, a county board of developmental disabilities, an 549
alcohol and drug addiction services board, a board of alcohol, 550
drug addiction, and mental health services, or a community 551
mental health board, as those terms are used in Chapters 340. 552
and 5126. of the Revised Code. Except as provided by division 553
(D) of section 1751.02 of the Revised Code, or as otherwise 554
provided by law, no board, commission, agency, or other entity 555
under the control of a political subdivision may accept 556
insurance risk in providing for health care services. However, 557
nothing in this division shall be construed as prohibiting such 558
entities from purchasing the services of a health insuring 559
corporation or a third-party administrator licensed under 560
Chapter 3959. of the Revised Code. 561

(P) "Intermediary organization" means a health delivery 562
network or other entity that contracts with licensed health 563

insuring corporations or self-insured employers, or both, to 564
provide health care services, and that enters into contractual 565
arrangements with other entities for the provision of health 566
care services for the purpose of fulfilling the terms of its 567
contracts with the health insuring corporations and self-insured 568
employers. 569

(Q) "Intermediate care" means residential care above the 570
level of room and board for patients who require personal 571
assistance and health-related services, but who do not require 572
skilled nursing care. 573

(R) "Medical record" means the personal information that 574
relates to an individual's physical or mental condition, medical 575
history, or medical treatment. 576

(S) (1) "Open panel plan" means a health care plan that 577
provides incentives for enrollees to use participating providers 578
and that also allows enrollees to use providers that are not 579
participating providers. 580

(2) No health insuring corporation may offer an open panel 581
plan, unless the health insuring corporation is also licensed as 582
an insurer under Title XXXIX of the Revised Code, the health 583
insuring corporation, on June 4, 1997, holds a certificate of 584
authority or license to operate under Chapter 1736. or 1740. of 585
the Revised Code, or an insurer licensed under Title XXXIX of 586
the Revised Code is responsible for the out-of-network risk as 587
evidenced by both an evidence of coverage filing under section 588
1751.11 of the Revised Code and a policy and certificate filing 589
under section 3923.02 of the Revised Code. 590

(T) "Osteopathic hospital" means a hospital registered 591
under section 3701.07 of the Revised Code that advocates 592

osteopathic principles and the practice and perpetuation of 593
osteopathic medicine by doing any of the following: 594

(1) Maintaining a department or service of osteopathic 595
medicine or a committee on the utilization of osteopathic 596
principles and methods, under the supervision of an osteopathic 597
physician; 598

(2) Maintaining an active medical staff, the majority of 599
which is comprised of osteopathic physicians; 600

(3) Maintaining a medical staff executive committee that 601
has osteopathic physicians as a majority of its members. 602

(U) "Panel" means a group of providers or health care 603
facilities that have joined together to deliver health care 604
services through a contractual arrangement with a health 605
insuring corporation, employer group, or other payor. 606

(V) "Person" has the same meaning as in section 1.59 of 607
the Revised Code, and, unless the context otherwise requires, 608
includes any insurance company holding a certificate of 609
authority under Title XXXIX of the Revised Code, any subsidiary 610
and affiliate of an insurance company, and any government 611
agency. 612

(W) "Premium rate" means any set fee regularly paid by a 613
subscriber to a health insuring corporation. A "premium rate" 614
does not include a one-time membership fee, an annual 615
administrative fee, or a nominal access fee, paid to a managed 616
health care system under which the recipient of health care 617
services remains solely responsible for any charges assessed for 618
those services by the provider or health care facility. 619

(X) "Primary care provider" means a provider that is 620
designated by a health insuring corporation to supervise, 621

coordinate, or provide initial care or continuing care to an 622
enrollee, and that may be required by the health insuring 623
corporation to initiate a referral for specialty care and to 624
maintain supervision of the health care services rendered to the 625
enrollee. 626

(Y) "Provider" means any natural person or partnership of 627
natural persons who are licensed, certified, accredited, or 628
otherwise authorized in this state to furnish health care 629
services, or any professional association organized under 630
Chapter 1785. of the Revised Code, provided that nothing in this 631
chapter or other provisions of law shall be construed to 632
preclude a health insuring corporation, health care 633
practitioner, or organized health care group associated with a 634
health insuring corporation from employing certified nurse 635
practitioners, certified nurse anesthetists, clinical nurse 636
specialists, certified nurse-midwives, pharmacists, dietitians, 637
physician assistants, dental assistants, dental hygienists, 638
optometric technicians, or other allied health personnel who are 639
licensed, certified, accredited, or otherwise authorized in this 640
state to furnish health care services. 641

(Z) "Provider sponsored organization" means a corporation, 642
as defined in division (H) of this section, that is at least 643
eighty per cent owned or controlled by one or more hospitals, as 644
defined in section 3727.01 of the Revised Code, or one or more 645
physicians licensed to practice medicine or surgery or 646
osteopathic medicine and surgery under Chapter 4731. of the 647
Revised Code, or any combination of such physicians and 648
hospitals. Such control is presumed to exist if at least eighty 649
per cent of the voting rights or governance rights of a provider 650
sponsored organization are directly or indirectly owned, 651
controlled, or otherwise held by any combination of the 652

physicians and hospitals described in this division. 653

(AA) "Solicitation document" means the written materials 654
provided to prospective subscribers or enrollees, or both, and 655
used for advertising and marketing to induce enrollment in the 656
health care plans of a health insuring corporation. 657

(BB) "Subscriber" means a person who is responsible for 658
making payments to a health insuring corporation for 659
participation in a health care plan, or an enrollee whose 660
employment or other status is the basis of eligibility for 661
enrollment in a health insuring corporation. 662

(CC) "Urgent care services" means those health care 663
services that are appropriately provided for an unforeseen 664
condition of a kind that usually requires medical attention 665
without delay but that does not pose a threat to the life, limb, 666
or permanent health of the injured or ill person, and may 667
include such health care services provided out of the health 668
insuring corporation's approved service area pursuant to 669
indemnity payments or service agreements. 670

Sec. 1751.06. Upon obtaining a certificate of authority as 671
required under this chapter, a health insuring corporation may 672
do all of the following: 673

(A) Enroll individuals and their dependents in either of 674
the following circumstances: 675

(1) The individual resides or lives in the approved 676
service area. 677

(2) The individual's place of employment is located in the 678
approved service area. 679

(B) Contract with providers and health care facilities for 680

the health care services to which enrollees are entitled under 681
the terms of the health insuring corporation's health care 682
contracts; 683

(C) Contract with insurance companies authorized to do 684
business in this state for insurance, indemnity, or 685
reimbursement against the cost of providing emergency and 686
nonemergency health care services for enrollees, subject to the 687
provisions set forth in this chapter and the limitations set 688
forth in the Revised Code; 689

(D) Contract with any person pursuant to the requirements 690
of division (A) (18) of section 1751.03 of the Revised Code for 691
managerial or administrative services, or for data processing, 692
actuarial analysis, billing services, or any other services 693
authorized by the superintendent of insurance. However, a health 694
insuring corporation shall not enter into a contract for any of 695
the services listed in this division with an insurance company 696
that is not authorized to engage in the business of insurance in 697
this state. 698

(E) Accept from governmental agencies, private agencies, 699
corporations, associations, groups, individuals, or other 700
persons, payments covering all or part of the costs of planning, 701
development, construction, and the provision of health care 702
services; 703

(F) Purchase, lease, construct, renovate, operate, or 704
maintain health care facilities, and their ancillary equipment, 705
and any property necessary in the transaction of the business of 706
the health insuring corporation; 707

(G) In the employer group market, impose an affiliation 708
period of not more than sixty days, or for late enrollees an 709

affiliation period of not more than ninety days, which period 710
begins on the individual's date of enrollment and runs 711
concurrently with any waiting period imposed under the coverage. 712
For purposes of this division, "affiliation period" means a 713
period of time which, under the terms of the coverage offered, 714
must expire before the coverage becomes effective. No health 715
care services or benefits need to be provided during an 716
affiliation period, and no periodic prepayments can be charged 717
for any coverage during that period. 718

(H) If a health insuring corporation offers coverage in 719
the small employer group market through a network plan, limit or 720
deny the coverage in accordance with section 3924.031 of the 721
Revised Code; 722

(I) Refuse to issue coverage in the small employer group 723
market pursuant to section 3924.032 of the Revised Code; 724

(J) Establish employer contribution rules or group 725
participation rules for the offering of coverage in connection 726
with a group contract in the small employer group market, as 727
provided in division ~~(E)~~ (D) (1) of section 3924.03 of the Revised 728
Code. 729

Nothing in this section shall be construed as prohibiting 730
a health insuring corporation without other commercial 731
enrollment from contracting solely with federal health care 732
programs regulated by federal regulatory bodies. 733

Nothing in this section shall be construed to limit the 734
authority of a health insuring corporation to perform those 735
functions not otherwise prohibited by law. 736

Sec. 1751.12. (A) (1) No contractual periodic prepayment 737
and no premium rate for nongroup and conversion policies for 738

health care services, or any amendment to them, may be used by 739
any health insuring corporation at any time until the 740
contractual periodic prepayment and premium rate, or amendment, 741
have been filed with the superintendent of insurance, and shall 742
not be effective until the expiration of sixty days after their 743
filing unless the superintendent sooner gives approval. The 744
filing shall be accompanied by an actuarial certification in the 745
form prescribed by the superintendent. The superintendent shall 746
disapprove the filing, if the superintendent determines within 747
the sixty-day period that the contractual periodic prepayment or 748
premium rate, or amendment, is not in accordance with sound 749
actuarial principles or is not reasonably related to the 750
applicable coverage and characteristics of the applicable class 751
of enrollees. The superintendent shall notify the health 752
insuring corporation of the disapproval, and it shall thereafter 753
be unlawful for the health insuring corporation to use the 754
contractual periodic prepayment or premium rate, or amendment. 755

(2) No contractual periodic prepayment for group policies 756
for health care services shall be used until the contractual 757
periodic prepayment has been filed with the superintendent. The 758
filing shall be accompanied by an actuarial certification in the 759
form prescribed by the superintendent. The superintendent may 760
reject a filing made under division (A)(2) of this section at 761
any time, with at least thirty days' written notice to a health 762
insuring corporation, if the contractual periodic prepayment is 763
not in accordance with sound actuarial principles or is not 764
reasonably related to the applicable coverage and 765
characteristics of the applicable class of enrollees. 766

(3) At any time, the superintendent, upon at least thirty 767
days' written notice to a health insuring corporation, may 768
withdraw the approval given under division (A)(1) of this 769

section, deemed or actual, of any contractual periodic 770
prepayment or premium rate, or amendment, based on information 771
that either of the following applies: 772

(a) The contractual periodic prepayment or premium rate, 773
or amendment, is not in accordance with sound actuarial 774
principles. 775

(b) The contractual periodic prepayment or premium rate, 776
or amendment, is not reasonably related to the applicable 777
coverage and characteristics of the applicable class of 778
enrollees. 779

(4) Any disapproval under division (A) (1) of this section, 780
any rejection of a filing made under division (A) (2) of this 781
section, or any withdrawal of approval under division (A) (3) of 782
this section, shall be effected by a written notice, which shall 783
state the specific basis for the disapproval, rejection, or 784
withdrawal and shall be issued in accordance with Chapter 119. 785
of the Revised Code. 786

(B) Notwithstanding division (A) of this section, a health 787
insuring corporation may use a contractual periodic prepayment 788
or premium rate for policies used for the coverage of 789
beneficiaries enrolled in medicare pursuant to a medicare risk 790
contract or medicare cost contract, or for policies used for the 791
coverage of beneficiaries enrolled in the federal employees 792
health benefits program pursuant to 5 U.S.C.A. 8905, or for 793
policies used for the coverage of medicaid recipients, or for 794
policies used for the coverage of beneficiaries under any other 795
federal health care program regulated by a federal regulatory 796
body, or for policies used for the coverage of beneficiaries 797
under any contract covering officers or employees of the state 798
that has been entered into by the department of administrative 799

services, if both of the following apply: 800

(1) The contractual periodic prepayment or premium rate 801
has been approved by the United States department of health and 802
human services, the United States office of personnel 803
management, the department of medicaid, or the department of 804
administrative services. 805

(2) The contractual periodic prepayment or premium rate is 806
filed with the superintendent prior to use and is accompanied by 807
documentation of approval from the United States department of 808
health and human services, the United States office of personnel 809
management, the department of medicaid, or the department of 810
administrative services. 811

(C) The administrative expense portion of all contractual 812
periodic prepayment or premium rate filings submitted to the 813
superintendent for review must reflect the actual cost of 814
administering the product. The superintendent may require that 815
the administrative expense portion of the filings be itemized 816
and supported. 817

(D) (1) Copayments, cost sharing, and deductibles must be 818
reasonable and must not be a barrier to the necessary 819
utilization of services by enrollees. 820

(2) A health insuring corporation, in order to ensure that 821
copayments, cost sharing, and deductibles are reasonable and not 822
a barrier to the necessary utilization of basic health care 823
services by enrollees shall impose copayment charges, cost 824
sharing, and deductible charges that annually do not exceed 825
forty per cent of the total annual cost to the health insuring 826
corporation of providing all covered health care services when 827
applied to a standard population expected to be covered under 828

the filed product in question. The total annual cost of 829
providing a health care service is the cost to the health 830
insuring corporation of providing the health care service to its 831
enrollees as reduced by any applicable provider discount. This 832
requirement shall be demonstrated by an actuary who is a member 833
of the American academy of actuaries and qualified to provide 834
such certifications as described in the United States 835
qualification standards promulgated by the American academy of 836
actuaries pursuant to the code of professional conduct. 837

(3) For purposes of division (D) of this section, all of 838
the following apply: 839

(a) Copayments imposed by health insuring corporations in 840
connection with a high deductible health plan that is linked to 841
a health savings account are reasonable and are not a barrier to 842
the necessary utilization of services by enrollees. 843

(b) Division (D)(2) of this section does not apply to a 844
high deductible health plan that is linked to a health savings 845
account. 846

(c) Catastrophic-only plans, as described in division (D) 847
(2) of section 3902.43 of the Revised Code and defined under the 848
"Patient Protection and Affordable Care Act," 124 Stat. 119, 42 849
U.S.C. 18022 and any related regulations, are not subject to the 850
limits prescribed in division (D) of this section, provided that 851
such plans meet all applicable minimum federal requirements. 852

(E) A health insuring corporation shall not impose 853
lifetime maximums on basic health care services. However, a 854
health insuring corporation may establish a benefit limit for 855
inpatient hospital services that are provided pursuant to a 856
policy, contract, certificate, or agreement for supplemental 857

health care services. 858

(F) The superintendent may adopt rules allowing different 859
copayment, cost sharing, and deductible amounts for plans with a 860
medical savings account, health reimbursement arrangement, 861
flexible spending account, or similar account; 862

(G) A health insuring corporation may impose higher 863
copayment, cost sharing, and deductible charges under health 864
plans if requested by the group contract, policy, certificate, 865
or agreement holder, or an individual seeking coverage under an 866
individual health plan. This shall not be construed as requiring 867
the health insuring corporation to create customized health 868
plans for group contract holders or individuals. 869

(H) As used in this section, "health savings account" and 870
"high deductible health plan" have the same meanings as in the 871
"Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 223, 872
as amended. 873

Sec. 1751.16. (A) Except as provided in division (F) of 874
this section, every group contract issued by a health insuring 875
corporation shall provide an option for conversion to an 876
individual contract issued on a direct-payment basis to any 877
subscriber covered by the group contract who terminates 878
employment or membership in the group, unless: 879

(1) Termination of the conversion option or contract is 880
based upon nonpayment of premium after reasonable notice in 881
writing has been given by the health insuring corporation to the 882
subscriber. 883

(2) The subscriber is, or is eligible to be, covered for 884
benefits at least comparable to the group contract under any of 885
the following: 886

(a) Medicare;	887
(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;	888 889 890 891
(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.	892 893 894
(B) (1) The direct payment contract offered by the health-insuring corporation pursuant to division (A) of this section shall provide the following:	895 896 897
(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;	898 899 900 901
(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:	902 903 904 905 906 907 908 909 910 911
(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;	912 913 914 915

~~(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.~~ 916
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~~(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.~~ 930
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~~(3) For purposes of division (B) of this section:~~ 933

~~(a) "Federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.~~ 934
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~~(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.~~ 936
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(C) The option for conversion shall be available: 942

(1) Upon the death of the subscriber, to the surviving spouse with respect to such of the spouse and dependents as are 943
944

then covered by the group contract; 945

(2) To a child solely with respect to the child upon the 946
child's attaining the limiting age of coverage under the group 947
contract while covered as a dependent under the contract; 948

(3) Upon the divorce, dissolution, or annulment of the 949
marriage of the subscriber, to the divorced spouse, or, in the 950
event of annulment, to the former spouse of the subscriber. 951

(D) No health insuring corporation shall use age or health 952
status as the basis for refusing to renew a converted contract. 953

(E) Written notice of the conversion option provided by 954
this section shall be given to the subscriber by the health 955
insuring corporation by mail. The notice shall be sent to the 956
subscriber's address in the records of the employer upon receipt 957
of notice from the employer of the event giving rise to the 958
conversion option. If the subscriber has not received notice of 959
the conversion privilege at least fifteen days prior to the 960
expiration of the thirty-day conversion period, then the 961
subscriber shall have an additional period within which to 962
exercise the privilege. This additional period shall expire 963
fifteen days after the subscriber receives notice, but in no 964
event shall the period extend beyond sixty days after the 965
expiration of the thirty-day conversion period. 966

(F) This section does not apply to any group contract 967
offering only supplemental health care services or specialty 968
health care services. 969

Sec. 1751.18. (A) (1) No health insuring corporation shall 970
cancel or fail to renew the coverage of a subscriber or enrollee 971
because of any health status-related factor in relation to the 972
subscriber or enrollee, the subscriber's or enrollee's 973

requirements for health care services, or for any other reason 974
designated under rules adopted by the superintendent of 975
insurance. 976

(2) Unless otherwise required by state or federal law, no 977
health insuring corporation, or health care facility or provider 978
through which the health insuring corporation has made 979
arrangements to provide health care services, shall discriminate 980
against any individual with regard to enrollment, disenrollment, 981
or the quality of health care services rendered, on the basis of 982
the individual's race, color, sex, age, religion, military 983
status as defined in section 4112.01 of the Revised Code, or 984
status as a recipient of medicare or medicaid, or any health 985
status-related factor in relation to the individual. However, a 986
health insuring corporation shall not be required to accept a 987
recipient of medicare or medical assistance, if an agreement has 988
not been reached on appropriate payment mechanisms between the 989
health insuring corporation and the governmental agency 990
administering these programs. ~~Further, except for open-~~ 991
~~enrollment coverage under sections 3923.58 and 3923.581 of the~~ 992
~~Revised Code and except as provided in section 1751.65 of the~~ 993
~~Revised Code, a health insuring corporation may reject an~~ 994
~~applicant for nongroup enrollment on the basis of any health-~~ 995
~~status-related factor in relation to the applicant.~~ 996

(B) A health insuring corporation may cancel or decide not 997
to renew the coverage of an enrollee if the enrollee has 998
performed an act or practice that constitutes fraud or 999
intentional misrepresentation of material fact under the terms 1000
of the coverage and if the cancellation or nonrenewal is not 1001
based, either directly or indirectly, on any health status- 1002
related factor in relation to the enrollee. 1003

(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 1031
that are not subject to section 3924.03 of the Revised Code: 1032

(A) (1) Except as provided in section 2712(b) to (e) of the 1033
"Health Insurance Portability and Accountability Act of 1996," 1034
if a health insuring corporation offers coverage in the small or 1035
large group market in connection with a group contract, the 1036
corporation shall renew or continue in force such coverage at 1037
the option of the contract holder. 1038

(2) A health insuring corporation may cancel or decide not 1039
to renew the coverage of any eligible employee or of a dependent 1040
of an eligible employee under the group contract in accordance 1041
with division (B) of section 1751.18 of the Revised Code. 1042

(B) Such group contracts are subject to ~~division (A) (3) of~~ 1043
~~section 3924.03 and sections 3924.033 and 3924.27~~ of the Revised 1044
Code. 1045

(C) Such group contracts shall provide for the special 1046
enrollment periods described in section 2701(f) of the "Health 1047
Insurance Portability and Accountability Act of 1996." 1048

(D) At least once in every twelve-month period, a health 1049
insuring corporation shall provide to all late enrollees, as 1050
defined in section 3924.01 of the Revised Code, who are 1051
identified by the contract holder, the option to enroll in the 1052
group contract. The enrollment option shall be provided for a 1053
minimum period of thirty consecutive days. All delays of 1054
coverage imposed under the group contract, including any 1055
affiliation period, shall begin on the date the health insuring 1056
corporation receives notice of the late enrollee's application 1057
or request for coverage, and shall run concurrently with each 1058
other. 1059

Sec. 1751.69. (A) As used in this section, "cost sharing" 1060
means the cost to an individual insured under an individual or 1061
group health insuring corporation policy, contract, or agreement 1062
according to any coverage limit, copayment, coinsurance, 1063
deductible, or other out-of-pocket expense requirements imposed 1064
by the policy, contract, or agreement. 1065

(B) Notwithstanding section 3901.71 of the Revised Code 1066
and subject to division (D) of this section, no individual or 1067
group health insuring corporation policy, contract, or agreement 1068
providing basic health care services or prescription drug 1069
services that is delivered, issued for delivery, or renewed in 1070
this state, if the policy, contract, or agreement provides 1071
coverage for cancer chemotherapy treatment, shall fail to comply 1072
with either of the following: 1073

(1) The policy, contract, or agreement shall not provide 1074
coverage or impose cost sharing for a prescribed, orally 1075
administered cancer medication on a less favorable basis than 1076
the coverage it provides or cost sharing it imposes for 1077
intravenously administered or injected cancer medications. 1078

(2) The policy, contract, or agreement shall not comply 1079
with division (B)(1) of this section by imposing an increase in 1080
cost sharing solely for orally administered, intravenously 1081
administered, or injected cancer medications. 1082

(C) Notwithstanding any provision of this section to the 1083
contrary, an individual or group health insuring corporation 1084
policy, contract, or agreement shall be deemed to be in 1085
compliance with this section if the cost sharing imposed under 1086
such a policy, contract, or agreement for orally administered 1087
cancer treatments does not exceed one hundred dollars per 1088
prescription fill. The cost sharing limit of one hundred 1089

dollars per prescription fill shall apply to a high deductible 1090
plan, as defined in 26 U.S.C. 223, or a catastrophic plan, as 1091
described in division (D) (2) of section 3902.43 of the Revised 1092
Code and defined in 42 U.S.C. 18022, only after the deductible 1093
has been met. 1094

(D) The prohibitions in division (B) of this section do 1095
not preclude an individual or group health insuring corporation 1096
policy, contract, or agreement from requiring an enrollee to 1097
obtain prior authorization before orally administered cancer 1098
medication is dispensed to the enrollee. 1099

(E) A health insuring corporation that offers coverage for 1100
basic health care services is not required to comply with 1101
division (B) of this section if all of the following apply: 1102

(1) The health insuring corporation submits documentation 1103
certified by an independent member of the American academy of 1104
actuaries to the superintendent of insurance showing that 1105
compliance with division (B) (1) of this section for a period of 1106
at least six months independently caused the health insuring 1107
corporation's costs for claims and administrative expenses for 1108
the coverage of basic health care services to increase by more 1109
than one per cent per year. 1110

(2) The health insuring corporation submits a signed 1111
letter from an independent member of the American academy of 1112
actuaries to the superintendent of insurance opining that the 1113
increase in costs described in division (E) (1) of this section 1114
could reasonably justify an increase of more than one per cent 1115
in the annual premiums or rates charged by the health insuring 1116
corporation for the coverage of basic health care services. 1117

(3) (a) The superintendent of insurance makes the following 1118

determinations from the documentation and opinion submitted 1119
pursuant to divisions (E) (1) and (2) of this section: 1120

(i) Compliance with division (B) (1) of this section for a 1121
period of at least six months independently caused the health 1122
insuring corporation's costs for claims and administrative 1123
expenses for the coverage of basic health care services to 1124
increase more than one per cent per year. 1125

(ii) The increase in costs reasonably justifies an 1126
increase of more than one per cent in the annual premiums or 1127
rates charged by the health insuring corporation for the 1128
coverage of basic health care services. 1129

(b) Any determination made by the superintendent under 1130
division (E) (3) of this section is subject to Chapter 119. of 1131
the Revised Code. 1132

Sec. 3901.381. (A) Except as provided in sections 1133
3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, 1134
a third-party payer shall process a claim for payment for health 1135
care services rendered by a provider to a beneficiary in 1136
accordance with this section. 1137

(B) (1) Unless division (B) (2) or (3) of this section 1138
applies, when a third-party payer receives from a provider or 1139
beneficiary a claim on the standard claim form prescribed in 1140
rules adopted by the superintendent of insurance under section 1141
3902.22 of the Revised Code, the third-party payer shall pay or 1142
deny the claim not later than thirty days after receipt of the 1143
claim. When a third-party payer denies a claim, the third-party 1144
payer shall notify the provider and the beneficiary. The notice 1145
shall state, with specificity, why the third-party payer denied 1146
the claim. 1147

(2) (a) Unless division (B) (3) of this section applies, 1148
when a provider or beneficiary has used the standard claim form, 1149
but the third-party payer determines that reasonable supporting 1150
documentation is needed to establish the third-party payer's 1151
responsibility to make payment, the third-party payer shall pay 1152
or deny the claim not later than forty-five days after receipt 1153
of the claim. Supporting documentation includes the verification 1154
of employer and beneficiary coverage under a benefits contract, 1155
confirmation of premium payment, medical information regarding 1156
the beneficiary and the services provided, information on the 1157
responsibility of another third-party payer to make payment or 1158
confirmation of the amount of payment by another third-party 1159
payer, and information that is needed to correct material 1160
deficiencies in the claim related to a diagnosis or treatment or 1161
the provider's identification. 1162

Not later than thirty days after receipt of the claim, the 1163
third-party payer shall notify all relevant external sources 1164
that the supporting documentation is needed. All such notices 1165
shall state, with specificity, the supporting documentation 1166
needed. If the notice was not provided in writing, the provider, 1167
beneficiary, or third-party payer may request the third-party 1168
payer to provide the notice in writing, and the third-party 1169
payer shall then provide the notice in writing. If any of the 1170
supporting documentation is under the control of the 1171
beneficiary, the beneficiary shall provide the supporting 1172
documentation to the third-party payer. 1173

The number of days that elapse between the third-party 1174
payer's last request for supporting documentation within the 1175
thirty-day period and the third-party payer's receipt of all of 1176
the supporting documentation that was requested shall not be 1177
counted for purposes of determining the third-party payer's 1178

compliance with the time period of not more than forty-five days 1179
for payment or denial of a claim. ~~Except as provided in division-~~ 1180
~~(B) (2) (b) of this section, if~~ If the third-party payer requests 1181
additional supporting documentation after receiving the 1182
initially requested documentation, the number of days that 1183
elapse between making the request and receiving the additional 1184
supporting documentation shall be counted for purposes of 1185
determining the third-party payer's compliance with the time 1186
period of not more than forty-five days. 1187

~~(b) If a third-party payer determines, after receiving-~~ 1188
~~initially requested documentation, that it needs additional-~~ 1189
~~supporting documentation pertaining to a beneficiary's-~~ 1190
~~preexisting condition, which condition was unknown to the third-~~ 1191
~~party payer and about which it was reasonable for the third-~~ 1192
~~party payer to have no knowledge at the time of its initial-~~ 1193
~~request for documentation, and the third party payer-~~ 1194
~~subsequently requests this additional supporting documentation,-~~ 1195
~~the number of days that elapse between making the request and-~~ 1196
~~receiving the additional supporting documentation shall not be-~~ 1197
~~counted for purposes of determining the third party payer's-~~ 1198
~~compliance with the time period of not more than forty five-~~ 1199
~~days.-~~ 1200

~~(e)~~ When a third-party payer denies a claim, the third- 1201
party payer shall notify the provider and the beneficiary. The 1202
notice shall state, with specificity, why the third-party payer 1203
denied the claim. 1204

~~(d)~~ (c) If a third-party payer determines that supporting 1205
documentation related to medical information is routinely 1206
necessary to process a claim for payment of a particular health 1207
care service, the third-party payer shall establish a 1208

description of the supporting documentation that is routinely 1209
necessary and make the description available to providers in a 1210
readily accessible format. 1211

Third-party payers and providers shall, in connection with 1212
a claim, use the most current CPT code in effect, as published 1213
by the American medical association, the most current ICD-10 1214
code in effect, as published by the United States department of 1215
health and human services, the most current CDT code in effect, 1216
as published by the American dental association, or the most 1217
current HCPCS code in effect, as published by the United States 1218
centers for medicare and medicaid services. 1219

(3) When a provider or beneficiary submits a claim by 1220
using the standard claim form prescribed in the superintendent's 1221
rules, but the information provided in the claim is materially 1222
deficient, the third-party payer shall notify the provider or 1223
beneficiary not later than fifteen days after receipt of the 1224
claim. The notice shall state, with specificity, the information 1225
needed to correct all material deficiencies. Once the material 1226
deficiencies are corrected, the third-party payer shall proceed 1227
in accordance with division (B) (1) or (2) of this section. 1228

It is not a violation of the notification time period of 1229
not more than fifteen days if a third-party payer fails to 1230
notify a provider or beneficiary of material deficiencies in the 1231
claim related to a diagnosis or treatment or the provider's 1232
identification. A third-party payer may request the information 1233
necessary to correct these deficiencies after the end of the 1234
notification time period. Requests for such information shall be 1235
made as requests for supporting documentation under division (B) 1236
(2) of this section, and payment or denial of the claim is 1237
subject to the time periods specified in that division. 1238

(C) For purposes of this section, if a dispute exists 1239
between a provider and a third-party payer as to the day a claim 1240
form was received by the third-party payer, both of the 1241
following apply: 1242

(1) If the provider or a person acting on behalf of the 1243
provider submits a claim directly to a third-party payer by mail 1244
and retains a record of the day the claim was mailed, there 1245
exists a rebuttable presumption that the claim was received by 1246
the third-party payer on the fifth business day after the day 1247
the claim was mailed, unless it can be proven otherwise. 1248

(2) If the provider or a person acting on behalf of the 1249
provider submits a claim directly to a third-party payer 1250
electronically, there exists a rebuttable presumption that the 1251
claim was received by the third-party payer twenty-four hours 1252
after the claim was submitted, unless it can be proven 1253
otherwise. 1254

(D) Nothing in this section requires a third-party payer 1255
to provide more than one notice to an employer whose premium for 1256
coverage of employees under a benefits contract has not been 1257
received by the third-party payer. 1258

(E) Compliance with the provisions of division (B) (3) of 1259
this section shall be determined separately from compliance with 1260
the provisions of divisions (B) (1) and (2) of this section. 1261

(F) A third-party payer shall transmit electronically any 1262
payment with respect to claims that the third-party payer 1263
receives electronically and pays to a contracted provider under 1264
this section and under sections 3901.383, 3901.384, and 3901.386 1265
of the Revised Code. A provider shall not refuse to accept a 1266
payment made under this section or sections 3901.383, 3901.384, 1267

and 3901.386 of the Revised Code on the basis that the payment 1268
was transmitted electronically. 1269

Sec. 3902.40. As used in sections 3902.40 to 3902.44 of 1270
the Revised Code: 1271

(A) "Cost sharing" means the cost to a covered person 1272
under a health benefit plan according to any coverage limit, 1273
copayment, coinsurance, deductible, or other out-of-pocket 1274
expense requirement. 1275

(B) "Covered person," "health care provider" or 1276
"provider," "health care services," and "health plan issuer" 1277
have the same meanings as in section 3922.01 of the Revised 1278
Code. 1279

(C) "Health benefit plan" has the same meaning as in 1280
section 3922.01 of the Revised Code, but does not include a 1281
limited benefit plan. 1282

(E) "Preexisting condition exclusion" means, with respect 1283
to a health benefit plan, a limitation or exclusion of benefits 1284
relating to a condition based on the fact that the condition was 1285
present before the date of enrollment in the plan, whether or 1286
not any medical advice, diagnosis, care, or treatment was 1287
recommended or received before such date. "Condition" does not 1288
include genetic information in the absence of a diagnosis of the 1289
condition related to such information. 1290

Sec. 3902.41. (A) With respect to the premium rate charged 1291
by a health plan issuer for a health benefit plan offered in the 1292
individual or small group market, all of the following apply: 1293

(1) The premium rate shall vary with respect to the health 1294
benefit plan involved only by the following: 1295

<u>(a) Whether the health benefit plan covers an individual</u>	1296
<u>or family;</u>	1297
<u>(b) Rating area, as established in accordance with</u>	1298
<u>division (C) (1) of this section;</u>	1299
<u>(c) Age, except that such rate shall not vary by more than</u>	1300
<u>three to one for adults;</u>	1301
<u>(d) Tobacco use, except that such rate shall not vary by</u>	1302
<u>more than one and one-half to one.</u>	1303
<u>(2) The premium rate shall not vary with respect to the</u>	1304
<u>health benefit plan involved by any other factor not described</u>	1305
<u>in division (A) of this section.</u>	1306
<u>(B) With respect to family coverage under a health benefit</u>	1307
<u>plan, the rating variations permitted under divisions (A) (1) (c)</u>	1308
<u>and (d) of this section shall be applied based on the portion of</u>	1309
<u>the premium that is attributable to each family member covered</u>	1310
<u>under the health benefit plan.</u>	1311
<u>(C) The superintendent of insurance shall adopt rules to</u>	1312
<u>do the following:</u>	1313
<u>(1) Establish one or more rating areas within the state;</u>	1314
<u>(2) Define the permissible age bands for rating purposes</u>	1315
<u>under division (A) (1) (c) of this section.</u>	1316
<u>(D) A health plan issuer shall not establish lifetime or</u>	1317
<u>annual limits on the dollar value of benefits described in</u>	1318
<u>section 3902.43 of the Revised Code for any covered person.</u>	1319
Sec. 3902.42. <u>(A) Every individual health benefit plan</u>	1320
<u>shall accept every individual in this state who applies for</u>	1321
<u>coverage and every group health benefit plan shall accept every</u>	1322

employer in this state that applies for coverage, regardless of 1323
whether any individual or employee has a preexisting condition. 1324
A health benefit plan may restrict enrollment in coverage to 1325
open or special enrollment periods under division (C) of this 1326
section. 1327

(B) A health plan issuer shall not impose any preexisting 1328
condition exclusion on any person. 1329

(C) (1) The superintendent of insurance shall adopt rules 1330
to ensure that each individual health benefit plan has open 1331
enrollment during a statewide open enrollment period to allow 1332
individuals, including individuals who are not covered persons, 1333
to enroll in the health benefit plan. 1334

(2) A health plan issuer shall provide special enrollment 1335
periods for individuals who lose coverage as a result of a 1336
qualifying event under 26 U.S.C. 9801(f) or 29 U.S.C. 1163. 1337

Sec. 3902.43. (A) For purposes of this section, "essential 1338
health benefits package" means, with respect to a health benefit 1339
plan, coverage that does all of the following: 1340

(1) Provides for the essential health benefits defined by 1341
the superintendent of insurance under division (B) of this 1342
section; 1343

(2) Limits cost sharing for such coverage in accordance 1344
with division (C) of this section; 1345

(3) Provides the level of coverage described in division 1346
(D) of this section. 1347

(B) (1) Subject to division (B) (2) of this section, the 1348
superintendent shall define the essential health benefits, 1349
except that such benefits shall include at least the following 1350

<u>general categories and the items and services covered within the</u>	1351
<u>categories:</u>	1352
<u>(a) Ambulatory patient services;</u>	1353
<u>(b) Emergency services;</u>	1354
<u>(c) Hospitalization;</u>	1355
<u>(d) Maternity and newborn care;</u>	1356
<u>(e) Mental health and substance use disorder services,</u>	1357
<u>including behavioral health treatment;</u>	1358
<u>(f) Prescription drugs;</u>	1359
<u>(g) Rehabilitative and habilitative services and devices;</u>	1360
<u>(h) Laboratory services;</u>	1361
<u>(i) Preventive and wellness services and chronic disease</u>	1362
<u>management;</u>	1363
<u>(j) Pediatric services, including oral and vision care.</u>	1364
<u>(2) (a) The superintendent shall ensure that the scope of</u>	1365
<u>the essential health benefits under division (B) (1) of this</u>	1366
<u>section is equal to the scope of benefits provided under a</u>	1367
<u>typical employer plan, as determined by the superintendent. To</u>	1368
<u>inform this determination, the superintendent shall conduct a</u>	1369
<u>survey of employer-sponsored coverage to determine the benefits</u>	1370
<u>typically covered by employers, including multi-employer plans.</u>	1371
<u>(b) In defining the essential health benefits described in</u>	1372
<u>division (B) (1) of this section, and in revising the benefits</u>	1373
<u>under division (B) (3) (g) of this section, the superintendent</u>	1374
<u>shall submit a report to the general assembly containing a</u>	1375
<u>certification that such essential health benefits meet the</u>	1376
<u>requirements described in division (B) (2) (a) of this section.</u>	1377

(3) In defining the essential health benefits under 1378
division (B)(1) of this section, the superintendent shall do all 1379
of the following: 1380

(a) Ensure that such essential health benefits reflect an 1381
appropriate balance among the categories described in division 1382
(B)(1) of this section, so that benefits are not unduly weighted 1383
toward any category; 1384

(b) Not make coverage decisions, determine reimbursement 1385
rates, establish incentive programs, or design benefits in ways 1386
that discriminate against individuals because of their age, 1387
disability, or expected length of life; 1388

(c) Take into account the health care needs of diverse 1389
segments of the population, including women, children, persons 1390
with disabilities, and other groups; 1391

(d) Ensure that benefits established as essential health 1392
benefits not be subject to denial to individuals against their 1393
wishes on the basis of the individuals' age or expected length 1394
of life or of the individuals' present or predicted disability, 1395
degree of medical dependency, or quality of life; 1396

(e) Provide that a qualified health benefit plan shall not 1397
be treated as providing coverage for the essential health 1398
benefits described in division (B)(1) of this section unless the 1399
plan does both of the following: 1400

(i) Provides that coverage for emergency services, as 1401
defined in section 3923.65 of the Revised Code, will be provided 1402
without imposing any requirement under the plan for prior 1403
authorization of services or any limitation on coverage where 1404
the provider of services does not have a contractual 1405
relationship with the plan for the providing of services that is 1406

more restrictive than the requirements or limitations that apply 1407
to emergency services received from providers who do have such a 1408
contractual relationship with the plan; 1409

(ii) Provides that if emergency services are provided out- 1410
of-network, the cost-sharing requirement is the same requirement 1411
that would apply if such services were provided in-network. 1412

(f) Periodically review the essential health benefits 1413
under division (B) (1) of this section and provide a report to 1414
the general assembly and the public that contains all of the 1415
following: 1416

(i) An assessment of whether covered persons are facing 1417
any difficulty accessing needed services for reasons of coverage 1418
or cost; 1419

(ii) An assessment of whether the essential health 1420
benefits need to be modified or updated to account for changes 1421
in medical evidence or scientific advancement; 1422

(iii) Information on how the essential health benefits 1423
will be modified to address any such gaps in access or changes 1424
in the evidence base; 1425

(iv) An assessment of the potential of additional or 1426
expanded benefits to increase costs and the interactions between 1427
the addition or expansion of benefits and reductions in existing 1428
benefits to meet the requirements of division (B) (2) (a) of this 1429
section. 1430

(g) Periodically update the essential health benefits 1431
under division (B) (1) of this section to address any gaps in 1432
access to coverage or changes in the evidence base the 1433
superintendent identifies in the review conducted under division 1434
(B) (3) (f) of this section. 1435

(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. 1436
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(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. 1439
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(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. 1443
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(2) For plan years beginning in a calendar year after 2021, the cost-sharing limit shall be as follows: 1448
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(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; 1450
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1453

(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. 1454
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(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 1459
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1462
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by the superintendent. 1465

(D) (1) (a) Except as provided in division (D) (2) of this 1466
section, a health benefit plan shall provide a level of coverage 1467
that is designed to provide benefits that are actuarially 1468
equivalent to at least sixty per cent of the full actuarial 1469
value of the benefits provided under the plan. 1470

(b) Under rules issued by the superintendent, the level of 1471
coverage of a plan shall be determined on the basis that the 1472
essential health benefits described in division (B) (1) of this 1473
section shall be provided to a standard population, without 1474
regard to the population the plan may actually provide benefits 1475
to. 1476

(2) A health benefit plan that does not provide the level 1477
of coverage described in division (D) (1) of this section shall 1478
be considered as meeting the requirements of that division with 1479
respect to any plan year if both of the following apply: 1480

(a) An individual is only eligible to enroll in the health 1481
benefit plan if the individual meets either of the following 1482
conditions: 1483

(i) The individual has not attained the age of thirty 1484
before the beginning of the plan year. 1485

(ii) The individual meets a hardship exemption as 1486
determined by the superintendent. 1487

(b) The health benefit plan provides both of the 1488
following: 1489

(i) Except as provided in division (D) (2) (b) (ii) of this 1490
section, the essential health benefits listed in division (B) (1) 1491
of this section, except that the health benefit plan provides no 1492

benefits for any plan year until the individual has incurred 1493
cost-sharing expenses in an amount equal to the annual 1494
limitation in effect under division (C) of this section for the 1495
plan year except as provided for in section 3902.44 of the 1496
Revised Code; 1497

(ii) Coverage for at least three primary care visits. 1498

(3) If a health plan issuer offers a health benefit plan 1499
described in division (D)(2) of this section, the issuer shall 1500
only offer the plan in the individual market. 1501

(E) The requirements of this section do not apply to 1502
health benefit plans offered in the large group market. 1503

(F) Nothing in this section is subject to the requirements 1504
of section 3901.71 of the Revised Code. 1505

Sec. 3902.44. (A) A health benefit plan shall provide 1506
coverage for and shall not impose any cost-sharing requirements 1507
for the following: 1508

(1) Evidence-based items or services that have in effect a 1509
rating of "A" or "B" in the current recommendations of the 1510
United States preventive services task force; 1511

(2) Immunizations that have in effect a recommendation 1512
from the advisory committee on immunization practices of the 1513
United States centers for disease control and prevention with 1514
respect to the individual involved; 1515

(3) With respect to infants, children, and adolescents, 1516
evidence-informed preventive care and screenings provided for in 1517
the comprehensive guidelines supported by the United States 1518
health resources and services administration; 1519

(4) With respect to women, such additional preventive care 1520

and screenings not described in division (A)(1) of this section 1521
as provided for in comprehensive guidelines supported by the 1522
United States health resources and services administration. 1523

(B) The superintendent shall adopt rules to implement 1524
sections 3902.40 to 3902.44 of the Revised Code. 1525

Sec. 3922.01. As used in this chapter: 1526

(A) "Adverse benefit determination" means a decision by a 1527
health plan issuer: 1528

(1) To deny, reduce, or terminate a requested health care 1529
service or payment in whole or in part, including all of the 1530
following: 1531

(a) A determination that the health care service does not 1532
meet the health plan issuer's requirements for medical 1533
necessity, appropriateness, health care setting, level of care, 1534
or effectiveness, including experimental or investigational 1535
treatments; 1536

(b) A determination of an individual's eligibility for 1537
individual health insurance coverage, including coverage offered 1538
to individuals through a nonemployer group, to participate in a 1539
plan or health insurance coverage; 1540

(c) A determination that a health care service is not a 1541
covered benefit; 1542

(d) The imposition of an exclusion, including exclusions 1543
for ~~pre-existing conditions~~, source of injury, network, or any 1544
other limitation on benefits that would otherwise be covered. 1545

(2) Not to issue individual health insurance coverage to 1546
an applicant, including coverage offered to individuals through 1547
a nonemployer group; 1548

(3) To rescind coverage on a health benefit plan.	1549
(B) "Ambulatory review" has the same meaning as in section 1751.77 of the Revised Code.	1550 1551
(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:	1552 1553 1554 1555
(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;	1556 1557 1558 1559
(2) A person authorized by law to provide substituted consent for a covered individual;	1560 1561
(3) A family member or a treating health care professional, but only when the covered person is unable to provide consent.	1562 1563 1564
(D) "Best evidence" means evidence based on all of the following sources, listed according to priority, as they are available:	1565 1566 1567
(1) Randomized clinical trials;	1568
(2) Cohort studies or case-control studies;	1569
(3) Case series;	1570
(4) Expert opinion.	1571
(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	1572 1573 1574 1575

external review in accordance with division (C) of this section. 1576
"Covered person" does not include the covered person's 1577
representative in any other context. 1578

(F) "Covered benefits" or "benefits" means those health 1579
care services to which a covered person is entitled under the 1580
terms of a health benefit plan. 1581

(G) "Emergency medical condition" has the same meaning as 1582
in section 1753.28 of the Revised Code. 1583

(H) "Emergency services" has the same meaning as in 1584
section 1753.28 of the Revised Code. 1585

(I) "Evidence-based standard" means the conscientious, 1586
explicit, and judicious use of the current best evidence, based 1587
on a systematic review of the relevant research, in making 1588
decisions about the care of individuals. 1589

(J) "Facility" means an institution providing health care 1590
services, or a health care setting, including hospitals and 1591
other licensed inpatient centers, ambulatory, surgical, 1592
treatment, skilled nursing, residential treatment, diagnostic, 1593
laboratory, and imaging centers, and rehabilitation and other 1594
therapeutic health settings. 1595

(K) "Final adverse benefit determination" means an adverse 1596
benefit determination that is upheld at the completion of a 1597
health plan issuer's internal appeals process. 1598

(L) "Health benefit plan" means a policy, contract, 1599
certificate, or agreement offered by a health plan issuer to 1600
provide, deliver, arrange for, pay for, or reimburse any of the 1601
costs of health care services, including benefit plans marketed 1602
in the individual or group market by all associations, whether 1603
bona fide or non-bona fide. "Health benefit plan" also means a 1604

limited benefit plan, except as follows. "Health benefit plan" 1605
does not mean any of the following types of coverage: a policy, 1606
contract, certificate, or agreement that covers only a specified 1607
accident, accident only, credit, dental, disability income, 1608
long-term care, hospital indemnity, supplemental coverage, as 1609
described in section 3923.37 of the Revised Code, specified 1610
disease, or vision care; coverage issued as a supplement to 1611
liability insurance; insurance arising out of workers' 1612
compensation or similar law; automobile medical payment 1613
insurance; or insurance under which benefits are payable with or 1614
without regard to fault and which is statutorily required to be 1615
contained in any liability insurance policy or equivalent self- 1616
insurance; a medicare supplement policy of insurance, as defined 1617
by the superintendent of insurance by rule, coverage under a 1618
plan through medicare, medicaid, or the federal employees 1619
benefit program; any coverage issued under Chapter 55 of Title 1620
10 of the United States Code and any coverage issued as a 1621
supplement to that coverage. 1622

(M) "Health care professional" means a physician, 1623
psychologist, nurse practitioner, or other health care 1624
practitioner licensed, accredited, or certified to perform 1625
health care services consistent with state law. 1626

(N) "Health care provider" or "provider" means a health 1627
care professional or facility. 1628

(O) "Health care services" means services for the 1629
diagnosis, prevention, treatment, cure, or relief of a health 1630
condition, illness, injury, or disease. 1631

(P) "Health plan issuer" means an entity subject to the 1632
insurance laws and rules of this state, or subject to the 1633
jurisdiction of the superintendent of insurance, that contracts, 1634

or offers to contract to provide, deliver, arrange for, pay for, 1635
or reimburse any of the costs of health care services under a 1636
health benefit plan, including a sickness and accident insurance 1637
company, a health insuring corporation, a fraternal benefit 1638
society, a self-funded multiple employer welfare arrangement, or 1639
a nonfederal, government health plan. "Health plan issuer" 1640
includes a third party administrator licensed under Chapter 1641
3959. of the Revised Code to the extent that the benefits that 1642
such an entity is contracted to administer under a health 1643
benefit plan are subject to the insurance laws and rules of this 1644
state or subject to the jurisdiction of the superintendent. 1645

(Q) "Health information" means information or data, 1646
whether oral or recorded in any form or medium, and personal 1647
facts or information about events or relationships that relates 1648
to all of the following: 1649

(1) The past, present, or future physical, mental, or 1650
behavioral health or condition of a covered person or a member 1651
of the covered person's family; 1652

(2) The provision of health care services or health- 1653
related benefits to a covered person; 1654

(3) Payment for the provision of health care services to 1655
or for a covered person. 1656

(R) "Independent review organization" means an entity that 1657
is accredited to conduct independent external reviews of adverse 1658
benefit determinations pursuant to section 3922.13 of the 1659
Revised Code. 1660

(S) "Medical or scientific evidence" means evidence found 1661
in any of the following sources: 1662

(1) Peer-reviewed scientific studies published in, or 1663

accepted for publication by, medical journals that meet 1664
nationally recognized requirements for scientific manuscripts 1665
and that submit most of their published articles for review by 1666
experts who are not part of the editorial staff; 1667

(2) Peer-reviewed medical literature, including literature 1668
relating to therapies reviewed and approved by a qualified 1669
institutional review board, biomedical compendia and other 1670
medical literature that meet the criteria of the national 1671
institutes of health's library of medicine for indexing in index 1672
medicus and elsevier science ltd. for indexing in excerpta 1673
medicus; 1674

(3) Medical journals recognized by the secretary of health 1675
and human services under section 1861(t)(2) of the federal 1676
social security act; 1677

(4) The following standard reference compendia: 1678

(a) The American hospital formulary service drug 1679
information; 1680

(b) Drug facts and comparisons; 1681

(c) The American dental association accepted dental 1682
therapeutics; 1683

(d) The United States pharmacopoeia drug information. 1684

(5) Findings, studies or research conducted by or under 1685
the auspices of a federal government agency or nationally 1686
recognized federal research institute, including any of the 1687
following: 1688

(a) The federal agency for health care research and 1689
quality; 1690

(b) The national institutes of health;	1691
(c) The national cancer institute;	1692
(d) The national academy of sciences;	1693
(e) The centers for medicare and medicaid services;	1694
(f) The federal food and drug administration;	1695
(g) Any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services.	1696 1697 1698
(6) Any other medical or scientific evidence that is comparable.	1699 1700
(T) "Person" has the same meaning as in section 3901.19 of the Revised Code.	1701 1702
(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.	1703 1704 1705 1706
(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.	1707 1708 1709 1710 1711 1712
(W) "Retrospective review" means a review conducted after services have been provided to a covered person.	1713 1714
(X) "Superintendent" means the superintendent of insurance.	1715 1716
(Y) "Utilization review" has the same meaning as in	1717

section 1751.77 of the Revised Code. 1718

(Z) "Utilization review organization" has the same meaning 1719
as in section 1751.77 of the Revised Code. 1720

Sec. 3923.122. (A) Every policy of group sickness and 1721
accident insurance providing hospital, surgical, or medical 1722
expense coverage for other than specific diseases or accidents 1723
only, and delivered, issued for delivery, or renewed in this 1724
state on or after January 1, 1976, shall include a provision 1725
giving each insured the option to convert to ~~the following:~~ 1726

~~(1) In the case of an individual who is not a federally~~ 1727
~~eligible individual,~~ any of the individual policies of hospital, 1728
surgical, or medical expense insurance then being issued by the 1729
insurer with benefit limits not to exceed those in effect under 1730
the group policy. 1731

~~(2) In the case of a federally eligible individual, a~~ 1732
~~basic or standard plan established in accordance with section~~ 1733
~~3924.10 of the Revised Code or plans substantially similar to~~ 1734
~~the basic and standard plan in benefit design and scope of~~ 1735
~~covered services. For purposes of division (A) (2) of this~~ 1736
~~section, the superintendent of insurance shall determine whether~~ 1737
~~a plan is substantially similar to the basic or standard plan in~~ 1738
~~benefit design and scope of covered services.~~ 1739

(B) An option for conversion to an individual policy shall 1740
be available without evidence of insurability to every insured, 1741
including any person eligible under division (D) of this 1742
section, who terminates employment or membership in the group 1743
holding the policy after having been continuously insured 1744
thereunder for at least one year. 1745

Upon receipt of the insured's written application and upon 1746

payment of at least the first quarterly premium not later than 1747
thirty-one days after the termination of coverage under the 1748
group policy, the insurer shall issue a converted policy on a 1749
form then available for conversion. The premium shall be in 1750
accordance with the insurer's table of premium rates in effect 1751
on the later of the following dates: 1752

(1) The effective date of the converted policy; 1753

(2) The date of application therefor; and shall be 1754
applicable to the class of risk to which each person covered 1755
belongs and to the form and amount of the policy at the person's 1756
then attained age. ~~However, premiums charged federally eligible-~~ 1757
~~individuals may not exceed the amounts specified below:~~ 1758

~~(a) For calendar years 2010 and 2011, an amount that is-~~ 1759
~~two times the base rate charged any other individual of a group-~~ 1760
~~to which the insurer is currently accepting new business and for-~~ 1761
~~which similar copayments and deductibles are applied;~~ 1762

~~(b) For calendar year 2012 and every year thereafter, an-~~ 1763
~~amount that is one and one half times the base rate charged any-~~ 1764
~~other individual of a group to which the insurer is currently-~~ 1765
~~accepting new business and for which similar copayments and-~~ 1766
~~deductibles are applied, unless the superintendent of insurance-~~ 1767
~~determines that the amendments by this act to sections 3923.58-~~ 1768
~~and 3923.581 of the Revised Code, have resulted in the market-~~ 1769
~~wide average medical loss ratio for coverage sold to individual-~~ 1770
~~insureds and nonemployer group insureds in this state, including-~~ 1771
~~open enrollment insureds, to increase by more than five and one-~~ 1772
~~quarter percentage points during calendar year 2010. If the-~~ 1773
~~superintendent makes that determination, the premium limit-~~ 1774
~~established by division (B) (2) (a) of this section shall remain-~~ 1775
~~in effect.~~ 1776

At the election of the insurer, a separate converted 1777
policy may be issued to cover any dependent of an employee or 1778
member of the group. 1779

Except as provided in division (H) of this section, any 1780
converted policy shall become effective as of the day following 1781
the date of termination of insurance under the group policy. 1782

Any probationary or waiting period set forth in the 1783
converted policy is deemed to commence on the effective date of 1784
the insured's coverage under the group policy. 1785

(C) No insurer shall be required to issue a converted 1786
policy to any person who is, or is eligible to be, covered for 1787
benefits at least comparable to the group policy under: 1788

(1) Title XVIII of the Social Security Act, as amended or 1789
superseded; 1790

(2) Any act of congress or law under this or any other 1791
state of the United States that duplicates coverage offered 1792
under division (C) (1) of this section; 1793

(3) Any policy that duplicates coverage offered under 1794
division (C) (1) of this section; 1795

(4) Any other group sickness and accident insurance 1796
providing hospital, surgical, or medical expense coverage for 1797
other than specific diseases or accidents only. 1798

(D) The option for conversion shall be available: 1799

(1) Upon the death of the employee or member, to the 1800
surviving spouse with respect to such of the spouse and 1801
dependents as are then covered by the group policy; 1802

(2) To a child solely with respect to the child upon 1803

attaining the limiting age of coverage under the group policy 1804
while covered as a dependent thereunder; 1805

(3) Upon the divorce, dissolution, or annulment of the 1806
marriage of the employee or member, to the divorced spouse, or 1807
former spouse in the event of annulment, of such employee or 1808
member, or upon the legal separation of the spouse from such 1809
employee or member, to the spouse. 1810

Persons possessing the option for conversion pursuant to 1811
this division shall be considered members for the purposes of 1812
division (H) of this section. 1813

(E) If coverage is continued under a group policy on an 1814
employee following retirement prior to the time the employee is, 1815
or is eligible to be, covered by Title XVIII of the Social 1816
Security Act, the employee may elect, in lieu of the continuance 1817
of group insurance, to have the same conversion rights as would 1818
apply had the employee's insurance terminated at retirement by 1819
reason of termination of employment. 1820

(F) If the insurer and the group policyholder agree upon 1821
one or more additional plans of benefits to be available for 1822
converted policies, the applicant for the converted policy may 1823
elect such a plan in lieu of a converted policy. 1824

(G) The converted policy may contain provisions for 1825
avoiding duplication of benefits provided pursuant to divisions 1826
(C) (1), (2), (3), and (4) of this section or provided under any 1827
other insured or noninsured plan or program. 1828

(H) If an employee or member becomes entitled to obtain a 1829
converted policy pursuant to this section, and if the employee 1830
or member has not received notice of the conversion privilege at 1831
least fifteen days prior to the expiration of the thirty-one-day 1832

conversion period provided in division (B) of this section, then 1833
the employee or member has an additional period within which to 1834
exercise the privilege. This additional period shall expire 1835
fifteen days after the employee or member receives notice, but 1836
in no event shall the period extend beyond sixty days after the 1837
expiration of the thirty-one-day conversion period. 1838

Written notice presented to the employee or member, or 1839
mailed by the policyholder to the last known address of the 1840
employee or member as indicated on its records, constitutes 1841
notice for the purpose of this division. In the case of a person 1842
who is eligible for a converted policy under division (D) (2) or 1843
(D) (3) of this section, a policyholder shall not be responsible 1844
for presenting or mailing such notice, unless such policyholder 1845
has actual knowledge of the person's eligibility for a converted 1846
policy. 1847

If an additional period is allowed by an employee or 1848
member for the exercise of a conversion privilege, and if 1849
written application for the converted policy, accompanied by at 1850
least the first quarterly premium, is made after the expiration 1851
of the thirty-one-day conversion period, but within the 1852
additional period allowed an employee or member in accordance 1853
with this division, the effective date of the converted policy 1854
shall be the date of application. 1855

(I) The converted policy may provide that any hospital, 1856
surgical, or medical expense benefits otherwise payable with 1857
respect to any person may be reduced by the amount of any such 1858
benefits payable under the group policy for the same loss after 1859
termination of coverage. 1860

(J) The converted policy may contain: 1861

(1) Any exclusion, reduction, or limitation contained in 1862
the group policy or customarily used in individual policies 1863
issued by the insurer; 1864

(2) Any provision permitted in this section; 1865

(3) Any other provision not prohibited by law. 1866

Any provision required or permitted in this section may be 1867
made a part of any converted policy by means of an endorsement 1868
or rider. 1869

(K) The time limit specified in a converted policy for 1870
certain defenses with respect to any person who was covered by a 1871
group policy shall commence on the effective date of such 1872
person's coverage under the group policy. 1873

(L) No insurer shall use deterioration of health as the 1874
basis for refusing to renew a converted policy. 1875

(M) No insurer shall use age or health status as the basis 1876
for refusing to renew a converted policy. 1877

(N) A converted policy made available pursuant to this 1878
section shall, if delivery of the policy is to be made in this 1879
state, comply with this section. If delivery of a converted 1880
policy is to be made in another state, it may be on a form 1881
offered by the insurer in the jurisdiction where the delivery is 1882
to be made and which provides benefits substantially in 1883
compliance with those required in a policy delivered in this 1884
state. 1885

~~(O) As used in this section:~~ 1886

~~(1) "Base rate" means, as to any health benefit plan that 1887
is issued by an insurer in the individual market, the lowest 1888
premium rate for new or existing business prescribed by the 1889~~

~~insurer for the same or similar coverage under a plan or~~ 1890
~~arrangement covering any individual of a group with similar ease-~~ 1891
~~characteristics.~~ 1892

~~(2) "Federally eligible individual" means an eligible~~ 1893
~~individual as defined in 45 C.F.R. 148.103.~~ 1894

Sec. 3923.57. Notwithstanding any provision of this 1895
chapter, every individual policy of sickness and accident 1896
insurance that is delivered, issued for delivery, or renewed in 1897
this state is subject to the following conditions, as 1898
applicable: 1899

~~(A) Pre-existing conditions provisions shall not exclude~~ 1900
~~or limit coverage for a period beyond twelve months following~~ 1901
~~the policyholder's effective date of coverage and may only~~ 1902
~~relate to conditions during the six months immediately preceding~~ 1903
~~the effective date of coverage.~~ 1904

~~(B) In determining whether a pre-existing conditions~~ 1905
~~provision applies to a policyholder or dependent, each policy~~ 1906
~~shall credit the time the policyholder or dependent was covered~~ 1907
~~under a previous policy, contract, or plan if the previous~~ 1908
~~coverage was continuous to a date not more than thirty days~~ 1909
~~prior to the effective date of the new coverage, exclusive of~~ 1910
~~any applicable service waiting period under the policy.~~ 1911

~~(C)~~ (1) Except as otherwise provided in division ~~(C)~~ (A) of 1912
this section, an insurer that provides an individual sickness 1913
and accident insurance policy to an individual shall renew or 1914
continue in force such coverage at the option of the individual. 1915

(2) An insurer may nonrenew or discontinue coverage of an 1916
individual in the individual market based only on one or more of 1917
the following reasons: 1918

(a) The individual failed to pay premiums or contributions 1919
in accordance with the terms of the policy or the insurer has 1920
not received timely premium payments. 1921

(b) The individual performed an act or practice that 1922
constitutes fraud or made an intentional misrepresentation of 1923
material fact under the terms of the policy. 1924

(c) The insurer is ceasing to offer coverage in the 1925
individual market in accordance with division ~~(D)~~ (B) of this 1926
section and the applicable laws of this state. 1927

(d) If the insurer offers coverage in the market through a 1928
network plan, the individual no longer resides, lives, or works 1929
in the service area, or in an area for which the insurer is 1930
authorized to do business; provided, however, that such coverage 1931
is terminated uniformly without regard to any health status- 1932
related factor of covered individuals. 1933

(e) If the coverage is made available in the individual 1934
market only through one or more bona fide associations, the 1935
membership of the individual in the association, on the basis of 1936
which the coverage is provided, ceases; provided, however, that 1937
such coverage is terminated under division ~~(C)~~ (A) (2) (e) of this 1938
section uniformly without regard to any health status-related 1939
factor of covered individuals. 1940

~~An insurer offering coverage to individuals solely through 1941
membership in a bona fide association shall not be deemed, by 1942
virtue of that offering, to be in the individual market for 1943
purposes of sections 3923.58 and 3923.581 of the Revised Code. 1944
Such an insurer shall not be required to accept applicants for 1945
coverage in the individual market pursuant to sections 3923.58 1946
and 3923.581 of the Revised Code unless the insurer also offers 1947~~

~~coverage to individuals other than through bona fide~~ 1948
~~associations.~~ 1949

(3) An insurer may cancel or decide not to renew the 1950
coverage of a dependent of an individual if the dependent has 1951
performed an act or practice that constitutes fraud or made an 1952
intentional misrepresentation of material fact under the terms 1953
of the coverage and if the cancellation or nonrenewal is not 1954
based, either directly or indirectly, on any health status- 1955
related factor in relation to the dependent. 1956

~~(D)~~ (B) (1) If an insurer decides to discontinue offering a 1957
particular type of health insurance coverage offered in the 1958
individual market, coverage of such type may be discontinued by 1959
the insurer if the insurer does all of the following: 1960

(a) Provides notice to each individual provided coverage 1961
of this type in such market of the discontinuation at least 1962
ninety days prior to the date of the discontinuation of the 1963
coverage; 1964

(b) Offers to each individual provided coverage of this 1965
type in such market, the option to purchase any other individual 1966
health insurance coverage currently being offered by the insurer 1967
for individuals in that market; 1968

(c) In exercising the option to discontinue coverage of 1969
this type and in offering the option of coverage under division 1970
~~(D)~~ (B) (1) (b) of this section, acts uniformly without regard to 1971
any health status-related factor of covered individuals or of 1972
individuals who may become eligible for such coverage. 1973

(2) If an insurer elects to discontinue offering all 1974
health insurance coverage in the individual market in this 1975
state, health insurance coverage may be discontinued by the 1976

insurer only if both of the following apply: 1977

(a) The insurer provides notice to the department of 1978
insurance and to each individual of the discontinuation at least 1979
one hundred eighty days prior to the date of the expiration of 1980
the coverage. 1981

(b) All health insurance delivered or issued for delivery 1982
in this state in such market is discontinued and coverage under 1983
that health insurance in that market is not renewed. 1984

(3) In the event of a discontinuation under division ~~(D)~~ 1985
(B)(2) of this section in the individual market, the insurer 1986
shall not provide for the issuance of any health insurance 1987
coverage in the market and this state during the five-year 1988
period beginning on the date of the discontinuation of the last 1989
health insurance coverage not so renewed. 1990

~~(E)~~(C) Notwithstanding divisions ~~(C)~~(A) and ~~(D)~~(B) of 1991
this section, an insurer may, at the time of coverage renewal, 1992
modify the health insurance coverage for a policy form offered 1993
to individuals in the individual market if the modification is 1994
consistent with the law of this state and effective on a uniform 1995
basis among all individuals with that policy form. 1996

~~(F)~~(D) Such policies are subject to sections 2743 and 1997
2747 of the "Health Insurance Portability and Accountability Act 1998
of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 1999
300gg-43 and 300gg-47, as amended. 2000

~~(G)~~(E) Sections 3924.031 and 3924.032 of the Revised Code 2001
shall apply to sickness and accident insurance policies offered 2002
in the individual market in the same manner as they apply to 2003
health benefit plans offered in the small employer market. 2004

In accordance with 45 C.F.R. 148.102, divisions ~~(C)~~(A) to 2005

~~(G)~~~~(E)~~ of this section also apply to all group sickness and 2006
accident insurance policies that are not sold in connection with 2007
an employment-related group health plan and that provide more 2008
than short-term, limited duration coverage. 2009

In applying divisions ~~(C)~~~~(A)~~ to ~~(G)~~~~(E)~~ of this section 2010
with respect to health insurance coverage that is made available 2011
by an insurer in the individual market to individuals only 2012
through one or more associations, the term "individual" includes 2013
the association of which the individual is a member. 2014

For purposes of this section, any policy issued pursuant 2015
to division (C) of section 3923.13 of the Revised Code in 2016
connection with a public or private college or university 2017
student health insurance program is considered to be issued to a 2018
bona fide association. 2019

As used in this section, "bona fide association" has the 2020
same meaning as in section 3924.03 of the Revised Code, and 2021
"health status-related factor" and "network plan" have the same 2022
meanings as in section 3924.031 of the Revised Code. 2023

This section does not apply to any policy that provides 2024
coverage for specific diseases or accidents only, or to any 2025
hospital indemnity, medicare supplement, long-term care, 2026
disability income, one-time-limited-duration policy that is less 2027
than twelve months, or other policy that offers only 2028
supplemental benefits. 2029

Sec. 3923.571. Except as otherwise provided in section 2030
2721 of the "Health Insurance Portability and Accountability Act 2031
of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 2032
300gg-21, as amended, the following conditions apply to all 2033
group policies of sickness and accident insurance that are sold 2034

in connection with an employment-related group health plan and 2035
that are not subject to section 3924.03 of the Revised Code: 2036

(A) Any such policy shall comply with the requirements of 2037
~~division (A) of section 3924.03 and section 3924.033~~ of the 2038
Revised Code. 2039

(B) (1) Except as provided in section 2712(b) to (e) of the 2040
"Health Insurance Portability and Accountability Act of 1996," 2041
if an insurer offers coverage in the small or large group market 2042
in connection with a group policy, the insurer shall renew or 2043
continue in force such coverage at the option of the 2044
policyholder. 2045

(2) An insurer may cancel or decide not to renew the 2046
coverage of an employee or of a dependent of an employee if the 2047
employee or dependent, as applicable, has performed an act or 2048
practice that constitutes fraud or made an intentional 2049
misrepresentation of material fact under the terms of the 2050
coverage and if the cancellation or nonrenewal is not based, 2051
either directly or indirectly, on any health status-related 2052
factor in relation to the employee or dependent. 2053

As used in division (B) (2) of this section, "health 2054
status-related factor" has the same meaning as in section 2055
3924.031 of the Revised Code. 2056

(C) (1) No such policy, or insurer offering health 2057
insurance coverage in connection with such a policy, shall 2058
require any individual, as a condition of coverage or continued 2059
coverage under the policy, to pay a premium or contribution that 2060
is greater than the premium or contribution for a similarly 2061
situated individual covered under the policy on the basis of any 2062
health status-related factor in relation to the individual or to 2063

an individual covered under the policy as a dependent of the individual. 2064
2065

(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. 2066
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(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." 2073
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(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. 2076
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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. 2087
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(B) Notwithstanding section 3901.71 of the Revised Code 2093
and subject to division (D) of this section, no individual or 2094
group policy of sickness and accident insurance that is 2095
delivered, issued for delivery, or renewed in this state and no 2096
public employee benefit plan that is established or modified in 2097
this state shall fail to comply with either of the following: 2098

(1) The policy or plan shall not provide coverage or 2099
impose cost sharing for a prescribed, orally administered cancer 2100
medication on a less favorable basis than the coverage it 2101
provides or cost sharing it imposes for intravenously 2102
administered or injected cancer medications. 2103

(2) The policy or plan shall not comply with division (B) 2104
(1) of this section by imposing an increase in cost sharing 2105
solely for orally administered, intravenously administered, or 2106
injected cancer medications. 2107

(C) Notwithstanding any provision of this section to the 2108
contrary, a policy or plan shall be deemed to be in compliance 2109
with this section if the cost sharing imposed under such a 2110
policy or plan for orally administered cancer treatments does 2111
not exceed one hundred dollars per prescription fill. The cost 2112
_sharing limit of one hundred dollars per prescription fill 2113
shall apply to a high deductible plan, as defined in 26 U.S.C. 2114
223, or a catastrophic plan, described in division (D) (2) of 2115
section 3902.43 of the Revised Code and as defined in 42 U.S.C. 2116
18022, only after the deductible has been met. 2117

(D) (1) The prohibitions in division (B) of this section do 2118
not preclude an individual or group policy of sickness and 2119
accident insurance or public employee benefit plan from 2120
requiring an insured or plan member to obtain prior 2121
authorization before orally administered cancer medication is 2122

dispensed to the insured or plan member. 2123

(2) Division (B) of this section does not apply to the 2124
offer or renewal of any individual or group policy of sickness 2125
and accident insurance that provides coverage for specific 2126
diseases or accidents only, or to any hospital indemnity, 2127
medicare supplement, disability income, or other policy that 2128
offers only supplemental benefits. 2129

(E) An insurer that offers any sickness and accident 2130
insurance or any public employee benefit plan that offers 2131
coverage for basic health care services is not required to 2132
comply with division (B) of this section if all of the following 2133
apply: 2134

(1) The insurer or plan submits documentation certified by 2135
an independent member of the American academy of actuaries to 2136
the superintendent of insurance showing that compliance with 2137
division (B)(1) of this section for a period of at least six 2138
months independently caused the insurer or plan's costs for 2139
claims and administrative expenses for the coverage of basic 2140
health care services to increase by more than one per cent per 2141
year. 2142

(2) The insurer or plan submits a signed letter from an 2143
independent member of the American academy of actuaries to the 2144
superintendent of insurance opining that the increase in costs 2145
described in division (E)(1) of this section could reasonably 2146
justify an increase of more than one per cent in the annual 2147
premiums or rates charged by the insurer or plan for the 2148
coverage of basic health care services. 2149

(3) (a) The superintendent of insurance makes the following 2150
determinations from the documentation and opinion submitted 2151

pursuant to divisions (E) (1) and (2) of this section:	2152
(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.	2153 2154 2155 2156 2157
(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.	2158 2159 2160 2161
(b) Any determination made by the superintendent under division (E) (3) of this section is subject to Chapter 119. of the Revised Code.	2162 2163 2164
Sec. 3924.01. As used in sections 3924.01 to 3924.14 <u>3924.06</u> of the Revised Code:	2165 2166
(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 <u>3924.06</u> 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.	2167 2168 2169 2170 2171 2172 2173 2174 2175 2176
(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	2177 2178 2179 2180

~~an OHC plan sold to groups with similar case characteristics by~~ 2181
~~all carriers selling OHC plans in the state, or on any other~~ 2182
~~equitable basis determined by the board.~~ 2183

~~(C)~~—"Base premium rate" means, as to any health benefit 2184
plan that is issued by a carrier and that covers at least two 2185
but no more than fifty employees of a small employer, the lowest 2186
premium rate for a new or existing business prescribed by the 2187
carrier for the same or similar coverage under a plan or 2188
arrangement covering any small employer with similar case 2189
characteristics. 2190

~~(D)~~ (C) "Carrier" means any sickness and accident 2191
insurance company or health insuring corporation authorized to 2192
issue health benefit plans in this state or a MEWA. A sickness 2193
and accident insurance company that owns or operates a health 2194
insuring corporation, either as a separate corporation or as a 2195
line of business, shall be considered as a separate carrier from 2196
that health insuring corporation for purposes of sections 2197
3924.01 to ~~3924.14~~ 3924.06 of the Revised Code. 2198

~~(E)~~ (D) "Case characteristics" means, with respect to a 2199
small employer, the geographic area in which the employees work; 2200
the age and sex of the individual employees and their 2201
dependents; the appropriate industry classification as 2202
determined by the carrier; the number of employees and 2203
dependents; and such other objective criteria as may be 2204
established by the carrier. "Case characteristics" does not 2205
include claims experience, health status, or duration of 2206
coverage from the date of issue. 2207

~~(F)~~ (E) "Dependent" means the spouse or child of an 2208
eligible employee, subject to applicable terms of the health 2209
benefits plan covering the employee. 2210

~~(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 2241
U.S.C.A. 1001, as amended, except for any arrangement which is 2242
fully insured as defined in division (b) (6) (D) of section 514 of 2243
that act. 2244

~~(K)~~ (J) "Midpoint rate" means, for small employers with 2245
similar case characteristics and plan designs and as determined 2246
by the applicable carrier for a rating period, the arithmetic 2247
average of the applicable base premium rate and the 2248
corresponding highest premium rate. 2249

~~(L)~~ "Pre-existing conditions provision" means a policy 2250
provision that excludes or limits coverage for charges or 2251
expenses incurred during a specified period following the 2252
insured's enrollment date as to a condition for which medical 2253
advice, diagnosis, care, or treatment was recommended or 2254
received during a specified period immediately preceding the 2255
enrollment date. Genetic information shall not be treated as 2256
such a condition in the absence of a diagnosis of the condition 2257
related to such information. 2258

~~For purposes of this division, "enrollment date" means,~~ 2259
~~with respect to an individual covered under a group health~~ 2260
~~benefit plan, the date of enrollment of the individual in the~~ 2261
~~plan or, if earlier, the first day of the waiting period for~~ 2262
~~such enrollment.~~ 2263

~~(M)~~ (K) "Service waiting period" means the period of time 2264
after employment begins before an employee is eligible to be 2265
covered for benefits under the terms of any applicable health 2266
benefit plan offered by the small employer. 2267

~~(N)~~ (L) (1) "Small employer" means, in connection with a 2268
group health benefit plan and with respect to a calendar year 2269

and a plan year, an employer who employed an average of at least 2270
two but no more than fifty eligible employees on business days 2271
during the preceding calendar year and who employs at least two 2272
employees on the first day of the plan year. 2273

(2) For purposes of division (N)(1) of this section, all 2274
persons treated as a single employer under subsection (b), (c), 2275
(m), or (o) of section 414 of the "Internal Revenue Code of 2276
1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be 2277
considered one employer. In the case of an employer that was not 2278
in existence throughout the preceding calendar year, the 2279
determination of whether the employer is a small or large 2280
employer shall be based on the average number of eligible 2281
employees that it is reasonably expected the employer will 2282
employ on business days in the current calendar year. Any 2283
reference in division (N) of this section to an "employer" 2284
includes any predecessor of the employer. Except as otherwise 2285
specifically provided, provisions of sections 3924.01 to ~~3924.14~~ 2286
3924.06 of the Revised Code that apply to a small employer that 2287
has a health benefit plan shall continue to apply until the plan 2288
anniversary following the date the employer no longer meets the 2289
requirements of this division. 2290

~~(O) "OHC plan" means an Ohio health care plan, which is~~ 2291
~~the basic, standard, or carrier reimbursement plan for small~~ 2292
~~employers and individuals established in accordance with section~~ 2293
~~3924.10 of the Revised Code.~~ 2294

Sec. 3924.02. (A) An individual or group health benefit 2295
plan is subject to sections 3924.01 to ~~3924.14~~3924.06 of the 2296
Revised Code if it provides health care benefits covering at 2297
least two but no more than fifty employees of a small employer, 2298
and if it meets either of the following conditions: 2299

(1) Any portion of the premium or benefits is paid by a 2300
small employer, or any covered individual is reimbursed, whether 2301
through wage adjustments or otherwise, by a small employer for 2302
any portion of the premium. 2303

(2) The health benefit plan is treated by the employer or 2304
any of the covered individuals as part of a plan or program for 2305
purposes of section 106 or 162 of the "Internal Revenue Code of 2306
1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended. 2307

(B) Notwithstanding division (A) of this section, 2308
divisions ~~(D)~~(C), ~~(E)~~(D)(2), ~~(F)~~(E), and ~~(G)~~(F) of section 2309
3924.03 of the Revised Code and section 3924.04 of the Revised 2310
Code do not apply to health benefit policies that are not sold 2311
to owners of small businesses as an employment benefit plan. 2312
Such policies shall clearly state that they are not being sold 2313
as an employment benefit plan and that the owner of the business 2314
is not responsible, either directly or indirectly, for paying 2315
the premium or benefits. 2316

(C) Every health benefit plan offered or delivered by a 2317
carrier, other than a health insuring corporation, to a small 2318
employer is subject to sections 3923.23, 3923.231, 3923.232, 2319
3923.233, and 3923.234 of the Revised Code and any other 2320
provision of the Revised Code that requires the reimbursement, 2321
utilization, or consideration of a specific category of a 2322
licensed or certified health care practitioner. 2323

(D) Except as expressly provided in sections 3924.01 to 2324
~~3924.14~~3924.06 of the Revised Code, no health benefit plan 2325
offered to a small employer is subject to any of the following: 2326

(1) Any law that would inhibit any carrier from 2327
contracting with providers or groups of providers with respect 2328

to health care services or benefits; 2329

(2) Any law that would impose any restriction on the 2330
ability to negotiate with providers regarding the level or 2331
method of reimbursing care or services provided under the health 2332
benefit plan; 2333

(3) Any law that would require any carrier to either 2334
include a specific provider or class of provider when 2335
contracting for health care services or benefits, or to exclude 2336
any class of provider that is generally authorized by statute to 2337
provide such care. 2338

Sec. 3924.03. Except as otherwise provided in section 2721 2339
of the "Health Insurance Portability and Accountability Act of 2340
1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg- 2341
21, as amended, health benefit plans covering small employers 2342
are subject to the following conditions, as applicable: 2343

~~(A) (1) Pre-existing conditions provisions shall not 2344
exclude or limit coverage for a period beyond twelve months, or 2345
eighteen months in the case of a late enrollee, following the 2346
individual's enrollment date and may only relate to a physical- 2347
or mental condition, regardless of the cause of the condition, 2348
for which medical advice, diagnosis, care, or treatment was 2349
recommended or received within the six months immediately 2350
preceding the enrollment date. 2351~~

~~Division (A) (1) of this section is subject to the 2352
exceptions set forth in section 2701(d) of the "Health Insurance- 2353
Portability and Accountability Act of 1996." 2354~~

~~(2) The period of any such pre-existing condition- 2355
exclusion shall be reduced by the aggregate of the periods of 2356
creditable coverage, if any, applicable to the employee or 2357~~

~~dependent as of the enrollment date.~~ 2358

~~(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.~~ 2359
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~~(4) As used in division (A) of this section:~~ 2367

~~(a) "Creditable coverage" has the same meaning as in section 2701(c) (1) of the "Health Insurance Portability and Accountability Act of 1996."~~ 2368
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~~(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.~~ 2371
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~~(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.~~ 2375
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(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 2381
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not based, either directly or indirectly, on any health status- 2387
related factor in relation to the employee or dependent. 2388

As used in division ~~(B)~~(A) (2) of this section, "health 2389
status-related factor" has the same meaning as in section 2390
3924.031 of the Revised Code. 2391

~~(C)~~(B) A carrier shall not exclude any eligible employee 2392
or dependent, who would otherwise be covered under a health 2393
benefit plan, on the basis of any actual or expected health 2394
condition of the employee or dependent. 2395

If, prior to November 24, 1995, a carrier excluded an 2396
eligible employee or dependent, other than a late enrollee, on 2397
the basis of an actual or expected health condition, the carrier 2398
shall, upon the initial renewal of the coverage on or after that 2399
date, extend coverage to the employee or dependent if all other 2400
eligibility requirements are met. 2401

~~(D)~~(C) No health benefit plan issued by a carrier shall 2402
limit or exclude, by use of a rider or amendment applicable to a 2403
specific individual, coverage by type of illness, treatment, 2404
medical condition, or accident, ~~except for pre-existing~~ 2405
~~conditions as permitted under division (A) of this section.~~ If a 2406
health benefit plan that is delivered or issued for delivery 2407
prior to April 14, 1993, contains such limitations or 2408
exclusions, by use of a rider or amendment applicable to a 2409
specific individual, the plan shall eliminate the use of such 2410
riders or amendments within eighteen months after April 14, 2411
1993. 2412

~~(E)~~(D) (1) Except as provided in sections 3924.031 and 2413
3924.032 of the Revised Code, and subject to such rules as may 2414
be adopted by the superintendent of insurance in accordance with 2415

Chapter 119. of the Revised Code, a carrier shall offer and make 2416
available every health benefit plan that it is actively 2417
marketing to every small employer that applies to the carrier 2418
for such coverage. 2419

Division ~~(E)~~(D)(1) of this section does not apply to a 2420
health benefit plan that a carrier makes available in the small 2421
employer market only through one or more bona fide associations. 2422

Division ~~(E)~~(D)(1) of this section shall not be construed 2423
to preclude a carrier from establishing employer contribution 2424
rules or group participation rules for the offering of coverage 2425
in connection with a group health benefit plan in the small 2426
employer market, as allowed under the law of this state. As used 2427
in division ~~(E)~~(D)(1) of this section, "employer contribution 2428
rule" means a requirement relating to the minimum level or 2429
amount of employer contribution toward the premium for 2430
enrollment of employees and dependents and "group participation 2431
rule" means a requirement relating to the minimum number of 2432
employees or dependents that must be enrolled in relation to a 2433
specified percentage or number of eligible individuals or 2434
employees of an employer. 2435

(2) Each health benefit plan, at the time of initial group 2436
enrollment, shall make coverage available to all the eligible 2437
employees of a small employer without a service waiting period. 2438
The decision of whether to impose a service waiting period shall 2439
be made by the small employer. Such waiting periods shall not be 2440
greater than ninety days. 2441

(3) Each health benefit plan shall provide for the special 2442
enrollment periods described in section 2701(f) of the "Health 2443
Insurance Portability and Accountability Act of 1996." 2444

(4) At least once in every twelve-month period, a carrier 2445
shall provide to all late enrollees who are identified by the 2446
small employer, the option to enroll in the health benefit plan. 2447
The enrollment option shall be provided for a minimum period of 2448
thirty consecutive days. All delays of coverage imposed under 2449
the health benefit plan, including any ~~pre-existing condition-~~ 2450
~~exclusion period, affiliation period,~~ or service waiting period, 2451
shall begin on the date the carrier receives notice of the late 2452
enrollee's application or request for coverage, and shall run 2453
concurrently with each other. 2454

~~(F)~~ (E) The benefit structure of any health benefit plan 2455
may, at the time of coverage renewal, be changed by the carrier 2456
to make it consistent with the benefit structure contained in 2457
health benefit plans being marketed to new small employer 2458
groups. If the health benefit plan is available in the small 2459
employer market other than only through one or more bona fide 2460
associations, the modification must be consistent with the law 2461
of this state and effective on a uniform basis among small 2462
employer group plans. 2463

~~(G)~~ (F) A carrier may obtain any facts and information 2464
necessary to apply this section, or supply those facts and 2465
information to any other third-party payer, without the consent 2466
of the beneficiary. Each person claiming benefits under a health 2467
benefit plan shall provide any facts and information necessary 2468
to apply this section. 2469

For purposes of this section, "bona fide association" 2470
means an association that has been actively in existence for at 2471
least five years; has been formed and maintained in good faith 2472
for purposes other than obtaining insurance; does not condition 2473
membership in the association on any health status-related 2474

factor, as defined in section 3924.031 of the Revised Code, 2475
relating to an individual, including an employee or dependent; 2476
makes health insurance coverage offered through the association 2477
available to all members regardless of any health status-related 2478
factor, as defined in section 3924.031 of the Revised Code, 2479
relating to such members or to individuals eligible for coverage 2480
through a member; does not make health insurance coverage 2481
offered through the association available other than in 2482
connection with a member of the association; and meets any other 2483
requirement imposed by the superintendent. To maintain its 2484
status as a "bona fide association," each association shall 2485
annually certify to the superintendent that it meets the 2486
requirements of this paragraph. 2487

Sec. 3924.033. (A) Each carrier, in connection with the 2488
offering of a health benefit plan to a small employer, shall 2489
disclose to the employer, as part of its solicitation and sales 2490
materials, the following information: 2491

(1) The provisions of the plan concerning the carrier's 2492
right to change premium rates and the factors that may affect 2493
changes in premium rates; 2494

(2) The provisions of the plan relating to renewability of 2495
coverage; 2496

(3) ~~The provisions of the plan relating to any pre-~~ 2497
~~existing condition exclusion;~~ 2498

~~(4) The benefits and premiums available under all health~~ 2499
~~benefit plans for which the employer is qualified.~~ 2500

(B) The information described in division (A) of this 2501
section shall be provided in a manner determined to be 2502
understandable by the average small employer, and in a manner 2503

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. 2533

Sec. 3924.51. (A) As used in this section: 2534

(1) "Child" means, in connection with any adoption or 2535
placement for adoption of the child, an individual who has not 2536
attained age eighteen as of the date of the adoption or 2537
placement for adoption. 2538

(2) "Health insurer" has the same meaning as in section 2539
3924.41 of the Revised Code. 2540

(3) "Placement for adoption" means the assumption and 2541
retention by a person of a legal obligation for total or partial 2542
support of a child in anticipation of the adoption of the child. 2543
The child's placement with a person terminates upon the 2544
termination of that legal obligation. 2545

(B) If an individual or group health plan of a health 2546
insurer makes coverage available for dependent children of 2547
participants or beneficiaries, the plan shall provide benefits 2548
to dependent children placed with participants or beneficiaries 2549
for adoption under the same terms and conditions as apply to the 2550
natural, dependent children of the participants and 2551
beneficiaries, irrespective of whether the adoption has become 2552
final. 2553

~~(C) A health plan described in division (B) of this 2554
section shall not restrict coverage under the plan of any 2555
dependent child adopted by a participant or beneficiary, or 2556
placed with a participant or beneficiary for adoption, solely on 2557
the basis of a pre-existing condition of the child at the time 2558
that the child would otherwise become eligible for coverage 2559
under the plan, if the adoption or placement for adoption occurs 2560
while the participant or beneficiary is eligible for coverage 2561~~

~~under the plan.~~ 2562

Sec. 3924.73. (A) As used in this section: 2563

(1) "Health care insurer" means any person legally engaged 2564
in the business of providing sickness and accident insurance 2565
contracts in this state, a health insuring corporation organized 2566
under Chapter 1751. of the Revised Code, or any legal entity 2567
that is self-insured and provides health care benefits to its 2568
employees or members. 2569

(2) "Small employer" has the same meaning as in section 2570
3924.01 of the Revised Code. 2571

(B) (1) Subject to division (B) (2) of this section, nothing 2572
in sections 3924.61 to 3924.74 of the Revised Code shall be 2573
construed to limit the rights, privileges, or protections of 2574
employees or small employers under sections 3924.01 to ~~3924.14~~ 2575
3924.06 of the Revised Code. 2576

(2) If any account holder enrolls or applies to enroll in 2577
a policy or contract offered by a health care insurer providing 2578
sickness and accident coverage that is more comprehensive than, 2579
and has a deductible amount that is less than, the coverage and 2580
deductible amount of the policy under which the account holder 2581
currently is enrolled, the health care insurer to which the 2582
account holder applies may subject the account holder to the 2583
same medical review, waiting periods, and underwriting 2584
requirements to which the health care insurer generally subjects 2585
other enrollees or applicants, unless the account holder enrolls 2586
or applies to enroll during a designated period of open 2587
enrollment. 2588

Section 2. That existing sections 1731.03, 1731.04, 2589
1731.05, 1731.09, 1739.05, 1751.01, 1751.06, 1751.12, 1751.16, 2590

1751.18, 1751.58, 1751.69, 3901.381, 3922.01, 3923.122, 3923.57, 2591
3923.571, 3923.85, 3924.01, 3924.02, 3924.03, 3924.033, 3924.06, 2592
3924.51, and 3924.73 of the Revised Code are hereby repealed. 2593

Section 3. That sections 1751.15, 3923.58, 3923.581, 2594
3923.582, 3923.59, 3924.07, 3924.08, 3924.09, 3924.10, 3924.11, 2595
3924.111, 3924.12, 3924.13, and 3924.14 of the Revised Code are 2596
hereby repealed. 2597

Section 4. The amendments to sections 1751.16 and 3923.122 2598
of the Revised Code in Section 1 of this act, which were 2599
suspended by Section 3 of Sub. S.B. 9 of the 130th General 2600
Assembly and which suspension was extended by Section 610.53 of 2601
Am. Sub. H.B. 49 of the 132nd General Assembly, do not affect 2602
the suspension of those sections. If either or both sections 2603
1751.16 and 3923.122 of the Revised Code become operational, 2604
they will be so in either their form as amended by this act or 2605
as they are later amended. 2606

Section 5. This act applies to health benefit plans, as 2607
defined in section 3922.01 of the Revised Code, delivered, 2608
issued for delivery, modified, or renewed on or after the 2609
effective date of this section. 2610

Section 6. Section 1751.12 of the Revised Code is 2611
presented in this act as a composite of the section as amended 2612
by both H.B. 59 and H.B. 3 of the 130th General Assembly. The 2613
General Assembly, applying the principle stated in division (B) 2614
of section 1.52 of the Revised Code that amendments are to be 2615
harmonized if reasonably capable of simultaneous operation, 2616
finds that the composite is the resulting version of the section 2617
in effect prior to the effective date of the section as 2618
presented in this act. 2619