

**As Reported by the House Insurance Committee**

**132nd General Assembly**

**Regular Session**

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**H. B. No. 367**

**Representative DeVitis**

**Cosponsors: Representatives Duffey, Hood, Johnson, Butler, Becker, Antani,  
Celebrezze, Retherford, Scherer, Blessing, Lipps**

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**A BILL**

To amend sections 1753.09, 3901.21, 3963.01, 1  
3963.02, and 3963.03 of the Revised Code to 2  
prohibit a health insurer from establishing a 3  
fee schedule for dental providers for services 4  
that are not covered by any contract or 5  
participating provider agreement between the 6  
health insurer and the dental provider. 7

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

**Section 1.** That sections 1753.09, 3901.21, 3963.01, 8  
3963.02, and 3963.03 of the Revised Code be amended to read as 9  
follows: 10

**Sec. 1753.09.** (A) Except as provided in division (D) of 11  
this section, prior to terminating the participation of a 12  
provider on the basis of the participating provider's failure to 13  
meet the health insuring corporation's standards for quality or 14  
utilization in the delivery of health care services, a health 15  
insuring corporation shall give the participating provider 16  
notice of the reason or reasons for its decision to terminate 17  
the provider's participation and an opportunity to take 18

corrective action. The health insuring corporation shall develop 19  
a performance improvement plan in conjunction with the 20  
participating provider. If after being afforded the opportunity 21  
to comply with the performance improvement plan, the 22  
participating provider fails to do so, the health insuring 23  
corporation may terminate the participation of the provider. 24

(B) (1) A participating provider whose participation has 25  
been terminated under division (A) of this section may appeal 26  
the termination to the appropriate medical director of the 27  
health insuring corporation. The medical director shall give the 28  
participating provider an opportunity to discuss with the 29  
medical director the reason or reasons for the termination. 30

(2) If a satisfactory resolution of a participating 31  
provider's appeal cannot be reached under division (B) (1) of 32  
this section, the participating provider may appeal the 33  
termination to a panel composed of participating providers who 34  
have comparable or higher levels of education and training than 35  
the participating provider making the appeal. A representative 36  
of the participating provider's specialty shall be a member of 37  
the panel, if possible. This panel shall hold a hearing, and 38  
shall render its recommendation in the appeal within thirty days 39  
after holding the hearing. The recommendation shall be presented 40  
to the medical director and to the participating provider. 41

(3) The medical director shall review and consider the 42  
panel's recommendation before making a decision. The decision 43  
rendered by the medical director shall be final. 44

(C) A provider's status as a participating provider shall 45  
remain in effect during the appeal process set forth in division 46  
(B) of this section unless the termination was based on any of 47  
the reasons listed in division (D) of this section. 48

(D) Notwithstanding division (A) of this section, a provider's participation may be immediately terminated if the participating provider's conduct presents an imminent risk of harm to an enrollee or enrollees; or if there has occurred unacceptable quality of care, fraud, patient abuse, loss of clinical privileges, loss of professional liability coverage, incompetence, or loss of authority to practice in the participating provider's field; or if a governmental action has impaired the participating provider's ability to practice.

(E) Divisions (A) to (D) of this section apply only to providers who are natural persons.

(F) (1) Nothing in this section prohibits a health insuring corporation from rejecting a provider's application for participation, or from terminating a participating provider's contract, if the health insuring corporation determines that the health care needs of its enrollees are being met and no need exists for the provider's or participating provider's services.

(2) Nothing in this section shall be construed as prohibiting a health insuring corporation from terminating a participating provider who does not meet the terms and conditions of the participating provider's contract.

(3) Nothing in this section shall be construed as prohibiting a health insuring corporation from terminating a participating provider's contract pursuant to any provision of the contract described in division ~~(E)~~ (F) (2) of section 3963.02 of the Revised Code, except that, notwithstanding any provision of a contract described in that division, this section applies to the termination of a participating provider's contract for any of the causes described in divisions (A), (D), and (F) (1) and (2) of this section.

(G) The superintendent of insurance may adopt rules as 79  
necessary to implement and enforce sections 1753.06, 1753.07, 80  
and 1753.09 of the Revised Code. Such rules shall be adopted in 81  
accordance with Chapter 119. of the Revised Code. 82

**Sec. 3901.21.** The following are hereby defined as unfair 83  
and deceptive acts or practices in the business of insurance: 84

(A) Making, issuing, circulating, or causing or permitting 85  
to be made, issued, or circulated, or preparing with intent to 86  
so use, any estimate, illustration, circular, or statement 87  
misrepresenting the terms of any policy issued or to be issued 88  
or the benefits or advantages promised thereby or the dividends 89  
or share of the surplus to be received thereon, or making any 90  
false or misleading statements as to the dividends or share of 91  
surplus previously paid on similar policies, or making any 92  
misleading representation or any misrepresentation as to the 93  
financial condition of any insurer as shown by the last 94  
preceding verified statement made by it to the insurance 95  
department of this state, or as to the legal reserve system upon 96  
which any life insurer operates, or using any name or title of 97  
any policy or class of policies misrepresenting the true nature 98  
thereof, or making any misrepresentation or incomplete 99  
comparison to any person for the purpose of inducing or tending 100  
to induce such person to purchase, amend, lapse, forfeit, 101  
change, or surrender insurance. 102

Any written statement concerning the premiums for a policy 103  
which refers to the net cost after credit for an assumed 104  
dividend, without an accurate written statement of the gross 105  
premiums, cash values, and dividends based on the insurer's 106  
current dividend scale, which are used to compute the net cost 107  
for such policy, and a prominent warning that the rate of 108

dividend is not guaranteed, is a misrepresentation for the 109  
purposes of this division. 110

(B) Making, publishing, disseminating, circulating, or 111  
placing before the public or causing, directly or indirectly, to 112  
be made, published, disseminated, circulated, or placed before 113  
the public, in a newspaper, magazine, or other publication, or 114  
in the form of a notice, circular, pamphlet, letter, or poster, 115  
or over any radio station, or in any other way, or preparing 116  
with intent to so use, an advertisement, announcement, or 117  
statement containing any assertion, representation, or 118  
statement, with respect to the business of insurance or with 119  
respect to any person in the conduct of the person's insurance 120  
business, which is untrue, deceptive, or misleading. 121

(C) Making, publishing, disseminating, or circulating, 122  
directly or indirectly, or aiding, abetting, or encouraging the 123  
making, publishing, disseminating, or circulating, or preparing 124  
with intent to so use, any statement, pamphlet, circular, 125  
article, or literature, which is false as to the financial 126  
condition of an insurer and which is calculated to injure any 127  
person engaged in the business of insurance. 128

(D) Filing with any supervisory or other public official, 129  
or making, publishing, disseminating, circulating, or delivering 130  
to any person, or placing before the public, or causing directly 131  
or indirectly to be made, published, disseminated, circulated, 132  
delivered to any person, or placed before the public, any false 133  
statement of financial condition of an insurer. 134

Making any false entry in any book, report, or statement 135  
of any insurer with intent to deceive any agent or examiner 136  
lawfully appointed to examine into its condition or into any of 137  
its affairs, or any public official to whom such insurer is 138

required by law to report, or who has authority by law to 139  
examine into its condition or into any of its affairs, or, with 140  
like intent, willfully omitting to make a true entry of any 141  
material fact pertaining to the business of such insurer in any 142  
book, report, or statement of such insurer, or mutilating, 143  
destroying, suppressing, withholding, or concealing any of its 144  
records. 145

(E) Issuing or delivering or permitting agents, officers, 146  
or employees to issue or deliver agency company stock or other 147  
capital stock or benefit certificates or shares in any common- 148  
law corporation or securities or any special or advisory board 149  
contracts or other contracts of any kind promising returns and 150  
profits as an inducement to insurance. 151

(F) Making or permitting any unfair discrimination among 152  
individuals of the same class and equal expectation of life in 153  
the rates charged for any contract of life insurance or of life 154  
annuity or in the dividends or other benefits payable thereon, 155  
or in any other of the terms and conditions of such contract. 156

(G) (1) Except as otherwise expressly provided by law, 157  
knowingly permitting or offering to make or making any contract 158  
of life insurance, life annuity or accident and health 159  
insurance, or agreement as to such contract other than as 160  
plainly expressed in the contract issued thereon, or paying or 161  
allowing, or giving or offering to pay, allow, or give, directly 162  
or indirectly, as inducement to such insurance, or annuity, any 163  
rebate of premiums payable on the contract, or any special favor 164  
or advantage in the dividends or other benefits thereon, or any 165  
valuable consideration or inducement whatever not specified in 166  
the contract; or giving, or selling, or purchasing, or offering 167  
to give, sell, or purchase, as inducement to such insurance or 168

annuity or in connection therewith, any stocks, bonds, or other 169  
securities, or other obligations of any insurance company or 170  
other corporation, association, or partnership, or any dividends 171  
or profits accrued thereon, or anything of value whatsoever not 172  
specified in the contract. 173

(2) Nothing in division (F) or division (G)(1) of this 174  
section shall be construed as prohibiting any of the following 175  
practices: (a) in the case of any contract of life insurance or 176  
life annuity, paying bonuses to policyholders or otherwise 177  
abating their premiums in whole or in part out of surplus 178  
accumulated from nonparticipating insurance, provided that any 179  
such bonuses or abatement of premiums shall be fair and 180  
equitable to policyholders and for the best interests of the 181  
company and its policyholders; (b) in the case of life insurance 182  
policies issued on the industrial debit plan, making allowance 183  
to policyholders who have continuously for a specified period 184  
made premium payments directly to an office of the insurer in an 185  
amount which fairly represents the saving in collection 186  
expenses; (c) readjustment of the rate of premium for a group 187  
insurance policy based on the loss or expense experience 188  
thereunder, at the end of the first or any subsequent policy 189  
year of insurance thereunder, which may be made retroactive only 190  
for such policy year. 191

(H) Making, issuing, circulating, or causing or permitting 192  
to be made, issued, or circulated, or preparing with intent to 193  
so use, any statement to the effect that a policy of life 194  
insurance is, is the equivalent of, or represents shares of 195  
capital stock or any rights or options to subscribe for or 196  
otherwise acquire any such shares in the life insurance company 197  
issuing that policy or any other company. 198

(I) Making, issuing, circulating, or causing or permitting 199  
to be made, issued or circulated, or preparing with intent to so 200  
issue, any statement to the effect that payments to a 201  
policyholder of the principal amounts of a pure endowment are 202  
other than payments of a specific benefit for which specific 203  
premiums have been paid. 204

(J) Making, issuing, circulating, or causing or permitting 205  
to be made, issued, or circulated, or preparing with intent to 206  
so use, any statement to the effect that any insurance company 207  
was required to change a policy form or related material to 208  
comply with Title XXXIX of the Revised Code or any regulation of 209  
the superintendent of insurance, for the purpose of inducing or 210  
intending to induce any policyholder or prospective policyholder 211  
to purchase, amend, lapse, forfeit, change, or surrender 212  
insurance. 213

(K) Aiding or abetting another to violate this section. 214

(L) Refusing to issue any policy of insurance, or 215  
canceling or declining to renew such policy because of the sex 216  
or marital status of the applicant, prospective insured, 217  
insured, or policyholder. 218

(M) Making or permitting any unfair discrimination between 219  
individuals of the same class and of essentially the same hazard 220  
in the amount of premium, policy fees, or rates charged for any 221  
policy or contract of insurance, other than life insurance, or 222  
in the benefits payable thereunder, or in underwriting standards 223  
and practices or eligibility requirements, or in any of the 224  
terms or conditions of such contract, or in any other manner 225  
whatever. 226

(N) Refusing to make available disability income insurance 227

solely because the applicant's principal occupation is that of 228  
managing a household. 229

(O) Refusing, when offering maternity benefits under any 230  
individual or group sickness and accident insurance policy, to 231  
make maternity benefits available to the policyholder for the 232  
individual or individuals to be covered under any comparable 233  
policy to be issued for delivery in this state, including family 234  
members if the policy otherwise provides coverage for family 235  
members. Nothing in this division shall be construed to prohibit 236  
an insurer from imposing a reasonable waiting period for such 237  
benefits under an individual sickness and accident insurance 238  
policy issued to an individual who is not a federally eligible 239  
individual or a nonemployer-related group sickness and accident 240  
insurance policy, but in no event shall such waiting period 241  
exceed two hundred seventy days. 242

For purposes of division (O) of this section, "federally 243  
eligible individual" means an eligible individual as defined in 244  
45 C.F.R. 148.103. 245

(P) Using, or permitting to be used, a pattern settlement 246  
as the basis of any offer of settlement. As used in this 247  
division, "pattern settlement" means a method by which liability 248  
is routinely imputed to a claimant without an investigation of 249  
the particular occurrence upon which the claim is based and by 250  
using a predetermined formula for the assignment of liability 251  
arising out of occurrences of a similar nature. Nothing in this 252  
division shall be construed to prohibit an insurer from 253  
determining a claimant's liability by applying formulas or 254  
guidelines to the facts and circumstances disclosed by the 255  
insurer's investigation of the particular occurrence upon which 256  
a claim is based. 257

(Q) Refusing to insure, or refusing to continue to insure, 258  
or limiting the amount, extent, or kind of life or sickness and 259  
accident insurance or annuity coverage available to an 260  
individual, or charging an individual a different rate for the 261  
same coverage solely because of blindness or partial blindness. 262  
With respect to all other conditions, including the underlying 263  
cause of blindness or partial blindness, persons who are blind 264  
or partially blind shall be subject to the same standards of 265  
sound actuarial principles or actual or reasonably anticipated 266  
actuarial experience as are sighted persons. Refusal to insure 267  
includes, but is not limited to, denial by an insurer of 268  
disability insurance coverage on the grounds that the policy 269  
defines "disability" as being presumed in the event that the 270  
eyesight of the insured is lost. However, an insurer may exclude 271  
from coverage disabilities consisting solely of blindness or 272  
partial blindness when such conditions existed at the time the 273  
policy was issued. To the extent that the provisions of this 274  
division may appear to conflict with any provision of section 275  
3999.16 of the Revised Code, this division applies. 276

(R) (1) Directly or indirectly offering to sell, selling, 277  
or delivering, issuing for delivery, renewing, or using or 278  
otherwise marketing any policy of insurance or insurance product 279  
in connection with or in any way related to the grant of a 280  
student loan guaranteed in whole or in part by an agency or 281  
commission of this state or the United States, except insurance 282  
that is required under federal or state law as a condition for 283  
obtaining such a loan and the premium for which is included in 284  
the fees and charges applicable to the loan; or, in the case of 285  
an insurer or insurance agent, knowingly permitting any lender 286  
making such loans to engage in such acts or practices in 287  
connection with the insurer's or agent's insurance business. 288

(2) Except in the case of a violation of division (G) of 289  
this section, division (R)(1) of this section does not apply to 290  
either of the following: 291

(a) Acts or practices of an insurer, its agents, 292  
representatives, or employees in connection with the grant of a 293  
guaranteed student loan to its insured or the insured's spouse 294  
or dependent children where such acts or practices take place 295  
more than ninety days after the effective date of the insurance; 296

(b) Acts or practices of an insurer, its agents, 297  
representatives, or employees in connection with the 298  
solicitation, processing, or issuance of an insurance policy or 299  
product covering the student loan borrower or the borrower's 300  
spouse or dependent children, where such acts or practices take 301  
place more than one hundred eighty days after the date on which 302  
the borrower is notified that the student loan was approved. 303

(S) Denying coverage, under any health insurance or health 304  
care policy, contract, or plan providing family coverage, to any 305  
natural or adopted child of the named insured or subscriber 306  
solely on the basis that the child does not reside in the 307  
household of the named insured or subscriber. 308

(T)(1) Using any underwriting standard or engaging in any 309  
other act or practice that, directly or indirectly, due solely 310  
to any health status-related factor in relation to one or more 311  
individuals, does either of the following: 312

(a) Terminates or fails to renew an existing individual 313  
policy, contract, or plan of health benefits, or a health 314  
benefit plan issued to an employer, for which an individual 315  
would otherwise be eligible; 316

(b) With respect to a health benefit plan issued to an 317

employer, excludes or causes the exclusion of an individual from 318  
coverage under an existing employer-provided policy, contract, 319  
or plan of health benefits. 320

(2) The superintendent of insurance may adopt rules in 321  
accordance with Chapter 119. of the Revised Code for purposes of 322  
implementing division (T) (1) of this section. 323

(3) For purposes of division (T) (1) of this section, 324  
"health status-related factor" means any of the following: 325

(a) Health status; 326

(b) Medical condition, including both physical and mental 327  
illnesses; 328

(c) Claims experience; 329

(d) Receipt of health care; 330

(e) Medical history; 331

(f) Genetic information; 332

(g) Evidence of insurability, including conditions arising 333  
out of acts of domestic violence; 334

(h) Disability. 335

(U) With respect to a health benefit plan issued to a 336  
small employer, as those terms are defined in section 3924.01 of 337  
the Revised Code, negligently or willfully placing coverage for 338  
adverse risks with a certain carrier, as defined in section 339  
3924.01 of the Revised Code. 340

(V) Using any program, scheme, device, or other unfair act 341  
or practice that, directly or indirectly, causes or results in 342  
the placing of coverage for adverse risks with another carrier, 343  
as defined in section 3924.01 of the Revised Code. 344

(W) Failing to comply with section 3923.23, 3923.231, 345  
3923.232, 3923.233, or 3923.234 of the Revised Code by engaging 346  
in any unfair, discriminatory reimbursement practice. 347

(X) Intentionally establishing an unfair premium for, or 348  
misrepresenting the cost of, any insurance policy financed under 349  
a premium finance agreement of an insurance premium finance 350  
company. 351

(Y) (1) (a) Limiting coverage under, refusing to issue, 352  
canceling, or refusing to renew, any individual policy or 353  
contract of life insurance, or limiting coverage under or 354  
refusing to issue any individual policy or contract of health 355  
insurance, for the reason that the insured or applicant for 356  
insurance is or has been a victim of domestic violence; 357

(b) Adding a surcharge or rating factor to a premium of 358  
any individual policy or contract of life or health insurance 359  
for the reason that the insured or applicant for insurance is or 360  
has been a victim of domestic violence; 361

(c) Denying coverage under, or limiting coverage under, 362  
any policy or contract of life or health insurance, for the 363  
reason that a claim under the policy or contract arises from an 364  
incident of domestic violence; 365

(d) Inquiring, directly or indirectly, of an insured 366  
under, or of an applicant for, a policy or contract of life or 367  
health insurance, as to whether the insured or applicant is or 368  
has been a victim of domestic violence, or inquiring as to 369  
whether the insured or applicant has sought shelter or 370  
protection from domestic violence or has sought medical or 371  
psychological treatment as a victim of domestic violence. 372

(2) Nothing in division (Y) (1) of this section shall be 373

construed to prohibit an insurer from inquiring as to, or from 374  
underwriting or rating a risk on the basis of, a person's 375  
physical or mental condition, even if the condition has been 376  
caused by domestic violence, provided that all of the following 377  
apply: 378

(a) The insurer routinely considers the condition in 379  
underwriting or in rating risks, and does so in the same manner 380  
for a victim of domestic violence as for an insured or applicant 381  
who is not a victim of domestic violence; 382

(b) The insurer does not refuse to issue any policy or 383  
contract of life or health insurance or cancel or refuse to 384  
renew any policy or contract of life insurance, solely on the 385  
basis of the condition, except where such refusal to issue, 386  
cancellation, or refusal to renew is based on sound actuarial 387  
principles or is related to actual or reasonably anticipated 388  
experience; 389

(c) The insurer does not consider a person's status as 390  
being or as having been a victim of domestic violence, in 391  
itself, to be a physical or mental condition; 392

(d) The underwriting or rating of a risk on the basis of 393  
the condition is not used to evade the intent of division (Y) (1) 394  
of this section, or of any other provision of the Revised Code. 395

(3) (a) Nothing in division (Y) (1) of this section shall be 396  
construed to prohibit an insurer from refusing to issue a policy 397  
or contract of life insurance insuring the life of a person who 398  
is or has been a victim of domestic violence if the person who 399  
committed the act of domestic violence is the applicant for the 400  
insurance or would be the owner of the insurance policy or 401  
contract. 402

(b) Nothing in division (Y) (2) of this section shall be 403  
construed to permit an insurer to cancel or refuse to renew any 404  
policy or contract of health insurance in violation of the 405  
"Health Insurance Portability and Accountability Act of 1996," 406  
110 Stat. 1955, 42 U.S.C.A. 300gg-41(b), as amended, or in a 407  
manner that violates or is inconsistent with any provision of 408  
the Revised Code that implements the "Health Insurance 409  
Portability and Accountability Act of 1996." 410

(4) An insurer is immune from any civil or criminal 411  
liability that otherwise might be incurred or imposed as a 412  
result of any action taken by the insurer to comply with 413  
division (Y) of this section. 414

(5) As used in division (Y) of this section, "domestic 415  
violence" means any of the following acts: 416

(a) Knowingly causing or attempting to cause physical harm 417  
to a family or household member; 418

(b) Recklessly causing serious physical harm to a family 419  
or household member; 420

(c) Knowingly causing, by threat of force, a family or 421  
household member to believe that the person will cause imminent 422  
physical harm to the family or household member. 423

For the purpose of division (Y) (5) of this section, 424  
"family or household member" has the same meaning as in section 425  
2919.25 of the Revised Code. 426

Nothing in division (Y) (5) of this section shall be 427  
construed to require, as a condition to the application of 428  
division (Y) of this section, that the act described in division 429  
(Y) (5) of this section be the basis of a criminal prosecution. 430

(Z) Disclosing a coroner's records by an insurer in violation of section 313.10 of the Revised Code. 431  
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(AA) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated any statement or representation that a life insurance policy or annuity is a contract for the purchase of funeral goods or services. 433  
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(BB) (1) Setting or requiring the insurer's approval of fees for dental services that are not covered dental services, as defined in section 3963.01 of the Revised Code, or making available any health benefit plan that sets fees for dental services that are not covered dental care services. 437  
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(2) Nothing in division (BB) (1) of this section shall be construed to apply to any health benefit plan subject to regulation by the "Employee Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq., as amended. 442  
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(CC) With respect to private passenger automobile insurance, charging premium rates that are excessive, inadequate, or unfairly discriminatory, pursuant to division (D) of section 3937.02 of the Revised Code, based solely on the location of the residence of the insured. 446  
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The enumeration in sections 3901.19 to 3901.26 of the Revised Code of specific unfair or deceptive acts or practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the superintendent of insurance to adopt rules to implement this section, or to take action under other sections of the Revised Code. 451  
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This section does not prohibit the sale of shares of any investment company registered under the "Investment Company Act of 1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any 457  
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policies, annuities, or other contracts described in section 460  
3907.15 of the Revised Code. 461

As used in this section, "estimate," "statement," 462  
"representation," "misrepresentation," "advertisement," or 463  
"announcement" includes oral or written occurrences. 464

**Sec. 3963.01.** As used in this chapter: 465

(A) "Affiliate" means any person or entity that has 466  
ownership or control of a contracting entity, is owned or 467  
controlled by a contracting entity, or is under common ownership 468  
or control with a contracting entity. 469

(B) "Basic health care services" has the same meaning as 470  
in division (A) of section 1751.01 of the Revised Code, except 471  
that it does not include any services listed in that division 472  
that are provided by a pharmacist or nursing home. 473

(C) "Contracting entity" means any person that has a 474  
primary business purpose of contracting with participating 475  
providers for the delivery of health care services. 476

(D) "Covered dental services" means dental services for 477  
which a reimbursement is available under an enrollee's health 478  
benefit plan contract, or for which a reimbursement would be 479  
available but for the application of contractual limitations 480  
such as a deductible, copayment, coinsurance, waiting period, 481  
annual or lifetime maximum, frequency limitation, alternative 482  
benefit payment, or any other limitation. 483

(E) "Credentialing" means the process of assessing and 484  
validating the qualifications of a provider applying to be 485  
approved by a contracting entity to provide basic health care 486  
services, specialty health care services, or supplemental health 487  
care services to enrollees. 488

~~(E)~~ (F) "Edit" means adjusting one or more procedure codes 489  
billed by a participating provider on a claim for payment or a 490  
practice that results in any of the following: 491

(1) Payment for some, but not all of the procedure codes 492  
originally billed by a participating provider; 493

(2) Payment for a different procedure code than the 494  
procedure code originally billed by a participating provider; 495

(3) A reduced payment as a result of services provided to 496  
an enrollee that are claimed under more than one procedure code 497  
on the same service date. 498

~~(F)~~ (G) "Electronic claims transport" means to accept and 499  
digitize claims or to accept claims already digitized, to place 500  
those claims into a format that complies with the electronic 501  
transaction standards issued by the United States department of 502  
health and human services pursuant to the "Health Insurance 503  
Portability and Accountability Act of 1996," 110 Stat. 1955, 42 504  
U.S.C. 1320d, et seq., as those electronic standards are 505  
applicable to the parties and as those electronic standards are 506  
updated from time to time, and to electronically transmit those 507  
claims to the appropriate contracting entity, payer, or third- 508  
party administrator. 509

~~(G)~~ (H) "Enrollee" means any person eligible for health 510  
care benefits under a health benefit plan, including an eligible 511  
recipient of medicaid, and includes all of the following terms: 512

(1) "Enrollee" and "subscriber" as defined by section 513  
1751.01 of the Revised Code; 514

(2) "Member" as defined by section 1739.01 of the Revised 515  
Code; 516

(3) "Insured" and "plan member" pursuant to Chapter 3923.	517
of the Revised Code;	518
(4) "Beneficiary" as defined by section 3901.38 of the	519
Revised Code.	520
<del>(H)</del> <u>(I)</u> "Health care contract" means a contract entered	521
into, materially amended, or renewed between a contracting	522
entity and a participating provider for the delivery of basic	523
health care services, specialty health care services, or	524
supplemental health care services to enrollees.	525
<del>(I)</del> <u>(J)</u> "Health care services" means basic health care	526
services, specialty health care services, and supplemental	527
health care services.	528
<del>(J)</del> <u>(K)</u> "Material amendment" means an amendment to a	529
health care contract that decreases the participating provider's	530
payment or compensation, changes the administrative procedures	531
in a way that may reasonably be expected to significantly	532
increase the provider's administrative expenses, or adds a new	533
product. A material amendment does not include any of the	534
following:	535
(1) A decrease in payment or compensation resulting solely	536
from a change in a published fee schedule upon which the payment	537
or compensation is based and the date of applicability is	538
clearly identified in the contract;	539
(2) A decrease in payment or compensation that was	540
anticipated under the terms of the contract, if the amount and	541
date of applicability of the decrease is clearly identified in	542
the contract;	543
(3) An administrative change that may significantly	544
increase the provider's administrative expense, the specific	545

applicability of which is clearly identified in the contract;	546
(4) Changes to an existing prior authorization,	547
precertification, notification, or referral program that do not	548
substantially increase the provider's administrative expense;	549
(5) Changes to an edit program or to specific edits if the	550
participating provider is provided notice of the changes	551
pursuant to division (A) (1) of section 3963.04 of the Revised	552
Code and the notice includes information sufficient for the	553
provider to determine the effect of the change;	554
(6) Changes to a health care contract described in	555
division (B) of section 3963.04 of the Revised Code.	556
<del>(K)</del> <u>(L)</u> "Participating provider" means a provider that has	557
a health care contract with a contracting entity and is entitled	558
to reimbursement for health care services rendered to an	559
enrollee under the health care contract.	560
<del>(L)</del> <u>(M)</u> "Payer" means any person that assumes the	561
financial risk for the payment of claims under a health care	562
contract or the reimbursement for health care services provided	563
to enrollees by participating providers pursuant to a health	564
care contract.	565
<del>(M)</del> <u>(N)</u> "Primary enrollee" means a person who is	566
responsible for making payments for participation in a health	567
care plan or an enrollee whose employment or other status is the	568
basis of eligibility for enrollment in a health care plan.	569
<del>(N)</del> <u>(O)</u> "Procedure codes" includes the American medical	570
association's current procedural terminology code, the American	571
dental association's current dental terminology, and the centers	572
for medicare and medicaid services health care common procedure	573
coding system.	574

~~(O)~~(P) "Product" means one of the following types of categories of coverage for which a participating provider may be obligated to provide health care services pursuant to a health care contract:

- (1) A health maintenance organization or other product provided by a health insuring corporation;
- (2) A preferred provider organization;
- (3) Medicare;
- (4) Medicaid;
- (5) Workers' compensation.

~~(P)~~(Q) "Provider" means a physician, podiatrist, dentist, chiropractor, optometrist, psychologist, physician assistant, advanced practice registered nurse, occupational therapist, massage therapist, physical therapist, licensed professional counselor, licensed professional clinical counselor, hearing aid dealer, orthotist, prosthetist, home health agency, hospice care program, pediatric respite care program, or hospital, or a provider organization or physician-hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts. "Provider" does not mean a pharmacist, pharmacy, nursing home, or a provider organization or physician-hospital organization that leases the provider organization's or physician-hospital organization's network to a third party or contracts directly with employers or health and welfare funds.

~~(Q)~~(R) "Specialty health care services" has the same meaning as in section 1751.01 of the Revised Code, except that it does not include any services listed in division (B) of section 1751.01 of the Revised Code that are provided by a

pharmacist or a nursing home. 604

~~(R)~~(S) "Supplemental health care services" has the same 605  
meaning as in division (B) of section 1751.01 of the Revised 606  
Code, except that it does not include any services listed in 607  
that division that are provided by a pharmacist or nursing home. 608

**Sec. 3963.02.** (A) (1) No contracting entity shall sell, 609  
rent, or give a third party the contracting entity's rights to a 610  
participating provider's services pursuant to the contracting 611  
entity's health care contract with the participating provider 612  
unless one of the following applies: 613

(a) The third party accessing the participating provider's 614  
services under the health care contract is an employer or other 615  
entity providing coverage for health care services to its 616  
employees or members, and that employer or entity has a contract 617  
with the contracting entity or its affiliate for the 618  
administration or processing of claims for payment for services 619  
provided pursuant to the health care contract with the 620  
participating provider. 621

(b) The third party accessing the participating provider's 622  
services under the health care contract either is an affiliate 623  
or subsidiary of the contracting entity or is providing 624  
administrative services to, or receiving administrative services 625  
from, the contracting entity or an affiliate or subsidiary of 626  
the contracting entity. 627

(c) The health care contract specifically provides that it 628  
applies to network rental arrangements and states that one 629  
purpose of the contract is selling, renting, or giving the 630  
contracting entity's rights to the services of the participating 631  
provider, including other preferred provider organizations, and 632

the third party accessing the participating provider's services 633  
is any of the following: 634

(i) A payer or a third-party administrator or other entity 635  
responsible for administering claims on behalf of the payer; 636

(ii) A preferred provider organization or preferred 637  
provider network that receives access to the participating 638  
provider's services pursuant to an arrangement with the 639  
preferred provider organization or preferred provider network in 640  
a contract with the participating provider that is in compliance 641  
with division (A) (1) (c) of this section, and is required to 642  
comply with all of the terms, conditions, and affirmative 643  
obligations to which the originally contracted primary 644  
participating provider network is bound under its contract with 645  
the participating provider, including, but not limited to, 646  
obligations concerning patient steerage and the timeliness and 647  
manner of reimbursement. 648

(iii) An entity that is engaged in the business of 649  
providing electronic claims transport between the contracting 650  
entity and the payer or third-party administrator and complies 651  
with all of the applicable terms, conditions, and affirmative 652  
obligations of the contracting entity's contract with the 653  
participating provider including, but not limited to, 654  
obligations concerning patient steerage and the timeliness and 655  
manner of reimbursement. 656

(2) The contracting entity that sells, rents, or gives the 657  
contracting entity's rights to the participating provider's 658  
services pursuant to the contracting entity's health care 659  
contract with the participating provider as provided in division 660  
(A) (1) of this section shall do both of the following: 661

(a) Maintain a web page that contains a listing of third parties described in divisions (A) (1) (b) and (c) of this section with whom a contracting entity contracts for the purpose of selling, renting, or giving the contracting entity's rights to the services of participating providers that is updated at least every six months and is accessible to all participating providers, or maintain a toll-free telephone number accessible to all participating providers by means of which participating providers may access the same listing of third parties;

(b) Require that the third party accessing the participating provider's services through the participating provider's health care contract is obligated to comply with all of the applicable terms and conditions of the contract, including, but not limited to, the products for which the participating provider has agreed to provide services, except that a payer receiving administrative services from the contracting entity or its affiliate shall be solely responsible for payment to the participating provider.

(3) Any information disclosed to a participating provider under this section shall be considered proprietary and shall not be distributed by the participating provider.

(4) Except as provided in division (A) (1) of this section, no entity shall sell, rent, or give a contracting entity's rights to the participating provider's services pursuant to a health care contract.

(B) (1) No contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider provide services for all of the products offered by the contracting entity.

(2) Division (B) (1) of this section shall not be construed 691  
to do any of the following: 692

(a) Prohibit any participating provider from voluntarily 693  
accepting an offer by a contracting entity to provide health 694  
care services under all of the contracting entity's products; 695

(b) Prohibit any contracting entity from offering any 696  
financial incentive or other form of consideration specified in 697  
the health care contract for a participating provider to provide 698  
health care services under all of the contracting entity's 699  
products; 700

(c) Require any contracting entity to contract with a 701  
participating provider to provide health care services for less 702  
than all of the contracting entity's products if the contracting 703  
entity does not wish to do so. 704

(3) (a) Notwithstanding division (B) (2) of this section, no 705  
contracting entity shall require, as a condition of contracting 706  
with the contracting entity, that the participating provider 707  
accept any future product offering that the contracting entity 708  
makes. 709

(b) If a participating provider refuses to accept any 710  
future product offering that the contracting entity makes, the 711  
contracting entity may terminate the health care contract based 712  
on the participating provider's refusal upon written notice to 713  
the participating provider no sooner than one hundred eighty 714  
days after the refusal. 715

(4) Once the contracting entity and the participating 716  
provider have signed the health care contract, it is presumed 717  
that the financial incentive or other form of consideration that 718  
is specified in the health care contract pursuant to division 719

(B) (2) (b) of this section is the financial incentive or other 720  
form of consideration that was offered by the contracting entity 721  
to induce the participating provider to enter into the contract. 722

(C) No contracting entity shall require, as a condition of 723  
contracting with the contracting entity, that a participating 724  
provider waive or ~~forego~~ forgo any right or benefit expressly 725  
conferred upon a participating provider by state or federal law. 726  
However, this division does not prohibit a contracting entity 727  
from restricting a participating provider's scope of practice 728  
for the services to be provided under the contract. 729

(D) No health care contract shall do any of the following: 730

(1) Prohibit any participating provider from entering into 731  
a health care contract with any other contracting entity; 732

(2) Prohibit any contracting entity from entering into a 733  
health care contract with any other provider; 734

(3) Preclude its use or disclosure for the purpose of 735  
enforcing this chapter or other state or federal law, except 736  
that a health care contract may require that appropriate 737  
measures be taken to preserve the confidentiality of any 738  
proprietary or trade-secret information. 739

(E) (1) No contracting entity shall require in any health 740  
care contract that covers any dental services, either directly 741  
or indirectly, that a participating provider who is a dentist 742  
provide services to an enrollee at a fee set by, or a fee 743  
subject to the approval of, the contracting entity unless the 744  
dental services are covered dental services. 745

(2) To the extent that the provisions in division (E) (1) 746  
of this section conflict with the provisions of the federal 747  
"Employee Retirement Income Security Act of 1974," 29 U.S.C. 748

1001, et seq., as amended, the federal law shall control. 749

(F)(1) In addition to any other lawful reasons for 750  
terminating a health care contract, a health care contract may 751  
only be terminated under the circumstances described in division 752  
(A) (3) of section 3963.04 of the Revised Code. 753

(2) If the health care contract provides for termination 754  
for cause by either party, the health care contract shall state 755  
the reasons that may be used for termination for cause, which 756  
terms shall be reasonable. Once the contracting entity and the 757  
participating provider have signed the health care contract, it 758  
is presumed that the reasons stated in the health care contract 759  
for termination for cause by either party are reasonable. 760  
Subject to division ~~(E)~~(F)(3) of this section, the health care 761  
contract shall state the time by which the parties must provide 762  
notice of termination for cause and to whom the parties shall 763  
give the notice. 764

(3) Nothing in divisions ~~(E)~~(F)(1) and (2) of this section 765  
shall be construed as prohibiting any health insuring 766  
corporation from terminating a participating provider's contract 767  
for any of the causes described in divisions (A), (D), and (F) 768  
(1) and (2) of section 1753.09 of the Revised Code. 769  
Notwithstanding any provision in a health care contract pursuant 770  
to division ~~(E)~~(F)(2) of this section, section 1753.09 of the 771  
Revised Code applies to the termination of a participating 772  
provider's contract for any of the causes described in divisions 773  
(A), (D), and (F) (1) and (2) of section 1753.09 of the Revised 774  
Code. 775

(4) Subject to sections 3963.01 to 3963.11 of the Revised 776  
Code, nothing in this section prohibits the termination of a 777  
health care contract without cause if the health care contract 778

otherwise provides for termination without cause. 779

~~(F)~~(G)(1) Disputes among parties to a health care contract 780  
that only concern the enforcement of the contract rights 781  
conferred by this section~~3963.02~~, divisions (A) and (D) of 782  
section 3963.03, and section 3963.04 of the Revised Code are 783  
subject to a mutually agreed upon arbitration mechanism that is 784  
binding on all parties. The arbitrator may award reasonable 785  
attorney's fees and costs for arbitration relating to the 786  
enforcement of this section to the prevailing party. 787

(2) The arbitrator shall make the arbitrator's decision in 788  
an arbitration proceeding having due regard for any applicable 789  
rules, bulletins, rulings, or decisions issued by the department 790  
of insurance or any court concerning the enforcement of the 791  
contract rights conferred by this section~~3963.02~~, divisions (A) 792  
and (D) of section 3963.03, and section 3963.04 of the Revised 793  
Code. 794

(3) A party shall not simultaneously maintain an 795  
arbitration proceeding as described in division ~~(F)~~(G)(1) of 796  
this section and pursue a complaint with the superintendent of 797  
insurance to investigate the subject matter of the arbitration 798  
proceeding. However, if a complaint is filed with the department 799  
of insurance, the superintendent may choose to investigate the 800  
complaint or, after reviewing the complaint, advise the 801  
complainant to proceed with arbitration to resolve the 802  
complaint. The superintendent may request to receive a copy of 803  
the results of the arbitration. If the superintendent of 804  
insurance notifies an insurer or a health insuring corporation 805  
in writing that the superintendent has initiated a market 806  
conduct examination into the specific subject matter of the 807  
arbitration proceeding pending against that insurer or health 808

insuring corporation, the arbitration proceeding shall be stayed 809  
at the request of the insurer or health insuring corporation 810  
pending the outcome of the market conduct investigation by the 811  
superintendent. 812

**Sec. 3963.03.** (A) Each health care contract shall include 813  
all of the following information: 814

(1) (a) Information sufficient for the participating 815  
provider to determine the compensation or payment terms for 816  
health care services, including all of the following, subject to 817  
division (A) (1) (b) of this section: 818

(i) The manner of payment, such as fee-for-service, 819  
capitation, or risk; 820

(ii) The fee schedule of procedure codes reasonably 821  
expected to be billed by a participating provider's specialty 822  
for services provided pursuant to the health care contract and 823  
the associated payment or compensation for each procedure code. 824  
A fee schedule may be provided electronically. Upon request, a 825  
contracting entity shall provide a participating provider with 826  
the fee schedule for any other procedure codes requested and a 827  
written fee schedule, that shall not be required more frequently 828  
than twice per year excluding when it is provided in connection 829  
with any change to the schedule. This requirement may be 830  
satisfied by providing a clearly understandable, readily 831  
available mechanism, such as a specific web site address, that 832  
allows a participating provider to determine the effect of 833  
procedure codes on payment or compensation before a service is 834  
provided or a claim is submitted. 835

(iii) The effect, if any, on payment or compensation if 836  
more than one procedure code applies to the service also shall 837

be stated. This requirement may be satisfied by providing a 838  
clearly understandable, readily available mechanism, such as a 839  
specific web site address, that allows a participating provider 840  
to determine the effect of procedure codes on payment or 841  
compensation before a service is provided or a claim is 842  
submitted. 843

(b) If the contracting entity is unable to include the 844  
information described in ~~division~~ divisions (A) (1) (a) (ii) and 845  
(iii) of this section, the contracting entity shall include both 846  
of the following types of information instead: 847

(i) The methodology used to calculate any fee schedule, 848  
such as relative value unit system and conversion factor or 849  
percentage of billed charges. If applicable, the methodology 850  
disclosure shall include the name of any relative value unit 851  
system, its version, edition, or publication date, any 852  
applicable conversion or geographic factor, and any date by 853  
which compensation or fee schedules may be changed by the 854  
methodology as anticipated at the time of contract. 855

(ii) The identity of any internal processing edits, 856  
including the publisher, product name, version, and version 857  
update of any editing software. 858

(c) If the contracting entity is not the payer and is 859  
unable to include the information described in division (A) (1) 860  
(a) or (b) of this section, then the contracting entity shall 861  
provide by telephone a readily available mechanism, such as a 862  
specific web site address, that allows the participating 863  
provider to obtain that information from the payer. 864

(2) Any product or network for which the participating 865  
provider is to provide services; 866

- (3) The term of the health care contract; 867
- (4) A specific web site address that contains the identity 868  
of the contracting entity or payer responsible for the 869  
processing of the participating provider's compensation or 870  
payment; 871
- (5) Any internal mechanism provided by the contracting 872  
entity to resolve disputes concerning the interpretation or 873  
application of the terms and conditions of the contract. A 874  
contracting entity may satisfy this requirement by providing a 875  
clearly understandable, readily available mechanism, such as a 876  
specific web site address or an appendix, that allows a 877  
participating provider to determine the procedures for the 878  
internal mechanism to resolve those disputes. 879
- (6) A list of addenda, if any, to the contract. 880
- (B) (1) Each contracting entity shall include a summary 881  
disclosure form with a health care contract that includes all of 882  
the information specified in division (A) of this section. The 883  
information in the summary disclosure form shall refer to the 884  
location in the health care contract, whether a page number, 885  
section of the contract, appendix, or other identifiable 886  
location, that specifies the provisions in the contract to which 887  
the information in the form refers. 888
- (2) The summary disclosure form shall include all of the 889  
following statements: 890
- (a) That the form is a guide to the health care contract 891  
and that the terms and conditions of the health care contract 892  
constitute the contract rights of the parties; 893
- (b) That reading the form is not a substitute for reading 894  
the entire health care contract; 895

(c) That by signing the health care contract, the participating provider will be bound by the contract's terms and conditions;

(d) That the terms and conditions of the health care contract may be amended pursuant to section 3963.04 of the Revised Code and the participating provider is encouraged to carefully read any proposed amendments sent after execution of the contract;

(e) That nothing in the summary disclosure form creates any additional rights or causes of action in favor of either party.

(3) No contracting entity that includes any information in the summary disclosure form with the reasonable belief that the information is truthful or accurate shall be subject to a civil action for damages or to binding arbitration based on the summary disclosure form. Division (B)(3) of this section does not impair or affect any power of the department of insurance to enforce any applicable law.

(4) The summary disclosure form described in divisions (B)(1) and (2) of this section shall be in substantially the following form:

"SUMMARY DISCLOSURE FORM

(1) Compensation terms

(a) Manner of payment

[ ] Fee for service

[ ] Capitation

[ ] Risk

[ ] Other .....	See .....	923	
(b) Fee schedule available at .....		924	
(c) Fee calculation schedule available at .....		925	
(d) Identity of internal processing edits available at .....		926 927	
(e) Information in (c) and (d) is not required if information in (b) is provided.		928 929	
(2) List of products or networks covered by this contract		930	
[ ] .....		931	
[ ] .....		932	
[ ] .....		933	
[ ] .....		934	
[ ] .....		935	
(3) Term of this contract .....		936	
(4) Contracting entity or payer responsible for processing payment available at .....		937 938	
(5) Internal mechanism for resolving disputes regarding contract terms available at .....		939 940	
(6) Addenda to contract		941	
	Title	Subject	942
(a)			943
(b)			944
(c)			945
(d)			946

(7) Telephone number to access a readily available 947  
mechanism, such as a specific web site address, to allow a 948  
participating provider to receive the information in (1) through 949  
(6) from the payer. 950

IMPORTANT INFORMATION - PLEASE READ CAREFULLY 951

The information provided in this Summary Disclosure Form 952  
is a guide to the attached Health Care Contract as defined in 953  
section ~~3963.01(G)~~3963.01(I) of the Ohio Revised Code. The 954  
terms and conditions of the attached Health Care Contract 955  
constitute the contract rights of the parties. 956

Reading this Summary Disclosure Form is not a substitute 957  
for reading the entire Health Care Contract. When you sign the 958  
Health Care Contract, you will be bound by its terms and 959  
conditions. These terms and conditions may be amended over time 960  
pursuant to section 3963.04 of the Ohio Revised Code. You are 961  
encouraged to read any proposed amendments that are sent to you 962  
after execution of the Health Care Contract. 963

Nothing in this Summary Disclosure Form creates any 964  
additional rights or causes of action in favor of either party." 965

(C) When a contracting entity presents a proposed health 966  
care contract for consideration by a provider, the contracting 967  
entity shall provide in writing or make reasonably available the 968  
information required in division (A)(1) of this section. 969

(D) The contracting entity shall identify any utilization 970  
management, quality improvement, or a similar program that the 971  
contracting entity uses to review, monitor, evaluate, or assess 972  
the services provided pursuant to a health care contract. The 973  
contracting entity shall disclose the policies, procedures, or 974  
guidelines of such a program applicable to a participating 975

provider upon request by the participating provider within 976  
fourteen days after the date of the request. 977

(E) Nothing in this section shall be construed as 978  
preventing or affecting the application of section 1753.07 of 979  
the Revised Code that would otherwise apply to a contract with a 980  
participating provider. 981

(F) The requirements of division (C) of this section do 982  
not prohibit a contracting entity from requiring a reasonable 983  
confidentiality agreement between the provider and the 984  
contracting entity regarding the terms of the proposed health 985  
care contract. If either party violates the confidentiality 986  
agreement, a party to the confidentiality agreement may bring a 987  
civil action to enjoin the other party from continuing any act 988  
that is in violation of the confidentiality agreement, to 989  
recover damages, to terminate the contract, or to obtain any 990  
combination of relief. 991

**Section 2.** That existing sections 1753.09, 3901.21, 992  
3963.01, 3963.02, and 3963.03 of the Revised Code are hereby 993  
repealed. 994

**Section 3.** The following represent the General Assembly's 995  
intent and findings: 996

(A) The provisions of this act seek to prevent dental 997  
insurers, dental benefit plans, and other contracting entities 998  
from establishing fee limitations on services that are not 999  
covered dental services for enrollees under a dental insurance 1000  
plan. 1001

(B) Strategies by dental insurers, dental benefit plans, 1002  
or other contracting entities to adopt or impose a deductible, 1003  
copayment, coinsurance, or any other requirement in such a way 1004

as to provide de minimus reimbursement for services as a method	1005
to avoid the impact of this law is contrary to the spirit and	1006
intent of the General Assembly.	1007