

As Introduced

133rd General Assembly

Regular Session

2019-2020

H. B. No. 390

Representatives Crossman, Clites

Cosponsors: Representatives Sweeney, Leland, Sobecki, Robinson, Galonski, Brent, Hicks-Hudson, Denson, Blair, Weinstein, Liston, Smith, K., Patterson, Miranda, Lightbody, Boyd, Skindell, Russo, Kelly, West, Brown, Upchurch, Crawley, Miller, J., Sheehy, Lepore-Hagan, Strahorn, Sykes, O'Brien, Howse, Boggs, Rogers, Ingram, Miller, A., Cera, Hillyer, Carfagna

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, 3922.01,	3
3923.122, 3923.57, 3923.571, 3923.85, 3924.01,	4
3924.02, 3924.03, 3924.033, 3924.06, 3924.51,	5
and 3924.73, to enact sections 3902.50, 3902.51,	6
3902.52, 3902.53, and 3902.54, and to repeal	7
sections 1751.15, 3923.58, 3923.581, 3923.582,	8
3923.59, 3924.07, 3924.08, 3924.09, 3924.10,	9
3924.11, 3924.111, 3924.12, 3924.13, and 3924.14	10
of the Revised Code regarding health insurance	11
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, 3922.01, 3923.122, 3923.57, 3923.571, 3923.85,	15
3924.01, 3924.02, 3924.03, 3924.033, 3924.06, 3924.51, and	16

3924.73 be amended and sections 3902.50, 3902.51, 3902.52, 17
3902.53, and 3902.54 of the Revised Code be enacted to read as 18
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 134
apply to each health benefit plan option or a formula or method 135
of determining the rates or charges; 136

~~(6)~~ (5) A provision prescribing the minimum employer 137
contribution toward premiums or other charges required in order 138
to permit a small employer to obtain coverage under a health 139
benefit plan option offered under an alliance program; 140

~~(7)~~ (6) A provision requiring that each health benefit 141
plan under the alliance program must provide for the 142
continuation of coverage of participants of an enrolled small 143
employer so long as the small employer determines that such 144
person is a qualified beneficiary entitled to such coverage 145
pursuant to Part 6 of Title I of the "Federal Employee 146
Retirement Income Security Act of 1974," 88 Stat. 832, 29 147
U.S.C.A. 1001, and the laws of this state, and regulations or 148
rulings interpreting such provisions. Such coverage provided by 149
the insurer under the plan to participants shall comply with the 150
"Federal Employee Retirement Income Security Act of 1974" and 151
the relevant statutes, regulations, and rulings interpreting 152
that act, including provisions regarding types of coverage to be 153
provided, apportionments of limitations on coverage, 154
apportionments of deductibles, and the rights of qualified 155
beneficiaries to elect coverage options relating to types of 156
coverage and otherwise. 157

(B) An agreement between an alliance and an insurer 158
referred to in division (B) of section 1731.01 of the Revised 159
Code may contain provisions relating to, but not limited to, any 160
of the following: 161

- (1) The application and enrollment process for a small employer and related provisions pertaining to historical experience, health statements, and underwriting standards;
- (2) The minimum number of those employees eligible to be participants that are required to participate in order to permit a small employer to obtain coverage under a health benefit plan option offered under the alliance program, which may vary with the number of employees or those eligible to be participants in respect of the small employer;
- (3) A procedure for allowing an enrolled small employer to change from one plan option to another under the alliance program, subject to qualifying by size or otherwise under the alliance program;
- (4) The application of any risk-related pooling or grouping programs and related premiums, conditions, reviews, and alternatives offered by the insurer;
- (5) The availability of a medicare supplement coverage option for eligible participants who are covered by Parts A and B of medicare, Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301;
- (6) Relevant experience periods, enrollment periods, and contract periods;
- (7) Effective dates for coverage of eligible participants;
- (8) Conditions under which denial or withdrawal of coverage of participants or small employers and their employees may occur by reason of falsification or misrepresentation of material facts or criminal conduct toward the insurer, small employer, or alliance under the program;

- (9) Premium rate structures, which may be uniform or make provision for age-specific rates, differentials based on number of participants of an enrolled small employer, products and plan options selected, and other factors, rate adjustments based on consumer price indices, utilization, or other relevant factors, notification of rate adjustments, and arbitration;
- (10) Any responsibilities of the alliance for billing, collection, and transmittal of premiums;
- (11) Inclusion under the alliance program of small employers that are members of other organizations described in division (A)(1) of section 1731.01 of the Revised Code that contract with the alliance for this purpose, and conditions pertaining to those small employer members and to their employees and retirees, and dependents and family members of those employees or retirees, as applicable under the alliance program;
- (12) The agreement of the insurer to offer and sell one or more health benefit plans to small employer members of another small employer health care alliance that contracts with the alliance for this purpose;
- (13) Use of the health benefit plan options of the insurer in the alliance program and use of the names of the alliance and the insurer;
- (14) Indemnification from claims and liability by reason of acts or omissions of others;
- (15) Ownership, use, availability, and maintenance of confidentiality of data and records relating to the alliance program;
- (16) Utilization reports to be provided to the alliance by

the insurer; 219

(17) Such other provisions as may be agreed upon by the 220
alliance and the insurer to better provide for the articulation, 221
promotion, financing, and operation of the alliance program or a 222
health benefit plan under the program in furtherance of the 223
public purposes stated in section 1731.02 of the Revised Code. 224

(C) Neither an alliance program nor an agreement between 225
an alliance and an insurer is itself a policy or contract of 226
insurance, or a certificate, indorsement, rider, or application 227
forming any part of a policy, contract, or certificate of 228
insurance. Chapters 3905., 3933., and 3959. of the Revised Code 229
do not apply to an alliance program or to an agreement between 230
an alliance and an insurer thereunder, as such, or to the 231
functions of the alliance under an alliance program. 232

Sec. 1731.05. If a qualified alliance, or an alliance 233
that, based upon evidence of interest satisfactory to the 234
superintendent of insurance, will be a qualified alliance within 235
a reasonable time, submits a request for a proposal on a health 236
benefit plan to at least three insurers and does not receive at 237
least one reasonably responsive proposal within ninety days from 238
the date the last such request is submitted, the superintendent, 239
at the request of such alliance, may require that insurers offer 240
proposals to such alliance for health benefit plans for the 241
small employers within such alliance. Such proposals shall 242
include such coverage and benefits for such premiums, as shall 243
take into account the functions provided by the alliance and the 244
economies of scale, and have other terms and provisions as are 245
approved by the superintendent, consistent with the purposes and 246
standards set forth in section 1731.02 of the Revised Code. ~~In-~~ 247
~~making the determination as to which insurers shall be asked to~~ 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 280
3924.04 of the Revised Code apply to each class of business 281
separate and apart from the insurer's other business; 282

(2) For purposes of applying sections 3924.01 to ~~3924.14~~ 283
3924.06 of the Revised Code to a class of business, the base 284
premium rate and midpoint rate shall be determined with respect 285
to each class of business separate and apart from the insurer's 286
other business. 287

(3) The midpoint rate for a class of business shall not 288
exceed the midpoint rate for any other class of business or the 289
insurer's non-alliance business by more than fifteen per cent. 290

(4) The insurer annually shall file with the 291
superintendent of insurance an actuarial certification 292
consistent with section 3924.06 of the Revised Code for each 293
class of business demonstrating that the underwriting and rating 294
methods of the insurer do all of the following: 295

(a) Comply with accepted actuarial practices; 296

(b) Are uniformly applied to health benefit plans covering 297
small employers within the class of business; 298

(c) Comply with the applicable provisions of this section 299
and sections 3924.01 to ~~3924.14~~ 3924.06 of the Revised Code. 300

(5) An insurer shall apply sections 3924.01 to ~~3924.14~~ 301
3924.06 of the Revised Code to the insurer's non-alliance 302
business and coverage sold through alliances not established as 303
a separate class of business. 304

(6) An insurer shall file with the superintendent a 305
notification identifying any alliance or alliances to be treated 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, 3923.89, 3923.90, 339
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 3902.53 of the 363

Revised Code: 364

(a) Physician's services, except when such services are 365
supplemental under division (B) of this section; 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 371
therapeutic radiologic services; 372

(g) Diagnostic and treatment services, other than 373
prescription drug services, for biologically based mental 374
illnesses; 375

(h) Preventive health care services, including, but not 376
limited to, voluntary family planning services, infertility 377
services, periodic physical examinations, prenatal obstetrical 378
care, and well-child care; 379

(i) Routine patient care for patients enrolled in an 380
eligible cancer clinical trial pursuant to section 3923.80 of 381
the Revised Code. 382

"Basic health care services" does not include experimental 383
procedures. 384

Except as provided by divisions (A) (2) and (3) of this 385
section in connection with the offering of coverage for 386
diagnostic and treatment services for biologically based mental 387
illnesses, a health insuring corporation shall not offer 388
coverage for a health care service, defined as a basic health 389
care service by this division, unless it offers coverage for all 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 475
superintendent of insurance. 476

(2) If a health insuring corporation offers prescription 477
drug services under this division, the coverage shall include 478
prescription drug services for the treatment of biologically 479
based mental illnesses on the same terms and conditions as other 480
physical diseases and disorders. 481

(C) "Specialty health care services" means one of the 482
supplemental health care services listed in division (B) of this 483
section, when provided by a health insuring corporation on an 484
outpatient-only basis and not in combination with other 485
supplemental health care services. 486

(D) "Biologically based mental illnesses" means 487
schizophrenia, schizoaffective disorder, major depressive 488
disorder, bipolar disorder, paranoia and other psychotic 489
disorders, obsessive-compulsive disorder, and panic disorder, as 490
these terms are defined in the most recent edition of the 491
diagnostic and statistical manual of mental disorders published 492
by the American psychiatric association. 493

(E) "Closed panel plan" means a health care plan that 494
requires enrollees to use participating providers. 495

(F) "Compensation" means remuneration for the provision of 496
health care services, determined on other than a fee-for-service 497
or discounted-fee-for-service basis. 498

(G) "Contractual periodic prepayment" means the formula 499
for determining the premium rate for all subscribers of a health 500
insuring corporation. 501

(H) "Corporation" means a corporation formed under Chapter 502
1701. or 1702. of the Revised Code or the similar laws of 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. of the 541
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 accessed 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. 1751.05. (A) The superintendent of insurance shall 671
issue or deny a certificate of authority to a health insuring 672
corporation filing an application pursuant to section 1751.03 of 673
the Revised Code, one hundred thirty-five days from the 674
superintendent's receipt of a complete application and 675
accompanying documents. 676

(B) A certificate of authority shall be issued upon 677
payment of the application fee prescribed in section 1751.44 of 678
the Revised Code if the superintendent is satisfied that the 679
following conditions are met: 680

(1) The persons responsible for the conduct of the affairs 681

of the applicant are competent, trustworthy, and possess good 682
reputations. 683

(2) The superintendent determines, in accordance with 684
division (B) of section 1751.04 of the Revised Code, that the 685
organization's proposed plan of operation meets the requirements 686
of division (A) of that section. 687

(3) The applicant constitutes an appropriate mechanism to 688
effectively provide or arrange for the provision of the basic 689
health care services, supplemental health care services, or 690
specialty health care services to be provided to enrollees. 691

(4) The applicant is financially responsible, complies 692
with section 1751.28 of the Revised Code, and may reasonably be 693
expected to meet its obligations to enrollees and prospective 694
enrollees. In making this determination, the superintendent may 695
consider: 696

(a) The financial soundness of the applicant's 697
arrangements for health care services, including the applicant's 698
proposed contractual periodic prepayments or premiums and the 699
use of copayments and deductibles; 700

(b) The adequacy of working capital; 701

(c) Any agreement with an insurer, a government, or any 702
other person for insuring the payment of the cost of health care 703
services or providing for automatic applicability of an 704
alternative coverage in the event of discontinuance of the 705
health insuring corporation's operations; 706

(d) Any agreement with providers or health care facilities 707
for the provision of health care services; 708

(e) Any deposit of securities submitted in accordance with 709

section 1751.27 of the Revised Code as a guarantee that the 710
obligations will be performed. 711

(5) The applicant has submitted documentation of an 712
arrangement to provide health care services to its enrollees 713
until the expiration of the enrollees' contracts with the 714
applicant if a health care plan or the operations of the health 715
insuring corporation are discontinued prior to the expiration of 716
the enrollees' contracts. An arrangement to provide health care 717
services may be made by using any one, or any combination, of 718
the following methods: 719

(a) The maintenance of insolvency insurance; 720

(b) A provision in contracts with providers and health 721
care facilities, but no health insuring corporation shall rely 722
solely on such a provision for more than thirty days; 723

(c) An agreement with other health insuring corporations 724
or insurers, providing enrollees with automatic conversion 725
rights upon the discontinuation of a health care plan or the 726
health insuring corporation's operations; 727

(d) Such other methods as approved by the superintendent. 728

(6) Nothing in the applicant's proposed method of 729
operation, as shown by the information submitted pursuant to 730
section 1751.03 of the Revised Code or by independent 731
investigation, will cause harm to an enrollee or to the public 732
at large, as determined by the superintendent. 733

(7) Any deficiencies identified by the superintendent 734
under section 1751.04 of the Revised Code have been corrected. 735

(8) The applicant has deposited securities as set forth in 736
section 1751.27 of the Revised Code. 737

(C) If an applicant elects to fulfill the requirements of 738
division (B) (5) of this section through an agreement with other 739
health insuring corporations or insurers, the agreement shall 740
require those health insuring corporations or insurers to give 741
thirty days' notice to the superintendent prior to cancellation 742
or discontinuation of the agreement for any reason. 743

(D) A certificate of authority shall be denied only after 744
compliance with the requirements of section 1751.36 of the 745
Revised Code. 746

Sec. 1751.06. Upon obtaining a certificate of authority as 747
required under this chapter, a health insuring corporation may 748
do all of the following: 749

(A) Enroll individuals and their dependents in either of 750
the following circumstances: 751

(1) The individual resides or lives in the approved 752
service area. 753

(2) The individual's place of employment is located in the 754
approved service area. 755

(B) Contract with providers and health care facilities for 756
the health care services to which enrollees are entitled under 757
the terms of the health insuring corporation's health care 758
contracts; 759

(C) Contract with insurance companies authorized to do 760
business in this state for insurance, indemnity, or 761
reimbursement against the cost of providing emergency and 762
nonemergency health care services for enrollees, subject to the 763
provisions set forth in this chapter and the limitations set 764
forth in the Revised Code; 765

(D) Contract with any person pursuant to the requirements 766
of division (A) (18) of section 1751.03 of the Revised Code for 767
managerial or administrative services, or for data processing, 768
actuarial analysis, billing services, or any other services 769
authorized by the superintendent of insurance. However, a health 770
insuring corporation shall not enter into a contract for any of 771
the services listed in this division with an insurance company 772
that is not authorized to engage in the business of insurance in 773
this state. 774

(E) Accept from governmental agencies, private agencies, 775
corporations, associations, groups, individuals, or other 776
persons, payments covering all or part of the costs of planning, 777
development, construction, and the provision of health care 778
services; 779

(F) Purchase, lease, construct, renovate, operate, or 780
maintain health care facilities, and their ancillary equipment, 781
and any property necessary in the transaction of the business of 782
the health insuring corporation; 783

(G) In the employer group market, impose an affiliation 784
period of not more than sixty days, or for late enrollees an 785
affiliation period of not more than ninety days, which period 786
begins on the individual's date of enrollment and runs 787
concurrently with any waiting period imposed under the coverage. 788
For purposes of this division, "affiliation period" means a 789
period of time which, under the terms of the coverage offered, 790
must expire before the coverage becomes effective. No health 791
care services or benefits need to be provided during an 792
affiliation period, and no periodic prepayments can be charged 793
for any coverage during that period. 794

(H) If a health insuring corporation offers coverage in 795

the small employer group market through a network plan, limit or 796
deny the coverage in accordance with section 3924.031 of the 797
Revised Code; 798

(I) Refuse to issue coverage in the small employer group 799
market pursuant to section 3924.032 of the Revised Code; 800

(J) Establish employer contribution rules or group 801
participation rules for the offering of coverage in connection 802
with a group contract in the small employer group market, as 803
provided in division ~~(E)~~(D) (1) of section 3924.03 of the Revised 804
Code. 805

Nothing in this section shall be construed as prohibiting 806
a health insuring corporation without other commercial 807
enrollment from contracting solely with federal health care 808
programs regulated by federal regulatory bodies. 809

Nothing in this section shall be construed to limit the 810
authority of a health insuring corporation to perform those 811
functions not otherwise prohibited by law. 812

Sec. 1751.12. (A) (1) No contractual periodic prepayment 813
and no premium rate for nongroup and conversion policies for 814
health care services, or any amendment to them, may be used by 815
any health insuring corporation at any time until the 816
contractual periodic prepayment and premium rate, or amendment, 817
have been filed with the superintendent of insurance, and shall 818
not be effective until the expiration of sixty days after their 819
filing unless the superintendent sooner gives approval. The 820
filing shall be accompanied by an actuarial certification in the 821
form prescribed by the superintendent. The superintendent shall 822
disapprove the filing, if the superintendent determines within 823
the sixty-day period that the contractual periodic prepayment or 824

premium rate, or amendment, is not in accordance with sound 825
actuarial principles or is not reasonably related to the 826
applicable coverage and characteristics of the applicable class 827
of enrollees. The superintendent shall notify the health 828
insuring corporation of the disapproval, and it shall thereafter 829
be unlawful for the health insuring corporation to use the 830
contractual periodic prepayment or premium rate, or amendment. 831

(2) No contractual periodic prepayment for group policies 832
for health care services shall be used until the contractual 833
periodic prepayment has been filed with the superintendent. The 834
filing shall be accompanied by an actuarial certification in the 835
form prescribed by the superintendent. The superintendent may 836
reject a filing made under division (A)(2) of this section at 837
any time, with at least thirty days' written notice to a health 838
insuring corporation, if the contractual periodic prepayment is 839
not in accordance with sound actuarial principles or is not 840
reasonably related to the applicable coverage and 841
characteristics of the applicable class of enrollees. 842

(3) At any time, the superintendent, upon at least thirty 843
days' written notice to a health insuring corporation, may 844
withdraw the approval given under division (A)(1) of this 845
section, deemed or actual, of any contractual periodic 846
prepayment or premium rate, or amendment, based on information 847
that either of the following applies: 848

(a) The contractual periodic prepayment or premium rate, 849
or amendment, is not in accordance with sound actuarial 850
principles. 851

(b) The contractual periodic prepayment or premium rate, 852
or amendment, is not reasonably related to the applicable 853
coverage and characteristics of the applicable class of 854

enrollees. 855

(4) Any disapproval under division (A) (1) of this section, 856
any rejection of a filing made under division (A) (2) of this 857
section, or any withdrawal of approval under division (A) (3) of 858
this section, shall be effected by a written notice, which shall 859
state the specific basis for the disapproval, rejection, or 860
withdrawal and shall be issued in accordance with Chapter 119. 861
of the Revised Code. 862

(B) Notwithstanding division (A) of this section, a health 863
insuring corporation may use a contractual periodic prepayment 864
or premium rate for policies used for the coverage of 865
beneficiaries enrolled in medicare pursuant to a medicare risk 866
contract or medicare cost contract, or for policies used for the 867
coverage of beneficiaries enrolled in the federal employees 868
health benefits program pursuant to 5 U.S.C.A. 8905, or for 869
policies used for the coverage of medicaid recipients, or for 870
policies used for the coverage of beneficiaries under any other 871
federal health care program regulated by a federal regulatory 872
body, or for policies used for the coverage of beneficiaries 873
under any contract covering officers or employees of the state 874
that has been entered into by the department of administrative 875
services, if both of the following apply: 876

(1) The contractual periodic prepayment or premium rate 877
has been approved by the United States department of health and 878
human services, the United States office of personnel 879
management, the department of medicaid, or the department of 880
administrative services. 881

(2) The contractual periodic prepayment or premium rate is 882
filed with the superintendent prior to use and is accompanied by 883
documentation of approval from the United States department of 884

health and human services, the United States office of personnel 885
management, the department of medicaid, or the department of 886
administrative services. 887

(C) The administrative expense portion of all contractual 888
periodic prepayment or premium rate filings submitted to the 889
superintendent for review must reflect the actual cost of 890
administering the product. The superintendent may require that 891
the administrative expense portion of the filings be itemized 892
and supported. 893

(D) (1) Copayments, cost sharing, and deductibles must be 894
reasonable and must not be a barrier to the necessary 895
utilization of services by enrollees. 896

(2) A health insuring corporation, in order to ensure that 897
copayments, cost sharing, and deductibles are reasonable and not 898
a barrier to the necessary utilization of basic health care 899
services by enrollees shall impose copayment charges, cost 900
sharing, and deductible charges that annually do not exceed 901
forty per cent of the total annual cost to the health insuring 902
corporation of providing all covered health care services when 903
applied to a standard population expected to be covered under 904
the filed product in question. The total annual cost of 905
providing a health care service is the cost to the health 906
insuring corporation of providing the health care service to its 907
enrollees as reduced by any applicable provider discount. This 908
requirement shall be demonstrated by an actuary who is a member 909
of the American academy of actuaries and qualified to provide 910
such certifications as described in the United States 911
qualification standards promulgated by the American academy of 912
actuaries pursuant to the code of professional conduct. 913

(3) For purposes of division (D) of this section, all of 914

the following apply: 915

(a) Copayments imposed by health insuring corporations in 916
connection with a high deductible health plan that is linked to 917
a health savings account are reasonable and are not a barrier to 918
the necessary utilization of services by enrollees. 919

(b) Division (D) (2) of this section does not apply to a 920
high deductible health plan that is linked to a health savings 921
account. 922

(c) Catastrophic-only plans, as described in division (D) 923
(2) of section 3902.53 of the Revised Code and defined under the 924
"Patient Protection and Affordable Care Act," 124 Stat. 119, 42 925
U.S.C. 18022 and any related regulations, are not subject to the 926
limits prescribed in division (D) of this section, provided that 927
such plans meet all applicable minimum federal requirements. 928

(E) A health insuring corporation shall not impose 929
lifetime maximums on basic health care services. However, a 930
health insuring corporation may establish a benefit limit for 931
inpatient hospital services that are provided pursuant to a 932
policy, contract, certificate, or agreement for supplemental 933
health care services. 934

(F) The superintendent may adopt rules allowing different 935
copayment, cost sharing, and deductible amounts for plans with a 936
medical savings account, health reimbursement arrangement, 937
flexible spending account, or similar account; 938

(G) A health insuring corporation may impose higher 939
copayment, cost sharing, and deductible charges under health 940
plans if requested by the group contract, policy, certificate, 941
or agreement holder, or an individual seeking coverage under an 942
individual health plan. This shall not be construed as requiring 943

the health insuring corporation to create customized health 944
plans for group contract holders or individuals. 945

(H) As used in this section, "health savings account" and 946
"high deductible health plan" have the same meanings as in the 947
"Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 223, 948
as amended. 949

Sec. 1751.16. (A) Except as provided in division (F) of 950
this section, every group contract issued by a health insuring 951
corporation shall provide an option for conversion to an 952
individual contract issued on a direct-payment basis to any 953
subscriber covered by the group contract who terminates 954
employment or membership in the group, unless: 955

(1) Termination of the conversion option or contract is 956
based upon nonpayment of premium after reasonable notice in 957
writing has been given by the health insuring corporation to the 958
subscriber. 959

(2) The subscriber is, or is eligible to be, covered for 960
benefits at least comparable to the group contract under any of 961
the following: 962

(a) Medicare; 963

(b) Any act of congress or law under this or any other 964
state of the United States providing coverage at least 965
comparable to the benefits under division (A) (2) (a) of this 966
section; 967

(c) Any policy of insurance or health care plan providing 968
coverage at least comparable to the benefits under division (A) 969
(2) (a) of this section. 970

~~(B) (1) The direct-payment contract offered by the health-~~ 971

~~insuring corporation pursuant to division (A) of this section~~ 972
~~shall provide the following:~~ 973

~~(a) In the case of an individual who is not a federally~~ 974
~~eligible individual, benefits comparable to benefits in any of~~ 975
~~the individual contracts then being issued to individual~~ 976
~~subscribers by the health insuring corporation;~~ 977

~~(b) In the case of a federally eligible individual, a~~ 978
~~basic and standard plan established under section 3924.10 of the~~ 979
~~Revised Code or plans substantially similar to the basic and~~ 980
~~standard plan in benefit design and scope of covered services.~~ 981
~~For purposes of division (B) (1) (b) of this section, the~~ 982
~~superintendent of insurance shall determine whether a plan is~~ 983
~~substantially similar to the basic or standard plan in benefit~~ 984
~~design and scope of covered services. The contractual periodic~~ 985
~~prepayments charged for such plans may not exceed the amounts~~ 986
~~specified below:~~ 987

~~(i) For calendar years 2010 and 2011, an amount that is~~ 988
~~two times the base rate charged any other individual of a group~~ 989
~~to which the organization is currently accepting new business~~ 990
~~and for which similar copayments and deductibles are applied;~~ 991

~~(ii) For calendar year 2012 and every calendar year~~ 992
~~thereafter, an amount that is one and one half times the base~~ 993
~~rate charged any other individual of a group to which the health~~ 994
~~insuring corporation is currently accepting new business and for~~ 995
~~which similar copayments and deductibles are applied, unless the~~ 996
~~superintendent of insurance determines that the amendments by~~ 997
~~this act to sections 3923.58 and 3923.581 of the Revised Code,~~ 998
~~have resulted in the market wide average medical loss ratio for~~ 999
~~coverage sold to individual insureds and nonemployer group~~ 1000
~~insureds in this state, including open enrollment insureds, to~~ 1001

~~increase by more than five and one quarter percentage points-- 1002~~
~~during calendar year 2010. If the superintendent makes that 1003~~
~~determination, the premium limit established by division (B) (1) 1004~~
~~(b) (i) of this section shall remain in effect. 1005~~

~~(2) The direct payment contract offered pursuant to 1006~~
~~division (A) of this section may include a coordination of 1007~~
~~benefits provision as approved by the superintendent. 1008~~

~~(3) For purposes of division (B) of this section: 1009~~

~~(a) "Federally eligible individual" means an eligible 1010~~
~~individual as defined in 45 C.F.R. 148.103. 1011~~

~~(b) "Base rate" means, as to any health benefit plan that 1012~~
~~is issued by a health insuring corporation, the lowest premium 1013~~
~~rate for new or existing business prescribed by the health 1014~~
~~insuring corporation for the same or similar coverage under a 1015~~
~~plan or arrangement covering any individual in a group with 1016~~
~~similar case characteristics. 1017~~

~~(C) The option for conversion shall be available: 1018~~

~~(1) Upon the death of the subscriber, to the surviving 1019~~
~~spouse with respect to such of the spouse and dependents as are 1020~~
~~then covered by the group contract; 1021~~

~~(2) To a child solely with respect to the child upon the 1022~~
~~child's attaining the limiting age of coverage under the group 1023~~
~~contract while covered as a dependent under the contract; 1024~~

~~(3) Upon the divorce, dissolution, or annulment of the 1025~~
~~marriage of the subscriber, to the divorced spouse, or, in the 1026~~
~~event of annulment, to the former spouse of the subscriber. 1027~~

~~(D) No health insuring corporation shall use age or health 1028~~
~~status as the basis for refusing to renew a converted contract. 1029~~

(E) Written notice of the conversion option provided by 1030
this section shall be given to the subscriber by the health 1031
insuring corporation by mail. The notice shall be sent to the 1032
subscriber's address in the records of the employer upon receipt 1033
of notice from the employer of the event giving rise to the 1034
conversion option. If the subscriber has not received notice of 1035
the conversion privilege at least fifteen days prior to the 1036
expiration of the thirty-day conversion period, then the 1037
subscriber shall have an additional period within which to 1038
exercise the privilege. This additional period shall expire 1039
fifteen days after the subscriber receives notice, but in no 1040
event shall the period extend beyond sixty days after the 1041
expiration of the thirty-day conversion period. 1042

(F) This section does not apply to any group contract 1043
offering only supplemental health care services or specialty 1044
health care services. 1045

Sec. 1751.18. (A) (1) No health insuring corporation shall 1046
cancel or fail to renew the coverage of a subscriber or enrollee 1047
because of any health status-related factor in relation to the 1048
subscriber or enrollee, the subscriber's or enrollee's 1049
requirements for health care services, or for any other reason 1050
designated under rules adopted by the superintendent of 1051
insurance. 1052

(2) Unless otherwise required by state or federal law, no 1053
health insuring corporation, or health care facility or provider 1054
through which the health insuring corporation has made 1055
arrangements to provide health care services, shall discriminate 1056
against any individual with regard to enrollment, disenrollment, 1057
or the quality of health care services rendered, on the basis of 1058
the individual's race, color, sex, age, religion, military 1059

status as defined in section 4112.01 of the Revised Code, or 1060
status as a recipient of medicare or medicaid, or any health 1061
status-related factor in relation to the individual. However, a 1062
health insuring corporation shall not be required to accept a 1063
recipient of medicare or medical assistance, if an agreement has 1064
not been reached on appropriate payment mechanisms between the 1065
health insuring corporation and the governmental agency 1066
administering these programs. ~~Further, except for open-~~ 1067
~~enrollment coverage under sections 3923.58 and 3923.581 of the~~ 1068
~~Revised Code and except as provided in section 1751.65 of the~~ 1069
~~Revised Code, a health insuring corporation may reject an~~ 1070
~~applicant for nongroup enrollment on the basis of any health-~~ 1071
~~status-related factor in relation to the applicant.~~ 1072

(B) A health insuring corporation may cancel or decide not 1073
to renew the coverage of an enrollee if the enrollee has 1074
performed an act or practice that constitutes fraud or 1075
intentional misrepresentation of material fact under the terms 1076
of the coverage and if the cancellation or nonrenewal is not 1077
based, either directly or indirectly, on any health status- 1078
related factor in relation to the enrollee. 1079

(C) An enrollee may appeal any action or decision of a 1080
health insuring corporation taken pursuant to section 2742(b) to 1081
(e) of the "Health Insurance Portability and Accountability Act 1082
of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 1083
300gg-42, as amended. To appeal, the enrollee may submit a 1084
written complaint to the health insuring corporation pursuant to 1085
section 1751.19 of the Revised Code. The enrollee may, within 1086
thirty days after receiving a written response from the health 1087
insuring corporation, appeal the health insuring corporation's 1088
action or decision to the superintendent. 1089

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

(1) Health status;

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

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

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

(8) Disability.

Sec. 1751.58. Except as otherwise provided in section 2721 of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-21, as amended, the following conditions apply to all group health insuring corporation contracts that are sold in connection with an employment-related group health care plan and that are not subject to section 3924.03 of the Revised Code:

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

(2) A health insuring corporation may cancel or decide not to renew the coverage of any eligible employee or of a dependent

of an eligible employee under the group contract in accordance 1117
with division (B) of section 1751.18 of the Revised Code. 1118

(B) Such group contracts are subject to ~~division (A)(3) of~~ 1119
~~section 3924.03 and~~ sections 3924.033 and 3924.27 of the Revised 1120
Code. 1121

(C) Such group contracts shall provide for the special 1122
enrollment periods described in section 2701(f) of the "Health 1123
Insurance Portability and Accountability Act of 1996." 1124

(D) At least once in every twelve-month period, a health 1125
insuring corporation shall provide to all late enrollees, as 1126
defined in section 3924.01 of the Revised Code, who are 1127
identified by the contract holder, the option to enroll in the 1128
group contract. The enrollment option shall be provided for a 1129
minimum period of thirty consecutive days. All delays of 1130
coverage imposed under the group contract, including any 1131
affiliation period, shall begin on the date the health insuring 1132
corporation receives notice of the late enrollee's application 1133
or request for coverage, and shall run concurrently with each 1134
other. 1135

Sec. 1751.69. (A) As used in this section, "cost sharing" 1136
means the cost to an individual insured under an individual or 1137
group health insuring corporation policy, contract, or agreement 1138
according to any coverage limit, copayment, coinsurance, 1139
deductible, or other out-of-pocket expense requirements imposed 1140
by the policy, contract, or agreement. 1141

(B) Notwithstanding section 3901.71 of the Revised Code 1142
and subject to division (D) of this section, no individual or 1143
group health insuring corporation policy, contract, or agreement 1144
providing basic health care services or prescription drug 1145

services that is delivered, issued for delivery, or renewed in 1146
this state, if the policy, contract, or agreement provides 1147
coverage for cancer chemotherapy treatment, shall fail to comply 1148
with either of the following: 1149

(1) The policy, contract, or agreement shall not provide 1150
coverage or impose cost sharing for a prescribed, orally 1151
administered cancer medication on a less favorable basis than 1152
the coverage it provides or cost sharing it imposes for 1153
intravenously administered or injected cancer medications. 1154

(2) The policy, contract, or agreement shall not comply 1155
with division (B)(1) of this section by imposing an increase in 1156
cost sharing solely for orally administered, intravenously 1157
administered, or injected cancer medications. 1158

(C) Notwithstanding any provision of this section to the 1159
contrary, an individual or group health insuring corporation 1160
policy, contract, or agreement shall be deemed to be in 1161
compliance with this section if the cost sharing imposed under 1162
such a policy, contract, or agreement for orally administered 1163
cancer treatments does not exceed one hundred dollars per 1164
prescription fill. The cost-sharing limit of one hundred dollars 1165
per prescription fill shall apply to a high deductible plan, as 1166
defined in 26 U.S.C. 223, or a catastrophic plan, as described 1167
in division (D)(2) of section 3902.53 of the Revised Code and 1168
defined in 42 U.S.C. 18022, only after the deductible has been 1169
met. 1170

(D) The prohibitions in division (B) of this section do 1171
not preclude an individual or group health insuring corporation 1172
policy, contract, or agreement from requiring an enrollee to 1173
obtain prior authorization before orally administered cancer 1174
medication is dispensed to the enrollee. 1175

(E) A health insuring corporation that offers coverage for 1176
basic health care services is not required to comply with 1177
division (B) of this section if all of the following apply: 1178

(1) The health insuring corporation submits documentation 1179
certified by an independent member of the American academy of 1180
actuaries to the superintendent of insurance showing that 1181
compliance with division (B) (1) of this section for a period of 1182
at least six months independently caused the health insuring 1183
corporation's costs for claims and administrative expenses for 1184
the coverage of basic health care services to increase by more 1185
than one per cent per year. 1186

(2) The health insuring corporation submits a signed 1187
letter from an independent member of the American academy of 1188
actuaries to the superintendent of insurance opining that the 1189
increase in costs described in division (E) (1) of this section 1190
could reasonably justify an increase of more than one per cent 1191
in the annual premiums or rates charged by the health insuring 1192
corporation for the coverage of basic health care services. 1193

(3) (a) The superintendent of insurance makes the following 1194
determinations from the documentation and opinion submitted 1195
pursuant to divisions (E) (1) and (2) of this section: 1196

(i) Compliance with division (B) (1) of this section for a 1197
period of at least six months independently caused the health 1198
insuring corporation's costs for claims and administrative 1199
expenses for the coverage of basic health care services to 1200
increase more than one per cent per year. 1201

(ii) The increase in costs reasonably justifies an 1202
increase of more than one per cent in the annual premiums or 1203
rates charged by the health insuring corporation for the 1204

coverage of basic health care services. 1205

(b) Any determination made by the superintendent under 1206
division (E)(3) of this section is subject to Chapter 119. of 1207
the Revised Code. 1208

Sec. 3902.50. As used in sections 3902.50 to 3902.54 of 1209
the Revised Code: 1210

(A) "Cost-sharing" means the cost to a covered person 1211
under a health benefit plan according to any coverage limit, 1212
copayment, coinsurance, deductible, or other out-of-pocket 1213
expense requirement. 1214

(B) "Covered person," "health benefit plan," "health care 1215
provider" or "provider," "health care services," and "health 1216
plan issuer" have the same meanings as in section 3922.01 of the 1217
Revised Code. 1218

(C) "Preexisting condition exclusion" means, with respect 1219
to a health benefit plan, a limitation or exclusion of benefits 1220
relating to a condition based on the fact that the condition was 1221
present before the date of enrollment in the plan, whether or 1222
not any medical advice, diagnosis, care, or treatment was 1223
recommended or received before such date. "Condition" does not 1224
include genetic information in the absence of a diagnosis of the 1225
condition related to such information. 1226

Sec. 3902.51. (A) With respect to the premium rate charged 1227
by a health plan issuer for a health benefit plan offered in the 1228
individual or small group market, all of the following apply: 1229

(1) The premium rate shall vary with respect to the health 1230
benefit plan involved only by the following: 1231

(a) Whether the health benefit plan covers an individual 1232

or family; 1233

(b) Rating area, as established in accordance with 1234
division (C) (1) of this section; 1235

(c) Age, except that such rate shall not vary by more than 1236
three to one for adults; 1237

(d) Tobacco use, except that such rate shall not vary by 1238
more than one and one-half to one. 1239

(2) The premium rate shall not vary with respect to the 1240
health benefit plan involved by any other factor not described 1241
in division (A) of this section. 1242

(B) With respect to family coverage under a health benefit 1243
plan, the rating variations permitted under divisions (A) (1) (c) 1244
and (d) of this section shall be applied based on the portion of 1245
the premium that is attributable to each family member covered 1246
under the health benefit plan. 1247

(C) The superintendent of insurance shall adopt rules to 1248
do the following: 1249

(1) Establish one or more rating areas within the state; 1250

(2) Define the permissible age bands for rating purposes 1251
under division (A) (3) of this section. 1252

(D) A health plan issuer shall not establish lifetime or 1253
annual limits on the dollar value of benefits described in 1254
section 3902.53 of the Revised Code for any covered person. 1255

Sec. 3902.52. (A) Every individual health benefit plan 1256
shall accept every individual in this state who applies for 1257
coverage and every group health benefit plan shall accept every 1258
employer in this state that applies for coverage, regardless of 1259

whether any individual or employee has a preexisting condition. 1260
A health benefit plan may restrict enrollment in coverage to 1261
open or special enrollment periods under division (C) of this 1262
section. 1263

(B) A health plan issuer shall not impose any preexisting 1264
condition exclusion on any person. 1265

(C) (1) The superintendent of insurance shall adopt rules 1266
to ensure that each individual health benefit plan has open 1267
enrollment during a statewide open enrollment period to allow 1268
individuals, including individuals who are not covered persons, 1269
to enroll in the health benefit plan. 1270

(2) A health plan issuer shall provide special enrollment 1271
periods for individuals who lose coverage as a result of a 1272
qualifying event under 42 U.S.C. 9801(f) or 29 U.S.C. 1163. 1273

Sec. 3902.53. (A) For purposes of this section, "essential 1274
health benefits package" means, with respect to a health benefit 1275
plan, coverage that does all of the following: 1276

(1) Provides for the essential health benefits defined by 1277
the superintendent of insurance under division (B) of this 1278
section; 1279

(2) Limits cost sharing for such coverage in accordance 1280
with division (C) of this section; 1281

(3) Provides the level of coverage described in division 1282
(D) of this section. 1283

(B) (1) Subject to division (B) (2) of this section, the 1284
superintendent shall define the essential health benefits, 1285
except that such benefits shall include at least the following 1286
general categories and the items and services covered within the 1287

<u>categories:</u>	1288
<u>(a) Ambulatory patient services;</u>	1289
<u>(b) Emergency services;</u>	1290
<u>(c) Hospitalization;</u>	1291
<u>(d) Maternity and newborn care;</u>	1292
<u>(e) Mental health and substance use disorder services,</u>	1293
<u>including behavioral health treatment;</u>	1294
<u>(f) Prescription drugs;</u>	1295
<u>(g) Rehabilitative and habilitative services and devices;</u>	1296
<u>(h) Laboratory services;</u>	1297
<u>(i) Preventive and wellness services and chronic disease</u>	1298
<u>management;</u>	1299
<u>(j) Pediatric services, including oral and vision care.</u>	1300
<u>(2)(a) The superintendent shall ensure that the scope of</u>	1301
<u>the essential health benefits under division (B)(1) of this</u>	1302
<u>section is equal to the scope of benefits provided under a</u>	1303
<u>typical employer plan, as determined by the superintendent. To</u>	1304
<u>inform this determination, the superintendent shall conduct a</u>	1305
<u>survey of employer-sponsored coverage to determine the benefits</u>	1306
<u>typically covered by employers, including multi-employer plans.</u>	1307
<u>(b) In defining the essential health benefits described in</u>	1308
<u>division (B)(1) of this section, and in revising the benefits</u>	1309
<u>under division (B)(3)(g) of this section, the superintendent</u>	1310
<u>shall submit a report to the general assembly containing a</u>	1311
<u>certification that such essential health benefits meet the</u>	1312
<u>requirements described in division (B)(2)(a) of this section.</u>	1313

(3) In defining the essential health benefits under 1314
division (B)(1) of this section, the superintendent shall do all 1315
of the following: 1316

(a) Ensure that such essential health benefits reflect an 1317
appropriate balance among the categories described in division 1318
(B)(1) of this section, so that benefits are not unduly weighted 1319
toward any category; 1320

(b) Not make coverage decisions, determine reimbursement 1321
rates, establish incentive programs, or design benefits in ways 1322
that discriminate against individuals because of their age, 1323
disability, or expected length of life; 1324

(c) Take into account the health care needs of diverse 1325
segments of the population, including women, children, persons 1326
with disabilities, and other groups; 1327

(d) Ensure that health benefits established as essential 1328
not be subject to denial to individuals against their wishes on 1329
the basis of the individuals' age or expected length of life or 1330
of the individuals' present or predicted disability, degree of 1331
medical dependency, or quality of life; 1332

(e) Provide that a qualified health benefit plan shall not 1333
be treated as providing coverage for the essential health 1334
benefits described in division (B)(1) of this section unless the 1335
plan does both of the following: 1336

(i) Provides that coverage for emergency services, as 1337
defined in section 3923.65 of the Revised Code, will be provided 1338
without imposing any requirement under the plan for prior 1339
authorization of services or any limitation on coverage where 1340
the provider of services does not have a contractual 1341
relationship with the plan for the providing of services that is 1342

more restrictive than the requirements or limitations that apply 1343
to emergency services received from providers who do have such a 1344
contractual relationship with the plan; 1345

(ii) Provides that if emergency services are provided out- 1346
of-network, the cost-sharing requirement is the same requirement 1347
that would apply if such services were provided in-network. 1348

(f) Periodically review the essential health benefits 1349
under division (B) (1) of this section and provide a report to 1350
the general assembly and the public that contains all of the 1351
following: 1352

(i) An assessment of whether covered persons are facing 1353
any difficulty accessing needed services for reasons of coverage 1354
or cost; 1355

(ii) An assessment of whether the essential health 1356
benefits needs to be modified or updated to account for changes 1357
in medical evidence or scientific advancement; 1358

(iii) Information on how the essential health benefits 1359
will be modified to address any such gaps in access or changes 1360
in the evidence base; 1361

(iv) An assessment of the potential of additional or 1362
expanded benefits to increase costs and the interactions between 1363
the addition or expansion of benefits and reductions in existing 1364
benefits to meet the requirements of division (B) (2) (a) of this 1365
section. 1366

(g) Periodically update the essential health benefits 1367
under division (B) (1) of this section to address any gaps in 1368
access to coverage or changes in the evidence base the 1369
superintendent identifies in the review conducted under division 1370
(B) (3) (f) of this section. 1371

(4) Nothing in this section shall be construed to prohibit 1372
a health benefit plan from providing benefits in excess of the 1373
essential health benefits described in this section. 1374

(C) (1) A health plan issuer shall not require cost sharing 1375
in an amount greater than seven thousand nine hundred dollars 1376
for self-only coverage and fifteen thousand eight hundred 1377
dollars for other than self-only coverage for plan years 1378
beginning in 2020. 1379

(2) For plan years beginning in a calendar year after 1380
2020, the cost-sharing limit shall be as follows: 1381

(a) In the case of self-only coverage, be equal to the 1382
dollar amount in division (C) (1) of this section, increased by 1383
the product of that amount and the premium adjustment percentage 1384
under division (C) (3) of this section for the calendar year; 1385

(b) In the case of other than self-only coverage, twice 1386
the amount in effect under division (C) (2) (a) of this section. 1387
If the amount of any increase under division (C) (2) (a) of this 1388
section is not a multiple of fifty dollars, such increase shall 1389
be rounded to the next lowest multiple of fifty dollars. 1390

(3) The premium adjustment percentage for any calendar 1391
year shall be the percentage by which the average per capita 1392
premium for health benefit plans in this state for the preceding 1393
calendar year, as estimated by the superintendent not later than 1394
the first day of October of such preceding calendar year, 1395
exceeds such average per capita premium for 2019, as determined 1396
by the superintendent. 1397

(D) (1) (a) Except as provided in division (D) (2) of this 1398
section, a health benefit plan shall provide a level of coverage 1399
that is designed to provide benefits that are actuarially 1400

equivalent to sixty per cent of the full actuarial value of the
benefits provided under the plan.

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

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

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

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

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

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

(i) Except as provided in division (D)(2)(b)(ii) of this
section, the essential health benefits listed in division (B)(1)
of this section, except that the health benefit plan provides no
benefits for any plan year until the individual has incurred
cost-sharing expenses in an amount equal to the annual
limitation in effect under division (C) of this section for the
plan year except as provided for in section 3902.54 of the
Revised Code;

(ii) Coverage for at least three primary care visits. 1430

(3) If a health plan issuer offers a health benefit plan 1431
described in division (D) (2) of this section, the issuer shall 1432
only offer the plan in the individual market. 1433

(E) The requirements of this section do not apply to 1434
health benefit plans offered in the large group market. 1435

(F) Nothing in this section is subject to the requirements 1436
of section 3901.71 of the Revised Code. 1437

Sec. 3902.54. (A) A health benefit plan shall provide 1438
coverage for and shall not impose any cost-sharing requirements 1439
for the following: 1440

(1) Evidence-based items or services that have in effect a 1441
rating of "A" or "B" in the current recommendations of the 1442
United States preventive services task force; 1443

(2) Immunizations that have in effect a recommendation 1444
from the advisory committee on immunization practices of the 1445
United States centers for disease control and prevention with 1446
respect to the individual involved; 1447

(3) With respect to infants, children, and adolescents, 1448
evidence-informed preventive care and screenings provided for in 1449
the comprehensive guidelines supported by the United States 1450
health resources and services administration; 1451

(4) With respect to women, such additional preventive care 1452
and screenings not described in division (A) (1) of this section 1453
as provided for in comprehensive guidelines supported by the 1454
United States health resources and services administration. 1455

(B) The superintendent shall adopt rules to implement 1456
sections 3902.50 to 3902.54 of the Revised Code. 1457

Sec. 3922.01. As used in this chapter:	1458
(A) "Adverse benefit determination" means a decision by a health plan issuer:	1459 1460
(1) To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:	1461 1462 1463
(a) A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;	1464 1465 1466 1467 1468
(b) A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a nonemployer group, to participate in a plan or health insurance coverage;	1469 1470 1471 1472
(c) A determination that a health care service is not a covered benefit;	1473 1474
(d) The imposition of an exclusion, including exclusions for pre-existing conditions , source of injury, network, or any other limitation on benefits that would otherwise be covered.	1475 1476 1477
(2) Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a nonemployer group;	1478 1479 1480
(3) To rescind coverage on a health benefit plan.	1481
(B) "Ambulatory review" has the same meaning as in section 1751.77 of the Revised Code.	1482 1483
(C) "Authorized representative" means an individual who	1484

represents a covered person in an internal appeal or external
review process of an adverse benefit determination who is any of
the following:

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

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

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

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

(1) Randomized clinical trials;

(2) Cohort studies or case-control studies;

(3) Case series;

(4) Expert opinion.

(E) "Covered person" means a policyholder, subscriber,
enrollee, member, or individual covered by a health benefit
plan. "Covered person" does include the covered person's
authorized representative with regard to an internal appeal or
external review in accordance with division (C) of this section.
"Covered person" does not include the covered person's
representative in any other context.

(F) "Covered benefits" or "benefits" means those health

care services to which a covered person is entitled under the 1512
terms of a health benefit plan. 1513

(G) "Emergency medical condition" has the same meaning as 1514
in section 1753.28 of the Revised Code. 1515

(H) "Emergency services" has the same meaning as in 1516
section 1753.28 of the Revised Code. 1517

(I) "Evidence-based standard" means the conscientious, 1518
explicit, and judicious use of the current best evidence, based 1519
on a systematic review of the relevant research, in making 1520
decisions about the care of individuals. 1521

(J) "Facility" means an institution providing health care 1522
services, or a health care setting, including hospitals and 1523
other licensed inpatient centers, ambulatory, surgical, 1524
treatment, skilled nursing, residential treatment, diagnostic, 1525
laboratory, and imaging centers, and rehabilitation and other 1526
therapeutic health settings. 1527

(K) "Final adverse benefit determination" means an adverse 1528
benefit determination that is upheld at the completion of a 1529
health plan issuer's internal appeals process. 1530

(L) "Health benefit plan" means a policy, contract, 1531
certificate, or agreement offered by a health plan issuer to 1532
provide, deliver, arrange for, pay for, or reimburse any of the 1533
costs of health care services, including benefit plans marketed 1534
in the individual or group market by all associations, whether 1535
bona fide or non-bona fide. "Health benefit plan" also means a 1536
limited benefit plan, except as follows. "Health benefit plan" 1537
does not mean any of the following types of coverage: a policy, 1538
contract, certificate, or agreement that covers only a specified 1539
accident, accident only, credit, dental, disability income, 1540

long-term care, hospital indemnity, supplemental coverage, as 1541
described in section 3923.37 of the Revised Code, specified 1542
disease, or vision care; coverage issued as a supplement to 1543
liability insurance; insurance arising out of workers' 1544
compensation or similar law; automobile medical payment 1545
insurance; or insurance under which benefits are payable with or 1546
without regard to fault and which is statutorily required to be 1547
contained in any liability insurance policy or equivalent self- 1548
insurance; a medicare supplement policy of insurance, as defined 1549
by the superintendent of insurance by rule, coverage under a 1550
plan through medicare, medicaid, or the federal employees 1551
benefit program; any coverage issued under Chapter 55 of Title 1552
10 of the United States Code and any coverage issued as a 1553
supplement to that coverage. 1554

(M) "Health care professional" means a physician, 1555
psychologist, nurse practitioner, or other health care 1556
practitioner licensed, accredited, or certified to perform 1557
health care services consistent with state law. 1558

(N) "Health care provider" or "provider" means a health 1559
care professional or facility. 1560

(O) "Health care services" means services for the 1561
diagnosis, prevention, treatment, cure, or relief of a health 1562
condition, illness, injury, or disease. 1563

(P) "Health plan issuer" means an entity subject to the 1564
insurance laws and rules of this state, or subject to the 1565
jurisdiction of the superintendent of insurance, that contracts, 1566
or offers to contract to provide, deliver, arrange for, pay for, 1567
or reimburse any of the costs of health care services under a 1568
health benefit plan, including a sickness and accident insurance 1569
company, a health insuring corporation, a fraternal benefit 1570

society, a self-funded multiple employer welfare arrangement, or 1571
a nonfederal, government health plan. "Health plan issuer" 1572
includes a third party administrator licensed under Chapter 1573
3959. of the Revised Code to the extent that the benefits that 1574
such an entity is contracted to administer under a health 1575
benefit plan are subject to the insurance laws and rules of this 1576
state or subject to the jurisdiction of the superintendent. 1577

(Q) "Health information" means information or data, 1578
whether oral or recorded in any form or medium, and personal 1579
facts or information about events or relationships that relates 1580
to all of the following: 1581

(1) The past, present, or future physical, mental, or 1582
behavioral health or condition of a covered person or a member 1583
of the covered person's family; 1584

(2) The provision of health care services or health- 1585
related benefits to a covered person; 1586

(3) Payment for the provision of health care services to 1587
or for a covered person. 1588

(R) "Independent review organization" means an entity that 1589
is accredited to conduct independent external reviews of adverse 1590
benefit determinations pursuant to section 3922.13 of the 1591
Revised Code. 1592

(S) "Medical or scientific evidence" means evidence found 1593
in any of the following sources: 1594

(1) Peer-reviewed scientific studies published in, or 1595
accepted for publication by, medical journals that meet 1596
nationally recognized requirements for scientific manuscripts 1597
and that submit most of their published articles for review by 1598
experts who are not part of the editorial staff; 1599

(2) Peer-reviewed medical literature, including literature 1600
relating to therapies reviewed and approved by a qualified 1601
institutional review board, biomedical compendia and other 1602
medical literature that meet the criteria of the national 1603
institutes of health's library of medicine for indexing in index 1604
medicus and elsevier science ltd. for indexing in excerpta 1605
medicus; 1606

(3) Medical journals recognized by the secretary of health 1607
and human services under section 1861(t)(2) of the federal 1608
social security act; 1609

(4) The following standard reference compendia: 1610

(a) The American hospital formulary service drug 1611
information; 1612

(b) Drug facts and comparisons; 1613

(c) The American dental association accepted dental 1614
therapeutics; 1615

(d) The United States pharmacopoeia drug information. 1616

(5) Findings, studies or research conducted by or under 1617
the auspices of a federal government agency or nationally 1618
recognized federal research institute, including any of the 1619
following: 1620

(a) The federal agency for health care research and 1621
quality; 1622

(b) The national institutes of health; 1623

(c) The national cancer institute; 1624

(d) The national academy of sciences; 1625

(e) The centers for medicare and medicaid services; 1626

(f) The federal food and drug administration; 1627

(g) Any national board recognized by the national 1628
institutes of health for the purpose of evaluating the medical 1629
value of health care services. 1630

(6) Any other medical or scientific evidence that is 1631
comparable. 1632

(T) "Person" has the same meaning as in section 3901.19 of 1633
the Revised Code. 1634

(U) "Protected health information" means health 1635
information related to the identity of an individual, or 1636
information that could reasonably be used to determine the 1637
identity of an individual. 1638

(V) "Rescind" means to retroactively cancel or discontinue 1639
coverage. "Rescind" does not include canceling or discontinuing 1640
coverage that only has a prospective effect or canceling or 1641
discontinuing coverage that is effective retroactively to the 1642
extent it is attributable to a failure to timely pay required 1643
premiums or contributions towards the cost of coverage. 1644

(W) "Retrospective review" means a review conducted after 1645
services have been provided to a covered person. 1646

(X) "Superintendent" means the superintendent of 1647
insurance. 1648

(Y) "Utilization review" has the same meaning as in 1649
section 1751.77 of the Revised Code. 1650

(Z) "Utilization review organization" has the same meaning 1651
as in section 1751.77 of the Revised Code. 1652

Sec. 3923.122. (A) Every policy of group sickness and 1653

accident insurance providing hospital, surgical, or medical 1654
expense coverage for other than specific diseases or accidents 1655
only, and delivered, issued for delivery, or renewed in this 1656
state on or after January 1, 1976, shall include a provision 1657
giving each insured the option to convert to ~~the following:~~ 1658

~~(1) In the case of an individual who is not a federally~~ 1659
~~eligible individual,~~ any of the individual policies of hospital, 1660
surgical, or medical expense insurance then being issued by the 1661
insurer with benefit limits not to exceed those in effect under 1662
the group policy. 1663

~~(2) In the case of a federally eligible individual, a~~ 1664
~~basic or standard plan established in accordance with section~~ 1665
~~3924.10 of the Revised Code or plans substantially similar to~~ 1666
~~the basic and standard plan in benefit design and scope of~~ 1667
~~covered services. For purposes of division (A) (2) of this~~ 1668
~~section, the superintendent of insurance shall determine whether~~ 1669
~~a plan is substantially similar to the basic or standard plan in~~ 1670
~~benefit design and scope of covered services.~~ 1671

(B) An option for conversion to an individual policy shall 1672
be available without evidence of insurability to every insured, 1673
including any person eligible under division (D) of this 1674
section, who terminates employment or membership in the group 1675
holding the policy after having been continuously insured 1676
thereunder for at least one year. 1677

Upon receipt of the insured's written application and upon 1678
payment of at least the first quarterly premium not later than 1679
thirty-one days after the termination of coverage under the 1680
group policy, the insurer shall issue a converted policy on a 1681
form then available for conversion. The premium shall be in 1682
accordance with the insurer's table of premium rates in effect 1683

on the later of the following dates: 1684

(1) The effective date of the converted policy; 1685

(2) The date of application therefor; and shall be 1686
applicable to the class of risk to which each person covered 1687
belongs and to the form and amount of the policy at the person's 1688
then attained age. ~~However, premiums charged federally eligible~~ 1689
~~individuals may not exceed the amounts specified below:~~ 1690

~~(a) For calendar years 2010 and 2011, an amount that is~~ 1691
~~two times the base rate charged any other individual of a group~~ 1692
~~to which the insurer is currently accepting new business and for~~ 1693
~~which similar copayments and deductibles are applied;~~ 1694

~~(b) For calendar year 2012 and every year thereafter, an~~ 1695
~~amount that is one and one half times the base rate charged any~~ 1696
~~other individual of a group to which the insurer is currently~~ 1697
~~accepting new business and for which similar copayments and~~ 1698
~~deductibles are applied, unless the superintendent of insurance~~ 1699
~~determines that the amendments by this act to sections 3923.58~~ 1700
~~and 3923.581 of the Revised Code, have resulted in the market~~ 1701
~~wide average medical loss ratio for coverage sold to individual~~ 1702
~~insureds and nonemployer group insureds in this state, including~~ 1703
~~open enrollment insureds, to increase by more than five and one~~ 1704
~~quarter percentage points during calendar year 2010. If the~~ 1705
~~superintendent makes that determination, the premium limit~~ 1706
~~established by division (B) (2) (a) of this section shall remain~~ 1707
~~in effect.~~ 1708

At the election of the insurer, a separate converted 1709
policy may be issued to cover any dependent of an employee or 1710
member of the group. 1711

Except as provided in division (H) of this section, any 1712

converted policy shall become effective as of the day following 1713
the date of termination of insurance under the group policy. 1714

Any probationary or waiting period set forth in the 1715
converted policy is deemed to commence on the effective date of 1716
the insured's coverage under the group policy. 1717

(C) No insurer shall be required to issue a converted 1718
policy to any person who is, or is eligible to be, covered for 1719
benefits at least comparable to the group policy under: 1720

(1) Title XVIII of the Social Security Act, as amended or 1721
superseded; 1722

(2) Any act of congress or law under this or any other 1723
state of the United States that duplicates coverage offered 1724
under division (C) (1) of this section; 1725

(3) Any policy that duplicates coverage offered under 1726
division (C) (1) of this section; 1727

(4) Any other group sickness and accident insurance 1728
providing hospital, surgical, or medical expense coverage for 1729
other than specific diseases or accidents only. 1730

(D) The option for conversion shall be available: 1731

(1) Upon the death of the employee or member, to the 1732
surviving spouse with respect to such of the spouse and 1733
dependents as are then covered by the group policy; 1734

(2) To a child solely with respect to the child upon 1735
attaining the limiting age of coverage under the group policy 1736
while covered as a dependent thereunder; 1737

(3) Upon the divorce, dissolution, or annulment of the 1738
marriage of the employee or member, to the divorced spouse, or 1739

former spouse in the event of annulment, of such employee or 1740
member, or upon the legal separation of the spouse from such 1741
employee or member, to the spouse. 1742

Persons possessing the option for conversion pursuant to 1743
this division shall be considered members for the purposes of 1744
division (H) of this section. 1745

(E) If coverage is continued under a group policy on an 1746
employee following retirement prior to the time the employee is, 1747
or is eligible to be, covered by Title XVIII of the Social 1748
Security Act, the employee may elect, in lieu of the continuance 1749
of group insurance, to have the same conversion rights as would 1750
apply had the employee's insurance terminated at retirement by 1751
reason of termination of employment. 1752

(F) If the insurer and the group policyholder agree upon 1753
one or more additional plans of benefits to be available for 1754
converted policies, the applicant for the converted policy may 1755
elect such a plan in lieu of a converted policy. 1756

(G) The converted policy may contain provisions for 1757
avoiding duplication of benefits provided pursuant to divisions 1758
(C) (1), (2), (3), and (4) of this section or provided under any 1759
other insured or noninsured plan or program. 1760

(H) If an employee or member becomes entitled to obtain a 1761
converted policy pursuant to this section, and if the employee 1762
or member has not received notice of the conversion privilege at 1763
least fifteen days prior to the expiration of the thirty-one-day 1764
conversion period provided in division (B) of this section, then 1765
the employee or member has an additional period within which to 1766
exercise the privilege. This additional period shall expire 1767
fifteen days after the employee or member receives notice, but 1768

in no event shall the period extend beyond sixty days after the 1769
expiration of the thirty-one-day conversion period. 1770

Written notice presented to the employee or member, or 1771
mailed by the policyholder to the last known address of the 1772
employee or member as indicated on its records, constitutes 1773
notice for the purpose of this division. In the case of a person 1774
who is eligible for a converted policy under division (D) (2) or 1775
(D) (3) of this section, a policyholder shall not be responsible 1776
for presenting or mailing such notice, unless such policyholder 1777
has actual knowledge of the person's eligibility for a converted 1778
policy. 1779

If an additional period is allowed by an employee or 1780
member for the exercise of a conversion privilege, and if 1781
written application for the converted policy, accompanied by at 1782
least the first quarterly premium, is made after the expiration 1783
of the thirty-one-day conversion period, but within the 1784
additional period allowed an employee or member in accordance 1785
with this division, the effective date of the converted policy 1786
shall be the date of application. 1787

(I) The converted policy may provide that any hospital, 1788
surgical, or medical expense benefits otherwise payable with 1789
respect to any person may be reduced by the amount of any such 1790
benefits payable under the group policy for the same loss after 1791
termination of coverage. 1792

(J) The converted policy may contain: 1793

(1) Any exclusion, reduction, or limitation contained in 1794
the group policy or customarily used in individual policies 1795
issued by the insurer; 1796

(2) Any provision permitted in this section; 1797

(3) Any other provision not prohibited by law. 1798

Any provision required or permitted in this section may be 1799
made a part of any converted policy by means of an endorsement 1800
or rider. 1801

(K) The time limit specified in a converted policy for 1802
certain defenses with respect to any person who was covered by a 1803
group policy shall commence on the effective date of such 1804
person's coverage under the group policy. 1805

(L) No insurer shall use deterioration of health as the 1806
basis for refusing to renew a converted policy. 1807

(M) No insurer shall use age or health status as the basis 1808
for refusing to renew a converted policy. 1809

(N) A converted policy made available pursuant to this 1810
section shall, if delivery of the policy is to be made in this 1811
state, comply with this section. If delivery of a converted 1812
policy is to be made in another state, it may be on a form 1813
offered by the insurer in the jurisdiction where the delivery is 1814
to be made and which provides benefits substantially in 1815
compliance with those required in a policy delivered in this 1816
state. 1817

~~(O) As used in this section:~~ 1818

~~(1) "Base rate" means, as to any health benefit plan that 1819
is issued by an insurer in the individual market, the lowest 1820
premium rate for new or existing business prescribed by the 1821
insurer for the same or similar coverage under a plan or 1822
arrangement covering any individual of a group with similar case 1823
characteristics. 1824~~

~~(2) "Federally eligible individual" means an eligible 1825~~

~~individual as defined in 45 C.F.R. 148.103.~~

1826

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

1827

1828

1829

1830

1831

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

1832

1833

1834

1835

1836

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

1837

1838

1839

1840

1841

1842

1843

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

1844

1845

1846

1847

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

1848

1849

1850

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

1851

1852

1853

(b) The individual performed an act or practice that

1854

constitutes fraud or made an intentional misrepresentation of 1855
material fact under the terms of the policy. 1856

(c) The insurer is ceasing to offer coverage in the 1857
individual market in accordance with division ~~(D)~~ (B) of this 1858
section and the applicable laws of this state. 1859

(d) If the insurer offers coverage in the market through a 1860
network plan, the individual no longer resides, lives, or works 1861
in the service area, or in an area for which the insurer is 1862
authorized to do business; provided, however, that such coverage 1863
is terminated uniformly without regard to any health status- 1864
related factor of covered individuals. 1865

(e) If the coverage is made available in the individual 1866
market only through one or more bona fide associations, the 1867
membership of the individual in the association, on the basis of 1868
which the coverage is provided, ceases; provided, however, that 1869
such coverage is terminated under division ~~(C)~~ (A) (2) (e) of this 1870
section uniformly without regard to any health status-related 1871
factor of covered individuals. 1872

~~An insurer offering coverage to individuals solely through 1873
membership in a bona fide association shall not be deemed, by 1874
virtue of that offering, to be in the individual market for 1875
purposes of sections 3923.58 and 3923.581 of the Revised Code. 1876
Such an insurer shall not be required to accept applicants for 1877
coverage in the individual market pursuant to sections 3923.58 1878
and 3923.581 of the Revised Code unless the insurer also offers 1879
coverage to individuals other than through bona fide 1880
associations. 1881~~

(3) An insurer may cancel or decide not to renew the 1882
coverage of a dependent of an individual if the dependent has 1883

performed an act or practice that constitutes fraud or made an 1884
intentional misrepresentation of material fact under the terms 1885
of the coverage and if the cancellation or nonrenewal is not 1886
based, either directly or indirectly, on any health status- 1887
related factor in relation to the dependent. 1888

~~(D)~~ (B) (1) If an insurer decides to discontinue offering a 1889
particular type of health insurance coverage offered in the 1890
individual market, coverage of such type may be discontinued by 1891
the insurer if the insurer does all of the following: 1892

(a) Provides notice to each individual provided coverage 1893
of this type in such market of the discontinuation at least 1894
ninety days prior to the date of the discontinuation of the 1895
coverage; 1896

(b) Offers to each individual provided coverage of this 1897
type in such market, the option to purchase any other individual 1898
health insurance coverage currently being offered by the insurer 1899
for individuals in that market; 1900

(c) In exercising the option to discontinue coverage of 1901
this type and in offering the option of coverage under division 1902
~~(D)~~ (B) (1) (b) of this section, acts uniformly without regard to 1903
any health status-related factor of covered individuals or of 1904
individuals who may become eligible for such coverage. 1905

(2) If an insurer elects to discontinue offering all 1906
health insurance coverage in the individual market in this 1907
state, health insurance coverage may be discontinued by the 1908
insurer only if both of the following apply: 1909

(a) The insurer provides notice to the department of 1910
insurance and to each individual of the discontinuation at least 1911
one hundred eighty days prior to the date of the expiration of 1912

the coverage. 1913

(b) All health insurance delivered or issued for delivery 1914
in this state in such market is discontinued and coverage under 1915
that health insurance in that market is not renewed. 1916

(3) In the event of a discontinuation under division ~~(D)~~ 1917
(B) (2) of this section in the individual market, the insurer 1918
shall not provide for the issuance of any health insurance 1919
coverage in the market and this state during the five-year 1920
period beginning on the date of the discontinuation of the last 1921
health insurance coverage not so renewed. 1922

~~(E)~~ (C) Notwithstanding divisions ~~(C)~~ (A) and ~~(D)~~ (B) of 1923
this section, an insurer may, at the time of coverage renewal, 1924
modify the health insurance coverage for a policy form offered 1925
to individuals in the individual market if the modification is 1926
consistent with the law of this state and effective on a uniform 1927
basis among all individuals with that policy form. 1928

~~(F)~~ (D) Such policies are subject to sections 2743 and 1929
2747 of the "Health Insurance Portability and Accountability Act 1930
of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 1931
300gg-43 and 300gg-47, as amended. 1932

~~(G)~~ (E) Sections 3924.031 and 3924.032 of the Revised Code 1933
shall apply to sickness and accident insurance policies offered 1934
in the individual market in the same manner as they apply to 1935
health benefit plans offered in the small employer market. 1936

In accordance with 45 C.F.R. 148.102, divisions ~~(C)~~ (A) to 1937
~~(G)~~ (E) of this section also apply to all group sickness and 1938
accident insurance policies that are not sold in connection with 1939
an employment-related group health plan and that provide more 1940
than short-term, limited duration coverage. 1941

In applying divisions ~~(C)-(A)~~ to ~~(G)-(E)~~ of this section 1942
with respect to health insurance coverage that is made available 1943
by an insurer in the individual market to individuals only 1944
through one or more associations, the term "individual" includes 1945
the association of which the individual is a member. 1946

For purposes of this section, any policy issued pursuant 1947
to division (C) of section 3923.13 of the Revised Code in 1948
connection with a public or private college or university 1949
student health insurance program is considered to be issued to a 1950
bona fide association. 1951

As used in this section, "bona fide association" has the 1952
same meaning as in section 3924.03 of the Revised Code, and 1953
"health status-related factor" and "network plan" have the same 1954
meanings as in section 3924.031 of the Revised Code. 1955

This section does not apply to any policy that provides 1956
coverage for specific diseases or accidents only, or to any 1957
hospital indemnity, medicare supplement, long-term care, 1958
disability income, one-time-limited-duration policy that is less 1959
than twelve months, or other policy that offers only 1960
supplemental benefits. 1961

Sec. 3923.571. Except as otherwise provided in section 1962
2721 of the "Health Insurance Portability and Accountability Act 1963
of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 1964
300gg-21, as amended, the following conditions apply to all 1965
group policies of sickness and accident insurance that are sold 1966
in connection with an employment-related group health plan and 1967
that are not subject to section 3924.03 of the Revised Code: 1968

(A) Any such policy shall comply with the requirements of 1969
~~division (A) of section 3924.03 and section 3924.033 of the~~ 1970

Revised Code. 1971

(B) (1) Except as provided in section 2712(b) to (e) of the 1972
"Health Insurance Portability and Accountability Act of 1996," 1973
if an insurer offers coverage in the small or large group market 1974
in connection with a group policy, the insurer shall renew or 1975
continue in force such coverage at the option of the 1976
policyholder. 1977

(2) An insurer may cancel or decide not to renew the 1978
coverage of an employee or of a dependent of an employee if the 1979
employee or dependent, as applicable, has performed an act or 1980
practice that constitutes fraud or made an intentional 1981
misrepresentation of material fact under the terms of the 1982
coverage and if the cancellation or nonrenewal is not based, 1983
either directly or indirectly, on any health status-related 1984
factor in relation to the employee or dependent. 1985

As used in division (B) (2) of this section, "health 1986
status-related factor" has the same meaning as in section 1987
3924.031 of the Revised Code. 1988

(C) (1) No such policy, or insurer offering health 1989
insurance coverage in connection with such a policy, shall 1990
require any individual, as a condition of coverage or continued 1991
coverage under the policy, to pay a premium or contribution that 1992
is greater than the premium or contribution for a similarly 1993
situated individual covered under the policy on the basis of any 1994
health status-related factor in relation to the individual or to 1995
an individual covered under the policy as a dependent of the 1996
individual. 1997

(2) Nothing in division (C) (1) of this section shall be 1998
construed to restrict the amount that an employer may be charged 1999

for coverage under a group policy, or to prevent a group policy, 2000
and an insurer offering group health insurance coverage, from 2001
establishing premium discounts or rebates or modifying otherwise 2002
applicable copayments or deductibles in return for adherence to 2003
programs of health promotion and disease prevention. 2004

(D) Such policies shall provide for the special enrollment 2005
periods described in section 2701(f) of the "Health Insurance 2006
Portability and Accountability Act of 1996." 2007

(E) At least once in every twelve-month period, an insurer 2008
shall provide to all late enrollees, as defined in section 2009
3924.01 of the Revised Code, who are identified by the 2010
policyholder, the option to enroll in the group policy. The 2011
enrollment option shall be provided for a minimum period of 2012
thirty consecutive days. All delays of coverage imposed under 2013
the group policy, including any pre-existing condition exclusion 2014
period or service waiting period, shall begin on the date the 2015
insurer receives notice of the late enrollee's application or 2016
request for coverage, and shall run concurrently with each 2017
other. 2018

Sec. 3923.85. (A) As used in this section, "cost sharing" 2019
means the cost to an individual insured under an individual or 2020
group policy of sickness and accident insurance or a public 2021
employee benefit plan according to any coverage limit, 2022
copayment, coinsurance, deductible, or other out-of-pocket 2023
expense requirements imposed by the policy or plan. 2024

(B) Notwithstanding section 3901.71 of the Revised Code 2025
and subject to division (D) of this section, no individual or 2026
group policy of sickness and accident insurance that is 2027
delivered, issued for delivery, or renewed in this state and no 2028
public employee benefit plan that is established or modified in 2029

this state shall fail to comply with either of the following: 2030

(1) The policy or plan shall not provide coverage or 2031
impose cost sharing for a prescribed, orally administered cancer 2032
medication on a less favorable basis than the coverage it 2033
provides or cost sharing it imposes for intravenously 2034
administered or injected cancer medications. 2035

(2) The policy or plan shall not comply with division (B) 2036
(1) of this section by imposing an increase in cost sharing 2037
solely for orally administered, intravenously administered, or 2038
injected cancer medications. 2039

(C) Notwithstanding any provision of this section to the 2040
contrary, a policy or plan shall be deemed to be in compliance 2041
with this section if the cost sharing imposed under such a 2042
policy or plan for orally administered cancer treatments does 2043
not exceed one hundred dollars per prescription fill. The cost_ 2044
sharing limit of one hundred dollars per prescription fill shall 2045
apply to a high deductible plan, as defined in 26 U.S.C. 223, or 2046
a catastrophic plan, described in division (D) (2) of section 2047
3902.53 of the Revised Code and as defined in 42 U.S.C. 18022, 2048
only after the deductible has been met. 2049

(D) (1) The prohibitions in division (B) of this section do 2050
not preclude an individual or group policy of sickness and 2051
accident insurance or public employee benefit plan from 2052
requiring an insured or plan member to obtain prior 2053
authorization before orally administered cancer medication is 2054
dispensed to the insured or plan member. 2055

(2) Division (B) of this section does not apply to the 2056
offer or renewal of any individual or group policy of sickness 2057
and accident insurance that provides coverage for specific 2058

diseases or accidents only, or to any hospital indemnity, 2059
medicare supplement, disability income, or other policy that 2060
offers only supplemental benefits. 2061

(E) An insurer that offers any sickness and accident 2062
insurance or any public employee benefit plan that offers 2063
coverage for basic health care services is not required to 2064
comply with division (B) of this section if all of the following 2065
apply: 2066

(1) The insurer or plan submits documentation certified by 2067
an independent member of the American academy of actuaries to 2068
the superintendent of insurance showing that compliance with 2069
division (B)(1) of this section for a period of at least six 2070
months independently caused the insurer or plan's costs for 2071
claims and administrative expenses for the coverage of basic 2072
health care services to increase by more than one per cent per 2073
year. 2074

(2) The insurer or plan submits a signed letter from an 2075
independent member of the American academy of actuaries to the 2076
superintendent of insurance opining that the increase in costs 2077
described in division (E)(1) of this section could reasonably 2078
justify an increase of more than one per cent in the annual 2079
premiums or rates charged by the insurer or plan for the 2080
coverage of basic health care services. 2081

(3)(a) The superintendent of insurance makes the following 2082
determinations from the documentation and opinion submitted 2083
pursuant to divisions (E)(1) and (2) of this section: 2084

(i) Compliance with division (B)(1) of this section for a 2085
period of at least six months independently caused the insurer 2086
or plan's costs for claims and administrative expenses for the 2087

coverage of basic health care services to increase more than one 2088
per cent per year. 2089

(ii) The increase in costs reasonably justifies an 2090
increase of more than one per cent in the annual premiums or 2091
rates charged by the insurer or plan for the coverage of basic 2092
health care services. 2093

(b) Any determination made by the superintendent under 2094
division (E) (3) of this section is subject to Chapter 119. of 2095
the Revised Code. 2096

Sec. 3924.01. As used in sections 3924.01 to ~~3924.14~~ 2097
3924.06 of the Revised Code: 2098

(A) "Actuarial certification" means a written statement 2099
prepared by a member of the American academy of actuaries, or by 2100
any other person acceptable to the superintendent of insurance, 2101
that states that, based upon the person's examination, a carrier 2102
offering health benefit plans to small employers is in 2103
compliance with sections 3924.01 to ~~3924.14~~ 3924.06 of the 2104
Revised Code. "Actuarial certification" shall include a review 2105
of the appropriate records of, and the actuarial assumptions and 2106
methods used by, the carrier relative to establishing premium 2107
rates for the health benefit plans. 2108

(B) ~~"Adjusted average market premium price" means the~~ 2109
~~average market premium price as determined by the board of~~ 2110
~~directors of the Ohio health reinsurance program either on the~~ 2111
~~basis of the arithmetic mean of all carriers' premium rates for~~ 2112
~~an OHC plan sold to groups with similar case characteristics by~~ 2113
~~all carriers selling OHC plans in the state, or on any other~~ 2114
~~equitable basis determined by the board.~~ 2115

~~(C)~~ "Base premium rate" means, as to any health benefit 2116

plan that is issued by a carrier and that covers at least two 2117
but no more than fifty employees of a small employer, the lowest 2118
premium rate for a new or existing business prescribed by the 2119
carrier for the same or similar coverage under a plan or 2120
arrangement covering any small employer with similar case 2121
characteristics. 2122

~~(D)~~ (C) "Carrier" means any sickness and accident 2123
insurance company or health insuring corporation authorized to 2124
issue health benefit plans in this state or a MEWA. A sickness 2125
and accident insurance company that owns or operates a health 2126
insuring corporation, either as a separate corporation or as a 2127
line of business, shall be considered as a separate carrier from 2128
that health insuring corporation for purposes of sections 2129
3924.01 to ~~3924.14~~ 3924.06 of the Revised Code. 2130

~~(E)~~ (D) "Case characteristics" means, with respect to a 2131
small employer, the geographic area in which the employees work; 2132
the age and sex of the individual employees and their 2133
dependents; the appropriate industry classification as 2134
determined by the carrier; the number of employees and 2135
dependents; and such other objective criteria as may be 2136
established by the carrier. "Case characteristics" does not 2137
include claims experience, health status, or duration of 2138
coverage from the date of issue. 2139

~~(F)~~ (E) "Dependent" means the spouse or child of an 2140
eligible employee, subject to applicable terms of the health 2141
benefits plan covering the employee. 2142

~~(G)~~ (F) "Eligible employee" means an employee who works a 2143
normal work week of thirty or more hours. "Eligible employee" 2144
does not include a temporary or substitute employee, or a 2145
seasonal employee who works only part of the calendar year on 2146

the basis of natural or suitable times or circumstances. 2147

~~(H)~~ (G) "Health benefit plan" means any hospital or 2148
medical expense policy or certificate or any health plan 2149
provided by a carrier, that is delivered, issued for delivery, 2150
renewed, or used in this state on or after the date occurring 2151
six months after November 24, 1995. "Health benefit plan" does 2152
not include policies covering only accident, credit, dental, 2153
disability income, long-term care, hospital indemnity, medicare 2154
supplement, specified disease, or vision care; coverage under a 2155
one-time-limited-duration policy that is less than twelve 2156
months; coverage issued as a supplement to liability insurance; 2157
insurance arising out of a workers' compensation or similar law; 2158
automobile medical-payment insurance; or insurance under which 2159
benefits are payable with or without regard to fault and which 2160
is statutorily required to be contained in any liability 2161
insurance policy or equivalent self-insurance. 2162

~~(I)~~ (H) "Late enrollee" means an eligible employee or 2163
dependent who enrolls in a small employer's health benefit plan 2164
other than during the first period in which the employee or 2165
dependent is eligible to enroll under the plan or during a 2166
special enrollment period described in section 2701(f) of the 2167
"Health Insurance Portability and Accountability Act of 1996," 2168
Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg, as 2169
amended. 2170

~~(J)~~ (I) "MEWA" means any "multiple employer welfare 2171
arrangement" as defined in section 3 of the "Federal Employee 2172
Retirement Income Security Act of 1974," 88 Stat. 832, 29 2173
U.S.C.A. 1001, as amended, except for any arrangement which is 2174
fully insured as defined in division (b) (6) (D) of section 514 of 2175
that act. 2176

~~(K)~~ (J) "Midpoint rate" means, for small employers with 2177
similar case characteristics and plan designs and as determined 2178
by the applicable carrier for a rating period, the arithmetic 2179
average of the applicable base premium rate and the 2180
corresponding highest premium rate. 2181

~~(L) "Pre-existing conditions provision" means a policy~~ 2182
~~provision that excludes or limits coverage for charges or~~ 2183
~~expenses incurred during a specified period following the~~ 2184
~~insured's enrollment date as to a condition for which medical~~ 2185
~~advice, diagnosis, care, or treatment was recommended or~~ 2186
~~received during a specified period immediately preceding the~~ 2187
~~enrollment date. Genetic information shall not be treated as~~ 2188
~~such a condition in the absence of a diagnosis of the condition~~ 2189
~~related to such information.~~ 2190

~~For purposes of this division, "enrollment date" means,~~ 2191
~~with respect to an individual covered under a group health~~ 2192
~~benefit plan, the date of enrollment of the individual in the~~ 2193
~~plan or, if earlier, the first day of the waiting period for~~ 2194
~~such enrollment.~~ 2195

~~(M)~~ (K) "Service waiting period" means the period of time 2196
after employment begins before an employee is eligible to be 2197
covered for benefits under the terms of any applicable health 2198
benefit plan offered by the small employer. 2199

~~(N)~~ (L) (1) "Small employer" means, in connection with a 2200
group health benefit plan and with respect to a calendar year 2201
and a plan year, an employer who employed an average of at least 2202
two but no more than fifty eligible employees on business days 2203
during the preceding calendar year and who employs at least two 2204
employees on the first day of the plan year. 2205

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

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

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

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

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

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

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

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

(1) Any law that would inhibit any carrier from
contracting with providers or groups of providers with respect
to health care services or benefits;

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

benefit plan; 2265

(3) Any law that would require any carrier to either 2266
include a specific provider or class of provider when 2267
contracting for health care services or benefits, or to exclude 2268
any class of provider that is generally authorized by statute to 2269
provide such care. 2270

Sec. 3924.03. Except as otherwise provided in section 2721 2271
of the "Health Insurance Portability and Accountability Act of 2272
1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg- 2273
21, as amended, health benefit plans covering small employers 2274
are subject to the following conditions, as applicable: 2275

(A) (1) ~~Pre-existing conditions provisions shall not~~ 2276
~~exclude or limit coverage for a period beyond twelve months, or~~ 2277
~~eighteen months in the case of a late enrollee, following the~~ 2278
~~individual's enrollment date and may only relate to a physical~~ 2279
~~or mental condition, regardless of the cause of the condition,~~ 2280
~~for which medical advice, diagnosis, care, or treatment was~~ 2281
~~recommended or received within the six months immediately~~ 2282
~~preceding the enrollment date.~~ 2283

~~Division (A) (1) of this section is subject to the~~ 2284
~~exceptions set forth in section 2701(d) of the "Health Insurance~~ 2285
~~Portability and Accountability Act of 1996."~~ 2286

~~(2) The period of any such pre-existing condition~~ 2287
~~exclusion shall be reduced by the aggregate of the periods of~~ 2288
~~creditable coverage, if any, applicable to the employee or~~ 2289
~~dependent as of the enrollment date.~~ 2290

~~(3) A period of creditable coverage shall not be counted,~~ 2291
~~with respect to enrollment of an individual under a group health~~ 2292
~~benefit plan, if, after that period and before the enrollment~~ 2293

~~date, there was a sixty three day period during all of which the~~ 2294
~~individual was not covered under any creditable coverage.~~ 2295
~~Subsections (c) (2) to (4) and (c) of section 2701 of the "Health~~ 2296
~~Insurance Portability and Accountability Act of 1996" apply with~~ 2297
~~respect to crediting previous coverage.~~ 2298

~~(4) As used in division (A) of this section:~~ 2299

~~(a) "Creditable coverage" has the same meaning as in~~ 2300
~~section 2701(c) (1) of the "Health Insurance Portability and~~ 2301
~~Accountability Act of 1996."~~ 2302

~~(b) "Enrollment date" means, with respect to an individual~~ 2303
~~covered under a group health benefit plan, the date of~~ 2304
~~enrollment of the individual in the plan or, if earlier, the~~ 2305
~~first day of the waiting period for such enrollment.~~ 2306

~~(B) (1)~~ Except as provided in section 2712(b) to (e) of the 2307
"Health Insurance Portability and Accountability Act of 1996," 2308
if a carrier offers coverage in the small employer market in 2309
connection with a group health benefit plan, the carrier shall 2310
renew or continue in force such coverage at the option of the 2311
plan sponsor of the plan. 2312

(2) A carrier may cancel or decide not to renew the 2313
coverage of any eligible employee or of a dependent of an 2314
eligible employee if the employee or dependent, as applicable, 2315
has performed an act or practice that constitutes fraud or made 2316
an intentional misrepresentation of material fact under the 2317
terms of the coverage and if the cancellation or nonrenewal is 2318
not based, either directly or indirectly, on any health status- 2319
related factor in relation to the employee or dependent. 2320

As used in division ~~(B)~~ (A) (2) of this section, "health 2321
status-related factor" has the same meaning as in section 2322

3924.031 of the Revised Code. 2323

~~(C)~~ (B) A carrier shall not exclude any eligible employee 2324
or dependent, who would otherwise be covered under a health 2325
benefit plan, on the basis of any actual or expected health 2326
condition of the employee or dependent. 2327

If, prior to November 24, 1995, a carrier excluded an 2328
eligible employee or dependent, other than a late enrollee, on 2329
the basis of an actual or expected health condition, the carrier 2330
shall, upon the initial renewal of the coverage on or after that 2331
date, extend coverage to the employee or dependent if all other 2332
eligibility requirements are met. 2333

~~(D)~~ (C) No health benefit plan issued by a carrier shall 2334
limit or exclude, by use of a rider or amendment applicable to a 2335
specific individual, coverage by type of illness, treatment, 2336
medical condition, or accident, ~~except for pre-existing~~ 2337
~~conditions as permitted under division (A) of this section.~~ If a 2338
health benefit plan that is delivered or issued for delivery 2339
prior to April 14, 1993, contains such limitations or 2340
exclusions, by use of a rider or amendment applicable to a 2341
specific individual, the plan shall eliminate the use of such 2342
riders or amendments within eighteen months after April 14, 2343
1993. 2344

~~(E)~~ (D) (1) Except as provided in sections 3924.031 and 2345
3924.032 of the Revised Code, and subject to such rules as may 2346
be adopted by the superintendent of insurance in accordance with 2347
Chapter 119. of the Revised Code, a carrier shall offer and make 2348
available every health benefit plan that it is actively 2349
marketing to every small employer that applies to the carrier 2350
for such coverage. 2351

Division ~~(E)~~(D) (1) of this section does not apply to a 2352
health benefit plan that a carrier makes available in the small 2353
employer market only through one or more bona fide associations. 2354

Division ~~(E)~~(D) (1) of this section shall not be construed 2355
to preclude a carrier from establishing employer contribution 2356
rules or group participation rules for the offering of coverage 2357
in connection with a group health benefit plan in the small 2358
employer market, as allowed under the law of this state. As used 2359
in division ~~(E)~~(D) (1) of this section, "employer contribution 2360
rule" means a requirement relating to the minimum level or 2361
amount of employer contribution toward the premium for 2362
enrollment of employees and dependents and "group participation 2363
rule" means a requirement relating to the minimum number of 2364
employees or dependents that must be enrolled in relation to a 2365
specified percentage or number of eligible individuals or 2366
employees of an employer. 2367

(2) Each health benefit plan, at the time of initial group 2368
enrollment, shall make coverage available to all the eligible 2369
employees of a small employer without a service waiting period. 2370
The decision of whether to impose a service waiting period shall 2371
be made by the small employer. Such waiting periods shall not be 2372
greater than ninety days. 2373

(3) Each health benefit plan shall provide for the special 2374
enrollment periods described in section 2701(f) of the "Health 2375
Insurance Portability and Accountability Act of 1996." 2376

(4) At least once in every twelve-month period, a carrier 2377
shall provide to all late enrollees who are identified by the 2378
small employer, the option to enroll in the health benefit plan. 2379
The enrollment option shall be provided for a minimum period of 2380
thirty consecutive days. All delays of coverage imposed under 2381

the health benefit plan, including any ~~pre-existing condition-~~ 2382
~~exclusion period,~~ affiliation period, or service waiting period, 2383
shall begin on the date the carrier receives notice of the late 2384
enrollee's application or request for coverage, and shall run 2385
concurrently with each other. 2386

~~(F)~~ (E) The benefit structure of any health benefit plan 2387
may, at the time of coverage renewal, be changed by the carrier 2388
to make it consistent with the benefit structure contained in 2389
health benefit plans being marketed to new small employer 2390
groups. If the health benefit plan is available in the small 2391
employer market other than only through one or more bona fide 2392
associations, the modification must be consistent with the law 2393
of this state and effective on a uniform basis among small 2394
employer group plans. 2395

~~(G)~~ (F) A carrier may obtain any facts and information 2396
necessary to apply this section, or supply those facts and 2397
information to any other third-party payer, without the consent 2398
of the beneficiary. Each person claiming benefits under a health 2399
benefit plan shall provide any facts and information necessary 2400
to apply this section. 2401

For purposes of this section, "bona fide association" 2402
means an association that has been actively in existence for at 2403
least five years; has been formed and maintained in good faith 2404
for purposes other than obtaining insurance; does not condition 2405
membership in the association on any health status-related 2406
factor, as defined in section 3924.031 of the Revised Code, 2407
relating to an individual, including an employee or dependent; 2408
makes health insurance coverage offered through the association 2409
available to all members regardless of any health status-related 2410
factor, as defined in section 3924.031 of the Revised Code, 2411

relating to such members or to individuals eligible for coverage 2412
through a member; does not make health insurance coverage 2413
offered through the association available other than in 2414
connection with a member of the association; and meets any other 2415
requirement imposed by the superintendent. To maintain its 2416
status as a "bona fide association," each association shall 2417
annually certify to the superintendent that it meets the 2418
requirements of this paragraph. 2419

Sec. 3924.033. (A) Each carrier, in connection with the 2420
offering of a health benefit plan to a small employer, shall 2421
disclose to the employer, as part of its solicitation and sales 2422
materials, the following information: 2423

(1) The provisions of the plan concerning the carrier's 2424
right to change premium rates and the factors that may affect 2425
changes in premium rates; 2426

(2) The provisions of the plan relating to renewability of 2427
coverage; 2428

(3) ~~The provisions of the plan relating to any pre-~~ 2429
~~existing condition exclusion;~~ 2430

~~(4)~~ The benefits and premiums available under all health 2431
benefit plans for which the employer is qualified. 2432

(B) The information described in division (A) of this 2433
section shall be provided in a manner determined to be 2434
understandable by the average small employer, and in a manner 2435
sufficient to reasonably inform a small employer regarding the 2436
employer's rights and obligations under the health benefit plan. 2437

(C) Nothing in this section requires a carrier to disclose 2438
any information that is by law proprietary and trade secret 2439
information. 2440

Sec. 3924.06. (A) Compliance with the underwriting and 2441
rating requirements contained in sections 3924.01 to ~~3924.14~~ 2442
3924.06 of the Revised Code shall be demonstrated through 2443
actuarial certification. Carriers offering health benefit plans 2444
to small employers shall file annually with the superintendent 2445
of insurance an actuarial certification stating that the 2446
underwriting and rating methods of the carrier do all of the 2447
following: 2448

(1) Comply with accepted actuarial practices; 2449

(2) Are uniformly applied to health benefit plans covering 2450
small employers; 2451

(3) Comply with the applicable provisions of sections 2452
3924.01 to ~~3924.14~~ 3924.06 of the Revised Code. 2453

(B) If a carrier has established a separate class of 2454
business for one or more small employer health care alliances in 2455
accordance with section 1731.09 of the Revised Code, this 2456
section shall apply in accordance with section 1731.09 of the 2457
Revised Code. 2458

(C) Carriers offering health benefit plans to small 2459
employers shall file premium rates with the superintendent in 2460
accordance with section 3923.02 of the Revised Code with respect 2461
to the carrier's sickness and accident insurance policies sold 2462
to small employers and in accordance with section 1751.12 of the 2463
Revised Code with respect to the carrier's health insuring 2464
corporation policies sold to small employers. 2465

Sec. 3924.51. (A) As used in this section: 2466

(1) "Child" means, in connection with any adoption or 2467
placement for adoption of the child, an individual who has not 2468
attained age eighteen as of the date of the adoption or 2469

placement for adoption. 2470

(2) "Health insurer" has the same meaning as in section 2471
3924.41 of the Revised Code. 2472

(3) "Placement for adoption" means the assumption and 2473
retention by a person of a legal obligation for total or partial 2474
support of a child in anticipation of the adoption of the child. 2475
The child's placement with a person terminates upon the 2476
termination of that legal obligation. 2477

(B) If an individual or group health plan of a health 2478
insurer makes coverage available for dependent children of 2479
participants or beneficiaries, the plan shall provide benefits 2480
to dependent children placed with participants or beneficiaries 2481
for adoption under the same terms and conditions as apply to the 2482
natural, dependent children of the participants and 2483
beneficiaries, irrespective of whether the adoption has become 2484
final. 2485

~~(C) A health plan described in division (B) of this 2486
section shall not restrict coverage under the plan of any 2487
dependent child adopted by a participant or beneficiary, or 2488
placed with a participant or beneficiary for adoption, solely on 2489
the basis of a pre-existing condition of the child at the time 2490
that the child would otherwise become eligible for coverage 2491
under the plan, if the adoption or placement for adoption occurs 2492
while the participant or beneficiary is eligible for coverage 2493
under the plan. 2494~~

Sec. 3924.73. (A) As used in this section: 2495

(1) "Health care insurer" means any person legally engaged 2496
in the business of providing sickness and accident insurance 2497
contracts in this state, a health insuring corporation organized 2498

under Chapter 1751. of the Revised Code, or any legal entity 2499
that is self-insured and provides health care benefits to its 2500
employees or members. 2501

(2) "Small employer" has the same meaning as in section 2502
3924.01 of the Revised Code. 2503

(B) (1) Subject to division (B) (2) of this section, nothing 2504
in sections 3924.61 to 3924.74 of the Revised Code shall be 2505
construed to limit the rights, privileges, or protections of 2506
employees or small employers under sections 3924.01 to ~~3924.14~~ 2507
3924.06 of the Revised Code. 2508

(2) If any account holder enrolls or applies to enroll in 2509
a policy or contract offered by a health care insurer providing 2510
sickness and accident coverage that is more comprehensive than, 2511
and has a deductible amount that is less than, the coverage and 2512
deductible amount of the policy under which the account holder 2513
currently is enrolled, the health care insurer to which the 2514
account holder applies may subject the account holder to the 2515
same medical review, waiting periods, and underwriting 2516
requirements to which the health care insurer generally subjects 2517
other enrollees or applicants, unless the account holder enrolls 2518
or applies to enroll during a designated period of open 2519
enrollment. 2520

Section 2. That existing sections 1731.03, 1731.04, 2521
1731.05, 1731.09, 1739.05, 1751.01, 1751.06, 1751.12, 1751.16, 2522
1751.18, 1751.58, 1751.69, 3922.01, 3923.122, 3923.57, 3923.571, 2523
3923.85, 3924.01, 3924.02, 3924.03, 3924.033, 3924.06, 3924.51, 2524
and 3924.73 of the Revised Code are hereby repealed. 2525

Section 3. That sections 1751.15, 3923.58, 3923.581, 2526
3923.582, 3923.59, 3924.07, 3924.08, 3924.09, 3924.10, 3924.11, 2527

3924.111, 3924.12, 3924.13, and 3924.14 of the Revised Code are 2528
hereby repealed. 2529

Section 4. The amendments to sections 1751.16, 1751.17, 2530
and 3923.122 of the Revised Code in Section 1 of this act, which 2531
were suspended by Section 3 of Sub. S.B. 9 of the 130th General 2532
Assembly and which suspension was extended by Section 610.53 of 2533
Am. Sub. H.B. 49 of the 132nd General Assembly, do not affect 2534
the suspension of those sections. If sections 1751.16, 1751.17, 2535
and 3923.122 of the Revised Code become operational, they will 2536
be so in either their form as amended by this act or as they are 2537
later amended. 2538

Section 5. This act shall apply to health benefit plans, 2539
as defined in section 3922.01 of the Revised Code, delivered, 2540
issued for delivery, modified, or renewed on or after the 2541
effective date of this act. 2542

Section 6. The General Assembly, applying the principle 2543
stated in division (B) of section 1.52 of the Revised Code that 2544
amendments are to be harmonized if reasonably capable of 2545
simultaneous operation, finds that the following sections, 2546
presented in this act as composites of the sections as amended 2547
by the acts indicated, are the resulting versions of the 2548
sections in effect prior to the effective date of the sections 2549
as presented in this act: 2550

Section 1739.05 of the Revised Code as amended by Sub. 2551
H.B. 156, Sub. S.B. 259, and Sub. S.B. 265, all of the 132nd 2552
General Assembly. 2553

Section 1751.12 of the Revised Code as amended by both Am. 2554
Sub. H.B. 59 and Sub. H.B. 3 of the 130th General Assembly. 2555