(122nd General Assembly)
(Substitute House Bill Number 374)

AN ACT

To amend sections 1739.05, 1751.06, 1751.15, 1751.16, 1751.18, 1751.59, 1751.61, 1751.64, 1751.65, 1751.67, 3901.21, 3901.49, 3901.491, 3901.50, 3901.501, 3923.021, 3923.122, 3923.26, 3923.40, 3923.57, 3923.58, 3923.59, 3923.63, 3923.64, 3924.01, 3924.02, 3924.03, 3924.07 to 3924.11, 3924.111, 3924.12 to 3924.14, 3924.51, 3924.61 to 3924.64, 3924.66 to 3924.68, and 3924.73, to enact sections 1751.57, 1751.58, 3901.044, 3923.571, 3923.581, 3924.031, 3924.032, 3924.033, and 3924.27, and to repeal section 3941.53 of the Revised Code relative to the implementation of the federal Health Insurance Portability and Accountability Act of 1996 and insurance coverage of follow-up care for a mother and newborn, and to declare an emergency.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That sections 1739.05, 1751.06, 1751.15, 1751.16, 1751.18, 1751.59, 1751.61, 1751.64, 1751.65, 1751.67, 3901.21, 3901.49, 3901.491, 3901.50, 3901.501, 3923.021, 3923.122, 3923.26, 3923.40, 3923.57, 3923.58, 3923.59, 3923.63, 3923.64, 3924.01, 3924.02, 3924.03, 3924.07, 3924.08, 3924.09, 3924.10, 3924.11, 3924.111, 3924.12, 3924.13, 3924.14, 3924.51, 3924.61, 3924.62, 3924.63, 3924.64, 3924.66, 3924.67, 3924.68, and 3924.73 be amended and sections 1751.57, 1751.58, 3901.044, 3923.571, 3923.581, 3924.031, 3924.032, 3924.033, and 3924.27 of the Revised Code be enacted to read as follows:

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

(1) The arrangement has and maintains a minimum enrollment of three

hundred employees of two or more employers.

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

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

(B) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program shall comply with all laws applicable to self-funded programs in this state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.40, 3901.45, 3901.46, 3902.01 to 3902.14, 3923.30, 3923.301, ~~and~~ 3923.38, 3923.581, 3923.63, 3924.031, 3924.032, and 3924.27 of the Revised Code.

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

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

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

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

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

(2) The individual's place of employment is located in the approved service area ~~and the individual has agreed to receive health care services in accordance with the evidence of coverage~~.

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

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

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

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

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

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

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

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

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

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

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

Sec. 1751.15. (A) After a health insuring corporation has furnished,

directly or indirectly, basic health care services for a period of twenty-four months, and if it currently meets the financial requirements set forth in section 1751.28 of the Revised Code and had net income as reported to the superintendent of insurance for at least one of the preceding four calendar quarters, it shall hold an annual open enrollment period of not less than thirty days during its month of licensure <u>for individuals who are not federally eligible individuals</u>.

(B) During the open enrollment period described in division (A) of this section, the health insuring corporation shall accept applicants and their dependents in the order in which they apply for enrollment and in accordance with any of the following:

(1) Up to its capacity, as determined by the health insuring corporation subject to review by the superintendent;

(2) If less than its capacity, one per cent of the health insuring corporation's total number of subscribers residing in this state as of the immediately preceding thirty-first day of December.

(C) Where a health insuring corporation demonstrates to the satisfaction of the superintendent that such open enrollment would jeopardize its economic viability, the superintendent may do any of the following:

(1) Waive the requirement for open enrollment;

(2) Impose a limit on the number of applicants and their dependents that must be enrolled;

(3) Authorize such underwriting restrictions upon open enrollment as are necessary to do any of the following:

(a) Preserve its financial stability;

(b) Prevent excessive adverse selection;

(c) Avoid unreasonably high or unmarketable charges for coverage of health care services.

(D)(1) A request to the superintendent under division (C) of this section for any restriction, limit, or waiver during an open enrollment period must be accompanied by supporting documentation, including financial data. In reviewing the request, the superintendent may consider various factors, including the size of the health insuring corporation, the health insuring corporation's net worth and profitability, the health insuring corporation's delivery system structure, and the effect on profitability of prior open enrollments.

(2) Any action taken by the superintendent under division (C) of this section shall be effective for a period of not more than one year. At the expiration of such time, a new demonstration of the health insuring corporation's need for the restriction, limit, or waiver shall be made before a

new restriction, limit, or waiver is granted by the superintendent.

(3) Irrespective of the granting of any restriction, limit, or waiver by the superintendent, a health insuring corporation may reject an applicant or a dependent of the applicant during its open enrollment period if the applicant or dependent:

(a) Was eligible for and was covered under any employer-sponsored health care coverage, or if employer-sponsored health care coverage was available at the time of open enrollment;

(b) Is eligible for ~~conversion or~~ continuation coverage under state or federal law;

(c) Is eligible for medicare, and the health insuring corporation does not have an agreement on appropriate payment mechanisms with the governmental agency administering the medicare program.

(E) A health insuring corporation shall not be required either to enroll applicants or their dependents who are confined to a health care facility because of chronic illness, permanent injury, or other infirmity that would cause economic impairment to the health insuring corporation if such applicants or their dependents were enrolled or to make the effective date of benefits for applicants or their dependents enrolled under this section earlier than ninety days after the date of enrollment.

(F) A health insuring corporation shall not be required to cover the fees or costs, or both, for any basic health care service related to a transplant of a body organ if the transplant occurs within one year after the effective date of an enrollee's coverage under this section. This limitation on coverage does not apply to a newly born child who meets the requirements for coverage under section 1751.61 of the Revised Code.

(G) Each health insuring corporation required to hold an open enrollment pursuant to division (A) of this section shall file with the superintendent, not later than sixty days prior to the commencement of the proposed open enrollment period, the following documents:

(1) The proposed public notice of open enrollment;

(2) The evidence of coverage approved pursuant to section 1751.11 of the Revised Code that will be used during open enrollment;

(3) The contractual periodic prepayment and premium rate approved pursuant to section 1751.12 of the Revised Code that will be applicable during open enrollment;

(4) Any solicitation document approved pursuant to section 1751.31 of the Revised Code to be sent to applicants, including the application form that will be used during open enrollment;

(5) A list of the proposed dates of publication of the public notice, and

the names of the newspapers in which the notice will appear;

(6) Any request for a restriction, limit, or waiver with respect to the open enrollment period, along with any supporting documentation.

(H)(1) An open enrollment period shall not satisfy the requirements of this section unless the health insuring corporation provides adequate public notice in accordance with divisions (H)(2) and (3) of this section. No public notice shall be used until the form of the public notice has been filed by the health insuring corporation with the superintendent. If the superintendent does not disapprove the public notice within sixty days after it is filed, it shall be deemed approved, unless the superintendent sooner gives approval for the public notice. If the superintendent determines within this sixty-day period that the public notice fails to meet the requirements of this section, the superintendent shall so notify the health insuring corporation and it shall be unlawful for the health insuring corporation to use the public notice. Such disapproval shall be effected by a written order, which shall state the grounds for disapproval and shall be issued in accordance with Chapter 119. of the Revised Code.

(2) A public notice pursuant to division (H)(1) of this section shall be published in at least one newspaper of general circulation in each county in the health insuring corporation's service area, at least once in each of the two weeks immediately preceding the month in which the open enrollment is to occur and in each week of that month, or until the enrollment limitation is reached, whichever occurs first. The notice published during the last week of open enrollment shall appear not less than five days before the end of the open enrollment period. It shall be at least two newspaper columns wide or two and one-half inches wide, whichever is larger. The first two lines of the text shall be published in not less than twelve-point, boldface type. The remainder of the text of the notice shall be published in not less than eight-point type. The entire public notice shall be surrounded by a continuous black line not less than one-eighth of an inch wide.

(3) The following information shall be included in the public notice provided under division (H)(2) of this section:

(a) The dates that open enrollment will be held and the date coverage obtained under the open enrollment will become effective;

(b) Notice that an applicant or the applicant's dependents will not be denied coverage during open enrollment because of a preexisting health condition, but that some limitations and restrictions may apply;

(c) The address where a person may obtain an application;

(d) The telephone number that a person may call to request an application or to ask questions;

(e) The date the first payment will be due;

(f) The actual rates or range of rates that will be applicable for applicants;

(g) Any limitation granted by the superintendent on the number of applications that will be accepted by the health insuring corporation.

(4) Within thirty days after the end of an open enrollment period, the health insuring corporation shall submit to the superintendent proof of publication for the public notices, and shall report the total number of applicants and their dependents enrolled during the open enrollment period.

(I)(1) No health insuring corporation may employ any scheme, plan, or device that restricts the ability of any person to enroll during open enrollment.

(2) No health insuring corporation may require enrollment to be made in person. Every health insuring corporation shall permit application for coverage by mail. A representative of the health insuring corporation may visit an applicant who has submitted an application by mail, in order to explain the operations of the health insuring corporation and to answer any questions the applicant may have. Every health insuring corporation shall make open enrollment applications and solicitation documents readily available to any potential applicant who requests such material.

(J) An application postmarked on the last day of an open enrollment period shall qualify as a valid application, regardless of the date on which it is received by the health insuring corporation.

(K) This section does not apply to any health insuring corporation that offers only supplemental health care services or specialty health care services, or to any health insuring corporation that offers plans only through Title XVIII or Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and that has no other commercial enrollment, or to any health insuring corporation that offers plans only through other federal health care programs regulated by federal regulatory bodies and that has no other commercial enrollment.

(L) Each health insuring corporation shall accept federally eligible individuals for open enrollment coverage as provided in section 3923.581 of the Revised Code. A health insuring corporation may reinsure coverage of any federally eligible individual acquired under that section with the open enrollment reinsurance program in accordance with division (G) of section 3924.11 of the Revised Code. Fixed periodic prepayment rates charged for coverage reinsured by the program shall be established in accordance with section 3924.12 of the Revised Code.

(M) As used in this section, "federally eligible individual" means an

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

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

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

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

(a) Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended;

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

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

(B)(1) The direct-payment contract offered by the health insuring corporation pursuant to division (A) of this section shall provide ~~benefits comparable to the benefits being provided by any of the individual contracts then being issued to individual subscribers by the health insuring corporation. The contract may contain a coordination of benefits provision as approved by the superintendent of insurance~~ the following:

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

(b) In the case of a federally eligible individual, a basic and standard plan established by the board of directors of the Ohio Health Reinsurance Program or plans substantially similar to the basic and standard plan in benefit design and scope of covered services. For purposes of division (B)(1)(b) of this section, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services. The contractual periodic prepayments charged for such plans may not exceed an amount that is two times the midpoint of the standard rate charged any other individual of a group to which the organization is currently accepting new business and for which similar copayments and deductibles are applied.

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

Superintendent.

(3) For purposes of division (B) of this section "federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.

(C) The option for conversion shall be available:

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

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

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

(D) No health insuring corporation shall ~~do any of the following:~~

~~(1) Use~~ Use age as the basis for refusing to renew a converted contract~~;~~

~~(2) Require a subscriber to produce evidence of insurability in order to exercise the option for conversion provided by this section;~~

~~(3) Include preexisting condition limitations in a converted contract~~.

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

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

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

(2) Unless otherwise required by state or federal law, no health insuring corporation, or health care facility or provider through which the health insuring corporation has made arrangements to provide health care services,

shall discriminate against any individual with regard to enrollment, disenrollment, or the quality of health care services rendered, on the basis of the individual's race, color, sex, age, religion, ~~state of health,~~ or status as a recipient of medicare or medical assistance under Title XVIII or XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or any health status-related factor in relation to the individual. However, a health insuring corporation shall not be required to accept a recipient of medicare or medical assistance, if an agreement has not been reached on appropriate payment mechanisms between the health insuring corporation and the governmental agency administering these programs. Further, except during a period of open enrollment under section 1751.15 of the Revised Code, a health insuring corporation may reject an applicant for nongroup enrollment on the basis of ~~the state of~~ any health ~~of~~ status-related factor in relation to the applicant.

(B) A health insuring corporation may cancel or decide not to renew the coverage of ~~a subscriber or~~ an enrollee ~~for any of the following reasons:~~

~~(1) Failure of the subscriber or enrollee to pay, or to have paid on the subscriber's or enrollee's behalf, the required premium rate or other charge;~~

~~(2) Fraud or forgery;~~

~~(3) Any material misrepresentation on the application for coverage;~~

~~(4) The subscriber's or enrollee's permitting the use of an identification card or similar documents by another person, allowing that person to receive services for which that person is not entitled;~~

~~(5) The subscriber's or enrollee's inability to establish or maintain a provider-patient relationship with any provider associated with the health insuring corporation, which inability may include the subscriber's or enrollee's disruptive or abusive behavior toward providers or the staff of the health care plan~~ IF THE ENROLLEE HAS PERFORMED AN ACT OR PRACTICE THAT CONSTITUTES FRAUD OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT UNDER THE TERMS OF THE COVERAGE AND IF THE CANCELLATION OR NONRENEWAL IS NOT BASED, EITHER DIRECTLY OR INDIRECTLY, ON ANY HEALTH STATUS-RELATED FACTOR IN RELATION TO THE ENROLLEE.

(C) ~~A subscriber or~~ An enrollee may appeal any action or decision of ~~the~~ a health insuring corporation ~~under division (B) of this section~~ taken pursuant to section 2742(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-42, as amended. To appeal, the ~~subscriber or~~ enrollee may submit a written complaint to the health insuring corporation pursuant to

section 1751.19 of the Revised Code. The ~~subscriber or~~ enrollee may, within thirty days after receiving a written response from the health insuring corporation, appeal the health insuring corporation's action or decision to the superintendent.

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

(1) Health status;

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

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

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

(8) Disability.

Sec. 1751.57. (A) The following conditions apply to all individual health insuring corporation contracts:

(1) Except as provided in section 2742(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-42, as amended, a health insuring corporation that provides individual coverage to an individual shall renew or continue in force such coverage at the option of the individual.

(2) Such individual contracts are subject to sections 2743 and 2747 of the "Health Insurance Portability and Accountability Act of 1996."

(3) Sections 3924.031 and 3924.032 of the Revised Code shall apply to health insuring corporation contracts offered in the individual market in the same manner as they apply to health benefit plans offered in the small employer market.

(B) In accordance with 45 C.F.R. 148.102, this section also applies to all group health insuring corporation contracts that are not sold in connection with an employment-related group health care plan and that provide more than short-term, limited duration coverage.

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) 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 organization shall renew or continue in force such coverage at the option of the contract holder.

(B) Such group contracts are subject to division (E)(1) of section 3924.03 and sections 3924.033 and 3924.27 of the Revised Code.

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

Sec. 1751.59. (A) No individual or group health insuring corporation policy, contract, or agreement ~~providing~~ that makes family coverage available may be delivered, issued for delivery, or renewed in this state, unless the policy, contract, or agreement covers adopted children of the subscriber on the same basis as other dependents.

(B) The coverage required by this section is subject to the requirements and restrictions set forth in section 3924.51 of the Revised Code. Coverage for dependent children living outside the health insuring corporation's approved service area must be provided if a court order requires the subscriber to provide health care coverage.

Sec. 1751.61. (A) Each individual or group evidence of coverage that is delivered, issued for delivery, or renewed by a health insuring corporation in this state, and that ~~provides~~ makes coverage available for family members of a subscriber, also shall provide that coverage applicable to children is payable from the moment of birth with respect to a newly born child of the subscriber or subscriber's spouse.

(B) Coverage for a newly born child is effective for a period of thirty-one days from the date of birth.

(C) To continue coverage for a newly born child beyond the thirty-one day period described in division (B) of this section, the subscriber shall notify the health insuring corporation within that period.

(D) If payment of a specific premium rate is required to provide coverage under this section for an additional child, the evidence of coverage may require the subscriber to make this payment to the health insuring corporation within the thirty-one day period described in division (B) of this section in order to continue the coverage beyond that period.

Sec. 1751.64. (A) As used in this section, "genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies,

and not an indirect manifestation of genetic disorders.

(B) No health insuring corporation, in processing an application for coverage for health care services under an individual or group health insuring corporation policy, contract, or agreement or in determining insurability under such a policy, contract, or agreement, shall do any of the following:

(1) Require an individual seeking coverage to submit to genetic screening or testing;

(2) Take into consideration~~, other than in accordance with division (F) of this section,~~ the results of genetic screening or testing;

(3) Make any inquiry to determine the results of genetic screening or testing;

(4) Make a decision adverse to the applicant based on entries in medical records or other reports of genetic screening or testing.

(C) In developing and asking questions regarding medical histories of applicants for coverage under an individual or group health insuring corporation policy, contract, or agreement, no health insuring corporation shall ask for the results of genetic screening or testing or ask questions designed to ascertain the results of genetic screening or testing.

(D) No health insuring corporation shall cancel or refuse to issue or renew coverage for health care services based on the results of genetic screening or testing.

(E) No health insuring corporation shall deliver, issue for delivery, or renew an individual or group policy, contract, or agreement in this state that limits benefits based on the results of genetic screening or testing.

(F) ~~A health insuring corporation may consider the results of genetic screening or testing if the results are voluntarily submitted by an applicant for coverage or renewal of coverage and the results are favorable to the applicant.~~

~~(G)~~ A violation of this section is an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

Sec. 1751.65. (A) As used in this section, "genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders.

(B) Upon the repeal of section 1751.64 of the Revised Code, no health

insuring corporation shall do either of the following:

(1) Consider~~, in a manner adverse to an applicant or insured,~~ any information obtained from genetic screening or testing ~~conducted prior to the repeal of section 1751.64 of the Revised Code~~ in processing an application for coverage for health care services under an individual or group policy, contract, or agreement or in determining insurability under such a policy, contract, or agreement;

(2) Inquire, directly or indirectly, into the results of genetic screening or testing ~~conducted prior to the repeal of section 1751.64 of the Revised Code,~~ or use such information, in whole or in part, to cancel, refuse to issue or renew, or limit benefits under, an individual or group policy, contract, or agreement.

(C) Any health insuring corporation that has engaged in, is engaged in, or is about to engage in a violation of division (B) of this section is subject to the jurisdiction of the superintendent of insurance under section 3901.04 of the Revised Code.

Sec. 1751.67. (A) Each individual or group health insuring corporation policy, contract, or agreement delivered, issued for delivery, or renewed in this state that provides maternity benefits shall provide coverage of inpatient care and follow-up care for a mother and her newborn as follows:

(1) The policy, contract, or agreement shall cover a minimum of forty-eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery. Services covered as inpatient care shall include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

(2) The policy, contract, or agreement shall cover a physician-directed source of follow-up care. Services covered as follow-up care shall include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any medically necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage shall apply to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the provider who conducts the visit is knowledgeable and experienced in maternity and newborn care.

When a decision is made in accordance with division (B) of this section

to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within ~~forty-eight~~ seventy-two hours after discharge. When a mother or newborn receives at least the number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to follow-up care that is determined to be medically necessary by the provider responsible for discharging the mother or newborn.

(B) Any decision to shorten the length of inpatient stay to less than that specified under division (A)(1) of this section shall be made by the physician attending the mother or newborn, except that if a nurse-midwife is attending the mother in collaboration with a physician, the decision may be made by the nurse-midwife. Decisions regarding early discharge shall be made only after conferring with the mother or a person responsible for the mother or newborn. For purposes of this division, a person responsible for the mother or newborn may include a parent, guardian, or any other person with authority to make medical decisions for the mother or newborn.

(C)(1) No health insuring corporation may do either of the following:

(a) Terminate the participation of a provider or health care facility in an individual or group health care plan solely for making recommendations for inpatient or follow-up care for a particular mother or newborn that are consistent with the care required to be covered by this section;

(b) Establish or offer monetary or other financial incentives for the purpose of encouraging a person to decline the inpatient or follow-up care required to be covered by this section.

(2) Whoever violates division (C)(1)(a) or (b) of this section has engaged in an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

(D) This section does not do any of the following:

(1) Require a policy, contract, or agreement to cover inpatient or follow-up care that is not received in accordance with the policy's, contract's, or agreement's terms pertaining to the providers and facilities from which an individual is authorized to receive health care services;

(2) Require a mother or newborn to stay in a hospital or other inpatient setting for a fixed period of time following delivery;

(3) Require a child to be delivered in a hospital or other inpatient setting;

(4) Authorize a nurse-midwife to practice beyond the authority to practice nurse-midwifery in accordance with Chapter 4723. of the Revised Code;

(5) Establish minimum standards of medical diagnosis, care, or treatment for inpatient or follow-up care for a mother or newborn. A deviation from the care required to be covered under this section shall not, solely on the basis of this section, give rise to a medical claim or to derivative claims for relief, as those terms are defined in section 2305.11 of the Revised Code.

Sec. 3901.044. The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code that the superintendent considers necessary and advisable for the purpose of implementing the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg, as amended, and any regulation adopted thereunder.

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

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

Any written statement concerning the premiums for a policy which refers to the net cost after credit for an assumed dividend, without an accurate written statement of the gross premiums, cash values, and dividends based on the insurer's current dividend scale, which are used to compute the net cost for such policy, and a prominent warning that the rate of dividend is not guaranteed, is a misrepresentation for the purposes of this division.

(B) Making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet,

letter, or poster, or over any radio station, or in any other way, or preparing with intent to so use, an advertisement, announcement, or statement containing any assertion, representation, or statement, with respect to the business of insurance or with respect to any person in the conduct of ~~his~~ the person's insurance business, which is untrue, deceptive, or misleading.

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

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

Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer, or mutilating, destroying, suppressing, withholding, or concealing any of its records.

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

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

(G)(1) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly,

as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing, or offering to give, sell, or purchase, as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities, or other obligations of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

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

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

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

(J) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, or preparing with intent to so use, any statement to the effect that any insurance company was required to change a policy form or related material to comply with Title XXXIX of the Revised Code or any regulation of the superintendent of insurance, for the purpose of inducing or

intending to induce any policyholder or prospective policyholder to purchase, amend, lapse, forfeit, change, or surrender insurance.

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

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

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

(N) Refusing to make available disability income insurance solely because the applicant's principal occupation is that of managing a household.

(O) Refusing, when offering maternity benefits under any individual or group sickness and accident insurance policy, to make maternity benefits available to the policyholder for the individual or individuals to be covered under any comparable policy to be issued for delivery in this state, including family members if the policy otherwise provides coverage for family members. Nothing in this division shall be construed to prohibit an insurer from imposing a reasonable waiting period for such benefits under an individual sickness and accident insurance policy, but in no event shall such waiting period exceed two hundred seventy days.

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

(Q) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent, or kind of life or sickness and accident insurance or annuity coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. With respect to all other conditions, including the underlying cause of blindness or partial blindness, persons who are blind or partially blind shall be subject

to the same standards of sound actuarial principles or actual or reasonably anticipated actuarial experience as are sighted persons. Refusal to insure includes, but is not limited to, denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the eyesight of the insured is lost. However, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when such conditions existed at the time the policy was issued. To the extent that the provisions of this division may appear to conflict with any provision of section 3999.16 of the Revised Code, this division applies.

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

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

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

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

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

(T)(1) Using any underwriting standard or engaging in any other act or practice that, directly or indirectly, due solely to ~~the actual or expected~~ any health ~~condition of~~ status-related factor in relation to one or more

individuals, does either of the following:

(a) Terminates or fails to renew an existing individual policy, contract, or plan of health benefits, or a health benefit plan issued to ~~a small~~ an employer ~~as those terms are defined in section 3924.01 of the Revised Code~~, for which an individual would otherwise be eligible;

(b) With respect to a health benefit plan issued to ~~a small~~ an employer~~,~~ ~~as those terms are defined in section 3924.01 of the Revised Code~~, excludes or causes the exclusion of an individual from coverage under an existing employer-provided policy, contract, or plan of health benefits~~, except that an insurer may exclude, on the basis of health status, a late enrollee as defined in section 3924.01 of the Revised Code~~.

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

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

(a) Health status;

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

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

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

(h) Disability.

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

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

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

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

With respect to private passenger automobile insurance, no insurer shall

charge different premium rates to persons residing within the limits of any municipal corporation based solely on the location of the residence of the insured within those limits.

The enumeration in sections 3901.19 to 3901.26 of the Revised Code of specific unfair or deceptive acts or practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the superintendent of insurance to adopt rules to implement this section, or to take action under other sections of the Revised Code.

This section does not prohibit the sale of shares of any investment company registered under the "Investment Company Act of 1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any policies, annuities, or other contracts described in section 3907.15 of the Revised Code.

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

Sec. 3901.49. (A) As used in this section:

(1) "Genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders.

(2) "Insurer" means any person authorized under Title XXXIX of the Revised Code to engage in the business of sickness and accident insurance.

(3) "Sickness and accident insurance" means sickness and accident insurance under Chapter 3923. of the Revised Code excluding disability income insurance and excluding supplemental policies of sickness and accident insurance.

(B) No insurer, in processing an application for an individual or group policy of sickness and accident insurance or in determining insurability under such a policy, shall do any of the following:

(1) Require an individual seeking coverage to submit to genetic screening or testing;

(2) Take into consideration~~, other than in accordance with division (F) of this section,~~ the results of genetic screening or testing;

(3) Make any inquiry to determine the results of genetic screening or testing;

(4) Make a decision adverse to the applicant based on entries in medical records or other reports of genetic screening or testing.

(C) In developing and asking questions regarding medical histories of applicants for sickness and accident insurance, no insurer shall ask for the results of genetic screening or testing or ask questions designed to ascertain the results of genetic screening or testing.

(D) No insurer shall cancel or refuse to issue or renew coverage under a sickness and accident insurance policy based on the results of genetic screening or testing.

(E) No insurer shall deliver, issue for delivery, or renew an individual or group policy of sickness and accident insurance in this state that limits benefits based on the results of genetic screening or testing.

(F) ~~An insurer may consider the results of genetic screening or testing if the results are voluntarily submitted by an applicant for coverage or renewal of coverage and the results are favorable to the applicant.~~

~~(G)~~ A violation of this section is an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

Sec. 3901.491. (A) As used in this section:

(1) "Genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders.

(2) "Insurer" means any person authorized under Title XXXIX of the Revised Code to engage in the business of sickness and accident insurance.

(3) "Sickness and accident insurance" means sickness and accident insurance under Chapter 3923. of the Revised Code excluding disability income insurance and excluding supplemental policies of sickness and accident insurance.

(B) Upon the repeal of section 3901.49 of the Revised Code by Sub. H.B. No. 71 of the 120th general assembly, no insurer shall do either of the following:

(1) Consider~~, in a manner adverse to an applicant or insured,~~ any information obtained from genetic screening or testing ~~conducted prior to the repeal of section 3901.49 of the Revised Code~~ in processing an application for an individual or group policy of sickness and accident insurance, or in determining insurability under such a policy;

(2) Inquire, directly or indirectly, into the results of genetic screening or testing ~~conducted prior to the repeal of section 3901.49 of the Revised Code,~~

or use such information, in whole or in part, to cancel, refuse to issue or renew, or limit benefits under, a sickness and accident insurance policy.

(C) Any insurer that has engaged in, is engaged in, or is about to engage in a violation of division (B) of this section is subject to the jurisdiction of the superintendent of insurance under section 3901.04 of the Revised Code.

Sec. 3901.50. (A) As used in this section:

(1) "Genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders.

(2) "Self-insurer" means any government entity providing coverage for health care services on a self-insurance basis.

(B) No self-insurer, in processing an application for coverage under a plan of self-insurance or in determining insurability under such a plan, shall do any of the following:

(1) Require an individual seeking coverage to submit to genetic screening or testing;

(2) Take into consideration~~, other than in accordance with division (F) of this section,~~ the results of genetic screening or testing;

(3) Make any inquiry to determine the results of genetic screening or testing;

(4) Make a decision adverse to the applicant based on entries in medical records or other reports of genetic screening or testing.

(C) In developing and asking questions regarding medical histories of applicants for coverage under a plan of self-insurance, no self-insurer shall ask for the results of genetic screening or testing or ask questions designed to ascertain the results of genetic screening or testing.

(D) No self-insurer shall cancel or refuse to provide or renew coverage for health care services based on the results of genetic screening or testing.

(E) No self-insurer shall establish or modify a plan of self-insurance in this state that limits benefits based on the results of genetic screening or testing.

(F) ~~A self-insurer may consider the results of genetic screening or testing if the results are voluntarily submitted by an applicant for coverage or renewal of coverage and the results are favorable to the applicant.~~

~~(G)~~ A violation of this section is an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the

Revised Code.

Sec. 3901.501. (A) As used in this section:

(1) "Genetic screening or testing" means a laboratory test of a person's genes or chromosomes for abnormalities, defects, or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease, or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects, or deficiencies, and not an indirect manifestation of genetic disorders.

(2) "Self-insurer" means any government entity providing coverage for health care services on a self-insurance basis.

(B) Upon the repeal of section 3901.50 of the Revised Code by Sub. H.B. No. 71 of the 120th general assembly, no self-insurer shall do either of the following:

(1) Consider~~, in a manner adverse to an applicant or insured,~~ any information obtained from genetic screening or testing ~~conducted prior to the repeal of section 3901.50 of the Revised Code~~ in processing an application for coverage under a plan of self-insurance or in determining insurability under such a plan;

(2) Inquire, directly or indirectly, into the results of genetic screening or testing ~~conducted prior to the repeal of section 3901.50 of the Revised Code,~~ or use such information, in whole or in part, to cancel, refuse to provide or renew, or limit benefits under, a plan of self-insurance.

(C) Any self-insurer that has engaged in, is engaged in, or is about to engage in a violation of division (B) of this section is subject to the jurisdiction of the superintendent of insurance under section 3901.04 of the Revised Code.

Sec. 3923.021. (A) As used in this section, "benefits provided are not unreasonable in relation to the premium charged" means the rates were calculated in accordance with sound actuarial principles.

(B) With respect to any filing, made pursuant to section 3923.02 of the Revised Code, of any premium rates for any individual policy of sickness and accident insurance or for any indorsement or rider pertaining thereto, the superintendent of insurance may, within thirty days after filing:

(1) Disapprove such filing ~~if he finds~~ after finding that the benefits provided are unreasonable in relation to the premium charged. Such disapproval shall be effected by written order of the superintendent, a copy of which shall be mailed to the insurer that has made the filing. In the order, the superintendent shall specify the reasons for ~~his~~ the disapproval and state that a hearing will be held within fifteen days after requested in writing by

the insurer. If a hearing is so requested, the superintendent shall also give such public notice as ~~he~~ the superintendent considers appropriate. The superintendent, within fifteen days after the commencement of any hearing, shall issue a written order, a copy of which shall be mailed to the insurer that has made the filing, either affirming ~~his~~ the prior disapproval or approving such filing ~~if he finds~~ after finding that the benefits provided are not unreasonable in relation to the premium charged.

(2) Set a date for a public hearing to commence no later than forty days after the filing. The superintendent shall give the insurer making the filing twenty days' written notice of the hearing and shall give such public notice as ~~he~~ the superintendent considers appropriate. The superintendent, within twenty days after the commencement of a hearing, shall issue a written order, a copy of which shall be mailed to the insurer that has made the filing, either approving such filing if ~~he~~ the superintendent finds that the benefits provided are not unreasonable in relation to the premium charged, or disapproving such filing if ~~he~~ the superintendent finds that the benefits provided are unreasonable in relation to the premium charged. This division does not apply to any insurer organized or transacting the business of insurance under Chapter 3907. or 3909. of the Revised Code.

(3) Take no action, in which case such filing shall be deemed to be approved and shall become effective upon the thirty-first day after such filing, unless the superintendent has previously given to the insurer ~~his~~ a written approval.

(C) At any time after any filing has been approved pursuant to this section, the superintendent may, after a hearing of which at least twenty days' written notice has been given to the insurer that has made such filing and for which such public notice as ~~he~~ the superintendent considers appropriate has been given, withdraw approval of such filing ~~if he finds~~ after finding that the benefits provided are unreasonable in relation to the premium charged. Such withdrawal of approval shall be effected by written order of the superintendent, a copy of which shall be mailed to the insurer that has made the filing, which shall state the ground for such withdrawal and the date, not less than forty days after the date of such order, when the withdrawal or approval shall become effective.

(D) The superintendent may retain at the insurer's expense such attorneys, actuaries, accountants, and other experts not otherwise a part of the superintendent's staff as shall be reasonably necessary to assist in the preparation for and conduct of any public hearing under this section. The expense for retaining such experts and the expenses of the department of insurance incurred in connection with such public hearing shall be assessed

against the insurer in an amount not to exceed one one-hundredth of one per cent of the sum of premiums earned plus net realized investment gain or loss of such insurer as reflected in the most current annual statement on file with the superintendent. Any person retained shall be under the direction and control of the superintendent and shall act in a purely advisory capacity.

(E) This section does not apply to any filing of any premium rate or rating formula for individual sickness and accident insurance policies offered in accordance with division ~~(M)~~(L) of section 3923.58 of the Revised Code, or for any amendment thereto.

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

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

(2) In the case of a federally eligible individual, a basic or standard plan established by the board of directors of the Ohio health reinsurance program or plans substantially similar to the basic and standard plan in benefit design and scope of covered services. For purposes of division (A)(2) of this section, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services.

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

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

(1) The effective date of the converted policy;

(2) The date of application therefor; and shall be applicable to the class of risk to which each person covered belongs and to the form and amount of the policy at ~~his~~ the person's then attained age. However, premiums charged

federally eligible individuals may not exceed an amount that is two times the midpoint of the standard rate charged any other individual of a group to which the insurer is currently accepting new business and for which similar copayments and deductibles are applied.

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

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

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

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

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

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

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

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

(D) The option for conversion shall be available:

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

(2) To a child solely with respect to ~~himself~~ THE CHILD upon ~~his~~ attaining the limiting age of coverage under the group policy while covered as a dependent thereunder;

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

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

(E) If coverage is continued under a group policy on an employee following ~~his~~ retirement prior to the time ~~he~~ the employee is, or is eligible to be, covered by Title XVIII of the Social Security Act, ~~he~~ the employee may elect, in lieu of the continuance of group insurance, to have the same

conversion rights as would apply had ~~his~~ the employee's insurance terminated at retirement by reason of termination of employment.

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

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

(H) If an employee or member becomes entitled to obtain a converted policy pursuant to this section, and if the employee or member has not received notice of the conversion privilege at least fifteen days prior to the expiration of the thirty-one-day conversion period provided in division (B) of this section, then the employee or member has an additional period within which to exercise the privilege. This additional period shall expire fifteen days after the employee or member receives notice, but in no event shall the period extend beyond sixty days after the expiration of the thirty-one-day conversion period.

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

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

(I) The converted policy may provide:

(1) That any hospital, surgical, or medical expense benefits otherwise payable with respect to any person may be reduced by the amount of any such benefits payable under the group policy for the same loss after termination of coverage;

(2) For termination of coverage on any person who is, or is eligible to be, covered pursuant to division (C) of this section;

(3) That the insurer may request information in advance of any premium due date of the policy as to whether the insured is, or is eligible to be, covered pursuant to division (C) of this section. If the insured is, or is eligible to be, covered, and ~~he~~ the insured fails to furnish the details of ~~his~~ the insured's coverage or eligibility to the insurer within thirty-one days after the date of the request, the benefits payable under the converted policy may be based on the hospital, surgical, or medical expenses actually incurred after excluding expenses to the extent of the amount of benefits for which the insured is, or is eligible to be, covered pursuant to division (C) of this section.

(J) The converted policy may contain:

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

(2) Any provision permitted in this section;

(3) Any other provision not prohibited by law.

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

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

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

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

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

(O) As used in this section, "federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.

Sec. 3923.26. Every ~~certificate furnished by an insurer in connection with, or pursuant to any provision of, any~~ group policy or certificate of sickness and accident insurance ~~policy~~ delivered, issued for delivery, or renewed in this state providing coverage on an expense-incurred basis, and every individual policy of sickness and accident insurance ~~policy~~ delivered, issued for delivery, or renewed in this state which provides coverage on an expense-incurred basis, either of which ~~provides~~ makes coverage available

for family members of the insured, shall, as to such family members' coverage, also provide that any sickness and accident insurance benefits applicable for children shall be payable with respect to a newly born child of the insured from the moment of birth.

The coverage for newly born children shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

If payment of a specific premium is required to provide coverage for an additional child, the certificate or policy may require that notification of birth of a newly born child and payment of the required premium must be furnished to the insurer within thirty-one days after the date of birth in order to have the coverage continue beyond such period.

The requirements of this section apply to all such individual or group sickness and accident insurance policies delivered or issued for delivery in this state on or after January 1, 1975, and all such individual or group sickness and accident insurance policies renewed in this state on or after January 1, 1978.

Sec. 3923.40. No individual or group policy of sickness and accident insurance ~~providing~~ that makes family coverage available may be delivered, issued for delivery, or renewed in this state on or after January 1, 1989, unless the policy covers adopted children of the insured on the same basis as other dependents.

The coverage required by this section is subject to the requirements and restrictions set forth in section 3924.51 of the Revised Code.

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

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

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

(C) ~~Any such policy shall be renewable with respect to the policyholder, or dependents of the policyholder, at the option of the policyholder, except~~

~~for any of the following reasons:~~

~~(1) Nonpayment of the required premiums by the policyholder;~~

~~(2) Fraud or misrepresentation of the policyholder;~~

~~(3) When the insurer ceases to do the business of individual sickness and accident insurance in this state, provided that all of the following conditions are met:~~

~~(a) Notice of the decision to cease doing the business of individual sickness and accident insurance is provided to the department of insurance and the policyholder.~~

~~(b) An individual policy shall not be canceled by the insurer for ninety days after the date of the notice required under division (C)(3)(a) of this section unless the business has been sold to another insurer.~~

~~(c) An insurer that ceases to do the business of individual sickness and accident insurance in this state shall not resume such business in this state for a period of five years from the date of the notice required under division (C)(3)(a) of this section~~ (1) Except as otherwise provided in division (C) of this section, an insurer that provides an individual sickness and accident insurance policy to an individual shall renew or continue in force such coverage at the option of the individual.

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

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

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

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

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

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

factor of covered individuals.

(3) An insurer may cancel or decide not to renew the coverage of a dependent of an INDIVIDUAL if the dependent has performed an act or practice that CONSTITUTES fraud or made an INTENTIONAL MISREPRESENTATION of material fact under the terms of the coverage and IF THE CANCELLATION OR NONRENEWAL IS NOT BASED, EITHER DIRECTLY OR INDIRECTLY, ON ANY HEALTH STATUS-RELATED FACTOR IN RELATION TO THE dependent.

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

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

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

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

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

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

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

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

(E) Notwithstanding ~~division~~ divisions (C) and (D) of this section, ~~both of the following apply:~~

~~(1) The benefit structure of any such policy may be changed by the~~

~~insurer to make it consistent with the benefit structure contained in individual policies being marketed to new individual insureds.~~

~~(2) Any such policy may be rescinded for fraud, material misrepresentation, or concealment by an applicant, policyholder, or dependent~~ an insurer may, at the time of coverage renewal, modify the health insurance coverage for a policy form offered to individuals in the individual market if the modification is consistent with the law of this state and effective on a uniform basis among all individuals with that policy form.

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

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

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

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

For purposes of this section, any policy issued pursuant to division (C) of section 3923.13 of the Revised Code in connection with a public or private college or university student health INSURANCE program is considered to be issued to a bona fide ASSOCIATION and is not subject to divisions (C) to (G) of this section.

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

This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy of no longer than six months, or other policy that offers only supplemental benefits.

Sec. 3923.571. Except as otherwise provided in section 2721 of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-21, as amended, the following

conditions apply to all group policies of sickness and accident insurance that are sold in connection with an employment-related group health plan and that are not subject to section 3924.03 of the Revised Code:

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

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

(2) An insurer may cancel or decide not to renew the coverage of an employee or of a dependent of an employee if the employee or dependent, as applicable, has performed an act or practice that CONSTITUTES fraud or made an INTENTIONAL MISREPRESENTATION of material fact under the terms of the coverage and IF THE CANCELLATION OR NONRENEWAL IS NOT BASED, EITHER DIRECTLY OR INDIRECTLY, ON ANY HEALTH STATUS-RELATED FACTOR IN RELATION TO THE employee or dependent.

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

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

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

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

Sec. 3923.58. (A) As used in sections 3923.58 and 3923.59 of the Revised Code:

(1) "~~Case characteristics," "eligible employee," "health~~ Health benefit plan~~,~~" ~~"late enrollee,"~~ and "MEWA~~," and "pre-existing conditions~~

" have the same meanings as in section 3924.01 of the Revised Code.

(2) "Insurer" means any sickness and accident insurance company authorized to ~~issue health benefit plans~~ do business in this state, or MEWA authorized to issue insured health benefit plans in this state. "Insurer" does not include any health insuring corporation that is owned or operated by an insurer.

(3) "~~Small employer" means any person, firm, corporation, or partnership actively engaged in business whose total employed work force, on at least fifty per cent of its working days during the preceding year, consisted of at least two unrelated eligible employees but no more than twenty-five eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. In determining whether the members of an association are small employers, each member of the association shall be considered as a separate person, firm, corporation, or partnership.~~

~~(4) "Small employer group" means any group consisting of all of the eligible employees of a small employer, except those employees who are covered, or are eligible for coverage, under any other private or public health benefits arrangement, including the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or any other act of congress or law of this or any other state of the United States that provides benefits comparable to the benefits provided under this section~~ Pre-existing conditions provision" means a policy provision that excludes or limits coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received, or a pregnancy existing on the effective date of coverage.

(B) Beginning in January of each year, insurers in the business of issuing individual policies of sickness and accident insurance as contemplated by section 3923.021 of the Revised Code, except individual policies issued pursuant to section 3923.122 of the Revised Code, shall accept applicants for open enrollment coverage, as set forth in ~~divisions (B)(1) and (2) of~~ this ~~section~~ division, in the order in which they apply for coverage and subject to the limitation set forth in division (G) of this

~~:~~. Insurers

~~(1) Insurers in the business of issuing health benefit plans to small employer groups~~ shall accept ~~small employer groups for which coverage is not otherwise available and for whom coverage had not been terminated by the employer or by an insurer, health maintenance organization, or health insuring corporation during the preceding twelve-month period;~~

~~(2) Insurers in the business of issuing individual policies of sickness and accident insurance as contemplated by section 3923.021 of the Revised Code, except individual policies issued pursuant to section 3923.122 of the Revised Code, shall either accept individuals pursuant to the open enrollment requirements of section 3941.53 of the Revised Code, if subject to that section, or accept~~ for coverage pursuant to this section individuals to whom both of the following conditions apply:

~~(a)~~(1) The individual is not applying for coverage as an employee of an employer, as a member of an association, or as a member of any other group.

~~(b)~~(2) The individual is not covered, and is not eligible for coverage, under any other private or public health benefits arrangement, including the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or any other act of congress or law of this or any other state of the United States that provides benefits comparable to the benefits provided under this section, any medicare supplement policy, or any ~~conversion or~~ continuation of coverage policy under state or federal law.

(C) An insurer shall offer to any individual ~~or small employer group~~ accepted under this section the small employer health care plan established by the board of directors of the Ohio ~~small employer~~ health reinsurance program under division (A) of section 3924.10 of the Revised Code or a health benefit plan that is substantially similar to the small employer health care plan in benefit plan design and scope of covered services.

An insurer may offer other health benefit plans in addition to, but not in lieu of, the plan required to be offered under this division. These additional health benefit plans shall provide, at a minimum, the coverage provided by the small employer health care plan or any health benefit plan that is substantially similar to the small employer health care plan in benefit plan design and scope of covered services.

For purposes of this division, the superintendent of insurance shall determine whether a health benefit plan is substantially similar to the small employer health care plan in benefit plan design and scope of covered services.

(D) Health benefit plans issued under this section may establish pre-existing conditions provisions that exclude or limit coverage for a period of up to twelve months following the individual's effective date of coverage and that may relate only to conditions during the six months immediately preceding the effective date of coverage. ~~However, an insurer may exclude a late enrollee for a period of up to eighteen months following the individual's date of application for coverage.~~

(E) Premiums charged to ~~groups or~~ individuals under this section may not exceed an amount that is two and one-half times the highest rate charged any other ~~group with similar case characteristics or any other~~ individual to which the insurer is currently accepting new business, and for which similar copayments and deductibles are applied.

(F) In offering health benefit plans under this section, an insurer may require the purchase of health benefit plans that condition the reimbursement of health services upon the use of a specific network of providers.

(G)(1) In no event shall an insurer be required to accept annually under this section ~~either~~ individuals ~~or small employer groups that~~ who, in the aggregate, would cause the insurer to have a total number of new insureds that is more than one-half per cent of its total number of insured individuals in this state per year, as contemplated by section 3923.021 of the Revised Code, ~~and small group certificate holders of health benefit plans in this state per year,~~ calculated as of the immediately preceding thirty-first day of December and excluding the insurer's medicare supplement policies and conversion or continuation of coverage policies under state or federal law and any policies described in division ~~(N)~~(M) of this section. ~~If an insurer is subject to, and elects to operate under, the individual open enrollment requirements of section 3941.53 of the Revised Code, in no event shall the insurer be required to accept annually under this section small employer groups that would cause the insurer to have a total number of new insureds that is more than one-half per cent of its total number of small group certificate holders calculated as set forth in division (G)(1) of this section.~~

(2) An officer of the insurer shall certify to the department of insurance when it has met the enrollment limit set forth in division (G)(1) of this section. Upon providing such certification, the insurer shall be relieved of its open enrollment requirement under this section for the remainder of the calendar year.

(H) An insurer shall not be required to accept under this section applicants who, at the time of enrollment, are confined to a health care facility because of chronic illness, permanent injury, or other infirmity that

would cause economic impairment to the insurer if the applicants were accepted, or to make the effective date of benefits for individuals ~~or groups~~ accepted under this section earlier than ninety days after the date of acceptance.

(I) The requirements of this section do not apply to any insurer that is currently in a state of supervision, insolvency, or liquidation. If an insurer demonstrates to the satisfaction of the superintendent that the requirements of this section would place the insurer in a state of supervision, insolvency, or liquidation, the superintendent may waive or modify the requirements of division (B) or (G) of this section. The actions of the superintendent under this division shall be effective for a period of not more than one year. At the expiration of such time, a new showing of need for a waiver or modification by the insurer shall be made before a new waiver or modification is issued or imposed.

(J) No hospital, health care facility, or health care practitioner, and no person who employs any health care practitioner, shall balance bill any individual or dependent of an individual ~~or any eligible employee or dependent of an employee~~ for any health care supplies or services provided to the individual or dependent ~~or the eligible employee or dependent,~~ who is insured under a policy ~~or enrolled under a health benefit plan~~ issued under this section. The hospital, health care facility, or health care practitioner, or any person that employs the health care practitioner, shall accept payments made to it by the insurer under the terms of the policy or contract insuring or covering such individual as payment in full for such health care supplies or services.

As used in this division, "hospital" has the same meaning as in section 3727.01 of the Revised Code; "health care practitioner" has the same meaning as in section 4769.01 of the Revised Code; and "balance bill" means charging or collecting an amount in excess of the amount reimbursable or payable under the policy or health care service contract issued to an individual ~~or group~~ under this section for such health care supply or service. "Balance bill" does not include charging for or collecting copayments or deductibles required by the policy or contract.

(K) An insurer shall pay an agent a commission in the amount of five per cent of the premium charged for initial placement or for otherwise securing the issuance of a policy or contract issued to an individual ~~or small employer group~~ under this section, and four per cent of the premium charged for the renewal of such a policy or contract. The superintendent may adopt, in accordance with Chapter 119. of the Revised Code, such rules as are necessary to enforce this division.

(L) ~~Except as otherwise provided in this section, sections 3924.01 to 3924.06 of the Revised Code apply to all health benefit plans issued under this section.~~

~~(M)~~ Individuals accepted for coverage under this section may be issued contracts and certificates subject to the requirements of section 3923.12 of the Revised Code. The coverage issued to such individuals is not subject to the requirements of section 3923.021 of the Revised Code.

~~(N)~~(M) This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy of no longer than six months, or other policy that offers only supplemental benefits.

Sec. 3923.581. (A) As used in this section:

(1) "Carrier," "Health benefit plan," "MEWA," and "pre-existing conditions provision" have the same meanings as in section 3924.01 Of the Revised Code.

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

(3) "Health status-related factor" means any of the following:

(a) Health status;

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

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

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

(h) Disability.

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

(5) "Network plan" means a health benefit plan of a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

(B) Beginning in January of each year, carriers in the business of issuing health benefit plans to individuals or nonemployer groups shall accept federally eligible individuals for open enrollment coverage, as provided in this section, in the order in which they apply for coverage and subject to the

limitation set forth in division (J) of this section.

(C) No carrier shall do either of the following:

(1) Decline to offer such coverage to, or deny enrollment of, such individuals;

(2) Apply any pre-existing conditions provision to such coverage.

(D) A carrier shall offer to federally eligible individuals the basic and standard plan established by the board of directors of the Ohio health reinsurance program or plans substantially similar to the basic and standard plan in benefit design and scope of covered services. For purposes of this division, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services.

(E) Premiums charged to individuals under this section may not exceed an amount that is two times the midpoint rate charged any other individual to which the carrier is currently accepting new business, and for which similar copayments and deductibles are applied.

(F) If a carrier offers a health benefit plan in the individual market through a network plan, the carrier may do both of the following:

(1) Limit the federally eligible individuals that may apply for such coverage to those who live, work, or reside in the service area of the network plan;

(2) Within the service area of the network plan, deny the coverage to federally eligible individuals if the carrier has demonstrated both of the following to the superintendent:

(a) The carrier will not have the capacity to deliver services adequately to any additional individuals because of the carrier's obligations to existing group contract holders and individuals.

(b) The carrier is applying division (F)(2) of this section uniformly to all federally eligible individuals without regard to any health status-related factor of those individuals.

(G) A carrier that, pursuant to division (F)(2) of this section, denies coverage to an individual in the service area of a network plan, shall not offer coverage in the individual market within that service area for at least one hundred eighty days after the date the coverage is denied.

(H) A carrier may refuse to issue health benefit plans to federally eligible individuals if the carrier has demonstrated both of the following to the superintendent:

(1) The carrier does not have the financial reserves necessary to underwrite additional coverage.

(2) The carrier is applying division (H) of this section uniformly to all

federally eligible individuals in this state consistent with the applicable laws and rules of this state and without regard to any health status-related factor relating to those individuals.

(I) A carrier that, pursuant to division (H) of this section, refuses to issue health benefit plans to federally eligible individuals, shall not offer health benefit plans in the individual market in this state for at least one hundred eighty days after the date the coverage is denied or until the carrier has demonstrated to the superintendent that the carrier has sufficient financial reserves to underwrite additional coverage, whichever is later.

(J)(1) Except as provided in division (J)(2) of this section, a carrier shall not be required to accept annually under this section federally eligible individuals who, in the aggregate, would cause the carrier to have a total number of new insureds that is more than one-half per cent of its total number of insured individuals and nonemployer groups in this state per year, calculated as of the immediately preceding thirty-first day of December and excluding the carrier's medicare supplement policies and conversion or continuation of coverage policies under state or federal law and any policies described in division (M) of section 3923.58 Of the Revised Code.

(2) An officer of the carrier shall certify to the department of insurance when it has met the enrollment limit set forth in division (J)(1) of this section. Upon providing such certification, the carrier shall be relieved of its open enrollment requirement under this section for the remainder of the calendar year unless, prior to the end of the calendar year, all the carriers subject to this section have individually met the enrollment limit set forth in division (J)(1) of this section. In that event, carriers shall again accept applicants for open enrollment coverage pursuant to this section, subject to the enrollment limit set forth in division (J)(1) of this section.

(K) The superintendent may provide for the application of this section on a service-area-specific basis.

(L) The requirements of this section do not apply to any health benefit plan described in division (M) of section 3923.58 Of the Revised Code.

Sec. 3923.59. Any insurer may reinsure coverage of any individual~~,~~ ~~small employer group,~~ or ~~member of that~~ nonemployer group acquired under section 3923.58 or 3923.581 of the Revised Code with the ~~Ohio small employer health~~ open enrollment reinsurance program in accordance with division (G) of section 3924.11 of the Revised Code. Premium rates charged for coverage reinsured by the program shall be established in accordance with section 3924.12 of the Revised Code.

Sec. 3923.63. (A) Notwithstanding section 3901.71 of the Revised

Code, each individual or group policy of sickness and accident insurance delivered, issued for delivery, or renewed in this state that provides maternity benefits shall provide coverage of inpatient care and follow-up care for a mother and her newborn as follows:

(1) The policy shall cover a minimum of forty-eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery. Services covered as inpatient care shall include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

(2) The policy shall cover a physician-directed source of follow-up care. Services covered as follow-up care shall include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any medically necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage shall apply to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

When a decision is made in accordance with division (B) of this section to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within ~~forty-eight~~ seventy-two hours after discharge. When a mother or newborn receives at least the number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to follow-up care that is determined to be medically necessary by the health care professionals responsible for discharging the mother or newborn.

(B) Any decision to shorten the length of inpatient stay to less than that specified under division (A)(1) of this section shall be made by the physician attending the mother or newborn, except that if a nurse-midwife is attending the mother in collaboration with a physician, the decision may be made by the nurse-midwife. Decisions regarding early discharge shall be made only after conferring with the mother or a person responsible for the mother or newborn. For purposes of this division, a person responsible for the mother or newborn may include a parent, guardian, or any other person

with authority to make medical decisions for the mother or newborn.

(C)(1) No sickness and accident insurer may do either of the following:

(a) Terminate the participation of a health care professional or health care facility as a provider under a sickness and accident insurance policy solely for making recommendations for inpatient or follow-up care for a particular mother or newborn that are consistent with the care required to be covered by this section;

(b) Establish or offer monetary or other financial incentives for the purpose of encouraging a person to decline the inpatient or follow-up care required to be covered by this section.

(2) Whoever violates division (C)(1)(a) or (b) of this section has engaged in an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

(D) This section does not do any of the following:

(1) Require a policy to cover inpatient or follow-up care that is not received in accordance with the policy's terms pertaining to the health care professionals and facilities from which an individual is authorized to receive health care services~~.~~;

(2) Require a mother or newborn to stay in a hospital or other inpatient setting for a fixed period of time following delivery;

(3) Require a child to be delivered in a hospital or other inpatient setting;

(4) Authorize a nurse-midwife to practice beyond the authority to practice nurse-midwifery in accordance with Chapter 4723. of the Revised Code;

(5) Establish minimum standards of medical diagnosis, care or treatment for inpatient or follow-up care for a mother or newborn. A deviation from the care required to be covered under this section shall not, solely on the basis of this section, give rise to a medical claim or derivative medical claim, as those terms are defined in section 2305.11 of the Revised Code.

Sec. 3923.64. (A) Notwithstanding section 3901.71 of the Revised Code, each public employee benefit plan established or modified in this state that provides maternity benefits shall provide coverage of inpatient care and follow-up care for a mother and her newborn as follows:

(1) The plan shall cover a minimum of forty-eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery. Services covered as inpatient care shall include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric,

obstetric, and nursing professionals.

(2) The plan shall cover a physician-directed source of follow-up care. Services covered as follow-up care shall include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any medically necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage shall apply to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

When a decision is made in accordance with division (B) of this section to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within ~~forty-eight~~ seventy-two hours after discharge. When a mother or newborn receives at least the number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to follow-up care that is determined to be medically necessary by the health care professionals responsible for discharging the mother or newborn.

(B) Any decision to shorten the length of inpatient stay to less than that specified under division (A)(1) of this section shall be made by the physician attending the mother or newborn, except that if a nurse-midwife is attending the mother in collaboration with a physician, the decision may be made by the nurse-midwife. Decisions regarding early discharge shall be made only after conferring with the mother or a person responsible for the mother or newborn. For purposes of this division, a person responsible for the mother or newborn may include a parent, guardian, or any other person with authority to make medical decisions for the mother or newborn.

(C)(1) No public employer who offers an employee benefit plan may do either of the following:

(a) Terminate the participation of a health care professional or health care facility as a provider under the plan solely for making recommendations for inpatient or follow-up care for a particular mother or newborn that are consistent with the care required to be covered by this section;

(b) Establish or offer monetary or other financial incentives for the purpose of encouraging a person to decline the inpatient or follow-up care

required to be covered by this section.

(2) Whoever violates division (C)(1)(a) or (b) of this section has engaged in an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

(D) This section does not do any of the following:

(1) Require a plan to cover inpatient or follow-up care that is not received in accordance with the plan's terms pertaining to the health care professionals and facilities from which an individual is authorized to receive health care services~~.~~:

(2) Require a mother or newborn to stay in a hospital or other inpatient setting for a fixed period of time following delivery;

(3) Require a child to be delivered in a hospital or other inpatient setting;

(4) Authorize a nurse-midwife to practice beyond the authority to practice nurse-midwifery in accordance with Chapter 4723. of the Revised Code;

(5) Establish minimum standards of medical diagnosis, care, or treatment for inpatient or follow-up care for a mother or newborn. A deviation from the care required to be covered under this section shall not, solely on the basis of this section, give rise to a medical claim or derivative medical claim, as those terms are defined in section 2305.11 of the Revised Code.

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

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

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

(C) "Base premium rate" means, as to any health benefit plan that is issued by a carrier and that covers at least two but no more than fifty

employees of a small employer, the lowest premium rate for a new or existing business prescribed by the carrier for the same or similar coverage under a plan or arrangement covering any small employer with similar case characteristics.

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

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

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

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

(H) ~~"Financially impaired" means a program member that, after April 14, 1993, is not insolvent but is determined by the superintendent to be potentially unable to fulfill its contractual obligations, or is placed under an order of rehabilitation or conservation by a court of competent jurisdiction or under an order of supervision by the superintendent.~~

~~(I)~~ "Health benefit plan" means any hospital or medical expense policy or certificate or any health plan provided by a carrier, that is delivered, issued for delivery, renewed, or used in this state on or after the date occurring six months after November 24, 1995. "Health benefit plan" does not include policies covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, or vision care; coverage under a one-time-limited-duration policy of no longer than six months; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law;

automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

~~(J) "Initial enrollment period" means the thirty-day period immediately following any service waiting period established by an employer.~~

~~(K)~~(I) "Late enrollee" means an eligible employee or dependent who ~~requests enrollment~~ enrolls in a small employer's health benefit plan ~~following~~ other than during the ~~initial enrollment~~ first period ~~provided under the terms of the first plan for~~ in which the employee or dependent ~~was~~ is eligible ~~through the small employer, unless any of the following apply:~~

~~(1) The individual:~~

~~(a) Was covered under another health benefit plan at the time the individual was eligible to enroll;~~

~~(b) States, at the time of the initial eligibility, that coverage under another health benefit plan was the reason for declining enrollment;~~

~~(c) Has lost coverage under another health benefit plan as a result of the termination of employment, a reduction of hours worked per week, the termination of the other plan's coverage, death of a spouse, or divorce; and~~

~~(d) Requests enrollment within thirty days after the termination of coverage under another health benefit plan.~~

~~(2) The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period.~~

~~(3) A court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and a request for enrollment is made within thirty days after issuance of the court order~~ to enroll under the plan or during a special enrollment period described in section 2701(f) of the "health insurance portability and accountability act of 1996," pub. l. no. 104-191, 110 stat. 1955, 42 u.s.c.a. 300gg, as amended.

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

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

~~(N)~~(L) "Pre-existing conditions provision" means a policy provision that excludes or limits coverage for charges or expenses incurred during a

specified period following the insured's ~~effective~~ enrollment date ~~of coverage~~ as to a condition ~~which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or~~ for which medical advice, diagnosis, care, or treatment was recommended or received~~, or~~ during a ~~pregnancy existing on~~ specified period immediately preceding the ~~effective~~ enrollment date ~~of coverage~~. Genetic information shall not be treated as such a CONDITION in the absence of a diagnosis of the condition related to such information.

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

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

~~(P)~~(N)(1) "Small employer" means ~~any person, firm, corporation, partnership, or association actively engaged in business whose total~~, in connection with a group health benefit plan and with respect to a calendar year and a plan year, an employer who employed ~~work force consisted of, on at least fifty per cent of its working days during the preceding year,~~ an average of at least two but no more than fifty eligible employees~~, the majority of whom were employed within the state~~ on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

(2) ~~In determining the number of eligible employees for~~ for purposes of division ~~(P)~~(N)(1) of this section, ~~companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation~~ 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 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.

~~(Q)~~(O) "SEHC plan" means an Ohio small employer health care plan, which is a health benefit plan for small individuals and employers established by the board 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 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), (E)(2), (F), and (G) ~~to (J)~~ 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 of the Revised Code, no health benefit plan offered to a small employer is subject to any of the following:

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

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

(3) Any law that would require any carrier to either include a specific

ovider or class of provider when contracting for health care services or benefits, or to exclude any class of provider that is generally authorized by statute to provide such care.

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

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

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

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

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

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

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

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

(B) ~~In determining whether a pre-existing conditions provision applies to an eligible employee or dependent, all health benefit plans shall credit the time the person was covered under a previous employer-based health benefit plan provided by a carrier 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 plan.~~

~~(C) Any such health benefit plan shall be renewable with respect to all eligible employees or dependents at the option of the policyholder, contract holder, or small employer, except for any of the following reasons:~~

~~(1) Nonpayment of the required premiums by the policyholder, contract holder, or employer;~~

~~(2) Fraud or misrepresentation of the policyholder, contract holder, or employer or, with respect to coverage of individual insureds, the insureds or their representatives ;~~

~~(3) When the total number of insured individuals covered under all of the health benefit plans of any one employer is less than the total number of individuals or percentage of individuals required by participation requirements under any specific health benefit plan of that employer;~~

~~(4) Noncompliance with any plan provision that has been approved by the superintendent of insurance;~~

~~(5) When the carrier ceases doing business in the small employer market, provided that all of the following conditions are met:~~

~~(a) Notice of the decision to cease to do business in the small employer market is provided to the department of insurance, the board of directors of the Ohio small employer health reinsurance program, the policyholder or contract holder, and the employer.~~

~~(b) Health benefit plans subject to sections 3924.01 to 3924.14 of the Revised Code shall not be canceled by the carrier for ninety days after the date of the notice required under division (C)(5)(a) of this section unless the business has been sold to another carrier or the cancellations are approved by the superintendent.~~

~~(c) A carrier that ceases to do business in the small employer marketplace is prohibited from re-entering the small employer marketplace for a period of five years from the date of the notice required under division (C)(5)(a) of this section.~~

~~(D) Notwithstanding division (C) of this section, any such health benefit plan or any coverage provided to an individual under such a plan may be rescinded for fraud, material misrepresentation, or concealment by an applicant, employee, dependent, or small employer.~~

~~(E) Every carrier doing business in the small employer market may underwrite and rate small employer groups, as permitted by sections 3924.01 to 3924.14 of the Revised Code, using accepted underwriting and actuarial practices~~ (1) Except as provided in section 2712(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," if a carrier offers coverage in the small employer market in connection with a group

health benefit plan, the carrier shall renew or continue in force such coverage at the option of the plan sponsor of the plan.

(2) A carrier may cancel or decide not to renew the coverage of any eligible employee or of a dependent of an eligible employee if the employee or dependent, as applicable, has performed an act or practice that CONSTITUTES fraud or made an INTENTIONAL MISREPRESENTATION of material fact under the terms of the coverage and IF THE CANCELLATION OR NONRENEWAL IS NOT BASED, EITHER DIRECTLY OR INDIRECTLY, ON ANY HEALTH STATUS-RELATED FACTOR IN RELATION TO THE employee or dependent.

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

~~(F)~~(C) A carrier shall not exclude any eligible employee or dependent, who would otherwise be covered under a health benefit plan, on the basis of any actual or expected health condition of the employee or dependent. ~~However, a carrier may exclude a late enrollee for a period of up to twenty-four months or may, in the discretion of the carrier, extend coverage to the late enrollee at any time during that period. A carrier also may medically underwrite a late enrollee.~~

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

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

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

such coverage.

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

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

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

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

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

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

For purposes of this section, "bona fide association" means an association that has been actively in existence for at least five years; has been formed and maintained in good faith for purposes other than obtaining insurance; does not condition membership in the association on any health status-related factor, as defined in section 3924.031 of the Revised Code,

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

Sec. 3924.031. (A) As used in this section and section 3924.032 of the Revised Code:

(1) "Health status-related factor" means any of the following:

(a) Health status;

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

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

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

(h) Disability.

(2) "Network plan" means a health benefit plan of a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

(B) If a carrier offers a health benefit plan in the small employer market through a network plan, the carrier may do both of the following:

(1) Limit the small employers that may apply for such coverage to those with eligible employees who live, work, or reside in the service area of the network plan;

(2) Within the service area of the network plan, deny the coverage to small employers if the carrier has demonstrated both of the following to the superintendent of insurance:

(a) The carrier will not have the capacity to deliver services adequately to the members of any additional groups because of the carrier's obligations to existing group contract holders and members.

(b) The carrier is applying division (B)(2) of this section uniformly to all small employers without regard to the claims experience of those employers and their eligible employees and dependents or to any health

status-related factor relating to such employees and dependents.

(C) A carrier that, pursuant to division (B)(2) of this section, denies coverage to a small employer in the service area of a network plan, shall not offer coverage in the small employer market within that service area for at least one hundred eighty days after the date the coverage is denied.

Sec. 3924.032. (A) A carrier may refuse to issue health benefit plans in the small employer market if the carrier has demonstrated both of the following to the superintendent of insurance:

(1) The carrier does not have the financial reserves necessary to underwrite additional coverage.

(2) The carrier is applying division (A) of this section uniformly to all employers in the small employer market in this state consistent with the applicable laws and rules of this state and without regard to the claims experience of those employers and their employees and dependents or to any health status-related factor relating to such employees and dependents.

(B) A carrier that, pursuant to division (A) of this section, refuses to issue health benefit plans in the small employer market, shall not offer health benefit plans in the small employer market in this state for at least one hundred eighty days after the date the coverage is denied or until the carrier has demonstrated to the superintendent that the carrier has sufficient financial reserves to underwrite additional coverage, whichever is later.

(C) The superintendent may provide for the application of this section on a service-area-specific basis.

Sec. 3924.033. (A) Each carrier, in connection with the offering of a health benefit plan to a small employer, shall disclose to the employer, as part of its solicitation and sales materials, that the information described in division (B) of this section is available upon request.

(B) A carrier shall provide the following information to a small employer upon request:

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

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

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

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

an.

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

Sec. 3924.07. (A) There is hereby established a nonprofit entity to be known as the "Ohio ~~small employer~~ health reinsurance program." Any carrier issuing health benefit plans in this state on or after April 14, 1993, may be a member of the program.

(B) A carrier may elect to be a member of the program by filing a written intention to participate with the superintendent of insurance at least thirty days prior to the implementation of the program. Any carrier that does not file a written intention to participate within that time period may not participate for three years after April 14, 1993, and may file an intention to participate only at that time or on any subsequent three-year anniversary date. However, the superintendent may permit a carrier to participate in the program at other intervals for reasons based on financial solvency.

(C) The board of directors of the program may permit a carrier to participate in the program at any time for good cause shown. The board shall establish an application process for carriers seeking to change their status under this division.

Sec. 3924.08. (A) The board of directors of the Ohio ~~small employer~~ health reinsurance program shall consist of nine appointed members who shall serve staggered terms as determined by the initial board for its members and by the plan of operation of the program for members of subsequent boards. Within thirty days after April 14, 1993, the members of the board shall be appointed, as follows:

(1) The chairperson of the senate committee having jurisdiction over insurance shall appoint the following members:

(a) Two member carriers that are small employer carriers;

(b) One member carrier that is a health maintenance organization predominantly in the small employer market;

(c) One representative of providers of health care.

(2) The chairperson of the committee in the house of representatives having jurisdiction over insurance shall appoint the following members:

(a) One member carrier that is a small employer carrier;

(b) One member carrier whose principal health insurance business is in the large employer market;

(c) One representative of an employer with fifty or fewer employees;

(d) One representative of consumers in this state.

(3) The superintendent of insurance shall appoint a representative of a member carrier operating in the small employer market who is a fellow of

the society of actuaries.

The superintendent, a member of the house of representatives appointed by the speaker of the house of representatives, and a member of the senate appointed by the president of the senate, shall be ex-officio members of the board. The membership of all boards subsequent to the initial board shall reflect the distribution described in division (A) of this section.

The chairperson of the initial board and each subsequent board shall represent a small employer member carrier and shall be elected by a majority of the voting members of the board. Each chairperson shall serve for the maximum duration established in the plan of operation.

(B) Within one hundred eighty days after the appointment of the initial board, the board shall establish a plan of operation and, thereafter, any amendments to the plan that are necessary or suitable, to assure the fair, reasonable, and equitable administration of the program. The board shall, immediately upon adoption, provide to the superintendent copies of the plan of operation and all subsequent amendments to it.

(C) The plan of operation shall establish rules, conditions, and procedures for all of the following:

(1) The handling and accounting of assets and moneys of the program and for an annual fiscal reporting to the superintendent;

(2) Filling vacancies on the board;

(3) Selecting an administering insurer, which shall be a carrier as defined in section 3924.01 of the Revised Code, and setting forth the powers and duties of the administering insurer;

(4) Reinsuring risks in accordance with sections 3924.07 to 3924.14 of the Revised Code;

(5) Collecting assessments subject to section 3924.13 of the Revised Code from all members to provide for claims reinsured by the program and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

(6) Providing protection for carriers from the financial risk associated with small employers that present poor credit risks;

(7) Establishing standards for the coverage of small employers that have a high turnover of employees;

(8) Establishing an appeals process for carriers to seek relief when a carrier has experienced an unfair share of administrative and credit risks;

(9) Establishing the adjusted average market premium prices for use by the SEHC plan for <u>individuals, for</u> groups of two to twenty-five employees<u>,</u> and for groups of twenty-six to fifty employees that are offered in the state;

(10) Establishing participation standards at issue and renewal for

reinsured cases;

(11) Reinsuring risks and collecting assessments in accordance with division (G) of section 3924.11 of the Revised Code;

(12) Any additional matters as determined by the board.

Sec. 3924.09. The Ohio ~~small employer~~ health reinsurance program shall have the general powers and authority granted under the laws of the state to insurance companies licensed to transact sickness and accident insurance, except the power to issue insurance. The board of directors of the program also shall have the specific authority to do all of the following:

(A) Enter into contracts as are necessary or proper to carry out the provisions and purposes of sections 3924.07 to 3924.14 of the Revised Code, including the authority to enter into contracts with similar programs of other states for the joint performance of common functions, or with persons or other organizations for the performance of administrative functions;

(B) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against any program or board member;

(C) Take such legal action as is necessary to avoid the payment of improper claims against the program;

(D) Design the SEHC plan which, when offered by a carrier, is eligible for reinsurance and issue reinsurance policies in accordance with the requirements of sections 3924.07 to 3924.14 of the Revised Code;

(E) Establish rules, conditions, and procedures pertaining to the reinsurance of members' risks by the program;

(F) Establish appropriate rates, rate schedules, rate adjustments, rate classifications, and any other actuarial functions appropriate to the operation of the program;

(G) Assess members in accordance with division (G) of section 3924.11 and the provisions of section 3924.13 of the Revised Code, and make such advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.

(H) Appoint members to appropriate legal, actuarial, and other committees if necessary to provide technical assistance with respect to the operation of the program, policy and other contract design, and any other function within the authority of the program;

(I) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal

investments for carriers and may be carried as admitted assets.

(J) Reinsure risks, collect assessments, and otherwise carry out its duties under division (G) of section 3924.11 of the Revised Code.;

(K) Study the operation of the Ohio ~~small employer~~ health reinsurance program and the open enrollment reinsurance program and, based on its findings, make legislative recommendations to the general assembly for improvements in the effectiveness, operation, and integrity of the programs;

(L) Design a basic and standard plan for purposes of sections 1751.16, 3923.122, and 3923.581 Of the Revised Code.

Sec. 3924.10. (A) The board of directors of the Ohio ~~small employer~~ health reinsurance program shall design the SEHC plan which, when offered by a carrier, is eligible for reinsurance under the program. The board shall establish the form and level of coverage to be made available by carriers in their SEHC plan. In designing the plan the board shall also establish benefit levels, deductibles, coinsurance factors, exclusions, and limitations for the plan. The forms and levels of coverage established by the board shall specify which components of a health benefit plan offered by a ~~small employer~~ carrier may be reinsured. The SEHC plan is subject to division (C) of section 3924.02 of the Revised Code and to the provisions in Chapters 1751., 3923., and any other chapter of the Revised Code that require coverage or the offer of coverage of a health care service or benefit.

(B) The board shall adopt the SEHC plan within one hundred eighty days after its appointment. The plan may include cost containment features including any of the following:

(1) Utilization review of health care services, including review of the medical necessity of hospital and physician services;

(2) Case management benefit alternatives;

(3) Selective contracting with hospitals, physicians, and other health care providers;

(4) Reasonable benefit differentials applicable to participating and nonparticipating providers;

(5) Employee assistance program options that provide preventive and early intervention mental health and substance abuse services;

(6) Other provisions for the cost-effective management of the plan.

(C) An SEHC plan established for use by health insuring corporations shall be consistent with the basic method of operation of such corporations.

(D) Each carrier shall certify to the superintendent of insurance, in the form and manner prescribed by the superintendent, that the SEHC plan filed by the carrier is in substantial compliance with the provisions of the board SEHC plan. Upon receipt by the superintendent of the certification, the

carrier may use the certified plan.

(E) Each carrier shall, on and after sixty days after the date that the program becomes operational and as a condition of transacting business in this state, renew coverage provided to any individual or group under its SEHC plan.

~~(F) A carrier shall not be required to renew coverage where the superintendent finds that renewal of coverage would place the carrier in a financially impaired condition. The superintendent shall determine when the carrier is no longer financially impaired and is, therefore, subject to the guaranteed renewability requirements.~~

Sec. 3924.11. Any member of the Ohio ~~small employer~~ health reinsurance program may reinsure small employer groups or individuals in accordance with the following conditions and limitations:

(A) With respect to eligible employees and their dependents who are hired subsequent to the commencement of the employer's coverage by a carrier and who are not late enrollees, and with respect to employees of an employer who are otherwise eligible for insurance but were excluded by the carrier's underwriting and who are not late enrollees, coverage may be reinsured in ~~either~~ any of the following ways:

(1) Except in the case of late enrollees, within sixty days after the commencement of their coverage under the plan;

(2) In the case of late enrollees WHO WERE NOT ELIGIBLE TO ENROLL DURING A SPECIAL ENROLLMENT PERIOD DESCRIBED IN SECTION 2701(f) OF THE "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996," PUB. L. NO. 104-191, 110 STAT. 1955, 42 U.S.C.A. 300gg-42, AS AMENDED, eighteen months after the date the late enrollee becomes a member of the small employer's plan;

(3) IN THE CASE OF LATE ENROLLEES WHO WERE ELIGIBLE TO ENROLL DURING A SPECIAL ENROLLMENT PERIOD DESCRIBED IN SECTION 2701(f) OF THE "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996," AS AMENDED, WITHIN SIXTY DAYS AFTER THE COMMENCEMENT OF THEIR COVERAGE UNDER THE PLAN.

(B)(1) The carrier may reinsure either the entire eligible group or any eligible individual, in accordance with the premium rates established in section 3924.12 of the Revised Code, upon commencement of the coverage.

(2) The carrier may reinsure an eligible employee, or the dependents of an eligible employee, who were previously excluded from group coverage for medical reasons, and shall reinsure such employees or dependents within sixty days after the carrier is required to include them in the group coverage.

(C) With respect to an SEHC plan, the program shall reinsure the level of coverage provided.

(D) With respect to other plans issued to small employers, the program shall reinsure the level of coverage provided up to, but not exceeding, the level of coverage provided in an SEHC plan. In the coverage provided to small employers, carriers shall be required to use high-cost care management, hospital precertification techniques, and other cost containment mechanisms established by the program.

(E) A carrier may not reinsure existing business, except pursuant to division (A) of this section.

(F) If an employer group is covered under a plan other than an SEHC plan and the carrier chooses to reinsure the group subsequent to the initial coverage period, or if a new individual joins the group and the carrier wants to reinsure that individual, the carrier shall not force the employer to change to an SEHC plan. The carrier shall allow the employer to maintain the same benefit plan and reinsure only that portion of the plan that is consistent with an SEHC plan.

(G) With respect to coverage provided to ~~a small employer group or~~ an individual acquired under section 3923.58 or a federally eligible individual acquired under section 3923.581 of the Revised Code, the following conditions and limitations apply:

(1) Within sixty days after the commencement of the initial coverage, any carrier may reinsure coverage of ~~an entire small employer group, or of eligible employees or dependents of such group, or any~~ such an individual ~~acquired under section 3923.58 of the Revised Code~~ with the open enrollment reinsurance program in accordance with division (G) of this section. ~~A carrier may reinsure, within sixty days after the effective date of coverage, an employee eligible for coverage under section 3923.58 of the Revised Code.~~ Premium rates charged for coverage reinsured by the program shall be established in accordance with section 3924.12 of the Revised Code.

(2) The board of directors of the Ohio health reinsurance program shall establish the open enrollment reinsurance fund for coverage provided under section 3923.58 of the Revised Code and, with respect to federally eligible individuals, coverage provided under section 3923.581 Of the Revised Code. The fund shall be maintained separately from any reinsurance fund established for small employer health care plans issued pursuant to sections 3924.07 to 3924.14 of the Revised Code. The board shall calculate, on a retrospective basis, the amount needed for maintenance of the open enrollment reinsurance fund and, on the basis of that calculation, shall

determine the amount to be assessed each carrier that is required to provide open enrollment coverage.

Assessments shall be apportioned by the board among all carriers participating in the open enrollment reinsurance program in proportion to their respective shares of the total premiums, net of reinsurance premiums paid by a carrier for open enrollment coverage and net of reinsurance premiums paid by the carrier for all other ~~small group and~~ individual health benefit plans, earned in this state from all health benefit plans covering ~~small employers and~~ individuals that are issued by all such carriers during the calendar year coinciding with or ending during the fiscal year of the open enrollment program, or on any other equitable basis reflecting coverage of ~~small employers and~~ individuals in this state as may be provided in the plan of operation adopted by the board. In no event shall the assessment of any carrier under this section exceed, on an annual basis, three per cent of its Ohio premiums for health benefit plans covering ~~small employers and~~ individuals as reported on its most recent annual statement filed with the superintendent of insurance.

The board shall submit its determination of the amount of the assessment to the superintendent for review of the accuracy of the calculation of the assessment. Upon approval by the superintendent, each carrier shall, within thirty days after receipt of the notice of assessment, submit the assessment to the board for purposes of the open enrollment reinsurance fund.

(3) If the assessments made and collected pursuant to division (G)(2) of this section are not sufficient to pay the claims reinsured under division (G) of this section and the allocated administrative expenses, incurred or estimated to be incurred during the period for which the assessment was made, the secretary of the board shall immediately notify the superintendent, and the superintendent shall suspend the operation of open enrollment under section 3923.58 of the Revised Code and, with respect to federally eligible individuals, under section 3923.581 Of the Revised Code until the board has collected in subsequent years through assessments made pursuant to division (G)(2) of this section an amount sufficient to pay such claims and administrative expenses.

(4)(a) Any carrier that is subject to open enrollment under section 3923.58 of the Revised Code may elect not to participate in the open enrollment reinsurance program under division (G) of this section by filing an application with the superintendent and obtaining the superintendent's approval. In determining whether to approve an application, the superintendent shall consider whether the carrier meets all of the following

standards:

(i) Demonstration by the carrier of a substantial and established market presence;

(ii) Demonstrated experience in the ~~small employer group~~ individual market and history of rating and underwriting ~~small employer groups~~ individual plans;

(iii) Commitment to comply with the requirements of section 3923.58 of the Revised Code;

(iv) Financial ability to assume and manage the risk of enrolling open enrollment ~~groups and~~ individuals without the need for, or protection of, reinsurance.

(b) A carrier whose application for nonparticipation has been rejected by the superintendent may appeal the decision in accordance with Chapter 119. of the Revised Code. A carrier that has received approval of the superintendent not to participate in the open enrollment reinsurance program shall, on or before the first day of December, annually certify to the superintendent that it continues to meet the standards described in division (G)(4)(a) of this section.

(c) In any year subsequent to the year in which its application not to participate has been approved, a carrier may elect to participate in the open enrollment reinsurance program by giving notice to the superintendent and board on or before the thirty-first day of December. If, after a period of nonparticipation, a carrier elects to participate in the open enrollment reinsurance program, the carrier retains the risks it assumed during the period when it was not participating.

(d) The superintendent may, at any time, authorize a carrier to modify an election not to participate if the risk from the carrier's open enrollment business jeopardizes the financial condition of the carrier. If the superintendent authorizes the carrier to again participate in the open enrollment reinsurance program, the carrier shall retain the risks it assumed during the period of nonparticipation.

(5) ~~At the time of acquiring a small employer group, a carrier shall determine whether to reinsure the entire group or any individual pursuant to section 3924.12 of the Revised Code.~~

~~(6)~~(a) The open enrollment reinsurance program shall be operated separately from the Ohio ~~small employer~~ health reinsurance program.

(b) A carrier's election to participate in the open enrollment reinsurance program under division (G) of this section shall not be construed as an election to participate in the Ohio ~~small employer~~ health reinsurance program under section 3924.07 of the Revised Code.

Sec. 3924.111. (A) The Ohio ~~small employer~~ health reinsurance program shall not provide reinsurance for any individual reinsured under the program until five thousand dollars in benefit payments have been made by a member of the program for services provided to that individual during a calendar year, which payments would have been reimbursed through the program but for the five-thousand-dollar deductible. The member shall retain ten per cent of the next fifty thousand dollars of benefit payments made during that calendar year, and the program shall reinsure the remainder. However, a member's maximum liability under this section with respect to any one individual reinsured under the program shall not exceed ten thousand dollars in any one calendar year.

(B) The board of directors of the Ohio ~~small employer~~ health reinsurance program shall periodically review the deductible amount and the maximum liability amount set forth in division (A) of this section and, considering the rate of inflation, adjust each amount as the board considers necessary.

Sec. 3924.12. (A) Except as provided in division (B) of this section, premium rates charged for coverage reinsured by the Ohio ~~small employer~~ health reinsurance program shall be established as follows:

(1) For whole group reinsurance coverage, one and one-half times the adjusted average market premium price established by the program for that classification or group with similar characteristics and coverage, with respect to the eligible employees of a small employer and their dependents, all of whose coverage is reinsured with the program, minus a ceding expense factor determined by the board of directors of the program;

(2) For individual reinsurance coverage, five times the adjusted average market premium price established by the program for an individual in that classification or group with similar characteristics and coverage, with respect to an eligible employee or the employee's dependents, minus a ceding expense factor determined by the board.

(B) Premium rates charged for reinsurance by the program to a health insuring corporation that is approved by the secretary of health and human services as a federally qualified health maintenance organization pursuant to the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, and as such is subject to requirements that limit the amount of risk that may be ceded to the program, may be modified to reflect the portion of risk that may be ceded to the program.

Sec. 3924.13. (A) Following the close of each calendar year, the administering insurer of the Ohio ~~small employer~~ health reinsurance program shall determine the net premiums, the program expenses for

administration, and the incurred losses, if any, for the year, taking into account investment income and other appropriate gains and losses. For purposes of this section, health benefit plan premiums earned by MEWAs shall be established by adding paid claim losses and administrative expenses of the MEWA. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board of directors of the program to justify the cost of collection shall not be considered for purposes of determining assessments. For purposes of this division, "net premiums" means health benefit plan premiums, less administrative expense allowances.

(B) Any net loss for the year shall be recouped first by assessments of carriers in accordance with this division. Assessments shall be apportioned by the board among all carriers participating in the program in proportion to their respective shares of the total premiums, net of reinsurance premiums paid for coverage under this program earned in the state from health benefit plans covering small employers that are issued by participating members during the calendar year coinciding with or ending during the fiscal year of the program, or on any other equitable basis reflecting coverage of small employers as may be provided in the plan of operation. An assessment shall be made pursuant to this division against a health insuring corporation that is approved by the secretary of health and human services as a federally qualified health maintenance organization pursuant to the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, subject to an assessment adjustment formula adopted by the board for such health insuring corporations that recognizes the restrictions imposed on the entities by federal law. The adjustment formula shall be adopted by the board prior to the first anniversary of the program's operation. In no event shall the assessment made pursuant to this division exceed, on an annual basis, one per cent of the carrier's Ohio small employer group premium as reported on its most recent annual statement filed with the superintendent of insurance. If an excess is actuarially projected, the superintendent may take any action necessary to lower the assessment to the maximum level of one per cent.

(C) If assessments exceed actual losses and administrative expenses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this division, "future losses" includes reserves for incurred but not reported claims.

(D) Each carrier's proportion of participation in the program shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the carrier with the board. MEWAs shall report to the board claims payments made and

administrative expenses incurred in this state on an annual basis on a form prescribed by the superintendent.

(E) Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments.

(F) A carrier may seek from the superintendent a deferment, in whole or in part, from any assessment issued by the board. The superintendent may defer, in whole or in part, the assessment of a carrier if, in the opinion of the superintendent, payment of the assessment would endanger the carrier's ability to fulfill its contractual obligations.

(G) In the event an assessment against a carrier is deferred in whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessments set forth in this section. In such event, the other carriers assessed shall have a claim in the amount of the assessment against the carrier receiving the deferment. The carrier receiving the deferment shall remain liable to the program for the amount deferred. The superintendent may attach appropriate conditions to any deferment.

Sec. 3924.14. Neither the participation as members of the Ohio ~~small employer~~ health reinsurance program or as members of the board of directors of the program, the establishment of rates, forms, or procedures for coverage issued by the program, nor any other joint or collective action required by sections 3924.01 to 3924.14 of the Revised Code, shall be the basis of any legal action or any criminal or civil liability or penalty against the program, the board, or any of its members either jointly or separately.

Sec. 3924.27. (A) As used in this section:

(1) "Carrier," "dependent," and "health benefit plan" have the same meanings as in section 3924.01 Of the Revised Code.

(2) "Health status-related factor" means any of the following:

(a) Health status;

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

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

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

(h) Disability.

(B) No group health benefit plan, or carrier offering health insurance coverage in connection with a group health benefit plan, shall require any individual, as a condition of enrollment or continued enrollment under the

plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

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

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

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

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

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

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

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

Sec. 3924.61. As used in sections 3924.61 to 3924.74 of the Revised Code:

(A) "Account holder" means the natural person who opens a medical savings account or on whose behalf a medical savings account is opened.

(B) "Eligible medical expense" means any expense for a service rendered by a licensed health care provider or a Christian Science

actitioner, or for an article, device, or drug prescribed by a licensed health care provider or provided by a Christian Science practitioner, when intended for use in the mitigation, treatment, or prevention of disease; any amount paid for transportation to the location at which such a service is rendered; any amount paid for lodging necessitated by the receipt of care at a nonlocal hospital; or premiums paid for comprehensive sickness and accident insurance, coverage under a health care plan of a health insuring corporation organized under Chapter 1751. of the Revised Code, long-term care insurance as defined in section 3923.41 of the Revised Code, ~~Medicare~~ MEDICARE supplemental coverage as defined in section 3923.33 of the Revised Code, or payments made pursuant to cost sharing agreements under comprehensive sickness and accident plans. An "eligible medical expense" does not include expenses otherwise paid or reimbursed, including medical expenses paid or reimbursed under an automobile or motor vehicle insurance policy, a workers' compensation insurance policy or plan, or an employer-sponsored health coverage policy, plan, or contract.

(C) "~~Qualified dependent" means a child of an account holder when any of the following applies:~~

~~(1) The child is under nineteen years of age, or is under twenty-three years of age and a full-time student at an accredited college or university;~~

~~(2) The child is not self-sufficient due to physical or mental disorders or impairments;~~

~~(3) The child is legally entitled to the provision of proper or necessary subsistence, education, medical care, or other care necessary for the child's health, guidance, or well-being and is not otherwise emancipated, self-supporting, married, or a member of the armed forces of the United States~~ dependent" has the same meaning as in section 152 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.

Sec. 3924.62. (A) A medical savings account may be opened by or on behalf of any natural person, to pay the person's eligible medical expenses and the eligible medical expenses of that person's spouse or ~~qualified~~ dependent. A medical savings account may be opened by or on behalf of a person only if that person participates in a sickness or accident insurance plan, a plan offered by a health insuring corporation organized under Chapter 1751. of the Revised Code, or a self-funded, employer-sponsored health benefit plan established pursuant to the "Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended. While the medical savings account is open, the account holder shall continue to participate in such a plan.

(B) A person who refuses to participate in a policy, plan, or contract of

health coverage that is funded by the person's employer, and who receives additional monetary compensation by virtue of refusing that coverage, may not open a medical savings account unless the medical savings account also is sponsored by the person's employer.

Sec. 3924.63. The owners of interest in a medical savings account are the account holder~~,~~ and the account holder's spouse~~,~~ and ~~qualified~~ dependents. No medical savings account shall be subject to garnishment or attachment.

Sec. 3924.64. (A) At the time a medical savings account is opened, an administrator for the account shall be designated. If an employer opens an account for an employee, the employer may designate the administrator. If an account is opened by any person other than an employer, or if an employer chooses not to designate an administrator for an account opened for an employee, the account holder shall designate the administrator. The administrator shall manage the account in a fiduciary capacity for the benefit of the account holder.

(B) Medical savings accounts shall be administered by one of the following:

(1) A federally or state-chartered bank, savings and loan association, savings bank, or credit union;

(2) A trust company authorized to act as a fiduciary;

(3) An insurer authorized under Title XXXIX of the Revised Code to engage in the business of sickness and accident insurance;

(4) A dealer or salesperson licensed under Chapter 1707. of the Revised Code;

(5) An administrator licensed under Chapter 3959. of the Revised Code;

(6) A certified public accountant;

(7) An employer that administers an employee benefit plan subject to regulation under the "Employee Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C.A. 1001, as amended, or that maintains medical savings accounts for its employees;

(8) Health insuring corporations organized under Chapter 1751. of the Revised Code.

(C) Each administrator shall send to the account holder, at least annually, a statement setting forth the balance remaining in the account holder's account and detailing the activity in the account since the last statement was issued. Upon an administrator's receipt of a written request from an account holder for a current statement, the administrator shall promptly send the statement to the account holder.

(D) When an account holder documents to the administrator of the

account the account holder's payment of, or the account holder's obligation for, an eligible medical expense for the account holder~~,~~ or the account holder's spouse~~,~~ or ~~qualified~~ dependents, the administrator shall reimburse the account holder for, or shall pay for, the eligible medical expense with funds from the account holder's account, if sufficient funds are available in the account holder's account. If there are not sufficient funds in the account to fully reimburse the account holder or pay the expenses, the administrator shall reimburse the account holder or pay the expenses using whatever funds are in the account. The reimbursement or payment shall be made within thirty days of the administrator's receipt of the documentation. At the time of making the reimbursement or payment, the administrator shall notify the account holder if the medical expense does not count toward meeting the deductible or other obligation for the receipt of benefits that is required by the insurer or other third-party payer providing health coverage to the account holder. The administrator shall keep a record of the amounts disbursed from the account for documented eligible medical expenses and of the dates on which the expenses were incurred. This record shall be made available to any sickness and accident insurer or other third-party payer providing health coverage to the account holder, for use by the insurer or third-party payer in determining whether the account holder has met the deductible or other obligation required for the receipt of benefits from the insurer or third-party payer.

(E) When an account is opened, the administrator shall give written notice to the account holder of the date of the last business day of the administrator's business year.

Sec. 3924.66. (A) In determining Ohio adjusted gross income under Chapter 5747. of the Revised Code, an account holder may deduct an amount equaling the total of the deposits that the account holder, the account holder's spouse, or the account holder's employer made to the account during the taxable year, to the extent that the funds for the deposits have not otherwise been deducted or excluded in determining the account holder's federal adjusted gross income. The amount deducted by an account holder for a taxable year shall not exceed three thousand dollars. If two married persons each have an account, each spouse may claim the deduction described in this section, and the amount deducted by each spouse shall not exceed three thousand dollars, whether the spouses file returns jointly or separately.

(B) The maximum deduction allowed under division (A) of this section shall be adjusted annually by the department of taxation to reflect increases in the consumer price index for all items for all urban consumers for the

north central region, as published by the United States bureau of labor statistics.

(C) In determining Ohio adjusted gross income under Chapter 5747. of the Revised Code, an account holder may deduct the investment earnings of a medical savings account from the account holder's federal adjusted gross income, to the extent that these earnings have been included in the account holder's federal adjusted gross income.

(D) In determining Ohio adjusted gross income under Chapter 5747. of the Revised Code, an account holder shall add to the account holder's federal adjusted gross income an amount equal to the sum of the amounts described in divisions (D)(1) and (2) of this section to the extent that those amounts were included in the account holder's federal adjusted gross income and previously deducted in determining the account holder's Ohio adjusted gross income. In determining the extent to which amounts withdrawn from the account shall be included in the account holder's Ohio adjusted gross income, the tax commissioner shall be guided by the provisions of sections 72 and 408 of the Internal Revenue Code governing the determination of the amount of withdrawals from an individual retirement account to be included in federal gross income.

(1) Amounts withdrawn from the account during the taxable year used for any purpose other than to reimburse the account holder for, or to pay, the eligible medical expenses of the account holder~~,~~ or the account holder's spouse~~,~~ or ~~qualified~~ dependents;

(2) Investment earnings during the taxable year on amounts withdrawn from the account that are described in division (D)(1) of this section.

(E) Amounts withdrawn from a medical savings account to reimburse the account holder for, or to pay, the account holder's eligible medical expenses, or the eligible medical expenses of the account holder's spouse or ~~qualified~~ dependents, shall not be included in the account holder's Ohio adjusted gross income in determining taxes due under Chapter 5747. of the Revised Code.

(F) If a ~~qualified~~ dependent of an account holder becomes ineligible to continue to participate in the account holder's policy, plan, or contract of health coverage, the account holder may withdraw funds from the account holder's account and use those funds to pay the premium for the first year of a policy, plan, or contract of health coverage for the ~~qualified~~ dependent and to pay any deductible for the first year of that policy, plan, or contract. Funds withdrawn and used for that purpose shall not be included in the account holder's Ohio adjusted gross income in determining taxes due under Chapter 5747. of the Revised Code.

Sec. 3924.67. An account holder may withdraw funds from the account holder's account at any time, for any purpose. However, the administrator of a medical savings account shall not disburse funds to an account holder during the year in which the funds were deposited, except to reimburse the account holder for, or pay for, a documented eligible medical expense of the account holder~~,~~ or the account holder's spouse~~,~~ or ~~a qualified~~ dependent.

Sec. 3924.68. (A) If an account holder, whose medical savings account has been opened by the account holder's employer, later ceases to be employed by that employer, the account holder may, within sixty days of the account holder's final date of employment, request in writing to the administrator of the account that the administrator continue to administer the account.

(1) If the administrator agrees to continue to administer the account, funds in the account may continue to be used to pay the eligible medical expenses of the account holder~~,~~ and the account holder's spouse~~,~~ and ~~qualified~~ dependents, pursuant to sections 3924.61 to 3924.74 of the Revised Code.

If the account holder later becomes employed by a new employer that opens a new medical savings account on the account holder's behalf, the account holder may transfer any funds remaining in the account opened by the account holder's former employer to the account opened by the account holder's new employer. For purposes of determining taxes due under Chapter 5747. of the Revised Code, this transfer of funds shall not be considered a withdrawal of funds from a medical savings account, nor shall it be considered a deposit to a medical savings account.

(2) If the administrator does not agree to continue to administer the account, or if the account holder requests that the account be closed, the administrator shall close the account and mail a check or other negotiable instrument in the amount of the account balance as of that date to the account holder. The amount distributed shall be included in the account holder's Ohio adjusted gross income in determining taxes due under Chapter 5747. of the Revised Code.

(B) Within sixty days of the account holder's final date of employment, the account holder may transfer any funds remaining in the account opened by the account holder's former employer to another medical savings account owned by the account holder. For purposes of determining taxes due under Chapter 5747~~,~~. of the Revised Code, this transfer of funds shall not be considered a withdrawal of funds from a medical savings account, nor shall it be considered a deposit to a medical savings account.

(C) An administrator of an account opened by an employer shall not

close an account without the permission of the account holder until at least sixty-one days after the account holder's final date of employment. The employer shall notify the administrator of the employee's final date of employment.

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

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

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

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

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

SECTION 2. That existing sections 1739.05, 1751.06, 1751.15, 1751.16, 1751.18, 1751.59, 1751.61, 1751.64, 1751.65, 1751.67, 3901.21, 3901.49, 3901.491, 3901.50, 3901.501, 3923.021, 3923.122, 3923.26, 3923.40, 3923.57, 3923.58, 3923.59, 3923.63, 3923.64, 3924.01, 3924.02, 3924.03, 3924.07, 3924.08, 3924.09, 3924.10, 3924.11, 3924.111, 3924.12, 3924.13, 3924.14, 3924.51, 3924.61, 3924.62, 3924.63, 3924.64, 3924.66, 3924.67, 3924.68, and 3924.73 and section 3941.53 of the Revised Code are hereby repealed.

SECTION 3. The amendments to sections 1751.59, 1751.61, 3923.122, 3923.26, 3923.40, and 3924.51 of the Revised Code by this act shall apply to contracts, evidences of coverage, policies, and plans that are delivered,

issued for delivery, renewed, or established in this state on or after the effective date of this section.

SECTION 4. The amendment of sections 1751.64, 3901.49, and 3901.50 of the Revised Code is not intended to supersede the earlier repeal, with delayed effective dates, of those sections.

SECTION 5. This act is hereby declared to be an emergency measure necessary for the immediate preservation of the public peace, health, and safety. The reason for such necessity is that Ohio must meet the federal deadline relative to the implementation of the federal Health Insurance Portability and Accountability Act of 1996. Ohio's failure to meet this deadline could result in the federal government assuming regulation over certain areas of health insurance, thereby disrupting the stable health insurance market in Ohio that currently exists under Ohio law. Meeting the federal deadline will protect the public health and safety of the citizens of this state by ensuring the stability of the health insurance market through the continued regulation of this market by the state. Therefore, this act shall go into immediate effect.

_____

Speaker _____ of the House of Representatives.

_____

President _____ of the Senate.

Passed _____, 20____

Approved _____, 20____

_____

Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

_____

Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the ____ day of _____, A. D. 20____.

_____

Secretary of State.

File No. _____ Effective Date _____