As Introduced

126th General Assembly
Regular Session
2005-2006

S. B. No. 5

Senator Hottinger

A BILL

To amend sections 1731.03, 1751.12, 3924.01, 3924.02, 3924.06, 3924.08, 3924.09, 3924.10, 3924.11, 3924.14, and 3924.73 and to enact sections 3923.81 and 3924.15 of the Revised Code to permit small employers to offer health care plans without benefits otherwise required by statute, to provide for the operation of health savings accounts consistent with federal laws, and to limit the amount of copayments and deductibles paid by persons insured by health benefit plans. 1 2 3 4 5 6 7 8 9 10

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

Section 1. That sections 1731.03, 1751.12, 3924.01, 3924.02, 3924.06, 3924.08, 3924.09, 3924.10, 3924.11, 3924.14, and 3924.73 be amended and sections 3923.81 and 3924.15 of the Revised Code be enacted to read as follows: 11 12 13 14

Sec. 1731.03. (A) A small employer health care alliance may do any of the following: 15 16

(1) Negotiate and enter into agreements with one or more insurers for the insurers to offer and provide one or more health benefit plans to small employers for their employees and retirees, and the dependents and members of the families of such employees 17 18 19 20

and retirees, which coverage may be made available to enrolled small employers without regard to industrial, rating, or other classifications among the enrolled small employers under an alliance program, except as otherwise provided under the alliance program, and for the alliance to perform, or contract with others for the performance of, functions under or with respect to the alliance program; 21 22 23 24 25 26 27

(2) Contract with another alliance for the inclusion of the small employer members of one in the alliance program of the other; 28 29 30

(3) Provide or cause to be provided to small employers information concerning the availability, coverage, benefits, premiums, and other information regarding an alliance program and promote the alliance program; 31 32 33 34

(4) Provide, or contract with others to provide, enrollment, record keeping, information, premium billing, collection and transmittal, and other services under an alliance program; 35 36 37

(5) Receive reports and information from the insurer and negotiate and enter into agreements with respect to inspection and audit of the books and records of the insurer; 38 39 40

(6) Provide services to and on behalf of an alliance program sponsored by another alliance, including entering into an agreement described in division (B) of section 1731.01 of the Revised Code on behalf of the other alliance; 41 42 43 44

(7) If it is a nonprofit corporation created under Chapter 1702. of the Revised Code, exercise all powers and authority of such corporations under the laws of the state, or, if otherwise constituted, exercise such powers and authority as apply to it under the applicable laws, and its articles, regulations, constitution, bylaws, or other relevant governing instruments. 45 46 47 48 49 50

(B) A small employer health care alliance is not and shall not be regarded for any purpose of law as an insurer, an offeror or seller of any insurance, a partner of or joint venturer with any insurer, an agent of, or solicitor for an agent of, or representative of, an insurer or an offeror or seller of any insurance, an adjuster of claims, or a third-party administrator, and will not be liable under or by reason of any insurance coverage or other health benefit plan provided or not provided by any insurer or by reason of any conditions or restrictions on eligibility or benefits under an alliance program or any insurance or other health benefit plan provided under an alliance program or by reason of the application of those conditions or restrictions. 51 52 53 54 55 56 57 58 59 60 61 62

(C) The promotion of an alliance program by an alliance or by an insurer is not and shall not be regarded for any purpose of law as the offer, solicitation, or sale of insurance. 63 64 65

(D)(1) No alliance shall adopt, impose, or enforce medical underwriting rules for the purpose of determining whether an alliance member is eligible to purchase a policy, contract, or plan of health insurance or health benefits from any insurer in connection with the alliance health care program. 66 67 68 69 70

(2) No alliance shall reject any applicant for membership in the alliance based on the health status of the applicant's employees or their dependents. 71 72 73

(3) A violation of division (D)(1) or (2) of this section is deemed to be an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code. 74 75 76 77

(4) Nothing in division (D)(1) or (2) of this section shall be construed as inhibiting or preventing an alliance from adopting, imposing, and enforcing rules, conditions, limitations, or restrictions that are based on factors other than the health 78 79 80 81

status of employees or their dependents for the purpose of determining whether a small employer is eligible to become a member of the alliance. Division (D)(1) of this section does not apply to an insurer that sells health coverage to an alliance member under an alliance health care program. 82 83 84 85 86

(E) Health benefit plans offered and sold to alliance members that are small employers as defined in section 3924.01 of the Revised Code are subject to sections 3924.01 to ~~3924.14~~ 3924.15 of the Revised Code. 87 88 89 90

(F) Any person who represents an alliance in bargaining or negotiating a health benefit plan with an insurer shall disclose to the governing board of the alliance any direct or indirect financial relationship the person has or had during the past two years with the insurer. 91 92 93 94 95

Sec. 1751.12. (A)(1) No contractual periodic prepayment and no premium rate for nongroup and conversion policies for health care services, or any amendment to them, may be used by any health insuring corporation at any time until the contractual periodic prepayment and premium rate, or amendment, have been filed with the superintendent of insurance, and shall not be effective until the expiration of sixty days after their filing unless the superintendent sooner gives approval. The filing shall be accompanied by an actuarial certification in the form prescribed by the superintendent. The superintendent shall disapprove the filing, if the superintendent determines within the sixty-day period that the contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees. The superintendent shall notify the health insuring corporation of the disapproval, and it shall thereafter be unlawful for the health 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112

insuring corporation to use the contractual periodic prepayment or premium rate, or amendment. 113 114

(2) No contractual periodic prepayment for group policies for health care services shall be used until the contractual periodic prepayment has been filed with the superintendent. The filing shall be accompanied by an actuarial certification in the form prescribed by the superintendent. The superintendent may reject a filing made under division (A)(2) of this section at any time, with at least thirty days' written notice to a health insuring corporation, if the contractual periodic prepayment is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees. 115 116 117 118 119 120 121 122 123 124 125

(3) At any time, the superintendent, upon at least thirty days' written notice to a health insuring corporation, may withdraw the approval given under division (A)(1) of this section, deemed or actual, of any contractual periodic prepayment or premium rate, or amendment, based on information that either of the following applies: 126 127 128 129 130 131

(a) The contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles. 132 133

(b) The contractual periodic prepayment or premium rate, or amendment, is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees. 134 135 136

(4) Any disapproval under division (A)(1) of this section, any rejection of a filing made under division (A)(2) of this section, or any withdrawal of approval under division (A)(3) of this section, shall be effected by a written notice, which shall state the specific basis for the disapproval, rejection, or withdrawal and shall be issued in accordance with Chapter 119. of the Revised Code. 137 138 139 140 141 142 143

(B) Notwithstanding division (A) of this section, a health insuring corporation may use a contractual periodic prepayment or premium rate for policies used for the coverage of beneficiaries enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare risk contract or medicare cost contract, or for policies used for the coverage of beneficiaries enrolled in the federal employees health benefits program pursuant to 5 U.S.C.A. 8905, or for policies used for the coverage of beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, provided by the department of job and family services under Chapter 5111. of the Revised Code, or for policies used for the coverage of beneficiaries under any other federal health care program regulated by a federal regulatory body, or for policies used for the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services, if both of the following apply: 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162

(1) The contractual periodic prepayment or premium rate has been approved by the United States department of health and human services, the United States office of personnel management, the department of job and family services, or the department of administrative services. 163 164 165 166 167

(2) The contractual periodic prepayment or premium rate is filed with the superintendent prior to use and is accompanied by documentation of approval from the United States department of health and human services, the United States office of personnel management, the department of job and family services, or the department of administrative services. 168 169 170 171 172 173

(C) The administrative expense portion of all contractual periodic prepayment or premium rate filings submitted to the 174 175

superintendent for review must reflect the actual cost of administering the product. The superintendent may require that the administrative expense portion of the filings be itemized and supported.

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

(2) A health insuring corporation, in order to ensure that copayments are reasonable and not a barrier to the necessary utilization of basic health care services by enrollees, may do one of the following:

(a) Impose copayment charges on any single covered basic health care service that does not exceed forty per cent of the average cost to the health insuring corporation of providing the service;

(b) Impose copayment charges that annually do not exceed twenty per cent of the total annual cost to the health insuring corporation of providing all covered basic health care services, including physician office visits, urgent care services, and emergency health services, when aggregated as to all persons covered under the filed product in question. In addition, annual copayment charges as to each enrollee shall not exceed twenty per cent of the total annual cost to the health insuring corporation of providing all covered basic health care services, including physician office visits, urgent care services, and emergency health services, as to such enrollee. The total annual cost of providing a health care service is the cost to the health insuring corporation of providing the health care service to its enrollees as reduced by any applicable provider discount.

(3) To ensure that copayments are reasonable and not a barrier to the utilization of basic health care services, a health insuring corporation may not impose, in any contract year, on any

subscriber or enrollee, copayments that exceed two hundred per cent of the average annual premium rate to subscribers or enrollees.

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

(F) A health insuring corporation may require that an enrollee pay an annual deductible that does not exceed one thousand dollars per enrollee or two thousand dollars per family~~.~~ ~~The~~, except that:

(1) A health insuring corporation may impose higher deductibles for federally qualified high deductible health plans that are linked to health savings accounts;

(2) The superintendent may adopt rules ~~defining~~ allowing different annual deductible amounts for plans with ~~an employer-sponsored~~ a medical savings account, health reimbursement arrangement, ~~or~~ flexible spending account, or similar account.

(G) If a health insuring corporation applies a deductible to coverage, the deductible shall not apply to preventive health care services required by division (A)(7) of section 1751.01 of the Revised Code except when required to qualify as a high deductible health plan under federal law.

(H) As used in this section, "health savings account" and "high deductible health plan" have the same meaning as in section 223 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended.

Sec. 3923.81. (A) If a person is covered by a health benefit plan issued by a sickness and accident insurer, health insuring

corporation, or multiple employer welfare arrangement that includes copayment, deductible, or cost-sharing requirements and the person is required to pay for health care costs out-of-pocket or with funds from a savings account, the amount the person is required to pay to a health care provider or pharmacy shall not exceed the amount the sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement would pay under applicable reimbursement rates. This division does not preclude a person from reaching an agreement with a health care provider or pharmacy on terms that are more favorable to the person than reimbursement rates that otherwise would apply. 237 238 239 240 241 242 243 244 245 246 247

(B) Within seven days after receiving a written request from a person covered by a health benefit plan issued by the sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement, the sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement shall provide the person with information about any applicable reimbursement rates that affect the person's required out-of-pocket payments or payments from a savings account. 248 249 250 251 252 253 254 255

(C) As used in this section: 256

(1) "Health benefit plan" means any policy of sickness and accident insurance or any policy, contract, or agreement covering one or more "basic health care services," "supplemental health care services," or "specialty health care services," as defined in section 1751.01 of the Revised Code, offered or provided by a health insuring corporation or by a sickness and accident insurer or multiple employer welfare arrangement. 257 258 259 260 261 262 263

(2) "Reimbursement rates" means any rates that apply to a payment made by a sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement for charges covered by a health benefit plan. 264 265 266 267

(3) "Savings account" includes health savings accounts, 268
health reimbursement arrangements, flexible savings accounts, 269
medical savings accounts, and similar accounts and arrangements. 270

Sec. 3924.01. As used in sections 3924.01 to ~~3924.14~~ 3924.15 271
of the Revised Code: 272

(A) "Actuarial certification" means a written statement 273
prepared by a member of the American academy of actuaries, or by 274
any other person acceptable to the superintendent of insurance, 275
that states that, based upon the person's examination, a carrier 276
offering health benefit plans to small employers is in compliance 277
with sections 3924.01 to ~~3924.14~~ 3924.15 of the Revised Code. 278
"Actuarial certification" shall include a review of the 279
appropriate records of, and the actuarial assumptions and methods 280
used by, the carrier relative to establishing premium rates for 281
the health benefit plans. 282

(B) "Adjusted average market premium price" means the average 283
market premium price as determined by the board of directors of 284
the Ohio health reinsurance program either on the basis of the 285
arithmetic mean of all carriers' premium rates for an OHC plan 286
sold to groups with similar case characteristics by all carriers 287
selling OHC plans in the state, or on any other equitable basis 288
determined by the board. 289

(C) "Base premium rate" means, as to any health benefit plan 290
that is issued by a carrier and that covers at least two but no 291
more than fifty employees of a small employer, the lowest premium 292
rate for a new or existing business prescribed by the carrier for 293
the same or similar coverage under a plan or arrangement covering 294
any small employer with similar case characteristics. 295

(D) "Carrier" means any sickness and accident insurance 296
company or health insuring corporation authorized to issue health 297

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~~ <u>3924.15</u> of the Revised Code. 298 299 300 301 302 303

(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. 304 305 306 307 308 309 310 311

(F) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefits plan covering the employee. 312 313 314

(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. 315 316 317 318 319

(H) "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; 320 321 322 323 324 325 326 327 328

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. 329 330 331 332 333 334

(I) "Late enrollee" means an eligible employee or dependent who enrolls in a small employer's health benefit plan other than during the first period in which the employee or dependent is eligible to enroll under the plan or during a special enrollment period described in section 2701(f) of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg, as amended. 335 336 337 338 339 340 341

(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. 342 343 344 345 346

(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. 347 348 349 350 351

(L) "Pre-existing conditions provision" means a policy provision that excludes or limits coverage for charges or expenses incurred during a specified period following the insured's enrollment date as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the enrollment date. Genetic information shall not be treated as such a condition in the absence of a diagnosis of the condition related to such 352 353 354 355 356 357 358 359

information.

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

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

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

(2) For purposes of division (N)(1) of this section, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be considered one employer. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected the employer will employ on business days in the current calendar year. Any reference in division (N) of this section to an "employer" includes any predecessor of the employer. Except as otherwise specifically provided, provisions of sections 3924.01 to ~~3924.14~~ 3924.15 of the Revised Code that apply to a small employer that has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this division.

(O) "OHC plan" means an Ohio health care plan, which is the basic, standard, or carrier reimbursement plan for small employers and individuals established 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~~ 3924.15 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) 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, except flexible health benefit plans offered in accordance with section 3924.15 of the Revised Code.

(D) Except as expressly provided in sections 3924.01 to ~~3924.14~~ 3924.15 of the Revised Code, no health benefit plan offered to a small employer is subject to any of the following:

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

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

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

Sec. 3924.06. Compliance with the underwriting and rating requirements contained in sections 3924.01 to ~~3924.14~~ 3924.15 of the Revised Code shall be demonstrated through actuarial certification. Carriers offering health benefit plans to small employers shall file annually with the superintendent of insurance an actuarial certification stating that the underwriting and rating methods of the carrier do all of the following:

(A) Comply with accepted actuarial practices;

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

(C) Comply with the applicable provisions of sections 3924.01 to ~~3924.14~~ 3924.15 of the Revised Code.

Sec. 3924.08. (A) The board of directors of the Ohio 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: 451 452 453 454 455 456

(1) The chairperson of the senate committee having jurisdiction over insurance shall appoint the following members: 457 458

(a) Two member carriers that are small employer carriers; 459

(b) One member carrier that is a health insuring corporation predominantly in the small employer market; 460 461

(c) One representative of providers of health care. 462

(2) The chairperson of the committee in the house of representatives having jurisdiction over insurance shall appoint the following members: 463 464 465

(a) One member carrier that is a small employer carrier; 466

(b) One member carrier whose principal health insurance business is in the large employer market; 467 468

(c) One representative of an employer with fifty or fewer employees; 469 470

(d) One representative of consumers in this state. 471

(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. 472 473 474

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 475 476 477 478 479

distribution described in division (A) of this section. 480

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. 481 482 483 484 485

(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. 486 487 488 489 490 491 492

(C) The plan of operation shall establish rules, conditions, and procedures for all of the following: 493 494

(1) The handling and accounting of assets and moneys of the program and for an annual fiscal reporting to the superintendent; 495 496

(2) Filling vacancies on the board; 497

(3) Selecting an administrator of the program, and setting forth the powers and duties of the administrator. The administrator may be a carrier as defined in section 3924.01 of the Revised Code or a person licensed as an administrator under Chapter 3959. of the Revised Code, or the board may, in its sole discretion, choose to serve as administrator of the program. 498 499 500 501 502 503

(4) Reinsuring risks in accordance with sections 3924.07 to ~~3924.14~~ 3924.15 of the Revised Code; 504 505

(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; 506 507 508 509

(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 OHC plans for individuals, for groups of two to twenty-five employees, 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 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~~ 3924.15 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; 539 540 541

(C) Take such legal action as is necessary to avoid the payment of improper claims against the program; 542 543

(D) Design the OHC plans which, when offered by a carrier, are eligible for reinsurance and issue reinsurance policies in accordance with the requirements of sections 3924.07 to ~~3924.14~~ <u>3924.15</u> of the Revised Code; 544 545 546 547

(E) Establish rules, conditions, and procedures pertaining to the reinsurance of members' risks by the program; 548 549

(F) Establish appropriate rates, rate schedules, rate adjustments, rate classifications, and any other actuarial functions appropriate to the operation of the program; 550 551 552

(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. 553 554 555 556 557 558

(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; 559 560 561 562 563

(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. 564 565 566 567

(J) Reinsure risks, collect assessments, and otherwise carry 568

out its duties under division (G) of section 3924.11 of the Revised Code; 569 570

(K) Study the operation of the Ohio 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; 571 572 573 574 575

(L) Design a basic and standard plan for purposes of sections 1751.16, 3923.122, and 3923.581 of the Revised Code. 576 577

Sec. 3924.10. (A) The board of directors of the Ohio health reinsurance program shall design the OHC basic, standard, and carrier reimbursement plans which, when offered by a carrier, are eligible for reinsurance under the program. The board shall establish the form and level of coverage to be made available by carriers in their OHC plans. In designing the plans the board shall also establish benefit levels, deductibles, coinsurance factors, exclusions, and limitations for the plans. The forms and levels of coverage established by the board shall specify which components of health benefit plans offered by a carrier may be reinsured. The OHC plans are subject to division (C) of section 3924.02 of the Revised Code and to the provisions in Chapters 1751., 1753., 3923., and any other chapter of the Revised Code that require coverage or the offer of coverage of a health care service or benefit, except that the board may design plans that are flexible health benefit plans consistent with section 3924.15 of the Revised Code. 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594

(B) The board shall adopt the OHC plans within one hundred eighty days after ~~the effective date of this amendment~~ March 22, 1999. The plans may include cost containment features including any of the following: 595 596 597 598

(1) Utilization review of health care services, including review of the medical necessity of hospital and physician services; 599 600 601

(2) Case management benefit alternatives; 602

(3) Selective contracting with hospitals, physicians, and other health care providers; 603 604

(4) Reasonable benefit differentials applicable to participating and nonparticipating providers; 605 606

(5) Employee assistance program options that provide preventive and early intervention mental health and substance abuse services; 607 608 609

(6) Other provisions for the cost-effective management of the plans. 610 611

(C) OHC plans established for use by health insuring corporations shall be consistent with the basic method of operation of such corporations. 612 613 614

(D) Each carrier shall certify to the superintendent of insurance, in the form and manner prescribed by the superintendent, that the OHC plans filed by the carrier are in substantial compliance with the provisions of the board OHC plans. Upon receipt by the superintendent of the certification, the carrier may use the certified plans. 615 616 617 618 619 620

(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 OHC plans. 621 622 623 624

Sec. 3924.11. Any member of the Ohio health reinsurance program may reinsure small employer groups or individuals in accordance with the following conditions and limitations: 625 626 627

(A) A small employer group or individual may be reinsured within sixty days after the commencement of the group's or individual's coverage under the plan. 628 629 630

(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. 631 632 633 634

(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. 635 636 637 638 639

(C) With respect to an OHC plan, the program shall reinsure the level of coverage provided. 640 641

(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 OHC carrier reimbursement 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. 642 643 644 645 646 647 648

(E) A carrier may not reinsure existing business, except pursuant to division (A) of this section. 649 650

(F) If an employer group is covered under a plan other than an OHC carrier reimbursement 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 OHC carrier reimbursement 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 OHC 651 652 653 654 655 656 657 658

carrier reimbursement plan. 659

(G) With respect to coverage provided to 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: 660 661 662 663

(1) Within sixty days after the commencement of the initial coverage, any carrier may reinsure coverage of such an individual with the open enrollment reinsurance program in accordance with division (G) of this section. Premium rates charged for coverage reinsured by the program shall be established in accordance with section 3924.12 of the Revised Code. 664 665 666 667 668 669

(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 Ohio health care plans issued pursuant to sections 3924.07 to ~~3924.14~~ <u>3924.15</u> 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. 670 671 672 673 674 675 676 677 678 679 680 681

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 individual health benefit plans, earned in this state from all health benefit plans covering individuals that are issued by all such carriers during the calendar year coinciding with or 682 683 684 685 686 687 688 689

ending during the fiscal year of the open enrollment program, or on any other equitable basis reflecting coverage of 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 individuals as reported on its most recent annual statement filed with the superintendent of insurance. 690 691 692 693 694 695 696 697

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. 698 699 700 701 702 703

(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. 704 705 706 707 708 709 710 711 712 713 714 715 716

(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 717 718 719 720 721

approve an application, the superintendent shall consider whether the carrier meets all of the following standards: 722 723

(i) Demonstration by the carrier of a substantial and established market presence; 724 725

(ii) Demonstrated experience in the individual market and history of rating and underwriting individual plans; 726 727

(iii) Commitment to comply with the requirements of section 3923.58 of the Revised Code; 728 729

(iv) Financial ability to assume and manage the risk of enrolling open enrollment individuals without the need for, or protection of, reinsurance. 730 731 732

(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. 733 734 735 736 737 738 739 740

(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. 741 742 743 744 745 746 747 748

(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 749 750 751

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)(a) The open enrollment reinsurance program shall be operated separately from the Ohio 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 health reinsurance program under section 3924.07 of the Revised Code.

Sec. 3924.14. Neither the participation as members of the Ohio 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~~ 3924.15 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. 3924.15. (A) As used in this section:

(1) "Mandated health benefits" means any coverage, or offering of coverage, required under the Revised Code or rules adopted thereunder for the expenses of specified services, treatments, screenings, conditions, diseases, medications and drugs under a health benefit plan, and includes any required coverage or offering of coverage for the reimbursement of the services of a specific category of health care provider.

(2) "Flexible health benefit plan" means a health benefit plan that does not provide one or more mandated health benefits.

(B) Any carrier offering a health benefit plan subject to sections 3924.01 to 3924.15 of the Revised Code may offer a flexible health benefit plan as an option, provided that the carrier also offers a health benefit plan that includes all mandated health benefits. 782 783 784 785 786

(C) In connection with the sale of a flexible health benefit plan to a small employer, a carrier shall comply with all of the following: 787 788 789

(1) The carrier shall provide a policyholder who is a small employer with a written notice that lists each mandated health benefit that is not included in the flexible health benefit plan. The employer shall provide the notice to each employee participating in the flexible health benefit plan. 790 791 792 793 794

(2) The carrier shall provide a policyholder with a written notice that contains the following language in bold, twelve-point type: 795 796 797

"NOTICE: THIS FLEXIBLE HEALTH BENEFIT PLAN DOES NOT PROVIDE ONE OR MORE MANDATED HEALTH BENEFITS THAT NORMALLY MUST BE INCLUDED IN A HEALTH BENEFIT PLAN UNDER OHIO LAW. THIS FLEXIBLE HEALTH BENEFIT PLAN MAY PROVIDE MORE AFFORDABLE HEALTH INSURANCE COVERAGE TO YOU, BUT AT THE SAME TIME, IT MAY PROVIDE YOU WITH FEWER BENEFITS THAN NORMALLY ARE INCLUDED IN A HEALTH BENEFIT PLAN." 798 799 800 801 802 803 804

(3) The carrier shall provide a policyholder with a statement that the policyholder shall sign and return to the carrier, acknowledging that the flexible health benefit plan being purchased does not provide coverage for the mandated health benefits listed on the form. The carrier shall maintain the statement and make it available to the superintendent of insurance upon request. 805 806 807 808 809 810 811

(D) This section does not affect the application of any of 812

the following state and federal laws, and rules and regulations adopted thereunder: 813 814

(1) Any section of the Revised Code that requires a carrier to cover or offer coverage to any specific category of individuals or group, including, but not limited to, any section requiring open enrollment, guaranteed issuance of coverage, continuation of coverage, right to renewal, or an option for conversion with respect to an individual or group; 815 816 817 818 819 820

(2) Any federal law or provision of the Revised Code enacted to comply with a federal law, including, but not limited to, the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C.A. 300gg, as amended; 821 822 823 824

(3) Sections 3901.38 and 3901.381 to 3901.3814 of the Revised Code; 825 826

(4) Sections 3902.11 to 3902.14 of the Revised Code; 827

(5) Sections 1751.77 to 1751.88 and 3923.66 to 3923.70 of the Revised Code; 828 829

(6) Section 1753.21 of the Revised Code. 830

(E) The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section. 831 832 833

Sec. 3924.73. (A) As used in this section: 834

(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. 835 836 837 838 839 840

(2) "Small employer" has the same meaning as in section 841

3924.01 of the Revised Code. 842

(B)(1) Subject to division (B)(2) of this section, nothing in sections 3924.61 to 3924.74 of the Revised Code shall be construed to limit the rights, privileges, or protections of employees or small employers under sections 3924.01 to ~~3924.14~~ 3924.15 of the Revised Code. 843 844 845 846 847

(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. 848 849 850 851 852 853 854 855 856 857 858

Section 2. That existing sections 1731.03, 1751.12, 3924.01, 3924.02, 3924.06, 3924.08, 3924.09, 3924.10, 3924.11, 3924.14, and 3924.73 of the Revised Code are hereby repealed. 859 860 861