As Reported by the House Insurance Committee

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Senators Hottinger, Harris
Representatives Daniels, Barrett, Blessing, Evans, D., Faber, Gibbs, Martin, Patton, T., Raussen, White, J.

A B I L L

To amend sections 1731.01, 1731.03, 1731.04, 1731.09, 1751.04, 1751.12, 1751.34, 3924.04, and 3924.06 and to enact sections 3905.56, 3923.81, and 3961.01 to 3961.09 of the Revised Code to regulate discount medical plan organizations concerning provider agreements and marketing, disclosure, cancellation, and refund requirements; to make changes to the Small Employer Health Care Alliances Law and the Small Employer Health Benefit Plans Law; to exempt health insuring corporations covering only medicaid recipients from examination by the director of health; to allow health insuring corporations to offer insurance products with a high annual deductible; to require insurance consultants to disclose compensation in certain circumstances; and to limit the amount of copayments and deductibles paid by persons insured by health benefit plans.

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

Section 1. That sections 1731.01, 1731.03, 1731.04, 1731.09,

1751.04, 1751.12, 1751.34, 3924.04, and 3924.06 be amended and sections 3905.56, 3923.81, 3961.01, 3961.02, 3961.03, 3961.04, 3961.05, 3961.06, 3961.07, 3961.08, and 3961.09 of the Revised Code be enacted to read as follows:

Sec. 1731.01. As used in this chapter:

(A) "Alliance" or "small employer health care alliance" means an existing or newly created organization that has been granted a certificate of authority by the superintendent of insurance under section 1731.021 of the Revised Code and that is either of the following:

(1) A chamber of commerce, trade association, professional organization, or any other organization that has all of the following characteristics:

(a) Is a nonprofit corporation or association;

(b) Has members that include or are exclusively small employers;

(c) Sponsors or is part of a program to assist such small employer members to obtain coverage for their employees under one or more health benefit plans;

(d) Except as provided in division (A)(1)(e) of this section, is not directly or indirectly controlled, through voting membership, representation on its governing board, or otherwise, by any insurance company, person, firm, or corporation that sells insurance, any provider, or by persons who are officers, trustees, or directors of such enterprises, or by any combination of such enterprises or persons.

(e) Division (A)(1)(d) of this section does not apply to an organization that is comprised of members who are either insurance agents or providers, that is controlled by the organization's members or by the organization itself, and that elects to offer

health insurance exclusively to any or all of the following:

(i) Employees and retirees of the organization;

(ii) Insurance agents and providers that are members of the organization;

(iii) Employees and retirees of the agents or providers specified in division (A)(1)(e)(ii) of this section;

(iv) Families and dependents of the employees, providers, agents, and retirees specified in divisions (A)(1)(e)(i), (A)(1)(e)(ii), and (A)(1)(e)(iii) of this section.

(2) A nonprofit corporation controlled by one or more organizations described in division (A)(1) of this section.

(B) "Alliance program" or "alliance health care program" means a program sponsored by a small employer health care alliance that assists small employer members of such small employer health care alliance or any other small employer health care alliance to obtain coverage for their employees under one or more health benefit plans, and that includes at least one agreement between a small employer health care alliance and an insurer that contains the insurer's agreement to offer and sell one or more health benefit plans to such small employers and contains all of the other features required under section 1731.04 of the Revised Code.

(C) "Eligible employees, retirees, their dependents, and members of their families," as used together or separately, means the active employees of a small employer, or retired former employees of a small employer or predecessor firm or organization, their dependents or members of their families, who are eligible for coverage under the terms of the applicable alliance program.

(D) "Enrolled small employer" or "enrolled employer" means a small employer that has obtained coverage for its eligible employees from an insurer under an alliance program.

(E) "Health benefit plan" means any hospital or medical expense policy of insurance or a health care plan provided by an insurer, including a health insuring corporation plan, provided by or through an insurer, or any combination thereof. "Health benefit plan" does not include any of the following:

(1) A policy covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, or vision care, except where any of the foregoing is offered as an addition, indorsement, or rider to a health benefit plan;

(2) 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;

(3) Coverage issued by a health insuring corporation authorized to offer supplemental health care services only.

(F) "Insurer" means an insurance company authorized to do the business of sickness and accident insurance in this state or, for the purposes of this chapter, a health insuring corporation authorized to issue health care plans in this state.

(G) "Participants" or "beneficiaries" means those eligible employees, retirees, their dependents, and members of their families who are covered by health benefit plans provided by an insurer to enrolled small employers under an alliance program.

(H) "Provider" means a hospital, urgent care facility, nursing home, physician, podiatrist, dentist, pharmacist, chiropractor, certified registered nurse anesthetist, dietitian, or other health care provider licensed by this state, or group of such health care providers.

(I) "Qualified alliance program" means an alliance program under which health care benefits are provided to ~~two~~ one thousand ~~five hundred~~ or more participants.

(J) "Small employer," regardless of its definition in any other chapter of the Revised Code, in this chapter means an employer that employs no more than ~~one~~ five hundred ~~fifty~~ full-time employees, at least a majority of whom are employed at locations within this state.

(1) For this purpose:

(a) Each entity that is controlled by, controls, or is under common control with, one or more other entities shall, together with such other entities, be considered to be a single employer.

(b) "Full-time employee" means a person who normally works at least twenty-five hours per week and at least forty weeks per year for the employer.

(c) An employer will be treated as having ~~one~~ five hundred ~~fifty~~ or fewer full-time employees on any day if, during the prior calendar year or any twelve consecutive months during the twenty-four full months immediately preceding that day, the mean number of full-time employees employed by the employer does not exceed ~~one~~ five hundred ~~fifty~~.

(2) An employer that qualifies as a small employer for purposes of becoming an enrolled small employer continues to be treated as a small employer for purposes of this chapter until such time as it fails to meet the conditions described in division (J)(1) of this section for any period of thirty-six consecutive months after first becoming an enrolled small employer, unless earlier disqualified under the terms of the alliance program.

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

(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 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;

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

(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;

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

(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;

(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;

(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.

(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.

(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.

(D)(1) No alliance shall adopt, impose, or enforce medical underwriting rules <u>or underwriting rules requiring a small employer to have more than a minimum number of employees</u> 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.

(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 <u>or because the small employer does not have more than a minimum number of employees</u>.

(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.

(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 status of employees or their dependents or the size of the small employer 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.

(E) ~~Health~~ Except as otherwise specified in section 1731.09 of the Revised Code, 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 of the Revised Code.

(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.

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

(1) A provision requiring the insurer to offer and sell to small employers served or to be served by an alliance one or more health benefit plan options for coverage of their eligible employees and the eligible dependents and members of the families of the eligible employees and, if applicable, such members'

eligible retirees and the eligible dependents and members of the families of the retirees, subject to such conditions and restrictions as may be set forth or incorporated into the agreement;

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

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

(4) A description of any pre-existing condition and waiting period rules;

(5) A statement of the premium rates or other charges that apply to each health benefit plan option or a formula or method of determining the rates or charges;

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

(7) A provision requiring that each health benefit plan under the alliance program must provide for the continuation of coverage of participants of an enrolled small employer so long as the small employer determines that such person is a qualified beneficiary entitled to such coverage pursuant to Part 6 of Title I of the "Federal Employee Retirement Income Security Act of 1974," 88

Stat. 832, 29 U.S.C.A. 1001, and the laws of this state, and regulations or rulings interpreting such provisions. Such coverage provided by the insurer under the plan to participants shall comply with the "Federal Employee Retirement Income Security Act of 1974" and the relevant statutes, regulations, and rulings interpreting that act, including provisions regarding types of coverage to be provided, apportionments of limitations on coverage, apportionments of deductibles, and the rights of qualified beneficiaries to elect coverage options relating to types of coverage and otherwise.

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

(1) The application and enrollment process for a small employer and related provisions pertaining to historical experience, health statements, and underwriting standards;

(2) The minimum number of those employees eligible to be participants that are required to participate in order to permit a small employer to obtain coverage under a health benefit plan option offered under the alliance program, which may vary with the number of employees or those eligible to be participants in respect of the small employer;

(3) A procedure for allowing an enrolled small employer to change from one plan option to another under the alliance program, subject to qualifying by size or otherwise under the alliance program;

(4) The application of any risk-related pooling or grouping programs and related premiums, conditions, reviews, and alternatives offered by the insurer;

(5) The availability of a medicare supplement coverage option

for eligible participants who are covered by Parts A and B of medicare, Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301;

(6) Relevant experience periods, enrollment periods, and contract periods;

(7) Effective dates for coverage of eligible participants;

(8) Conditions under which denial or withdrawal of coverage of participants or small employers and their employees may occur by reason of falsification or misrepresentation of material facts or criminal conduct toward the insurer, small employer, or alliance under the program;

(9) Premium rate structures, which may be uniform or make provision for age-specific rates, differentials based on number of participants of an enrolled small employer, products and plan options selected, and other factors, rate adjustments based on consumer price indices, utilization, or other relevant factors, notification of rate adjustments, and arbitration;

(10) Any responsibilities of the alliance for billing, collection, and transmittal of premiums;

(11) Inclusion under the alliance program of small employers that are members of other organizations described in division (A)(1) of section 1731.01 of the Revised Code that contract with the alliance for this purpose, and conditions pertaining to those small employer members and to their employees and retirees, and dependents and family members of those employees or retirees, as applicable under the alliance program;

(12) The agreement of the insurer to offer and sell one or more health benefit plans to small employer members of another small employer health care alliance that contracts with the alliance for this purpose;

(13) Use of the health benefit plan options of the insurer in the alliance program and use of the names of the alliance and the insurer;

(14) Indemnification from claims and liability by reason of acts or omissions of others;

(15) ~~Onwership~~ Ownership, use, availability, and maintenance of confidentiality of data and records relating to the alliance program;

(16) Utilization reports to be provided to the alliance by the insurer;

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

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

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

Code.

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

(1) The premium rate limitations set forth in section 3924.04 of the Revised Code apply to each class of business separate and apart from the insurer's other business;

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

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

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

(a) Comply with accepted actuarial practices;

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

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

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

(6) An insurer shall file with the superintendent a

notification identifying any alliance or alliances to be treated as a separate class of business at least sixty days prior to the date the rates for that class of business take effect.

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

(C) As used in this section:

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

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

Sec. 1751.04. (A) Except as provided by division (F) of this section, upon the receipt by the superintendent of insurance of a complete application for a certificate of authority to establish or operate a health insuring corporation, which application sets forth or is accompanied by the information and documents required by division (A) of section 1751.03 of the Revised Code, the superintendent shall transmit copies of the application and accompanying documents to the director of health.

(B) The director shall review the application and accompanying documents and make findings as to whether the applicant for a certificate of authority has done all of the following with respect to any basic health care services and supplemental health care services to be furnished:

(1) Demonstrated the willingness and potential ability to ensure that all basic health care services and supplemental health care services described in the evidence of coverage will be

provided to all its enrollees as promptly as is appropriate and in a manner that assures continuity;

(2) Made effective arrangements to ensure that its enrollees have reliable access to qualified providers in those specialties that are generally available in the geographic area or areas to be served by the applicant and that are necessary to provide all basic health care services and supplemental health care services described in the evidence of coverage;

(3) Made appropriate arrangements for the availability of short-term health care services in emergencies within the geographic area or areas to be served by the applicant, twenty-four hours per day, seven days per week, and for the provision of adequate coverage whenever an out-of-area emergency arises;

(4) Made appropriate arrangements for an ongoing evaluation and assurance of the quality of health care services provided to enrollees, including, if applicable, the development of a quality assurance program complying with the requirements of sections 1751.73 to 1751.75 of the Revised Code, and the adequacy of the personnel, facilities, and equipment by or through which the services are rendered;

(5) Developed a procedure to gather and report statistics relating to the cost and effectiveness of its operations, the pattern of utilization of its services, and the quality, availability, and accessibility of its services.

(C) Within ninety days of the director's receipt of the application for issuance of a certificate of authority, the director shall certify to the superintendent whether or not the applicant meets the requirements of division (B) of this section and sections 3702.51 to 3702.62 of the Revised Code. If the director certifies that the applicant does not meet these

requirements, the director shall specify in what respects it is deficient. However, the director shall not certify that the requirements of this section are not met unless the applicant has been given an opportunity for a hearing.

(D) If the applicant requests a hearing, the director shall hold a hearing before certifying that the applicant does not meet the requirements of this section. The hearing shall be held in accordance with Chapter 119. of the Revised Code.

(E) The ninety-day review period provided for under division (C) of this section shall cease to run as of the date on which the notice of the applicant's right to request a hearing is mailed and shall remain suspended until the director issues a final certification order.

(F) Nothing in this section requires the director to review or make findings with regard to an application and accompanying documents to establish or operate a health insuring corporation to cover solely recipients of assistance under the medicaid program operated pursuant to Chapter 5111. of the Revised Code, a health insuring corporation to cover solely recipients of assistance under the federal medicare program under Title XVIII of the "Social Security Act," 49 Stat. 62 (1935), 42 U.S.C. 301, as amended, or a health insuring corporation to cover solely recipients of assistance under both the medicaid and medicare programs.

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

(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.

(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:

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

(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.

(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.

(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:

(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.

(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.

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

(4) For purposes of division (D) of this section, both of the following apply:

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

(b) Divisions (D)(2) and (3) of this section do not apply to a high deductible health plan that is linked to a health savings account.

(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, except that:

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

(2) The superintendent may adopt rules allowing different annual deductible amounts for plans with a medical savings account, health reimbursement arrangement, flexible spending account, or similar account;

(3) A health insuring corporation may impose higher deductibles under health plans if requested by the group contract, policy, certificate, or agreement holder, or an individual seeking coverage under an individual health plan. This shall not be construed as requiring the health insuring corporation to create customized health plans for group contract holders or individuals.

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

Sec. 1751.34. (A) Each health insuring corporation and each applicant for a certificate of authority under this chapter shall be subject to examination by the superintendent of insurance in accordance with section 3901.07 of the Revised Code. Section 3901.07 of the Revised Code shall govern every aspect of the examination, including the circumstances under and frequency with which it is conducted, the authority of the superintendent and any examiner or other person appointed by the superintendent, the liability for the assessment of expenses incurred in conducting the examination, and the remittance of the assessment to the superintendent's examination fund.

(B) The director of health shall make an examination concerning the matters subject to the director's consideration in

section 1751.04 of the Revised Code as often as the director considers it necessary for the protection of the interests of the people of this state, but not less frequently than once every three years. The expenses of such examinations shall be assessed against the health insuring corporation being examined in the manner in which expenses of examinations are assessed against an insurance company under section 3901.07 of the Revised Code. Nothing in this division requires the director to make an examination of a health insuring corporation that covers solely recipients of assistance under the medicaid program operated pursuant to Chapter 5111. of the Revised Code, a health insuring corporation that covers solely recipients of assistance under the federal medicare program under Title XVIII of the "Social Security Act," 49 Stat. 62 (1935), 42 U.S.C. 301, as amended, or a health insuring corporation that covers solely recipients of assistance under both the medicaid and medicare programs.

(C) An examination, pursuant to section 3901.07 of the Revised Code, of an insurance company holding a certificate of authority under this chapter to organize and operate a health insuring corporation shall include an examination of the health insuring corporation pursuant to this section and the examination shall satisfy the requirements of divisions (A) and (B) of this section.

(D) The superintendent may conduct market conduct examinations pursuant to section 3901.011 of the Revised Code of any health insuring corporation as often as the superintendent considers it necessary for the protection of the interests of subscribers and enrollees. The expenses of such market conduct examinations shall be assessed against the health insuring corporation being examined. All costs, assessments, or fines collected under this division shall be paid into the state treasury to the credit of the department of insurance operating

fund.

Sec. 3905.56. (A)(1) Where an insurance agent or an affiliate of an insurance agent receives any compensation from a public entity related to the placement of insurance, or is entitled to receive such compensation from a public entity even if the agent or affiliate waives receipt or collection of that compensation, neither that agent nor the affiliate shall accept or receive any compensation from an insurer or other third party related to that placement of insurance with the public entity unless the agent or affiliate has, prior to the placement of insurance, obtained the public entity's documented acknowledgement that such third-party compensation will be received by the agent or affiliate.

(2) This division shall not apply to any of the following:

(a) A person licensed as an insurance agent who acts only as an intermediary between an insurer and the public entity's agent, such as a managing general agent, a sales manager, or wholesale broker;

(b) A reinsurance intermediary;

(c) An insurance agent or affiliate of an insurance agent whose sole compensation related to the placement of insurance with the public entity is compensation from an insurer or other third party.

(3) Execution and receipt of a public entity's documented acknowledgment in accordance with this section shall not supersede an otherwise valid and enforceable contract between the public entity and the agent or affiliate nor shall it supersede the superintendent's authority to enforce the laws relating to insurance in the state of Ohio.

(B) When an insurance agent or affiliate is acting as a public servant, the agent's or affiliate's acceptance of

compensation from an insurer or the other third party exclusively related to the placement of insurance with the public entity shall not constitute a violation of division (A) of section 2921.43 of the Revised Code if the insurance agent or affiliate complies with this section.

(C) For purposes of this section:

(1) "Affiliate" means a person who controls, is controlled by, or is under common control with the agent.

(2) "Compensation from an insurer or other third party" means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration, whether or not payable pursuant to a written agreement.

(3) "Compensation from a public entity" shall not include either of the following:

(a) Any fee charged to, and paid by, a public entity pursuant to section 3905.55 of the Revised Code if such fee does not exceed fifty dollars; or

(b) Any portion of an insurance premium paid by a public entity to an insurance agent or any affiliate of such agent that an insurer or other third party has authorized the agent or affiliate to retain as commission after the balance of the public entity's premium payment has been remitted to the insurer or other third party.

(4) "Documented acknowledgment" means the public entity's written acknowledgment obtained prior to the placement of insurance. In the case of a purchase over the telephone or by electronic means for which written acknowledgment cannot reasonably be obtained, acknowledgment documented by the agent shall be acceptable.

(5) "Insurance product" includes a fully insured product or partially or fully self-insured product.

(6) "Placement of insurance" means the initial purchase of an insurance product or the renewal of an existing product unless the insurer independently generates and processes the renewal without the agent's participation or involvement. "Placement of insurance" does not mean the servicing or modification of an existing contract that does not involve the public entity evaluating options for the purchase or renewal of an insurance product.

(7) "Public entity" means the state and any political subdivision as defined in section 2744.01 of the Revised Code; any state institution of higher education as defined in section 3345.12 of the Revised Code; and any instrumentality or retirement system of the state, any political subdivision, or any state institution of higher education.

(8) "Public servant" shall have the same definition as in section 2921.01 of the Revised Code.

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 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 negotiated with the provider or pharmacy. 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 negotiated reimbursement rates that otherwise would apply as long as the claim submitted reflects the alternative amount negotiated, except

that a health care provider or pharmacy shall not waive all or part of a copay or deductible if prohibited by any other provision of the Revised Code. The requirements of this division do not apply to amounts owed to a provider or pharmacy with whom the sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement has no applicable negotiated reimbursement rate.

(B) Each sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement shall establish and maintain a system whereby a person covered by a health benefit plan may obtain information regarding potential out of pocket costs for services provided by in-network providers.

(C) As used in this section:

(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.

(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.

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

Sec. 3924.04. (A)(1) With respect to any health benefit plan of a carrier and except as otherwise provided in ~~division~~ divisions (A)(2) and (3) of this section, the premium rates

charged or offered for a rating period for the same or similar coverage under a health benefit plan covering any small employer with similar case characteristics shall not vary from the applicable midpoint rate by more than ~~thirty-five~~ forty per cent of the midpoint rate, as to all health benefit plans issued on or after the effective date of this section.

(2) A carrier may apply a low claims discount not to exceed five per cent of the midpoint rate to small employers with favorable claims experience. A premium rate for a rating period may fall outside the range set forth in division (A) of this section as the result of a low claims discount.

(3) If the premium rates charged or offered for the same or similar coverage under a health benefit plan covering any small employer with similar case characteristics, as determined by the carrier, exceeds the ~~applicable midpoint~~ premium rate ~~by more than thirty-five points~~ limitations described in divisions (A)(1) and (2) of this section, any increase in premium rates for a new rating period shall not exceed the sum of both of the following:

(a) Any percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period;

(b) Any adjustment due to change in case characteristics or plan design of the small employer, as determined by the carrier.

~~(3) With respect to any health benefit plan of a carrier that is delivered or issued for delivery prior to the effective date of this section, a premium rate for a rating period may exceed the ranges set forth in divisions (A)(1) and (2) of this section for the eighteen-month period immediately following the effective date of this section. The percentage increase in the premium rate charged to a small employer for a new rating period, however, shall not exceed the sum of the following:~~

~~(a) Any percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period;~~

~~(b) Any adjustment due to a change in case characteristics or plan design of the small employer, as determined by the carrier.~~

(4) For purposes of this section, a small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(B) If a carrier utilizes industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification shall not vary by more than fifteen per cent from the arithmetic average of the rate factors associated with all industry classifications.

(C) Subject to divisions (A) and (B) of this section, any increase in premium rates for a new rating period shall not exceed any percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period plus fifteen per cent, adjusted on a pro rata basis for rating periods greater or less than one year, of the base premium rate for the new rating period and any adjustments due to a change in case characteristics or plan design of the small employer, as determined by the carrier.

(D) The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code that set forth alternative methods of calculating the premium rates required under this section, which methods result in premium rates that are consistent with, and meet the applicable requirements of, this section. A carrier that utilizes any such method of calculation is deemed to be in compliance with this section.

(E) If a carrier has established a separate class of business for one or more small employer health care alliances in accordance

with section 1731.09 of the Revised Code, this section shall apply in accordance with section 1731.09 of the Revised Code.

Sec. 3924.06. (A) Compliance with the underwriting and rating requirements contained in sections 3924.01 to 3924.14 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)~~(1) Comply with accepted actuarial practices;

~~(B)~~(2) Are uniformly applied to health benefit plans covering small employers;

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

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

Sec. 3961.01. As used in sections 3961.01 to 3961.09 of the Revised Code:

(A)(1) "Discount medical plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, offers access to members to providers of medical services and the right to receive discounted medical services from those providers.

(2) "Discount medical plan" does not include any of the following:

(a) A plan that does not require a membership or charge a fee to use the plan's medical card;

(b) A plan that offers discounts for only pharmaceutical supplies or prescription drugs, or both, and no other medical services;

(c) A plan offered by a sickness and accident insurer that is regulated under Title XXXIX of the Revised Code, a health insuring corporation that is regulated under Title XVII of the Revised Code, or an affiliate of such insurer or corporation if the insurer, corporation, or affiliate discloses in writing in not less than twelve-point type on any applications, advertisements, marketing materials, and brochures describing the plan that the plan is not insurance.

(B)(1) "Discount medical plan organization" or "organization" means a person who does business in this state; offers to members access to providers of medical services and the right to receive discounted medical services from those providers; contracts with providers, provider networks, or other discount medical plan organizations to offer discounted medical services to members; and determines the fee members pay to participate in the plan.

(2) "Discount medical plan organization" does not include a sickness and accident insurer that is regulated under Title XXXIX of the Revised Code or a health insuring corporation that is regulated under Title XVII of the Revised Code.

(C) "Facility" means an institution where medical services are performed, including, but not limited to, a hospital or other licensed inpatient center; ambulatory surgical or treatment center; skilled nursing center; residential treatment center; rehabilitation center; diagnostic, laboratory, and imaging center; and any other health care setting.

(D) "Health care professional" means a physician or other health care provider who is licensed, accredited, certified, or otherwise authorized to perform specified medical services within

the scope of the person's license, accreditation, certification, or other authorization and performs medical services consistent with the laws of this state.

(E)(1) "Marketer" means a person or entity who markets, promotes, sells, or distributes a discount medical plan, including, but not limited to, a private label entity that places its name on and markets or distributes a discount medical plan pursuant to a written agreement with a discount medical plan organization described under section 3961.03 of the Revised Code.

(2) "Marketer" does not mean a sickness and accident insurer that is regulated under Title XXXIX of the Revised Code, a health insuring corporation that is regulated under Title XVII of the Revised Code, or an affiliate of such insurer or corporation if the insurer, corporation, or affiliate discloses in writing in not less than twelve-point type on any applications, advertisements, marketing materials, and brochures describing the plan that the plan is not insurance.

(F) "Medical services" means any maintenance care of the human body; preventative care for the human body; or care, service, or treatment of an illness or dysfunction of, or injury to, the human body. "Medical services" includes, but is not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, dental care services, vision care services, pharmaceutical supplies, prescription drugs, mental health services, substance abuse services, chiropractic services, podiatric services, laboratory services, and medical equipment and supplies.

(G) "Member" means any individual who pays fees, dues, charges, or other consideration to a discount medical plan organization for access to providers of medical services and the right to receive the benefits of a discount medical plan.

(H) "Person" means an individual, corporation, partnership, association, joint venture, joint stock company, trust, unincorporated organization, any similar entity, or any combination of these entities.

(I) "Provider" means any health care professional or facility that has contracted, directly or indirectly, with a discount medical plan organization to offer discounted medical services to members.

(J) "Provider agreement" means any agreement entered into between a discount medical plan organization and a provider or provider network to offer discounted medical services to members as described in section 3961.02 of the Revised Code.

(K) "Provider network" means a person that negotiates, directly or indirectly, with a discount medical plan organization on behalf of more than one provider to offer discounted medical services to members.

Sec. 3961.02. (A) A discount medical plan organization shall not offer to members, or advertise to prospective members, discounted medical services unless the services are offered pursuant to a provider agreement. A discount medical plan organization may enter into a provider agreement directly with a provider, indirectly through a provider network to which a provider belongs, or through another discount medical plan organization that contracts with providers directly or through a provider network.

(B) A provider agreement between a discount medical plan organization and a provider shall contain all of the following:

(1) A list of medical services and products offered at a discount;

(2) The discounted rates for medical services or a fee

schedule that reflects the provider's discounted rates;

(3) A statement that the provider will not charge members more than the discounted rates described in division (B)(2) of this section.

(C) A provider agreement between a discount medical plan organization and a provider network shall require the provider network to do all of the following:

(1) Maintain an up-to-date list of the provider network's contracted providers and supply that list to the discount medical plan organization on a monthly basis;

(2) Have a written agreement with each provider who offers discounted medical services that contains both of the following:

(a) The items listed in division (B) of this section;

(b) A grant of authority that allows the provider network to contract with discount medical plan organizations on behalf of the provider.

(D) A provider agreement between a discount medical plan organization and another discount medical plan organization shall require that the other discount medical plan organization have provider agreements in place that comply with division (A) of this section and division (B) or (C) of this section, as applicable.

(E) A discount medical plan organization shall keep for the duration of the agreement a copy of each provider agreement into which the organization has entered.

Sec. 3961.03. (A) Prior to a discount medical plan organization allowing a marketer to market, promote, sell, or distribute a discount medical plan, the organization shall enter into a written agreement with the marketer. This agreement shall prohibit the marketer from using or issuing any advertising,

marketing materials, brochures, or discount medical cards without the organization's written approval.

(B) A discount medical plan organization is bound by and responsible for a marketer's activities that are within the scope of the marketer's agency relationship with the organization.

(C) A discount medical plan organization shall approve in writing all advertisements, marketing materials, brochures, and discount cards prior to a marketer using these materials to market, promote, sell, or distribute the discount medical plan.

Sec. 3961.04. (A) A discount medical plan organization or marketer shall disclose all of the following information in writing in not less than twelve-point type on the first content page of any advertisements, marketing materials, or brochures made available to the public relating to a discount medical plan and with any enrollment forms:

(1) A statement that the discount medical plan is not insurance;

(2) A statement that the range of discounts for medical services offered under the discount medical plan will vary depending on the type of provider and medical services;

(3) A statement that the discount medical plan is prohibited from making members' payments to providers for medical services received under the discount medical plan;

(4) A statement that the member is obligated to pay for all discounted medical services received under the discount medical plan;

(5) The discount medical plan organization's toll-free telephone number and internet web site address that a member or prospective member may use to obtain additional information about

and assistance with the discount medical plan and up-to-date lists of providers participating in the discount medical plan.

(B) If a discount medical plan organization's or marketer's initial contact with a prospective member is by telephone, the organization or marketer shall disclose all of the information listed in division (A) of this section orally in addition to including such disclosures in the initial written materials provided to the prospective or new member.

(C) In addition to the disclosures required under division (A) of this section, a discount medical plan organization shall provide to each prospective member, at the time of enrollment, a copy of the terms and conditions of the discount medical plan, including any limitations or restrictions on the refund of any processing fees or periodic charges associated with the discount medical plan. A discount medical plan organization also shall provide each new member a written document containing the terms and conditions of the discount medical plan and including all of the following:

(1) Name of the member;

(2) Benefits provided under the discount medical plan;

(3) Any processing fees and periodic charges associated with the discount medical plan, including, but not limited to, if applicable, the procedures for changing the mode of payment and any accompanying additional charges;

(4) Any limitations, exclusions, or exceptions regarding the receipt of discount medical plan benefits;

(5) Any waiting periods for certain medical services under the discount medical plan;

(6) Procedures for obtaining discounts under the discount medical plan, such as requiring members to contact the discount

medical plan organization to request that the organization make an appointment with a provider on the member's behalf;

(7) Cancellation and refund rights described in section 3961.06 of the Revised Code;

(8) Membership renewal, termination, and cancellation terms and conditions;

(9) Procedures for adding new family members to the discount medical plan;

(10) Procedures for filing complaints under the discount medical plan organization's complaint system and a statement explaining that, if the member remains dissatisfied after completing the organization's complaint system, the member may contact the department of insurance;

(11) Name, mailing address, and toll-free telephone number of the discount medical plan organization that a member may use to make inquiries about the discount medical plan, send cancellation notices, and file complaints.

(D) A discount medical plan organization shall maintain on an internet web site page an up-to-date list of the names and addresses of the providers with which the organization has contracted directly or indirectly through a provider network. The organization's internet web site address shall be prominently displayed on all of the organization's advertisements, marketing materials, brochures, and discount medical plan cards.

(E) When a discount medical plan organization or marketer sells a discount medical plan together with any other product, the organization or marketer shall do either of the following:

(1) Provide the charges for each discount medical plan in writing to the member;

(2) Reimburse the member for all periodic charges for the

discount medical plan and all periodic charges for any other product if the member cancels his or her membership in accordance with division (B) of section 3901.06 of the Revised Code.

Sec. 3961.05. A discount medical plan organization shall not do any of the following:

(A) Except when otherwise permitted in sections 3961.01 to 3961.09 of the Revised Code, as a disclaimer of any relationship between discount medical plan benefits and insurance, or in a description of an insurance product connected with a discount medical plan, use the term "insurance" in the organization's advertisements, marketing material, brochures, or discount medical plan cards.

(B) Use in the organization's advertisements, marketing material, brochures, or discount medical plan cards the terms "health plan," "coverage," "benefits," "copay," "copayments," "deductible," "pre-existing conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or any other terms in a manner that could mislead a person into believing that the discount medical plan is health insurance.

(C) Make misleading, deceptive, or fraudulent statements or representations regarding the terms or benefits of the discount medical plan, including, but not limited to, statements or representations regarding discounts, range of discounts, or access to those discounts offered under the discount medical plan.

(D) Except for hospital services, have restrictions on access to discount medical plan providers, including, but not limited to, waiting and notification periods.

(E) Pay providers fees for medical services or collect or accept money from a member to pay a provider for medical services received under the discount medical plan.

Sec. 3961.06. (A) A discount medical plan organization shall permit members to cancel membership in a discount medical plan at any time.

(B) If a member gives notice of cancellation within thirty days after the date the member receives the written document described in division (C) of section 3961.04 of the Revised Code for the discount medical plan, the discount medical plan organization, within thirty days of the member giving notice of cancellation, shall fully refund any fees except for a nominal fee associated with enrollment costs that shall not exceed thirty dollars.

(C) A discount medical plan organization shall not charge or collect a periodic fee after the member has returned to the organization the member's discount medical plan card or given the organization notice of cancellation.

(D) Cancellation of membership in a discount medical plan occurs when the member gives notice of cancellation to the discount medical plan organization or marketer by delivering the notice by hand, depositing the notice in a mailbox if the notice is properly addressed to the discount medical plan organization or marketer and postage is prepaid, or sending an electronic message to the discount medical plan organization's or marketer's electronic message address.

(E) A discount medical plan organization shall make a pro rata reimbursement of all periodic fees charged to a member, less nominal fees associated with enrollment, if a discount medical plan organization cancels a member's membership for any reason other than the member's failure to pay fees.

Sec. 3961.07. (A) The superintendent of insurance may examine or investigate the business and affairs of a discount medical plan

organization as the superintendent deems appropriate to protect the interests of the residents of this state.

(B) When examining or investigating a discount medical plan organization pursuant to division (A) of this section, the superintendent may do both of the following:

(1) Order a discount medical plan organization to produce any records, files, advertising and solicitation materials, lists of providers with which the organization contracted, lists of members, provider agreements described in section 3961.02 of the Revised Code, agreements between a marketer and discount medical plan organization described in section 3961.03 of the Revised Code, or other information;

(2) Take statements under oath to determine whether a discount medical plan organization has violated or is violating sections 3961.01 to 3961.08 of the Revised Code or is acting contrary to the public interest.

(C)(1) All records and other information concerning a discount medical plan organization obtained by the superintendent or the superintendent's deputies, examiners, assistants, agents, or other employees pursuant to division (B) of this section are confidential and not public records as defined in section 149.43 of the Revised Code unless the organization is given notice and opportunity for hearing pursuant to Chapter 119. of the Revised Code concerning the records and other information obtained under division (B) of this section. If no administrative action is initiated with respect to a particular matter about which the superintendent obtained records or other information under division (B) of this section, the records and other information shall remain confidential for three years after the file on the matter is closed. Release of the records and other information after the three-year period shall be governed by section 149.43 of

the Revised Code.

(2) The records and other information described in division (C)(1) of this section shall remain confidential for all purposes except where the superintendent or the superintendent's deputies, examiners, assistants, agents, or other employees appropriately take official action regarding the affairs of the discount medical plan organization or marketer or in connection with actual or potential criminal proceeding.

(D) Notwithstanding division (C) of this section, the superintendent may do any of the following:

(1) Share records and other information obtained pursuant to division (B) of this section with other persons employed by or acting on behalf of the superintendent; local, state, federal, and international regulatory and law enforcement agencies; local, state, and federal prosecutors; and the national association of insurance commissioners and its affiliates and subsidiaries if the recipient agrees and has authority to agree to maintain the confidential status of the records or other information;

(2) Disclose records and other information obtained pursuant to division (B) of this section in furtherance of any regulatory or legal action brought by or on behalf of the superintendent or this state resulting from the exercise of the superintendent's official duties.

(E) Notwithstanding divisions (C) and (D) of this section, the superintendent may authorize the national association of insurance commissioners and its affiliates and subsidiaries by agreement to share confidential records and other information obtained pursuant to division (B) of this section with local, state, federal, and international regulatory and law enforcement agencies and local, state, and federal prosecutors if the recipient agrees and has authority to agree to maintain the

confidential status of the records and other information.

(F) Any applicable privilege or claim of confidentiality is not waived as a result of sharing or disclosing information pursuant to division (D)(1) or (E) of this section.

(G) Employees or agents of the department of insurance shall not be required by any court in this state to testify in a civil action if the testimony concerns any matter related to records or other information considered confidential under this section.

(H) Nothing in this section shall be construed to limit the superintendent's powers under section 3901.04 of the Revised Code.

Sec. 3961.08. (A) No person shall fail to comply with sections 3961.01 to 3961.09 of the Revised Code. If the superintendent of insurance determines that any person has violated sections 3961.01 to 3961.07 of the Revised Code, the superintendent may take one or more of the following actions:

(1) Assess a civil penalty in an amount not to exceed twenty-five thousand dollars per violation if the person knew or should have known of the violation;

(2) Assess administrative costs to cover the expenses incurred in the administrative action, including, but not limited to, expenses incurred in the investigation and hearing process. Costs collected under this division shall be paid into the state treasury to the credit of the department of insurance operating fund created in section 3901.021 of the Revised Code.

(3) Order corrective actions in lieu of or in addition to the other penalties described in this section, including, but not limited to, suspending civil penalties if a discount medical plan organization complies with the terms of the corrective action order;

(4) Order restitution to members.

(B) Before imposing a penalty under division (A) of this section, the superintendent shall give a discount medical plan organization notice and opportunity for hearing as described in Chapter 119. of the Revised Code to the extent that Chapter 119. of the Revised Code does not conflict with any of the following service requirements:

(1)(a) A notice of opportunity for hearing, a hearing officer's findings and recommendations, or any order issued by the superintendent under division (A) of this section shall be served by certified mail, return receipt requested, to the last known address of a discount medical plan organization. For purposes of division (B) of this section, an organization's last known address is the address listed on the organization's disclosures required under section 3961.04 of the Revised Code.

(b) If the certified mail envelope described in division (B)(1)(a) of this section is returned to the superintendent with an endorsement showing that service was refused or that the envelope was unclaimed, the notices, findings and recommendations, and orders described in division (B)(1)(a) of this section and all subsequent notices required under Chapter 119. of the Revised Code may be served by ordinary mail to the discount medical plan organization's last known address. The time period to request an administrative hearing described in Chapter 119. of the Revised Code shall begin to run from the date the ordinary mailing was sent. A certificate of mailing shall evidence any mailings sent by ordinary mail pursuant to this division and shall complete service to the organization unless the ordinary mail envelope is returned to the superintendent with an endorsement showing failure of delivery.

(c) If service by ordinary mail as described in division (B)(1)(b) of this section fails, the superintendent may publish a summary of the substantive provisions of the notice, findings and

recommendations, or orders described in division (B)(1)(a) of this section once a week for three consecutive weeks in a newspaper of general circulation in the county of the discount medical plan organization's last known address. The notice shall be considered served on the date of the third publication.

(d) Any notice required to be served under Chapter 119. of the Revised Code also shall be served upon the party's attorney by ordinary mail if the party's attorney has entered an appearance in the matter.

(e) In lieu of certified or ordinary mail or publication notice as described in divisions (B)(1)(a), (b), and (c) of this section, the superintendent may perfect service on a party by personal delivery of the notice by the superintendent's designee.

(f) Notices regarding the scheduling of hearings and all other notices not described in division (B)(1)(a) of this section shall be sent by ordinary mail to the party and the party's attorney.

(2) A subpoena or subpoena duces tecum from the superintendent or the superintendent's designee or attorney to a witness for appearance at a hearing, for the production of documents or other evidence, or for taking testimony for use at a hearing shall be served by certified mail, return receipt requested. The subpoenas described in this division shall be enforced in the manner described in section 119.09 of the Revised Code. Nothing in this division shall be construed to limit the superintendent's other statutory powers to issue subpoenas.

(C)(1) If a violation of sections 3961.01 to 3961.07 of the Revised Code has caused, is causing, or is about to cause substantial and material harm, the superintendent may issue a cease-and-desist order requiring a person to cease and desist from engaging in a violation.

(2) The superintendent shall, immediately after issuing an order pursuant to division (C)(1) of this section, serve notice of the order by certified mail, return receipt requested, or by any other manner described in division (B) of this section to the person subject to the order and all other persons involved in the violation. The notice shall specify the particular act, omission, practice, or transaction that is the subject of the order and set a date, not more than fifteen days after the date the order was issued, for a hearing on the continuation or revocation of the order. The person subject to the order shall comply with the order immediately upon receiving the order. After an order is issued pursuant to division (C)(1) of this section, the superintendent may publicize and notify all interested parties that a cease-and-desist order was issued.

(3) Upon application by the person subject to the order and for good cause, the superintendent may continue the hearing date described in division (C)(2) of this section. Chapter 119. of the Revised Code applies to the hearing on the order to the extent that the chapter does not conflict with the procedures described in this section. The superintendent shall, within fifteen days after objections are submitted concerning the hearing officer's report and recommendations, issue a final order either confirming or revoking the cease-and-desist order described in division (C)(1) of this section. The final order may be appealed as described in section 119.12 of the Revised Code.

(4) The remedy described in division (C) of this section is cumulative and concurrent with other remedies available under this section.

(D) If the superintendent has reasonable cause to believe that an order issued pursuant to this section has been violated in whole or in part, the superintendent may request the attorney general to commence any appropriate action against the violator.

In an action described in this division, a court may impose any of the following penalties:

(1) A civil penalty of not more than twenty-five thousand dollars per violation;

(2) Injunctive relief;

(3) Restitution;

(4) Any other appropriate relief.

(E) The superintendent shall deposit any penalties assessed under division (A)(1) or (D) of this section into the state treasury to the credit of the department of insurance operating fund created in section 3901.021 of the Revised Code.

Sec. 3961.09. The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code for purposes of implementing sections 3961.01 to 3961.08 of the Revised Code.

Section 2. That existing sections 1731.01, 1731.03, 1731.04, 1731.09, 1751.04, 1751.12, 1751.34, 3924.04, and 3924.06 of the Revised Code are hereby repealed.

Section 3. Section 3923.81 of the Revised Code, as enacted by this act, takes effect on the effective date of this act; however, the amendment of division (B) of that section does not apply to any facts occurring before six months after the effective date of this act.