As Introduced

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Senator Coughlin

Cosponsors: Senators Boccieri, Gardner, Spada, Cafaro, Clancy, Padgett, Schuring, Mumper, Miller, D., Morano, Schaffer

A B I L L

To amend sections 1751.13 and 1753.09, to enact sections 3963.01 to 3963.09, and to repeal sections 1753.03, 1753.04, 1753.05, and 1753.08 of the Revised Code to establish certain uniform contract provisions between health care providers and third-party payers, to establish standardized credentialing, and to require third-party payers to provide to health care providers specified information concerning enrollees.

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

Section 1. That sections 1751.13 and 1753.09 be amended and sections 3963.01, 3963.02, 3963.03, 3963.04, 3963.05, 3963.06, 3963.07, 3963.08, and 3963.09 of the Revised Code be enacted to read as follows:

Sec. 1751.13. (A)(1)(a) A health insuring corporation shall, either directly or indirectly, enter into contracts for the provision of health care services with a sufficient number and types of providers and health care facilities to ensure that all covered health care services will be accessible to enrollees from

a contracted provider or health care facility.

(b) A health insuring corporation shall not refuse to contract with a physician for the provision of health care services or refuse to recognize a physician as a specialist on the basis that the physician attended an educational program or a residency program approved or certified by the American osteopathic association. A health insuring corporation shall not refuse to contract with a health care facility for the provision of health care services on the basis that the health care facility is certified or accredited by the American osteopathic association or that the health care facility is an osteopathic hospital as defined in section 3702.51 of the Revised Code.

(c) Nothing in division (A)(1)(b) of this section shall be construed to require a health insuring corporation to make a benefit payment under a closed panel plan to a physician or health care facility with which the health insuring corporation does not have a contract, provided that none of the bases set forth in that division are used as a reason for failing to make a benefit payment.

(2) When a health insuring corporation is unable to provide a covered health care service from a contracted provider or health care facility, the health insuring corporation must provide that health care service from a noncontracted provider or health care facility consistent with the terms of the enrollee's policy, contract, certificate, or agreement. The health insuring corporation shall either ensure that the health care service be provided at no greater cost to the enrollee than if the enrollee had obtained the health care service from a contracted provider or health care facility, or make other arrangements acceptable to the superintendent of insurance.

(3) Nothing in this section shall prohibit a health insuring corporation from entering into contracts with out-of-state

providers or health care facilities that are licensed, certified, accredited, or otherwise authorized in that state.

(B)(1) A health insuring corporation shall, either directly or indirectly, enter into contracts with all providers and health care facilities through which health care services are provided to its enrollees.

(2) A health insuring corporation, upon written request, shall assist its contracted providers in finding stop-loss or reinsurance carriers.

(C) A health insuring corporation shall file an annual certificate with the superintendent certifying that all provider contracts and contracts with health care facilities through which health care services are being provided contain the following:

(1) A description of the method by which the provider or health care facility will be notified of the specific health care services for which the provider or health care facility will be responsible, including any limitations or conditions on such services;

(2) The specific hold harmless provision specifying protection of enrollees set forth as follows:

"[Provider/Health Care Facility] agrees that in no event, including but not limited to nonpayment by the health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall [Provider/Health Care Facility] bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, person to whom health care services have been provided, or person acting on behalf of the covered enrollee, for health care services provided pursuant to this agreement. This does not prohibit [Provider/Health Care Facility] from collecting co-insurance, deductibles, or copayments as specifically provided

in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor."

(3) Provisions requiring the provider or health care facility to continue to provide covered health care services to enrollees in the event of the health insuring corporation's insolvency or discontinuance of operations. The provisions shall require the provider or health care facility to continue to provide covered health care services to enrollees as needed to complete any medically necessary procedures commenced but unfinished at the time of the health insuring corporation's insolvency or discontinuance of operations. The completion of a medically necessary procedure shall include the rendering of all covered health care services that constitute medically necessary follow-up care for that procedure. If an enrollee is receiving necessary inpatient care at a hospital, the provisions may limit the required provision of covered health care services relating to that inpatient care in accordance with division (D)(3) of section 1751.11 of the Revised Code, and may also limit such required provision of covered health care services to the period ending thirty days after the health insuring corporation's insolvency or discontinuance of operations.

The provisions required by division (C)(3) of this section shall not require any provider or health care facility to continue to provide any covered health care service after the occurrence of any of the following:

(a) The end of the thirty-day period following the entry of a liquidation order under Chapter 3903. of the Revised Code;

(b) The end of the enrollee's period of coverage for a contractual prepayment or premium;

(c) The enrollee obtains equivalent coverage with another health insuring corporation or insurer, or the enrollee's employer obtains such coverage for the enrollee;

(d) The enrollee or the enrollee's employer terminates coverage under the contract;

(e) A liquidator effects a transfer of the health insuring corporation's obligations under the contract under division (A)(8) of section 3903.21 of the Revised Code.

(4) A provision clearly stating the rights and responsibilities of the health insuring corporation, and of the contracted providers and health care facilities, with respect to administrative policies and programs, including, but not limited to, payments systems, utilization review, quality assurance, assessment, and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs;

(5) A provision regarding the availability and confidentiality of those health records maintained by providers and health care facilities to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of health care services provided to enrollees. The provision shall include terms requiring the provider or health care facility to make these health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of enrollees, and requiring the provider or health care facility to comply with applicable state and federal laws related to the confidentiality of medical or health records.

(6) A provision that states that contractual rights and responsibilities may not be assigned or delegated by the provider

or health care facility without the prior written consent of the health insuring corporation;

(7) A provision requiring the provider or health care facility to maintain adequate professional liability and malpractice insurance. The provision shall also require the provider or health care facility to notify the health insuring corporation not more than ten days after the provider's or health care facility's receipt of notice of any reduction or cancellation of such coverage.

(8) A provision requiring the provider or health care facility to observe, protect, and promote the rights of enrollees as patients;

(9) A provision requiring the provider or health care facility to provide health care services without discrimination on the basis of a patient's participation in the health care plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the provider or health care facility appropriately does not render services due to limitations arising from the provider's or health care facility's lack of training, experience, or skill, or due to licensing restrictions.

(10) A provision containing the specifics of any obligation on the primary care provider to provide, or to arrange for the provision of, covered health care services twenty-four hours per day, seven days per week;

(11) A provision setting forth procedures for the resolution of disputes arising out of the contract;

(12) A provision stating that the hold harmless provision required by division (C)(2) of this section shall survive the termination of the contract with respect to services covered and

provided under the contract during the time the contract was in effect, regardless of the reason for the termination, including the insolvency of the health insuring corporation;

(13) A provision requiring those terms that are used in the contract and that are defined by this chapter, be used in the contract in a manner consistent with those definitions.

This division does not apply to 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 to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to 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 to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to 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.

(D)(1) No health insuring corporation contract with a provider or health care facility shall contain any of the following:

(a) A provision that directly or indirectly offers an inducement to the provider or health care facility to reduce or limit medically necessary health care services to a covered enrollee;

(b) A provision that penalizes a provider or health care facility that assists an enrollee to seek a reconsideration of the health insuring corporation's decision to deny or limit benefits

to the enrollee;

(c) A provision that limits or otherwise restricts the provider's or health care facility's ethical and legal responsibility to fully advise enrollees about their medical condition and about medically appropriate treatment options;

(d) A provision that penalizes a provider or health care facility for principally advocating for medically necessary health care services;

(e) A provision that penalizes a provider or health care facility for providing information or testimony to a legislative or regulatory body or agency. This shall not be construed to prohibit a health insuring corporation from penalizing a provider or health care facility that provides information or testimony that is libelous or slanderous or that discloses trade secrets which the provider or health care facility has no privilege or permission to disclose.

(f) A provision that violates Chapter 3963. of the Revised Code.

(2) Nothing in this division shall be construed to prohibit a health insuring corporation from doing either of the following:

(a) Making a determination not to reimburse or pay for a particular medical treatment or other health care service;

(b) Enforcing reasonable peer review or utilization review protocols, or determining whether a particular provider or health care facility has complied with these protocols.

(E) Any contract between a health insuring corporation and an intermediary organization shall clearly specify that the health insuring corporation must approve or disapprove the participation of any provider or health care facility with which the intermediary organization contracts.

(F) If an intermediary organization that is not a health delivery network contracting solely with self-insured employers subcontracts with a provider or health care facility, the subcontract with the provider or health care facility shall do all of the following:

(1) Contain the provisions required by divisions (C) and (G) of this section, as made applicable to an intermediary organization, without the inclusion of inducements or penalties described in division (D) of this section;

(2) Acknowledge that the health insuring corporation is a third-party beneficiary to the agreement;

(3) Acknowledge the health insuring corporation's role in approving the participation of the provider or health care facility, pursuant to division (E) of this section.

(G) Any provider contract or contract with a health care facility shall clearly specify the health insuring corporation's statutory responsibility to monitor and oversee the offering of covered health care services to its enrollees.

(H)(1) A health insuring corporation shall maintain its provider contracts and its contracts with health care facilities at one or more of its places of business in this state, and shall provide copies of these contracts to facilitate regulatory review upon written notice by the superintendent of insurance.

(2) Any contract with an intermediary organization that accepts compensation shall include provisions requiring the intermediary organization to provide the superintendent with regulatory access to all books, records, financial information, and documents related to the provision of health care services to subscribers and enrollees under the contract. The contract shall require the intermediary organization to maintain such books, records, financial information, and documents at its principal

place of business in this state and to preserve them for at least three years in a manner that facilitates regulatory review.

(I)(1) A health insuring corporation shall notify its affected enrollees of the termination of a contract for the provision of health care services between the health insuring corporation and a primary care physician or hospital, by mail, within thirty days after the termination of the contract.

(a) Notice shall be given to subscribers of the termination of a contract with a primary care physician if the subscriber, or a dependent covered under the subscriber's health care coverage, has received health care services from the primary care physician within the previous twelve months or if the subscriber or dependent has selected the physician as the subscriber's or dependent's primary care physician within the previous twelve months.

(b) Notice shall be given to subscribers of the termination of a contract with a hospital if the subscriber, or a dependent covered under the subscriber's health care coverage, has received health care services from that hospital within the previous twelve months.

(2) The health insuring corporation shall pay, in accordance with the terms of the contract, for all covered health care services rendered to an enrollee by a primary care physician or hospital between the date of the termination of the contract and five days after the notification of the contract termination is mailed to a subscriber at the subscriber's last known address.

(J) Divisions (A) and (B) of this section do not apply to any health insuring corporation that, on June 4, 1997, holds a certificate of authority or license to operate under Chapter 1740. of the Revised Code.

(K) Nothing in this section shall restrict the governing body

of a hospital from exercising the authority granted it pursuant to section 3701.351 of the Revised Code.

Sec. 1753.09. (A) Except as provided in division (D) of this section, prior to terminating the participation of a provider on the basis of the participating provider's failure to meet the health insuring corporation's standards for quality or utilization in the delivery of health care services, a health insuring corporation shall give the participating provider notice of the reason or reasons for its decision to terminate the provider's participation and an opportunity to take corrective action. The health insuring corporation shall develop a performance improvement plan in conjunction with the participating provider. If after being afforded the opportunity to comply with the performance improvement plan, the participating provider fails to do so, the health insuring corporation may terminate the participation of the provider.

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

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

hearing. The recommendation shall be presented to the medical director and to the participating provider.

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

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

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

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

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

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

(G) The superintendent of insurance may adopt rules as

necessary to implement and enforce sections ~~1753.04 to~~ 1753.06, 1753.07, and 1753.09 of the Revised Code. Such rules shall be adopted in accordance with Chapter 119. of the Revised Code. The director of health may make recommendations to the superintendent for rules necessary to implement and enforce sections ~~1753.04 to~~ 1753.06, 1753.07, and 1753.09 of the Revised Code. In adopting any rules pursuant to this division, the Superintendent shall consider the recommendations of the Director.

Sec. 3963.01. As used in this chapter:

(A) "Edit" means adjusting one or more procedure codes billed by a provider on a claim for payment or a third-party payer's practice that results in:

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

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

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

(B) "Health care contract" means a contract entered into or renewed between a third-party payer and a provider for the delivery of basic or supplemental health care services to enrollees.

(C) "Procedure codes" includes the American medical association's current procedural terminology code, and the centers for medicare and medicaid services health care common procedure coding system.

(D) "Product" means a product line for health services, including, but not limited to a health insuring corporation product or a medicare or medicaid product as established by a

third-party payer and for which the provider may be obligated to provide services pursuant to a contract.

(E) "Provider" means a physician, podiatrist, dentist, pharmacist, chiropractor, optometrist, psychologist, or other health care provider entitled to reimbursement by a third-party payer for services rendered to an enrollee under a heath care contract. "Provider" does not mean a hospital or nursing home.

(F) "Third-party payer" means any person that has a primary business purpose of contracting with health care providers for the delivery of basic health care services.

(G) "Credentialing" means the process of assessing and validating the qualifications of a provider applying to be approved by a third-party payer to provide basic health care services to the third-party payer's enrollees.

(H) "Enrollee" means any person eligible for health care benefits under a health benefit plan and includes all of the following terms:

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

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

(3) Insured and plan member pursuant to Chapter 3923. of the Revised Code;

(4) Beneficiary as defined by section 3901.38 of the Revised Code;

(5) Claimant pursuant to Chapter 4121., 4123., 4127., or 4131. of the Revised Code.

(I) "Participating provider" means a provider that has a health care contract with the third-party payer.

Sec. 3963.02. (A) No third-party payer shall do either of the

following:

(1) Sell, rent, or give its provider network information to any other person, except for the purpose of providing claims processing for the third-party payer;

(2) Require, as a condition of contracting with the third-party payer, that a provider:

(a) Provide services under more than one product offered by the third-party payer;

(b) Waive or forego any right or benefit to which the provider may be entitled under state or federal law.

(B) No third-party payer, other than the third-party payer that executes a health care contract, shall enforce against the provider the payment or compensation terms of the health care contract unless the other third-party payer is contractually bound to all terms and conditions of the health care contract executed by the provider, and;

(1) The other third-party payer is clearly identified in the health care contract executed by the provider, or

(2) Before health care services are provided, the health care contract is amended by a writing in which the provider agrees to provide health care services for the payment or compensation described in the health care contract to be paid by the other third-party payer.

(C) No health care contract shall:

(1) Interfere with a provider's right to set the provider's payer-mix ratio in the provider's practice;

(2) Preclude its use or disclosure for the purpose of enforcing this chapter or other state or federal law, except that a health care contract may require that appropriate measures be taken to preserve the confidentiality of any proprietary or

trade-secret information.

(3)(a) Include a most favored nation clause if a third-party payer controls more than twenty per cent of a health insurance market share in a particular county. "Most favored nation clause" means a contract provision that:

(i) Prohibits, or grants a third-party payer an option to prohibit, the provider from contracting with another third-party payer to provide services at a lower price than the payment specified in the contract;

(ii) Requires, or grants a third-party payer an option to require, the provider to accept a lower payment in the event the provider agrees to provide services to any other third-party payer at a lower price;

(iii) Requires, or grants the third-party payer an option to require, termination or renegotiation of the existing health care contract in the event the provider agrees to provide services to any other third-party payer at a lower price;

(iv) Requires the provider to disclose the provider's contractual reimbursement rates with other third-party payers.

(b) Any health care contract provision violating division (C)(3) of this section is null and void.

(D) No term for compensation or payment in a health care contract shall survive the termination of the contract, except with the agreement of the provider or for a continuation of coverage arrangement otherwise required by law.

(E) Each health care contract shall provide that the third-party payer or the provider may terminate the health care contract without cause by giving not less than ninety days written notice to the other party.

(F) If the health care contract provides for termination for

cause by either party, the health care contract shall state the reasons that may be used for termination for cause, which terms shall be reasonable. The health care contract shall state the time by which the parties must provide notice of termination for cause and to whom the parties shall give the notice.

(G) Disputes among parties concerning the enforcement of sections 3963.01 to 3963.04 of the Revised Code are subject to a mutually agreed upon arbitration mechanism, which is binding on all parties. The arbitrator may award reasonable attorney's fees and costs for arbitration relating to the enforcement of this section to the prevailing party. The limitation to reasonable attorney's fees and costs shall not apply to disputes regarding breach of contract.

Sec. 3963.03. (A) Each third-party payer shall include a summary disclosure form with a health care contract that discloses in plain language the following information:

(1) Information sufficient for the provider to determine the compensation or payment terms for health care services, including all of the following:

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

(b) The fee schedule of codes reasonably expected to be billed by a provider's specialty for services provided pursuant to the health care contract, including, if applicable, current procedural terminology codes and the centers for medicare and medicaid services health care common procedure coding system and the associated payment or compensation for each procedure code. A fee schedule may be provided electronically. Upon request, a third-party payer shall provide a provider with the fee schedule for any other codes requested and a written fee schedule, which shall not be required more frequently than twice per year

excluding when it is provided in connection with any change to the schedule. The third-party payer also shall state the effect, if any, on payment or compensation if more than one procedure code applies to the service. A third-party payer may satisfy this requirement by providing a clearly understandable, readily available mechanism, such as a web site, that allows a provider to determine the effect of service codes on payment or compensation before a service is provided or a claim is submitted.

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

(d) The identity of any internal processing edits used by the third-party payer, including the publisher, product name, version, and version update of any editing software used by the third-party payer.

(2) Any product for which the provider is to provide services;

(3) The term of the health care contract and how it may be terminated;

(4) The identity of the third-party payer responsible for the processing of the provider's compensation or payment;

(5) Any internal mechanism provided by the third-party payer to resolve disputes concerning the interpretation or application of the terms or conditions of the contract;

(6) Any provisions for the amendment of the contract;

(7) A list of addenda, if any, to the contract.

(B) When a third-party payer presents a proposed health care contract for consideration by a provider, the third-party payer shall provide in writing or make reasonably available the information required in division (A)(1) of this section. If the information is not disclosed in writing, it shall be disclosed in a manner that allows the provider to evaluate the provider's payment or compensation for services under the health care contract. After the health care contract is executed, a third-party payer shall disclose the information required by division (A)(1) of this section upon request by the provider. The third-party payer need not provide such information in written format more than twice a year.

(C) The third-party payer shall identify any utilization management, quality improvement, or a similar program the third-party payer uses to review, monitor, evaluate, or assess the services provided pursuant to a health care contract. The third-party payer shall disclose the policies, procedures, or guidelines of such a program applicable to a provider upon request by the provider within fourteen days after the date of the request.

Sec. 3963.04. (A) A third-party payer shall notify a provider one hundred twenty days prior to the effective date of an amendment to the provider's contract with the third-party payer, and one hundred twenty days prior to the effective date of an amendment to any document incorporated by reference into the contract if the amendment of the document directly and materially affects the provider. Such amendments shall not be effective with regard to a provider until the provider has agreed in writing to the change.

(B)(1) Division (A) of this section does not apply if the

delay caused by compliance with that division could result in imminent harm to an enrollee or if the amendment is required by state or federal law, rule, or regulation.

(2) This section does not apply if the provider's payment or compensation is based on the current medicare physician fee schedule final rule as published by the centers for medicaid and medicare services annually in the federal register and the change in payment or compensation results solely from a change in the physician fee schedule.

(C) Notwithstanding divisions (A) and (B) of this section, a health care contract may be modified, without the need for amendment, by operation of law as required by any applicable state or federal law or rule or regulation. Nothing in this section shall be construed to require the renegotiation of a contract in existence before the effective date of this section, until such time as the contract is renewed or modified.

Sec. 3963.05. (A) The credentialing form used by the council for affordable quality healthcare (CAQH), in electronic or paper format, shall be the standard credentialing form.

(B) No third-party payer shall fail to use the standard credentialing form described in division (A) of this section when initially credentialing or recredentialing providers in connection with policies, health care contracts, and agreements providing basic or supplemental health care services.

(C) No third-party payer shall require a provider to provide any information in addition to the information required by the standard credentialing form described in division (A) of this section in connection with policies, health care contracts, and agreements providing basic or supplemental health care services.

Sec. 3963.06. (A) If a provider submits to a third-party

payer a credentialing form that is not complete the third-party payer that receives the form shall notify the provider of the deficiency not later than fourteen days after the third-party payer receives the form.

(B) A third-party payer shall reimburse a provider who has submitted a complete credentialing form for entrance into a health care contract with the third-party payer when the period of review of the provider's credentialing form exceeds forty-five days and until the third-party payer rejects or approves the provider for a health care contract.

(C)(1) If the third-party payer and the provider enter into a health care contract, the third-party payer shall retroactively reimburse the provider according to the terms of the contract for any basic or supplemental health care services the provider provided to enrollees after the provider submitted to the third-party payer a complete credentialing form and until the third-party payer and the provider enter into a health care contract.

(2) A provider may keep record of in-network claims incurred while the provider's credentialing is pending and submit the claims to be paid by the third-party payer once the third-party payer and the provider enter into a health care contract.

Sec. 3963.07. (A) Each third-party payer shall, upon a participating provider's submission of an enrollee's name, the enrollee's relationship to the primary enrollee, and the enrollee's birth date, make available information maintained in the ordinary course of business that is sufficient for the provider to determine at the time of the enrollee's visit all of the following:

(1) The enrollee's identification number assigned by the

third-party payer;

(2) The birth date and gender of the primary enrollee;

(3) The names, birth dates and gender of all covered dependents;

(4) The current enrollment and eligibility status of the enrollee;

(5) Whether a specific type or category of service is a covered benefit for the enrollee;

(6) The enrollee's excluded benefits or limitations, whether group or individual;

(7) The enrollee's copayment requirements;

(8) The unmet amount of the enrollee's deductible or the enrollee's financial responsibility.

(B) A third-party payer shall make available the information required by this section electronically or by an internet portal.

(C) Notwithstanding division (A) of this section, no third-party payer shall make the information required by this section available to any person except to a participating provider who is authorized under state and federal law to receive personally identifiable information concerning an enrollee or an enrollee's dependent.

(D) No third-party payer directly or indirectly shall charge a provider any fee for the information the third-party payer makes available pursuant to this section.

Sec. 3963.08. The superintendent of insurance shall adopt any rules necessary for the implementation of this chapter.

Sec. 3963.09. Unless otherwise stated, a violation of this chapter is an unfair and deceptive act or practice in the business

of insurance under sections 3901.19 to 3901.26 of the Revised Code.

Section 2. That existing sections 1751.13 and 1753.09 and sections 1753.03, 1753.04, 1753.05, and 1753.08 of the Revised Code are hereby repealed.

Section 3. Sections 3963.01 to 3963.09 of the Revised Code, as enacted by this act, shall apply only to contracts that are delivered, issued for delivery, or renewed or modified in this state on or after the effective date of this act. A health insuring corporation having fewer than fifteen thousand enrollees shall comply with the provisions of this section within twelve months after the effective date of this act.