

As Introduced

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H. B. No. 159

Representatives Hackett, Schuring

**Cosponsors: Representatives Johnson, Brenner, Grossman, Thompson,
Duffey, Maag, Green, Barborak, Stebelton, Cera, Buchy**

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A B I L L

To amend sections 1753.07, 1753.09, 3901.21, 3963.01, 1
3963.02, and 3963.03 of the Revised Code to 2
prohibit a health insurer from establishing a fee 3
schedule for dental providers for services that 4
are not covered by any contract or participating 5
provider agreement between the health insurer and 6
the dental provider. 7

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

Section 1. That sections 1753.07, 1753.09, 3901.21, 3963.01, 8
3963.02, and 3963.03 of the Revised Code be amended to read as 9
follows: 10

Sec. 1753.07. (A)(1) Prior to entering into a participation 11
contract with a provider under section 1751.13 of the Revised 12
Code, a health insuring corporation shall disclose basic 13
information regarding its programs and procedures to the provider. 14
The information shall include all of the following: 15

(a) How a participating provider is reimbursed for the 16
participating provider's services, including the range and 17
structure of any financial risk sharing arrangements, a 18

description of any incentive plans, and, if reimbursed according 19
to a type of fee-for-service arrangement, the level of 20
reimbursement for the participating provider's services; 21

(b) Insofar as division (A)(1) of section 3963.03 of the 22
Revised Code is applicable, all of the information that is 23
described in that division and is not included in division 24
(A)(1)(a) of this section. 25

(2) Prior to entering into a participation contract with a 26
provider under section 1751.13 of the Revised Code, a health 27
insuring corporation shall disclose the following information upon 28
the provider's request: 29

(a) How referrals to other participating providers or to 30
nonparticipating providers are made; 31

(b) The availability of dispute resolution procedures and the 32
potential for cost to be incurred; 33

(c) How a participating provider's name and address will be 34
used in marketing materials. 35

(B) A health insuring corporation shall provide all of the 36
following to a participating provider: 37

(1) Any material incorporated by reference into the 38
participation contract, that is not otherwise available as a 39
public record, if such material affects the participating 40
provider; 41

(2) Administrative manuals related to provider participation, 42
if any; 43

(3) Insofar as division (B) of section 3963.03 of the Revised 44
Code is applicable, the summary disclosure form with the 45
disclosures required under that division; 46

(4) A signed and dated copy of the final participation 47
contract. 48

(C) ~~Nothing~~ Except as otherwise provided in division (E) of 49
section 3963.02 of the Revised Code, nothing in this section 50
requires a health insuring corporation providing specialty health 51
care services or supplemental health care services to disclose the 52
health insuring corporation's aggregate maximum allowable fee 53
table used to determine providers' fees or fee schedules. 54

Sec. 1753.09. (A) Except as provided in division (D) of this 55
section, prior to terminating the participation of a provider on 56
the basis of the participating provider's failure to meet the 57
health insuring corporation's standards for quality or utilization 58
in the delivery of health care services, a health insuring 59
corporation shall give the participating provider notice of the 60
reason or reasons for its decision to terminate the provider's 61
participation and an opportunity to take corrective action. The 62
health insuring corporation shall develop a performance 63
improvement plan in conjunction with the participating provider. 64
If after being afforded the opportunity to comply with the 65
performance improvement plan, the participating provider fails to 66
do so, the health insuring corporation may terminate the 67
participation of the provider. 68

(B)(1) A participating provider whose participation has been 69
terminated under division (A) of this section may appeal the 70
termination to the appropriate medical director of the health 71
insuring corporation. The medical director shall give the 72
participating provider an opportunity to discuss with the medical 73
director the reason or reasons for the termination. 74

(2) If a satisfactory resolution of a participating 75
provider's appeal cannot be reached under division (B)(1) of this 76
section, the participating provider may appeal the termination to 77
a panel composed of participating providers who have comparable or 78
higher levels of education and training than the participating 79

provider making the appeal. A representative of the participating 80
provider's specialty shall be a member of the panel, if possible. 81
This panel shall hold a hearing, and shall render its 82
recommendation in the appeal within thirty days after holding the 83
hearing. The recommendation shall be presented to the medical 84
director and to the participating provider. 85

(3) The medical director shall review and consider the 86
panel's recommendation before making a decision. The decision 87
rendered by the medical director shall be final. 88

(C) A provider's status as a participating provider shall 89
remain in effect during the appeal process set forth in division 90
(B) of this section unless the termination was based on any of the 91
reasons listed in division (D) of this section. 92

(D) Notwithstanding division (A) of this section, a 93
provider's participation may be immediately terminated if the 94
participating provider's conduct presents an imminent risk of harm 95
to an enrollee or enrollees; or if there has occurred unacceptable 96
quality of care, fraud, patient abuse, loss of clinical 97
privileges, loss of professional liability coverage, incompetence, 98
or loss of authority to practice in the participating provider's 99
field; or if a governmental action has impaired the participating 100
provider's ability to practice. 101

(E) Divisions (A) to (D) of this section apply only to 102
providers who are natural persons. 103

(F)(1) Nothing in this section prohibits a health insuring 104
corporation from rejecting a provider's application for 105
participation, or from terminating a participating provider's 106
contract, if the health insuring corporation determines that the 107
health care needs of its enrollees are being met and no need 108
exists for the provider's or participating provider's services. 109

(2) Nothing in this section shall be construed as prohibiting 110

a health insuring corporation from terminating a participating 111
provider who does not meet the terms and conditions of the 112
participating provider's contract. 113

(3) Nothing in this section shall be construed as prohibiting 114
a health insuring corporation from terminating a participating 115
provider's contract pursuant to any provision of the contract 116
described in division ~~(E)~~ (F)(2) of section 3963.02 of the Revised 117
Code, except that, notwithstanding any provision of a contract 118
described in that division, this section applies to the 119
termination of a participating provider's contract for any of the 120
causes described in divisions (A), (D), and (F)(1) and (2) of this 121
section. 122

(G) The superintendent of insurance may adopt rules as 123
necessary to implement and enforce sections 1753.06, 1753.07, and 124
1753.09 of the Revised Code. Such rules shall be adopted in 125
accordance with Chapter 119. of the Revised Code. 126

Sec. 3901.21. The following are hereby defined as unfair and 127
deceptive acts or practices in the business of insurance: 128

(A) Making, issuing, circulating, or causing or permitting to 129
be made, issued, or circulated, or preparing with intent to so 130
use, any estimate, illustration, circular, or statement 131
misrepresenting the terms of any policy issued or to be issued or 132
the benefits or advantages promised thereby or the dividends or 133
share of the surplus to be received thereon, or making any false 134
or misleading statements as to the dividends or share of surplus 135
previously paid on similar policies, or making any misleading 136
representation or any misrepresentation as to the financial 137
condition of any insurer as shown by the last preceding verified 138
statement made by it to the insurance department of this state, or 139
as to the legal reserve system upon which any life insurer 140
operates, or using any name or title of any policy or class of 141

policies misrepresenting the true nature thereof, or making any 142
misrepresentation or incomplete comparison to any person for the 143
purpose of inducing or tending to induce such person to purchase, 144
amend, lapse, forfeit, change, or surrender insurance. 145

Any written statement concerning the premiums for a policy 146
which refers to the net cost after credit for an assumed dividend, 147
without an accurate written statement of the gross premiums, cash 148
values, and dividends based on the insurer's current dividend 149
scale, which are used to compute the net cost for such policy, and 150
a prominent warning that the rate of dividend is not guaranteed, 151
is a misrepresentation for the purposes of this division. 152

(B) Making, publishing, disseminating, circulating, or 153
placing before the public or causing, directly or indirectly, to 154
be made, published, disseminated, circulated, or placed before the 155
public, in a newspaper, magazine, or other publication, or in the 156
form of a notice, circular, pamphlet, letter, or poster, or over 157
any radio station, or in any other way, or preparing with intent 158
to so use, an advertisement, announcement, or statement containing 159
any assertion, representation, or statement, with respect to the 160
business of insurance or with respect to any person in the conduct 161
of the person's insurance business, which is untrue, deceptive, or 162
misleading. 163

(C) Making, publishing, disseminating, or circulating, 164
directly or indirectly, or aiding, abetting, or encouraging the 165
making, publishing, disseminating, or circulating, or preparing 166
with intent to so use, any statement, pamphlet, circular, article, 167
or literature, which is false as to the financial condition of an 168
insurer and which is calculated to injure any person engaged in 169
the business of insurance. 170

(D) Filing with any supervisory or other public official, or 171
making, publishing, disseminating, circulating, or delivering to 172
any person, or placing before the public, or causing directly or 173

indirectly to be made, published, disseminated, circulated, 174
delivered to any person, or placed before the public, any false 175
statement of financial condition of an insurer. 176

Making any false entry in any book, report, or statement of 177
any insurer with intent to deceive any agent or examiner lawfully 178
appointed to examine into its condition or into any of its 179
affairs, or any public official to whom such insurer is required 180
by law to report, or who has authority by law to examine into its 181
condition or into any of its affairs, or, with like intent, 182
willfully omitting to make a true entry of any material fact 183
pertaining to the business of such insurer in any book, report, or 184
statement of such insurer, or mutilating, destroying, suppressing, 185
withholding, or concealing any of its records. 186

(E) Issuing or delivering or permitting agents, officers, or 187
employees to issue or deliver agency company stock or other 188
capital stock or benefit certificates or shares in any common-law 189
corporation or securities or any special or advisory board 190
contracts or other contracts of any kind promising returns and 191
profits as an inducement to insurance. 192

(F) Making or permitting any unfair discrimination among 193
individuals of the same class and equal expectation of life in the 194
rates charged for any contract of life insurance or of life 195
annuity or in the dividends or other benefits payable thereon, or 196
in any other of the terms and conditions of such contract. 197

(G)(1) Except as otherwise expressly provided by law, 198
knowingly permitting or offering to make or making any contract of 199
life insurance, life annuity or accident and health insurance, or 200
agreement as to such contract other than as plainly expressed in 201
the contract issued thereon, or paying or allowing, or giving or 202
offering to pay, allow, or give, directly or indirectly, as 203
inducement to such insurance, or annuity, any rebate of premiums 204
payable on the contract, or any special favor or advantage in the 205

dividends or other benefits thereon, or any valuable consideration 206
or inducement whatever not specified in the contract; or giving, 207
or selling, or purchasing, or offering to give, sell, or purchase, 208
as inducement to such insurance or annuity or in connection 209
therewith, any stocks, bonds, or other securities, or other 210
obligations of any insurance company or other corporation, 211
association, or partnership, or any dividends or profits accrued 212
thereon, or anything of value whatsoever not specified in the 213
contract. 214

(2) Nothing in division (F) or division (G)(1) of this 215
section shall be construed as prohibiting any of the following 216
practices: (a) in the case of any contract of life insurance or 217
life annuity, paying bonuses to policyholders or otherwise abating 218
their premiums in whole or in part out of surplus accumulated from 219
nonparticipating insurance, provided that any such bonuses or 220
abatment of premiums shall be fair and equitable to policyholders 221
and for the best interests of the company and its policyholders; 222
(b) in the case of life insurance policies issued on the 223
industrial debit plan, making allowance to policyholders who have 224
continuously for a specified period made premium payments directly 225
to an office of the insurer in an amount which fairly represents 226
the saving in collection expenses; (c) readjustment of the rate of 227
premium for a group insurance policy based on the loss or expense 228
experience thereunder, at the end of the first or any subsequent 229
policy year of insurance thereunder, which may be made retroactive 230
only for such policy year. 231

(H) Making, issuing, circulating, or causing or permitting to 232
be made, issued, or circulated, or preparing with intent to so 233
use, any statement to the effect that a policy of life insurance 234
is, is the equivalent of, or represents shares of capital stock or 235
any rights or options to subscribe for or otherwise acquire any 236
such shares in the life insurance company issuing that policy or 237

any other company.	238
(I) Making, issuing, circulating, or causing or permitting to be made, issued or circulated, or preparing with intent to so issue, any statement to the effect that payments to a policyholder of the principal amounts of a pure endowment are other than payments of a specific benefit for which specific premiums have been paid.	239 240 241 242 243 244
(J) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, or preparing with intent to so use, any statement to the effect that any insurance company was required to change a policy form or related material to comply with Title XXXIX of the Revised Code or any regulation of the superintendent of insurance, for the purpose of inducing or intending to induce any policyholder or prospective policyholder to purchase, amend, lapse, forfeit, change, or surrender insurance.	245 246 247 248 249 250 251 252 253
(K) Aiding or abetting another to violate this section.	254
(L) Refusing to issue any policy of insurance, or canceling or declining to renew such policy because of the sex or marital status of the applicant, prospective insured, insured, or policyholder.	255 256 257 258
(M) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, other than life insurance, or in the benefits payable thereunder, or in underwriting standards and practices or eligibility requirements, or in any of the terms or conditions of such contract, or in any other manner whatever.	259 260 261 262 263 264 265
(N) Refusing to make available disability income insurance solely because the applicant's principal occupation is that of managing a household.	266 267 268

(O) Refusing, when offering maternity benefits under any individual or group sickness and accident insurance policy, to make maternity benefits available to the policyholder for the individual or individuals to be covered under any comparable policy to be issued for delivery in this state, including family members if the policy otherwise provides coverage for family members. Nothing in this division shall be construed to prohibit an insurer from imposing a reasonable waiting period for such benefits under an individual sickness and accident insurance policy issued to an individual who is not a federally eligible individual or a nonemployer-related group sickness and accident insurance policy, but in no event shall such waiting period exceed two hundred seventy days.

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

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

(Q) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent, or kind of life or sickness and accident insurance or annuity coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. With respect to

all other conditions, including the underlying cause of blindness 301
or partial blindness, persons who are blind or partially blind 302
shall be subject to the same standards of sound actuarial 303
principles or actual or reasonably anticipated actuarial 304
experience as are sighted persons. Refusal to insure includes, but 305
is not limited to, denial by an insurer of disability insurance 306
coverage on the grounds that the policy defines "disability" as 307
being presumed in the event that the eyesight of the insured is 308
lost. However, an insurer may exclude from coverage disabilities 309
consisting solely of blindness or partial blindness when such 310
conditions existed at the time the policy was issued. To the 311
extent that the provisions of this division may appear to conflict 312
with any provision of section 3999.16 of the Revised Code, this 313
division applies. 314

(R)(1) Directly or indirectly offering to sell, selling, or 315
delivering, issuing for delivery, renewing, or using or otherwise 316
marketing any policy of insurance or insurance product in 317
connection with or in any way related to the grant of a student 318
loan guaranteed in whole or in part by an agency or commission of 319
this state or the United States, except insurance that is required 320
under federal or state law as a condition for obtaining such a 321
loan and the premium for which is included in the fees and charges 322
applicable to the loan; or, in the case of an insurer or insurance 323
agent, knowingly permitting any lender making such loans to engage 324
in such acts or practices in connection with the insurer's or 325
agent's insurance business. 326

(2) Except in the case of a violation of division (G) of this 327
section, division (R)(1) of this section does not apply to either 328
of the following: 329

(a) Acts or practices of an insurer, its agents, 330
representatives, or employees in connection with the grant of a 331
guaranteed student loan to its insured or the insured's spouse or 332

dependent children where such acts or practices take place more 333
than ninety days after the effective date of the insurance; 334

(b) Acts or practices of an insurer, its agents, 335
representatives, or employees in connection with the solicitation, 336
processing, or issuance of an insurance policy or product covering 337
the student loan borrower or the borrower's spouse or dependent 338
children, where such acts or practices take place more than one 339
hundred eighty days after the date on which the borrower is 340
notified that the student loan was approved. 341

(S) Denying coverage, under any health insurance or health 342
care policy, contract, or plan providing family coverage, to any 343
natural or adopted child of the named insured or subscriber solely 344
on the basis that the child does not reside in the household of 345
the named insured or subscriber. 346

(T)(1) Using any underwriting standard or engaging in any 347
other act or practice that, directly or indirectly, due solely to 348
any health status-related factor in relation to one or more 349
individuals, does either of the following: 350

(a) Terminates or fails to renew an existing individual 351
policy, contract, or plan of health benefits, or a health benefit 352
plan issued to an employer, for which an individual would 353
otherwise be eligible; 354

(b) With respect to a health benefit plan issued to an 355
employer, excludes or causes the exclusion of an individual from 356
coverage under an existing employer-provided policy, contract, or 357
plan of health benefits. 358

(2) The superintendent of insurance may adopt rules in 359
accordance with Chapter 119. of the Revised Code for purposes of 360
implementing division (T)(1) of this section. 361

(3) For purposes of division (T)(1) of this section, "health 362
status-related factor" means any of the following: 363

(a) Health status;	364
(b) Medical condition, including both physical and mental illnesses;	365 366
(c) Claims experience;	367
(d) Receipt of health care;	368
(e) Medical history;	369
(f) Genetic information;	370
(g) Evidence of insurability, including conditions arising out of acts of domestic violence;	371 372
(h) Disability.	373
(U) With respect to a health benefit plan issued to a small employer, as those terms are defined in section 3924.01 of the Revised Code, negligently or willfully placing coverage for adverse risks with a certain carrier, as defined in section 3924.01 of the Revised Code.	374 375 376 377 378
(V) Using any program, scheme, device, or other unfair act or practice that, directly or indirectly, causes or results in the placing of coverage for adverse risks with another carrier, as defined in section 3924.01 of the Revised Code.	379 380 381 382
(W) Failing to comply with section 3923.23, 3923.231, 3923.232, 3923.233, or 3923.234 of the Revised Code by engaging in any unfair, discriminatory reimbursement practice.	383 384 385
(X) Intentionally establishing an unfair premium for, or misrepresenting the cost of, any insurance policy financed under a premium finance agreement of an insurance premium finance company.	386 387 388
(Y)(1)(a) Limiting coverage under, refusing to issue, canceling, or refusing to renew, any individual policy or contract of life insurance, or limiting coverage under or refusing to issue any individual policy or contract of health insurance, for the	389 390 391 392

reason that the insured or applicant for insurance is or has been 393
a victim of domestic violence; 394

(b) Adding a surcharge or rating factor to a premium of any 395
individual policy or contract of life or health insurance for the 396
reason that the insured or applicant for insurance is or has been 397
a victim of domestic violence; 398

(c) Denying coverage under, or limiting coverage under, any 399
policy or contract of life or health insurance, for the reason 400
that a claim under the policy or contract arises from an incident 401
of domestic violence; 402

(d) Inquiring, directly or indirectly, of an insured under, 403
or of an applicant for, a policy or contract of life or health 404
insurance, as to whether the insured or applicant is or has been a 405
victim of domestic violence, or inquiring as to whether the 406
insured or applicant has sought shelter or protection from 407
domestic violence or has sought medical or psychological treatment 408
as a victim of domestic violence. 409

(2) Nothing in division (Y)(1) of this section shall be 410
construed to prohibit an insurer from inquiring as to, or from 411
underwriting or rating a risk on the basis of, a person's physical 412
or mental condition, even if the condition has been caused by 413
domestic violence, provided that all of the following apply: 414

(a) The insurer routinely considers the condition in 415
underwriting or in rating risks, and does so in the same manner 416
for a victim of domestic violence as for an insured or applicant 417
who is not a victim of domestic violence; 418

(b) The insurer does not refuse to issue any policy or 419
contract of life or health insurance or cancel or refuse to renew 420
any policy or contract of life insurance, solely on the basis of 421
the condition, except where such refusal to issue, cancellation, 422
or refusal to renew is based on sound actuarial principles or is 423

related to actual or reasonably anticipated experience; 424

(c) The insurer does not consider a person's status as being 425
or as having been a victim of domestic violence, in itself, to be 426
a physical or mental condition; 427

(d) The underwriting or rating of a risk on the basis of the 428
condition is not used to evade the intent of division (Y)(1) of 429
this section, or of any other provision of the Revised Code. 430

(3)(a) Nothing in division (Y)(1) of this section shall be 431
construed to prohibit an insurer from refusing to issue a policy 432
or contract of life insurance insuring the life of a person who is 433
or has been a victim of domestic violence if the person who 434
committed the act of domestic violence is the applicant for the 435
insurance or would be the owner of the insurance policy or 436
contract. 437

(b) Nothing in division (Y)(2) of this section shall be 438
construed to permit an insurer to cancel or refuse to renew any 439
policy or contract of health insurance in violation of the "Health 440
Insurance Portability and Accountability Act of 1996," 110 Stat. 441
1955, 42 U.S.C.A. 300gg-41(b), as amended, or in a manner that 442
violates or is inconsistent with any provision of the Revised Code 443
that implements the "Health Insurance Portability and 444
Accountability Act of 1996." 445

(4) An insurer is immune from any civil or criminal liability 446
that otherwise might be incurred or imposed as a result of any 447
action taken by the insurer to comply with division (Y) of this 448
section. 449

(5) As used in division (Y) of this section, "domestic 450
violence" means any of the following acts: 451

(a) Knowingly causing or attempting to cause physical harm to 452
a family or household member; 453

(b) Recklessly causing serious physical harm to a family or household member; 454
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(c) Knowingly causing, by threat of force, a family or household member to believe that the person will cause imminent physical harm to the family or household member. 456
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For the purpose of division (Y)(5) of this section, "family or household member" has the same meaning as in section 2919.25 of the Revised Code. 459
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Nothing in division (Y)(5) of this section shall be construed to require, as a condition to the application of division (Y) of this section, that the act described in division (Y)(5) of this section be the basis of a criminal prosecution. 462
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(Z) Disclosing a coroner's records by an insurer in violation of section 313.10 of the Revised Code. 466
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(AA) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated any statement or representation that a life insurance policy or annuity is a contract for the purchase of funeral goods or services. 468
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(BB)(1) Setting or requiring the insurer's approval of fees for dental services that are not covered dental services, as defined in section 3963.01 of the Revised Code, or making available any health benefit plan that sets fees for dental services that are not covered dental care services. 472
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(2) Nothing in division (BB)(1) of this section shall be construed to apply to any health benefit plan subject to regulation by the "Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C. 1001, et seq., as amended. 477
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(CC) With respect to private passenger automobile insurance, charging premium rates that are excessive, inadequate, or unfairly discriminatory, pursuant to division (D) of section 3937.02 of the 481
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Revised Code, based solely on the location of the residence of the 484
insured. 485

The enumeration in sections 3901.19 to 3901.26 of the Revised 486
Code of specific unfair or deceptive acts or practices in the 487
business of insurance is not exclusive or restrictive or intended 488
to limit the powers of the superintendent of insurance to adopt 489
rules to implement this section, or to take action under other 490
sections of the Revised Code. 491

This section does not prohibit the sale of shares of any 492
investment company registered under the "Investment Company Act of 493
1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any 494
policies, annuities, or other contracts described in section 495
3907.15 of the Revised Code. 496

As used in this section, "estimate," "statement," 497
"representation," "misrepresentation," "advertisement," or 498
"announcement" includes oral or written occurrences. 499

Sec. 3963.01. As used in this chapter: 500

(A) "Affiliate" means any person or entity that has ownership 501
or control of a contracting entity, is owned or controlled by a 502
contracting entity, or is under common ownership or control with a 503
contracting entity. 504

(B) "Basic health care services" has the same meaning as in 505
division (A) of section 1751.01 of the Revised Code, except that 506
it does not include any services listed in that division that are 507
provided by a pharmacist or nursing home. 508

(C) "Contracting entity" means any person that has a primary 509
business purpose of contracting with participating providers for 510
the delivery of health care services. 511

(D) "Covered dental services" means dental services for which 512
a reimbursement is available under an enrollee's health benefit 513

plan contract, or for which a reimbursement would be available but 514
for the application of contractual limitations such as a 515
deductible, copayment, coinsurance, waiting period, annual or 516
lifetime maximum, frequency limitation, alternative benefit 517
payment, or any other limitation. 518

(E) "Credentialing" means the process of assessing and 519
validating the qualifications of a provider applying to be 520
approved by a contracting entity to provide basic health care 521
services, specialty health care services, or supplemental health 522
care services to enrollees. 523

~~(E)~~(F) "Edit" means adjusting one or more procedure codes 524
billed by a participating provider on a claim for payment or a 525
practice that results in any of the following: 526

(1) Payment for some, but not all of the procedure codes 527
originally billed by a participating provider; 528

(2) Payment for a different procedure code than the procedure 529
code originally billed by a participating provider; 530

(3) A reduced payment as a result of services provided to an 531
enrollee that are claimed under more than one procedure code on 532
the same service date. 533

~~(F)~~(G) "Electronic claims transport" means to accept and 534
digitize claims or to accept claims already digitized, to place 535
those claims into a format that complies with the electronic 536
transaction standards issued by the United States department of 537
health and human services pursuant to the "Health Insurance 538
Portability and Accountability Act of 1996," 110 Stat. 1955, 42 539
U.S.C. 1320d, et seq., as those electronic standards are 540
applicable to the parties and as those electronic standards are 541
updated from time to time, and to electronically transmit those 542
claims to the appropriate contracting entity, payer, or 543
third-party administrator. 544

~~(G)~~(H) "Enrollee" means any person eligible for health care 545
benefits under a health benefit plan, including an eligible 546
recipient of medicaid under Chapter 5111. of the Revised Code, and 547
includes all of the following terms: 548

(1) "Enrollee" and "subscriber" as defined by section 1751.01 549
of the Revised Code; 550

(2) "Member" as defined by section 1739.01 of the Revised 551
Code; 552

(3) "Insured" and "plan member" pursuant to Chapter 3923. of 553
the Revised Code; 554

(4) "Beneficiary" as defined by section 3901.38 of the 555
Revised Code. 556

~~(H)~~(I) "Health care contract" means a contract entered into, 557
materially amended, or renewed between a contracting entity and a 558
participating provider for the delivery of basic health care 559
services, specialty health care services, or supplemental health 560
care services to enrollees. 561

~~(I)~~(J) "Health care services" means basic health care 562
services, specialty health care services, and supplemental health 563
care services. 564

~~(J)~~(K) "Material amendment" means an amendment to a health 565
care contract that decreases the participating provider's payment 566
or compensation, changes the administrative procedures in a way 567
that may reasonably be expected to significantly increase the 568
provider's administrative expenses, or adds a new product. A 569
material amendment does not include any of the following: 570

(1) A decrease in payment or compensation resulting solely 571
from a change in a published fee schedule upon which the payment 572
or compensation is based and the date of applicability is clearly 573
identified in the contract; 574

(2) A decrease in payment or compensation that was 575
anticipated under the terms of the contract, if the amount and 576
date of applicability of the decrease is clearly identified in the 577
contract; 578

(3) An administrative change that may significantly increase 579
the provider's administrative expense, the specific applicability 580
of which is clearly identified in the contract; 581

(4) Changes to an existing prior authorization, 582
precertification, notification, or referral program that do not 583
substantially increase the provider's administrative expense; 584

(5) Changes to an edit program or to specific edits if the 585
participating provider is provided notice of the changes pursuant 586
to division (A)(1) of section 3963.04 of the Revised Code and the 587
notice includes information sufficient for the provider to 588
determine the effect of the change; 589

(6) Changes to a health care contract described in division 590
(B) of section 3963.04 of the Revised Code. 591

~~(K)~~(L) "Participating provider" means a provider that has a 592
health care contract with a contracting entity and is entitled to 593
reimbursement for health care services rendered to an enrollee 594
under the health care contract. 595

~~(L)~~(M) "Payer" means any person that assumes the financial 596
risk for the payment of claims under a health care contract or the 597
reimbursement for health care services provided to enrollees by 598
participating providers pursuant to a health care contract. 599

~~(M)~~(N) "Primary enrollee" means a person who is responsible 600
for making payments for participation in a health care plan or an 601
enrollee whose employment or other status is the basis of 602
eligibility for enrollment in a health care plan. 603

~~(N)~~(O) "Procedure codes" includes the American medical 604

association's current procedural terminology code, the American 605
dental association's current dental terminology, and the centers 606
for medicare and medicaid services health care common procedure 607
coding system. 608

~~(O)~~(P) "Product" means one of the following types of 609
categories of coverage for which a participating provider may be 610
obligated to provide health care services pursuant to a health 611
care contract: 612

(1) A health maintenance organization or other product 613
provided by a health insuring corporation; 614

(2) A preferred provider organization; 615

(3) Medicare; 616

(4) Medicaid; 617

(5) Workers' compensation. 618

~~(P)~~(O) "Provider" means a physician, podiatrist, dentist, 619
chiropractor, optometrist, psychologist, physician assistant, 620
advanced practice registered nurse, occupational therapist, 621
massage therapist, physical therapist, professional counselor, 622
professional clinical counselor, hearing aid dealer, orthotist, 623
prosthetist, home health agency, hospice care program, pediatric 624
respite care program, or hospital, or a provider organization or 625
physician-hospital organization that is acting exclusively as an 626
administrator on behalf of a provider to facilitate the provider's 627
participation in health care contracts. "Provider" does not mean a 628
pharmacist, pharmacy, nursing home, or a provider organization or 629
physician-hospital organization that leases the provider 630
organization's or physician-hospital organization's network to a 631
third party or contracts directly with employers or health and 632
welfare funds. 633

~~(O)~~(R) "Specialty health care services" has the same meaning 634

as in section 1751.01 of the Revised Code, except that it does not
include any services listed in division (B) of section 1751.01 of
the Revised Code that are provided by a pharmacist or a nursing
home.

~~(R)~~(S) "Supplemental health care services" has the same
meaning as in division (B) of section 1751.01 of the Revised Code,
except that it does not include any services listed in that
division that are provided by a pharmacist or nursing home.

Sec. 3963.02. (A)(1) No contracting entity shall sell, rent,
or give a third party the contracting entity's rights to a
participating provider's services pursuant to the contracting
entity's health care contract with the participating provider
unless one of the following applies:

(a) The third party accessing the participating provider's
services under the health care contract is an employer or other
entity providing coverage for health care services to its
employees or members, and that employer or entity has a contract
with the contracting entity or its affiliate for the
administration or processing of claims for payment for services
provided pursuant to the health care contract with the
participating provider.

(b) The third party accessing the participating provider's
services under the health care contract either is an affiliate or
subsidiary of the contracting entity or is providing
administrative services to, or receiving administrative services
from, the contracting entity or an affiliate or subsidiary of the
contracting entity.

(c) The health care contract specifically provides that it
applies to network rental arrangements and states that one purpose
of the contract is selling, renting, or giving the contracting
entity's rights to the services of the participating provider,

including other preferred provider organizations, and the third 666
party accessing the participating provider's services is any of 667
the following: 668

(i) A payer or a third-party administrator or other entity 669
responsible for administering claims on behalf of the payer; 670

(ii) A preferred provider organization or preferred provider 671
network that receives access to the participating provider's 672
services pursuant to an arrangement with the preferred provider 673
organization or preferred provider network in a contract with the 674
participating provider that is in compliance with division 675
(A)(1)(c) of this section, and is required to comply with all of 676
the terms, conditions, and affirmative obligations to which the 677
originally contracted primary participating provider network is 678
bound under its contract with the participating provider, 679
including, but not limited to, obligations concerning patient 680
steerage and the timeliness and manner of reimbursement. 681

(iii) An entity that is engaged in the business of providing 682
electronic claims transport between the contracting entity and the 683
payer or third-party administrator and complies with all of the 684
applicable terms, conditions, and affirmative obligations of the 685
contracting entity's contract with the participating provider 686
including, but not limited to, obligations concerning patient 687
steerage and the timeliness and manner of reimbursement. 688

(2) The contracting entity that sells, rents, or gives the 689
contracting entity's rights to the participating provider's 690
services pursuant to the contracting entity's health care contract 691
with the participating provider as provided in division (A)(1) of 692
this section shall do both of the following: 693

(a) Maintain a web page that contains a listing of third 694
parties described in divisions (A)(1)(b) and (c) of this section 695
with whom a contracting entity contracts for the purpose of 696

selling, renting, or giving the contracting entity's rights to the 697
services of participating providers that is updated at least every 698
six months and is accessible to all participating providers, or 699
maintain a toll-free telephone number accessible to all 700
participating providers by means of which participating providers 701
may access the same listing of third parties; 702

(b) Require that the third party accessing the participating 703
provider's services through the participating provider's health 704
care contract is obligated to comply with all of the applicable 705
terms and conditions of the contract, including, but not limited 706
to, the products for which the participating provider has agreed 707
to provide services, except that a payer receiving administrative 708
services from the contracting entity or its affiliate shall be 709
solely responsible for payment to the participating provider. 710

(3) Any information disclosed to a participating provider 711
under this section shall be considered proprietary and shall not 712
be distributed by the participating provider. 713

(4) Except as provided in division (A)(1) of this section, no 714
entity shall sell, rent, or give a contracting entity's rights to 715
the participating provider's services pursuant to a health care 716
contract. 717

(B)(1) No contracting entity shall require, as a condition of 718
contracting with the contracting entity, that a participating 719
provider provide services for all of the products offered by the 720
contracting entity. 721

(2) Division (B)(1) of this section shall not be construed to 722
do any of the following: 723

(a) Prohibit any participating provider from voluntarily 724
accepting an offer by a contracting entity to provide health care 725
services under all of the contracting entity's products; 726

(b) Prohibit any contracting entity from offering any 727

financial incentive or other form of consideration specified in 728
the health care contract for a participating provider to provide 729
health care services under all of the contracting entity's 730
products; 731

(c) Require any contracting entity to contract with a 732
participating provider to provide health care services for less 733
than all of the contracting entity's products if the contracting 734
entity does not wish to do so. 735

(3)(a) Notwithstanding division (B)(2) of this section, no 736
contracting entity shall require, as a condition of contracting 737
with the contracting entity, that the participating provider 738
accept any future product offering that the contracting entity 739
makes. 740

(b) If a participating provider refuses to accept any future 741
product offering that the contracting entity makes, the 742
contracting entity may terminate the health care contract based on 743
the participating provider's refusal upon written notice to the 744
participating provider no sooner than one hundred eighty days 745
after the refusal. 746

(4) Once the contracting entity and the participating 747
provider have signed the health care contract, it is presumed that 748
the financial incentive or other form of consideration that is 749
specified in the health care contract pursuant to division 750
(B)(2)(b) of this section is the financial incentive or other form 751
of consideration that was offered by the contracting entity to 752
induce the participating provider to enter into the contract. 753

(C) No contracting entity shall require, as a condition of 754
contracting with the contracting entity, that a participating 755
provider waive or forego any right or benefit expressly conferred 756
upon a participating provider by state or federal law. However, 757
this division does not prohibit a contracting entity from 758

restricting a participating provider's scope of practice for the 759
services to be provided under the contract. 760

(D) No health care contract shall do any of the following: 761

(1) Prohibit any participating provider from entering into a 762
health care contract with any other contracting entity; 763

(2) Prohibit any contracting entity from entering into a 764
health care contract with any other provider; 765

(3) Preclude its use or disclosure for the purpose of 766
enforcing this chapter or other state or federal law, except that 767
a health care contract may require that appropriate measures be 768
taken to preserve the confidentiality of any proprietary or 769
trade-secret information. 770

(E)(1) No contracting entity shall require in any health care 771
contract that covers any dental services, either directly or 772
indirectly, that a participating provider who is a dentist provide 773
services to an enrollee at a fee set by, or a fee subject to the 774
approval of, the contracting entity unless the dental services are 775
covered dental services. 776

(2) To the extent that the provisions in division (E)(1) of 777
this section conflict with the provisions of the federal "Employee 778
Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C. 779
1001, et seq., as amended, the federal law shall control. 780

(F)(1) In addition to any other lawful reasons for 781
terminating a health care contract, a health care contract may 782
only be terminated under the circumstances described in division 783
(A)(3) of section 3963.04 of the Revised Code. 784

(2) If the health care contract provides for termination for 785
cause by either party, the health care contract shall state the 786
reasons that may be used for termination for cause, which terms 787
shall be reasonable. Once the contracting entity and the 788

participating provider have signed the health care contract, it is 789
presumed that the reasons stated in the health care contract for 790
termination for cause by either party are reasonable. Subject to 791
division ~~(E)~~(F)(3) of this section, the health care contract shall 792
state the time by which the parties must provide notice of 793
termination for cause and to whom the parties shall give the 794
notice. 795

(3) Nothing in divisions ~~(E)~~(F)(1) and (2) of this section 796
shall be construed as prohibiting any health insuring corporation 797
from terminating a participating provider's contract for any of 798
the causes described in divisions (A), (D), and (F)(1) and (2) of 799
section 1753.09 of the Revised Code. Notwithstanding any provision 800
in a health care contract pursuant to division ~~(E)~~(F)(2) of this 801
section, section 1753.09 of the Revised Code applies to the 802
termination of a participating provider's contract for any of the 803
causes described in divisions (A), (D), and (F)(1) and (2) of 804
section 1753.09 of the Revised Code. 805

(4) Subject to sections 3963.01 to 3963.11 of the Revised 806
Code, nothing in this section prohibits the termination of a 807
health care contract without cause if the health care contract 808
otherwise provides for termination without cause. 809

~~(F)~~(G)(1) Disputes among parties to a health care contract 810
that only concern the enforcement of the contract rights conferred 811
by section 3963.02, divisions (A) and (D) of section 3963.03, and 812
section 3963.04 of the Revised Code are subject to a mutually 813
agreed upon arbitration mechanism that is binding on all parties. 814
The arbitrator may award reasonable attorney's fees and costs for 815
arbitration relating to the enforcement of this section to the 816
prevailing party. 817

(2) The arbitrator shall make the arbitrator's decision in an 818
arbitration proceeding having due regard for any applicable rules, 819
bulletins, rulings, or decisions issued by the department of 820

insurance or any court concerning the enforcement of the contract 821
rights conferred by section 3963.02, divisions (A) and (D) of 822
section 3963.03, and section 3963.04 of the Revised Code. 823

(3) A party shall not simultaneously maintain an arbitration 824
proceeding as described in division ~~(F)~~(G)(1) of this section and 825
pursue a complaint with the superintendent of insurance to 826
investigate the subject matter of the arbitration proceeding. 827
However, if a complaint is filed with the department of insurance, 828
the superintendent may choose to investigate the complaint or, 829
after reviewing the complaint, advise the complainant to proceed 830
with arbitration to resolve the complaint. The superintendent may 831
request to receive a copy of the results of the arbitration. If 832
the superintendent of insurance notifies an insurer or a health 833
insuring corporation in writing that the superintendent has 834
initiated a market conduct examination into the specific subject 835
matter of the arbitration proceeding pending against that insurer 836
or health insuring corporation, the arbitration proceeding shall 837
be stayed at the request of the insurer or health insuring 838
corporation pending the outcome of the market conduct 839
investigation by the superintendent. 840

Sec. 3963.03. (A) Each health care contract shall include all 841
of the following information: 842

(1)(a) Information sufficient for the participating provider 843
to determine the compensation or payment terms for health care 844
services, including all of the following, subject to division 845
(A)(1)(b) of this section: 846

(i) The manner of payment, such as fee-for-service, 847
capitation, or risk; 848

(ii) The fee schedule of procedure codes reasonably expected 849
to be billed by a participating provider's specialty for services 850
provided pursuant to the health care contract and the associated 851

payment or compensation for each procedure code. A fee schedule 852
may be provided electronically. Upon request, a contracting entity 853
shall provide a participating provider with the fee schedule for 854
any other procedure codes requested and a written fee schedule, 855
that shall not be required more frequently than twice per year 856
excluding when it is provided in connection with any change to the 857
schedule. This requirement may be satisfied by providing a clearly 858
understandable, readily available mechanism, such as a specific 859
web site address, that allows a participating provider to 860
determine the effect of procedure codes on payment or compensation 861
before a service is provided or a claim is submitted. 862

(iii) The effect, if any, on payment or compensation if more 863
than one procedure code applies to the service also shall be 864
stated. This requirement may be satisfied by providing a clearly 865
understandable, readily available mechanism, such as a specific 866
web site address, that allows a participating provider to 867
determine the effect of procedure codes on payment or compensation 868
before a service is provided or a claim is submitted. 869

(b) If the contracting entity is unable to include the 870
information described in ~~division~~ divisions (A)(1)(a)(ii) and 871
(iii) of this section, the contracting entity shall include both 872
of the following types of information instead: 873

(i) The methodology used to calculate any fee schedule, such 874
as relative value unit system and conversion factor or percentage 875
of billed charges. If applicable, the methodology disclosure shall 876
include the name of any relative value unit system, its version, 877
edition, or publication date, any applicable conversion or 878
geographic factor, and any date by which compensation or fee 879
schedules may be changed by the methodology as anticipated at the 880
time of contract. 881

(ii) The identity of any internal processing edits, including 882
the publisher, product name, version, and version update of any 883

editing software. 884

(c) If the contracting entity is not the payer and is unable 885
to include the information described in division (A)(1)(a) or (b) 886
of this section, then the contracting entity shall provide by 887
telephone a readily available mechanism, such as a specific web 888
site address, that allows the participating provider to obtain 889
that information from the payer. 890

(2) Any product or network for which the participating 891
provider is to provide services; 892

(3) The term of the health care contract; 893

(4) A specific web site address that contains the identity of 894
the contracting entity or payer responsible for the processing of 895
the participating provider's compensation or payment; 896

(5) Any internal mechanism provided by the contracting entity 897
to resolve disputes concerning the interpretation or application 898
of the terms and conditions of the contract. A contracting entity 899
may satisfy this requirement by providing a clearly 900
understandable, readily available mechanism, such as a specific 901
web site address or an appendix, that allows a participating 902
provider to determine the procedures for the internal mechanism to 903
resolve those disputes. 904

(6) A list of addenda, if any, to the contract. 905

(B)(1) Each contracting entity shall include a summary 906
disclosure form with a health care contract that includes all of 907
the information specified in division (A) of this section. The 908
information in the summary disclosure form shall refer to the 909
location in the health care contract, whether a page number, 910
section of the contract, appendix, or other identifiable location, 911
that specifies the provisions in the contract to which the 912
information in the form refers. 913

(2) The summary disclosure form shall include all of the following statements:	914 915
(a) That the form is a guide to the health care contract and that the terms and conditions of the health care contract constitute the contract rights of the parties;	916 917 918
(b) That reading the form is not a substitute for reading the entire health care contract;	919 920
(c) That by signing the health care contract, the participating provider will be bound by the contract's terms and conditions;	921 922 923
(d) That the terms and conditions of the health care contract may be amended pursuant to section 3963.04 of the Revised Code and the participating provider is encouraged to carefully read any proposed amendments sent after execution of the contract;	924 925 926 927
(e) That nothing in the summary disclosure form creates any additional rights or causes of action in favor of either party.	928 929
(3) No contracting entity that includes any information in the summary disclosure form with the reasonable belief that the information is truthful or accurate shall be subject to a civil action for damages or to binding arbitration based on the summary disclosure form. Division (B)(3) of this section does not impair or affect any power of the department of insurance to enforce any applicable law.	930 931 932 933 934 935 936
(4) The summary disclosure form described in divisions (B)(1) and (2) of this section shall be in substantially the following form:	937 938 939
"SUMMARY DISCLOSURE FORM	940
(1) Compensation terms	941
(a) Manner of payment	942
[] Fee for service	943

[] Capitation	944
[] Risk	945
[] Other See	946
(b) Fee schedule available at	947
(c) Fee calculation schedule available at	948
(d) Identity of internal processing edits available at	949 950
(e) Information in (c) and (d) is not required if information in (b) is provided.	951 952
(2) List of products or networks covered by this contract	953
[]	954
[]	955
[]	956
[]	957
[]	958
(3) Term of this contract	959
(4) Contracting entity or payer responsible for processing payment available at	960 961
(5) Internal mechanism for resolving disputes regarding contract terms available at	962 963
(6) Addenda to contract	964
Title Subject	965
(a)	966
(b)	967
(c)	968
(d)	969

(7) Telephone number to access a readily available mechanism, 970
such as a specific web site address, to allow a participating 971
provider to receive the information in (1) through (6) from the 972
payer. 973

IMPORTANT INFORMATION - PLEASE READ CAREFULLY 974

The information provided in this Summary Disclosure Form is a 975
guide to the attached Health Care Contract as defined in section 976
~~3963.01(G)~~ 3963.01(I) of the Ohio Revised Code. The terms and 977
conditions of the attached Health Care Contract constitute the 978
contract rights of the parties. 979

Reading this Summary Disclosure Form is not a substitute for 980
reading the entire Health Care Contract. When you sign the Health 981
Care Contract, you will be bound by its terms and conditions. 982
These terms and conditions may be amended over time pursuant to 983
section 3963.04 of the Ohio Revised Code. You are encouraged to 984
read any proposed amendments that are sent to you after execution 985
of the Health Care Contract. 986

Nothing in this Summary Disclosure Form creates any 987
additional rights or causes of action in favor of either party." 988

(C) When a contracting entity presents a proposed health care 989
contract for consideration by a provider, the contracting entity 990
shall provide in writing or make reasonably available the 991
information required in division (A)(1) of this section. 992

(D) The contracting entity shall identify any utilization 993
management, quality improvement, or a similar program that the 994
contracting entity uses to review, monitor, evaluate, or assess 995
the services provided pursuant to a health care contract. The 996
contracting entity shall disclose the policies, procedures, or 997
guidelines of such a program applicable to a participating 998
provider upon request by the participating provider within 999
fourteen days after the date of the request. 1000

(E) Nothing in this section shall be construed as preventing 1001
or affecting the application of section 1753.07 of the Revised 1002
Code that would otherwise apply to a contract with a participating 1003
provider. 1004

(F) The requirements of division (C) of this section do not 1005
prohibit a contracting entity from requiring a reasonable 1006
confidentiality agreement between the provider and the contracting 1007
entity regarding the terms of the proposed health care contract. 1008
If either party violates the confidentiality agreement, a party to 1009
the confidentiality agreement may bring a civil action to enjoin 1010
the other party from continuing any act that is in violation of 1011
the confidentiality agreement, to recover damages, to terminate 1012
the contract, or to obtain any combination of relief. 1013

Section 2. That existing sections 1753.07, 1753.09, 3901.21, 1014
3963.01, 3963.02, and 3963.03 of the Revised Code are hereby 1015
repealed. 1016

Section 3. The following represent the General Assembly's 1017
intent and findings: 1018

(A) The provisions of this act seek to prevent dental 1019
insurers, dental benefit plans, and other contracting entities 1020
from establishing fee limitations on services that are not covered 1021
dental services for enrollees under a dental insurance plan. 1022

(B) Strategies by dental insurers, dental benefit plans, or 1023
other contracting entities to adopt or impose a deductible, 1024
copayment, coinsurance, or any other requirement in such a way as 1025
to provide de minimis reimbursement for services as a method to 1026
avoid the impact of this law is contrary to the spirit and intent 1027
of the General Assembly. 1028