(130th General Assembly)
(Substitute House Bill Number 3)

AN ACT

To amend sections 1751.12, 3905.01, and 4713.62 and to enact sections 3905.47, 3905.471, 3905.472, 3905.473, and 3905.474 of the Revised Code to specify licensing and continuing education requirements for insurance agents involved in selling, soliciting, or negotiating sickness and accident insurance through a health benefit exchange, to make changes to copayments, cost sharing, and deductibles for health insuring corporations, and to make changes to the law related to continuing education requirements for cosmetologists.

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

SECTION 1. That sections 1751.12, 3905.01, and 4713.62 be amended and sections 3905.47, 3905.471, 3905.472, 3905.473, and 3905.474 of the Revised Code be enacted to read as follows:

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

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

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

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

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

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

(B) Notwithstanding division (A) of this section, a health insuring corporation may use a contractual periodic prepayment or premium rate for policies used for the coverage of beneficiaries enrolled in medicare pursuant to a medicare risk contract or medicare cost contract, or for policies used for the coverage of beneficiaries enrolled in the federal employees health benefits program pursuant to 5 U.S.C.A. 8905, or for policies used for the coverage of medicaid recipients, or for policies used for the coverage of beneficiaries under any other federal health care program regulated by a federal regulatory body, or for policies used for the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services, if both of the following apply:

(1) The contractual periodic prepayment or premium rate has been approved by the United States department of health and human services, the United States office of personnel management, the department of job and

family services, or the department of administrative services.

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

(C) The administrative expense portion of all contractual periodic prepayment or premium rate filings submitted to the superintendent for review must reflect the actual cost of administering the product. The superintendent may require that the administrative expense portion of the filings be itemized and supported.

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

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

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

~~(b) Impose~~ shall impose copayment charges, cost sharing, and deductible charges that annually do not exceed ~~twenty~~ forty per cent of the total annual cost to the health insuring corporation of providing all covered ~~basic~~ health care services~~, including physician office visits, urgent care services, and emergency health services,~~ when ~~aggregated as to all persons~~ applied to a standard population expected to be covered under the filed product in question. ~~In addition, annual copayment charges as to each enrollee shall not exceed twenty per cent of the total annual cost to the health insuring corporation of providing all covered basic health care services, including physician office visits, urgent care services, and emergency health services, as to such enrollee.~~ The total annual cost of providing a health care service is the cost to the health insuring corporation of providing the health care service to its enrollees as reduced by any applicable provider discount. This requirement shall be demonstrated by an actuary who is a member of the American academy of actuaries and qualified to provide such certifications as described in the United States qualification standards promulgated by the American academy of actuaries pursuant to the code of professional conduct.

(3) ~~To ensure that copayments are reasonable and not a barrier to the~~

~~utilization of basic health care services, a health insuring corporation may not impose, in any contract year, on any subscriber or enrollee, copayments that exceed two hundred per cent of the average annual premium rate to subscribers or enrollees.~~

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

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

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

(c) Catastrophic-only plans, as defined under the "Patient Protection and Affordable Care Act," 124 Stat. 119, 42 U.S.C. 18022 and any related regulations, are not subject to the limits prescribed in division (D) of this section, provided that such plans meet all applicable minimum federal requirements.

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

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

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

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

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

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

Sec. 3905.01. As used in this chapter:

(A) "Affordable Care Act" means the "Patient Protection and Affordable Care Act," 124 Stat. 119, 42 U.S.C. 18031 (2011).

(B) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

~~(B)~~(C) "Home state" means the state or territory of the United States, including the District of Columbia, in which an insurance agent maintains the insurance agent's principal place of residence or principal place of business and is licensed to act as an insurance agent.

~~(C)~~(D) "In-person assister" means any person, other than a navigator, who receives any funding from, or who is selected or designated by, an exchange, the state, or the federal government to perform any of the activities and duties identified in division (i) of section 1311 of the Affordable Care Act. "In-person assister" includes any individual that is employed by, supervised by, or affiliated with an in-person assister and performs any of the activities and duties identified in division (i) of section 1311 of the Affordable Care Act, any non-navigator assistance personnel, and any other person deemed as such by rules adopted by the superintendent under division (L) of section 3905.471 of the Revised Code.

(E) "Insurance" means any of the lines of authority set forth in Chapter 1739., 1751., or 1761. or Title XXXIX of the Revised Code, or as additionally determined by the superintendent of insurance.

~~(D)~~(F) "Insurance agent" or "agent" means any person that, in order to sell, solicit, or negotiate insurance, is required to be licensed under the laws of this state, including limited lines insurance agents and surplus line brokers.

~~(E)~~(G) "Insurer" has the same meaning as in section 3901.32 of the Revised Code.

~~(F)~~(H) "License" means the authority issued by the superintendent to a person to act as an insurance agent for the lines of authority specified, but that does not create any actual, apparent, or inherent authority in the person to represent or commit an insurer.

~~(G)~~(I) "Limited line credit insurance" means credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance, or any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation and that is designated by the superintendent as limited line credit insurance.

~~(H)~~(J) "Limited line credit insurance agent" means a person that sells,

solicits, or negotiates one or more forms of limited line credit insurance to individuals through a master, corporate, group, or individual policy.

~~(I)~~(K) "Limited lines insurance" means those lines of authority set forth in divisions (B)(7) to (11) of section 3905.06 of the Revised Code or in rules adopted by the superintendent, or any lines of authority the superintendent considers necessary to recognize for purposes of complying with section 3905.072 of the Revised Code.

~~(J)~~(L) "Limited lines insurance agent" means a person authorized by the superintendent to sell, solicit, or negotiate limited lines insurance.

~~(K)~~(M) "NAIC" means the national association of insurance commissioners.

~~(L)~~(N) "Insurance navigator" means a person selected to perform the activities and duties identified in division (i) of section 1311 of the Affordable Care Act that is certified by the superintendent of insurance under section 3905.471 of the Revised Code. "Insurance navigator" refers to a navigator specified in section 1311 of the Affordable Care Act, 42 U.S.C. 13031.

(O) "Negotiate" means to confer directly with, or offer advice directly to, a purchaser or prospective purchaser of a particular contract of insurance with respect to the substantive benefits, terms, or conditions of the contract, provided the person that is conferring or offering advice either sells insurance or obtains insurance from insurers for purchasers.

~~(M)~~(P) "Person" means an individual or a business entity.

~~(N)~~(Q) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurer.

~~(O)~~(R) "Solicit" means to attempt to sell insurance, or to ask or urge a person to apply for a particular kind of insurance from a particular insurer.

~~(P)~~(S) "Superintendent" or "superintendent of insurance" means the superintendent of insurance of this state.

~~(Q)~~(T) "Terminate" means to cancel the relationship between an insurance agent and the insurer or to terminate an insurance agent's authority to transact insurance.

~~(R)~~(U) "Uniform application" means the NAIC uniform application for resident and nonresident agent licensing, as amended by the NAIC from time to time.

~~(S)~~(V) "Uniform business entity application" means the NAIC uniform business entity application for resident and nonresident business entities, as amended by the NAIC from time to time.

(W) "Exchange" means a health benefit exchange established by the state government of Ohio or an exchange established by the United States

department of health and human services in accordance with the "Patient Protection and Affordable Care Act," 124 Stat. 119, 42 U.S.C. 18031 (2011).

Sec. 3905.47. (A)(1) No agent shall sell, solicit, or negotiate insurance through an exchange, or enroll or offer to enroll a person in a health benefit plan offered through an exchange, on or after October 1, 2013, without first completing a training program either required by an exchange or approved by the superintendent of insurance in accordance with division (B) of this section.

(2) If an exchange does not require the completion of a training program pursuant to division (A)(1) of this section, the superintendent shall establish such a program.

(B) The superintendent shall approve courses to be used for compliance with division (A) of this section and shall approve courses established by an exchange, provided that the courses are in accordance with section 3905.484 of the Revised Code. Any course the superintendent approves shall consist of topics related to insurance offered within an exchange, including all of the following:

(1) The levels of coverage provided in an exchange;

(2) The eligibility requirements for individuals to purchase insurance through an exchange;

(3) The eligibility requirements for employers to make insurance available to their employees through a small business health options program;

(4) Individual eligibility requirements for medicaid;

(5) The use of enrollment forms used in an exchange;

(6) Any other topics as required by the superintendent.

(C) Agents that complete the training program required under division (A) of this section shall receive continuing education course credit under sections 3905.481 to 3905.486 of the Revised Code. All such credit shall count toward satisfying the continuing education requirement in section 3905.481 of the Revised Code.

Sec. 3905.471. (A) No individual or entity shall act as or hold itself out to be an insurance navigator unless that individual or entity is certified as an insurance navigator under this section and is receiving funding under division (i) of section 1311 of the Affordable Care Act.

(B) An insurance navigator who complies with the requirements of this section may do any of the following:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) Distribute fair and impartial general information concerning enrollment in all qualified health plans offered within the exchange and the availability of the premium tax credits under section 36B of the Internal Revenue Code of 1986, 26 U.S.C. 36B, and cost-sharing reductions under section 1402 of the Affordable Care Act;

(3) Facilitate enrollment in qualified health plans, without suggesting that an individual select a particular plan;

(4) Provide referrals to appropriate state agencies for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan coverage;

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange.

(C) An insurance navigator shall not do any of the following:

(1) Sell, solicit, or negotiate health insurance;

(2) Provide advice concerning the substantive benefits, terms, and conditions of a particular health benefit plan or offer advice about which health benefit plan is better or worse or suitable for a particular individual or entity;

(3) Recommend a particular health plan or advise consumers about which health benefit plan to choose;

(4) Provide any information or services related to health benefit plans or other products not offered in the exchange. Division (C)(4) of this section shall not be interpreted as prohibiting an insurance navigator from providing information on eligibility for medicaid;

(5) Engage in any unfair method of competition or any fraudulent, deceptive, or dishonest act or practice.

(D) An individual shall not act in the capacity of an insurance navigator, or perform insurance navigator duties on behalf of an organization serving as an insurance navigator, unless the individual has applied for certification and the superintendent finds that the applicant meets all of the following requirements:

(1) Is at least eighteen years of age;

(2) Has completed and submitted the application and disclosure form required under division (F)(2) of this section and has declared, under penalty of refusal, suspension, or revocation of the insurance navigator's certification, that the statements made in the form are true, correct, and complete to the best of the applicant's knowledge and belief;

(3) Has successfully completed a criminal records check under section 3905.051 of the Revised Code, as required by the superintendent;

(4) Has successfully completed the certification and training

requirements adopted by the superintendent in accordance with division (F) of this section;

(5) Has paid all fees required by the superintendent.

(E)(1) A business entity that acts as an insurance navigator, supervises the activities of individual insurance navigators, or receives funding to provide insurance navigator services shall obtain an insurance navigator business entity certification.

(2) Any entity applying for a business entity certification shall apply in a form specified, and provide any information required by, the superintendent.

(3) A business entity certified as an insurance navigator shall, in a manner prescribed by the superintendent, make available a list of all individual insurance navigators that the business entity employs, supervises, or with which the business entity is affiliated.

(F) The superintendent of insurance shall, prior to any exchange becoming operational in this state, do all of the following:

(1)(a) Adopt rules to establish a certification and training program for a prospective insurance navigator and the insurance navigator's employees that includes screening via a criminal records check performed in accordance with section 3905.051 of the Revised Code, initial and continuing education requirements, and an examination;

(b) The certification and training program shall include training on compliance with the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as amended, training on ethics, and training on provisions of the Affordable Care Act relating to insurance navigators and exchanges.

(2) Develop an application and disclosure form by which an insurance navigator may disclose any potential conflicts of interest, as well as any other information the superintendent considers pertinent.

(G)(1) The superintendent may suspend, revoke, or refuse to issue or renew the insurance navigator certification of any person, or levy a civil penalty against any person, that violates the requirements of this section or commits any act that would be a ground for denial, suspension, or revocation of an insurance agent license, as prescribed in section 3905.14 of the Revised Code.

(2) The superintendent shall have the power to examine and investigate the business affairs and records of any insurance navigator.

(3)(a) The superintendent shall not certify as an insurance navigator, and shall revoke any existing insurance navigator certification of, any individual, organization, or business entity that is receiving financial compensation,

including monetary and in-kind compensation, gifts, or grants, on or after October 1, 2013, from an insurer offering a qualified health benefit plan through an exchange operating in this state.

(b) Notwithstanding division (G)(3)(a) of this section, the superintendent may certify as a navigator a qualified health center and a federally qualified health center look-alike, as defined in section 3701.047 of the Revised Code.

(4)(a) If the superintendent finds that a violation of this section made by an individual insurance navigator was made with the knowledge of the employing or supervising entity, or that the employing or supervising entity should reasonably have been aware of the individual insurance navigator's violation, and the violation was not reported to the superintendent and no corrective action was undertaken on a timely basis, then the superintendent may suspend, revoke, or refuse to renew the insurance navigator certification of the supervising or employing entity.

(b) In addition to, or in lieu of, any disciplinary action taken under division (G)(4)(a) of this section, the superintendent may levy a civil penalty against such an entity.

(H) A business entity that terminates the employment, engagement, affiliation, or other relationship with an individual insurance navigator shall notify the superintendent within thirty days following the effective date of the termination, using a format prescribed by the superintendent, if the reason for termination is one of the reasons set forth in section 3905.14 of the Revised Code, or the entity has knowledge that the insurance navigator was found by a court or government body to have engaged in any of the activities in section 3905.14 of the Revised Code.

(I) Insurance navigators are subject to the laws of this chapter, and any rules adopted pursuant to the chapter, in so far as such laws are applicable.

(J) The superintendent may deny, suspend, approve, renew, or revoke the certification of an insurance navigator if the superintendent determines that doing so would be in the interest of Ohio insureds or the general public. Such an action is not subject to Chapter 119. of the Revised Code.

(K) The superintendent may adopt rules in accordance with Chapter 119. of the Revised Code to implement sections 3905.47 to 3905.473 of the Revised Code.

(L) The superintendent may, by rule, apply the requirements of this chapter to any entity or person designated by an exchange, the state, or the federal government to assist consumers or participate in exchange activities.

(M) Any fees collected under this section shall be paid into the state treasury to the credit of the department of insurance operating fund created

under section 3901.021 of the Revised Code.

Sec. 3905.472. An exchange shall permit an insurer to offer any health benefit plan that the insurer seeks to offer through the exchange, so long as the health benefit plan in question is a qualified health plan under the Affordable Care Act, as approved by the superintendent of insurance. Nothing in this section shall be construed to allow the superintendent of insurance to impose any additional state certification requirements in order to be a qualified health plan.

Sec. 3905.473. (A) An exchange operating in this state shall maintain a current list of both of the following:

(1) Licensed insurance agents that have met all of the requirements necessary to offer or sell insurance through an exchange;

(2) Individuals and business entities that have been certified by the superintendent as an insurance navigator.

(B) An exchange shall make available a list of insurance agents operating near the individual's residence address that are certified to sell a health benefit plan through an exchange and insurance navigators that are certified under section 3905.471 of the Revised Code. An exchange operating in this state shall maintain a means of communication by which an individual may make such a request.

(C) Any web site, software application, or other electronic medium, or an exchange-sanctioned outreach event that enables a consumer to determine eligibility for and to purchase a qualified health plan through an exchange shall include information on how an individual can obtain from an exchange the contact information of insurance agents operating near the individual's residence address that are certified to sell health benefit plans through an exchange and insurance navigators that are certified under section 3905.471 of the Revised Code.

Sec. 3905.474. No person shall act as, perform the duties of, or hold one's self out to be an in-person assister unless that person is either a licensed insurance agent certified to sell insurance through an exchange under section 3905.47 of the Revised Code or an insurance navigator certified under section 3905.471 of the Revised Code.

Sec. 4713.62. (A) A person holding a practicing license, managing license, or instructor license may satisfy a continuing education requirement established by rules adopted under section 4713.09 of the Revised Code only by completing continuing education programs approved under division (B) of this section or developed under division (C) of this section.

(B) The state board of cosmetology shall approve a continuing education program if all of the following conditions are satisfied:

(1) The person operating the program submits to the board a written application for approval.

(2) The person operating the program pays to the board a fee established by rules adopted under section 4713.08 of the Revised Code.

(3) The program is operated by an employee, officer, or director of a nonprofit professional association, college or university, proprietary continuing education institutions providing programs approved by the board, vocational school, postsecondary proprietary school of cosmetology licensed by the board, salon licensed by the board, or manufacturer of supplies or equipment used in the practice of a branch of cosmetology.

(4) The program will do at least one of the following:

(a) Enhance the professional competency of the affected licensees;

(b) Protect the public;

(c) Educate the affected licensees in the application of the laws and rules regulating the practice of a branch of cosmetology.

(5) The person operating the program provides the board a tentative schedule of when the program will be available so that the board can make the schedule readily available to all licensees throughout the state.

SECTION 2. That existing sections 1751.12, 3905.01, and 4713.62 of the Revised Code are hereby repealed.

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Speaker _____ of the House of Representatives.

_____

President _____ of the Senate.

Passed _____, 20____

Approved _____, 20____

_____

Governor.

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

_____

Director, Legislative Service Commission.

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

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Secretary of State.

File No. _____ Effective Date _____