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Representative Sears

Cosponsors: Representatives Boose, Grossman, Henne, Romanchuk, Smith, Wachtmann, Young, Amstutz, Beck, Blessing, Burkley, Conditt, Green, Hackett, Hill, Scherer, Thompson Speaker Batchelder

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A BILL

To amend sections 1739.061, 1751.14, 3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 3923.601, 3923.65, 3923.83, and 3924.01, to enact sections 505.377, 737.082, and 737.222 of the Revised Code to clarify the status of volunteer firefighters for purposes of the Patient Protection and Affordable Care Act, to make changes regarding coverage for a dependent child under a parent's health insurance plan and the hours of work needed to qualify for coverage under a small employer health benefit plan, and to increase the duration of the health insurance considered to be short-term under certain insurance laws. 1 2 3 4 5 6 7 8 9 10 11 12 13 14

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

Section 1. That sections 1739.061, 1751.14, 3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 3923.601, 3923.65, 3923.83, and 3924.01 be amended and sections 505.377, 737.082, and 737.222 of the Revised Code be enacted to read as follows: 15 16 17 18

Sec. 505.377. A volunteer firefighter appointed pursuant to this chapter is a bona fide volunteer and not an employee for purposes of section 513 of the "Patient Protection and Affordable Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for providing those fire protection services, the volunteer receives any of the benefits provided in Chapter 146., 4121., or 4123. or section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised Code.

Sec. 737.082. A volunteer firefighter appointed pursuant to this chapter is a bona fide volunteer and not an employee for purposes of section 513 of the "Patient Protection and Affordable Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for providing those fire protection services, the volunteer receives any of the benefits provided in Chapter 146., 4121., or 4123. or section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised Code.

Sec. 737.222. A volunteer firefighter appointed pursuant to this chapter is a bona fide volunteer and not an employee for purposes of section 513 of the "Patient Protection and Affordable Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for providing those fire protection services, the volunteer receives any of the benefits provided in Chapter 146., 4121., or 4123. or section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised Code.

Sec. 1739.061. (A)(1) This section applies to both of the following:

(a) A multiple employer welfare arrangement that issues or requires the use of a standardized identification card or an electronic technology for submission and routing of prescription

drug claims;

(b) A person or entity that a multiple employer welfare arrangement contracts with to issue a standardized identification card or an electronic technology described in division (A)(1)(a) of this section.

(2) Notwithstanding division (A)(1) of this section, this section does not apply to the issuance or required use of a standardized identification card or an electronic technology for the submission and routing of prescription drug claims in connection with any of the following:

(a) Any program or arrangement covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time-limited-duration policy ~~of not longer~~ that is less than ~~six~~ twelve months; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) Coverage provided under the medicaid program.

(c) Coverage provided under an employer's self-insurance plan or by any of its administrators, as defined in section 3959.01 of the Revised Code, to the extent that federal law supersedes, preempts, prohibits, or otherwise precludes the application of this section to the plan and its administrators.

(B) A standardized identification card or an electronic technology issued or required to be used as provided in division (A)(1) of this section shall contain uniform prescription drug information in accordance with either division (B)(1) or (2) of

this section. 79

(1) The standardized identification card or the electronic technology shall be in a format and contain information fields approved by the national council for prescription drug programs or a successor organization, as specified in the council's or successor organization's pharmacy identification card implementation guide in effect on the first day of October most immediately preceding the issuance or required use of the standardized identification card or the electronic technology. 80 81 82 83 84 85 86 87

(2) If the multiple employer welfare arrangement or person under contract with it to issue a standardized identification card or an electronic technology requires the information for the submission and routing of a claim, the standardized identification card or the electronic technology shall contain any of the following information: 88 89 90 91 92 93

(a) The name of the multiple employer welfare arrangement; 94

(b) The individual's name, group number, and identification number; 95 96

(c) A telephone number to inquire about pharmacy-related issues; 97 98

(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN"; 99 100

(e) The processor's control number, labeled as "RxPCN"; 101

(f) The individual's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp." 102 103 104

(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be 105 106 107 108

included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer's international identification number or the processor's control number is different for medical and pharmacy claims. 109 110 111 112

(D) Each multiple employer welfare arrangement described in division (A) of this section shall annually file a certificate with the superintendent of insurance certifying that it or any person it contracts with to issue a standardized identification card or electronic technology for submission and routing of prescription drug claims complies with this section. 113 114 115 116 117 118

(E)(1) Except as provided in division (E)(2) of this section, if there is a change in the information contained in the standardized identification card or the electronic technology issued to an individual, the multiple employer welfare arrangement or person under contract with it to issue a standardized identification card or an electronic technology shall issue a new card or electronic technology to the individual. 119 120 121 122 123 124 125

(2) A multiple employer welfare arrangement or person under contract with it is not required under division (E)(1) of this section to issue a new card or electronic technology to an individual more than once during a twelve-month period. 126 127 128 129

(F) Nothing in this section shall be construed as requiring a multiple employer welfare arrangement to produce more than one standardized identification card or one electronic technology for use by individuals accessing health care benefits provided under a multiple employer welfare arrangement. 130 131 132 133 134

Sec. 1751.14. (A) Notwithstanding section 3901.71 of the Revised Code, any policy, contract, or agreement for health care services authorized by this chapter that is issued, delivered, or renewed in this state and that provides that coverage of an unmarried dependent child will terminate upon attainment of the 135 136 137 138 139

limiting age for dependent children specified in the policy, contract, or agreement, shall also provide in substance both of the following: 140 141 142

(1) Once an unmarried child has attained the limiting age for dependent children, as provided in the policy, contract, or agreement, upon the request of the subscriber, the health insuring corporation shall offer to cover the unmarried child until the child attains ~~twenty-eight~~ <u>twenty-six</u> years of age if all of the following are true: 143 144 145 146 147 148

(a) The child is the natural child, stepchild, or adopted child of the subscriber. 149 150

(b) The child is a resident of this state or a full-time student at an accredited public or private institution of higher education. 151 152 153

(c) The child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage. 154 155 156

(d) The child is not eligible for coverage under the medicaid program or the medicare program. 157 158

(2) That attainment of the limiting age for dependent children shall not operate to terminate the coverage of a dependent child if the child is and continues to be both of the following: 159 160 161 162

(a) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; 163 164

(b) Primarily dependent upon the subscriber for support and maintenance. 165 166

(B) Proof of incapacity and dependence for purposes of division (A)(2) of this section shall be furnished to the health insuring corporation within thirty-one days of the child's 167 168 169

attainment of the limiting age. Upon request, but not more frequently than annually, the health insuring corporation may require proof satisfactory to it of the continuance of such incapacity and dependency. 170 171 172 173

(C) Nothing in this section shall do any of the following: 174

(1) Require that any policy, contract, or agreement offer coverage for dependent children or provide coverage for an unmarried dependent child's children as dependents on the policy, contract, or agreement; 175 176 177 178

(2) Require an employer to pay for any part of the premium for an unmarried dependent child that has attained the limiting age for dependents, as provided in the policy, contract, or agreement; 179 180 181 182

(3) Require an employer to offer health insurance coverage to the dependents of any employee. 183 184

(D) This section does not apply to any health insuring corporation policy, contract, or agreement offering only supplemental health care services or specialty health care services. 185 186 187 188

(E) As used in this section, "health benefit plan" has the same meaning as in section 3924.01 of the Revised Code and also includes both of the following: 189 190 191

(1) A public employee benefit plan; 192

(2) A health benefit plan as regulated under the "Employee Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq. 193 194

Sec. 3923.022. (A) As used in this section: 195

(1)(a) "Administrative expense" means the amount resulting from the following: the amount of premiums earned by the insurer for sickness and accident insurance business plus the amount of 196 197 198

losses recovered from reinsurance coverage minus the sum of the amount of claims for losses paid; the amount of losses incurred but not reported; the amount incurred for state fees, federal and state taxes, and reinsurance; and the incurred costs and expenses related, either directly or indirectly, to the payment of commissions, measures to control fraud, and managed care.

(b) "Administrative expense" does not include any amounts collected, or administrative expenses incurred, by an insurer for the administration of an employee health benefit plan subject to regulation by the federal "Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended. "Amounts collected or administrative expenses incurred" means the total amount paid to an administrator for the administration and payment of claims minus the sum of the amount of claims for losses paid and the amount of losses incurred but not reported.

(2) "Insurer" means any insurance company authorized under Title XXXIX of the Revised Code to do the business of sickness and accident insurance in this state.

(3) "Sickness and accident insurance business" does not include coverage provided by an insurer for specific diseases or accidents only; any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy ~~of no longer~~ <u>that is less</u> than ~~six~~ <u>twelve</u> months, or other policy that offers only supplemental benefits; or coverage provided to individuals who are not residents of this state.

(4) "Individual business" includes both individual sickness and accident insurance and sickness and accident insurance made available by insurers in the individual market to individuals, with or without family members or dependents, through group policies issued to one or more associations or entities.

(B) Notwithstanding section 3941.14 of the Revised Code, each

insurer shall have aggregate administrative expenses of no more than twenty per cent of the premium income of the insurer, based on the premiums earned in that year on the sickness and accident insurance business of the insurer. 230 231 232 233

(C)(1) Each insurer, on the first day of January or within sixty days thereafter, shall annually prepare, under oath, and deposit in the office of the superintendent of insurance a statement of the aggregate administrative expenses of the insurer, based on the premiums earned in the immediately preceding calendar year on the sickness and accident insurance business of the insurer. The statement shall itemize and separately detail all of the following information with respect to the insurer's sickness and accident insurance business: 234 235 236 237 238 239 240 241 242

(a) The amount of premiums earned by the insurer both before and after any costs related to the insurer's purchase of reinsurance coverage; 243 244 245

(b) The total amount of claims for losses paid by the insurer both before and after any reimbursement from reinsurance coverage; 246 247

(c) The amount of any losses incurred by the insurer but not reported by the insurer in the current or prior year; 248 249

(d) The amount of costs incurred by the insurer for state fees and federal and state taxes; 250 251

(e) The amount of costs incurred by the insurer for reinsurance coverage; 252 253

(f) The amount of costs incurred by the insurer that are related to the insurer's payment of commissions; 254 255

(g) The amount of costs incurred by the insurer that are related to the insurer's fraud prevention measures; 256 257

(h) The amount of costs incurred by the insurer that are related to managed care; and 258 259

(i) Any other administrative expenses incurred by the insurer. 260 261

(2) The statement also shall include all of the information required under division (C)(1) of this section separately detailed for the insurer's individual business, small group business, and large group business. 262 263 264 265

(D) No insurer shall fail to comply with this section. 266

(E) If the superintendent determines that an insurer has violated this section, the superintendent, pursuant to an adjudication conducted in accordance with Chapter 119. of the Revised Code, may order the suspension of the insurer's license to do the business of sickness and accident insurance in this state until the superintendent is satisfied that the insurer is in compliance with this section. If the insurer continues to do the business of sickness and accident insurance in this state while under the suspension order, the superintendent shall order the insurer to pay one thousand dollars for each day of the violation. 267 268 269 270 271 272 273 274 275 276

(F) Any money collected by the superintendent under division (E) of this section shall be deposited by the superintendent into the state treasury to the credit of the department of insurance operating fund. 277 278 279 280

(G) The statement of aggregate expenses filed pursuant to this section separately detailing an insurer's individual, small group, and large group business shall be considered work papers resulting from the conduct of a market analysis of an entity subject to examination by the superintendent under division (C) of section 3901.48 of the Revised Code, except that the superintendent may share aggregated market information that identifies the premiums earned as reported under division (C)(1)(a) of this section, the administrative expenses reported under division (C)(1)(i) of this section, the amount of 281 282 283 284 285 286 287 288 289 290

commissions reported under division (C)(1)(f) of this section, the amount of taxes paid as reported under division (C)(1)(d) of this section, the total of the remaining benefit costs as reported under divisions (C)(1)(b) and (c) of this section, and the amount of fraud and managed care expenses reported under divisions (C)(1)(g) and (h) of this section. 291 292 293 294 295 296

Sec. 3923.24. (A) Notwithstanding section 3901.71 of the Revised Code, every certificate furnished by an insurer in connection with, or pursuant to any provision of, any group sickness and accident insurance policy delivered, issued for delivery, renewed, or used in this state on or after January 1, 1972, every policy of sickness and accident insurance delivered, issued for delivery, renewed, or used in this state on or after January 1, 1972, and every multiple employer welfare arrangement offering an insurance program, which provides that coverage of an unmarried dependent child of a parent or legal guardian will terminate upon attainment of the limiting age for dependent children specified in the contract shall also provide in substance both of the following: 297 298 299 300 301 302 303 304 305 306 307 308 309

(1) Once an unmarried child has attained the limiting age for dependent children, as provided in the policy, upon the request of the insured, the insurer shall offer to cover the unmarried child until the child attains ~~twenty-eight~~ <u>twenty-six</u> years of age if all of the following are true: 310 311 312 313 314

(a) The child is the natural child, stepchild, or adopted child of the insured. 315 316

(b) The child is a resident of this state or a full-time student at an accredited public or private institution of higher education. 317 318 319

(c) The child is not employed by an employer that offers any health benefit plan under which the child is eligible for 320 321

coverage. 322

(d) The child is not eligible for the medicaid program or the medicare program. 323 324

(2) That attainment of the limiting age for dependent children shall not operate to terminate the coverage of a dependent child if the child is and continues to be both of the following: 325 326 327 328

(a) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; 329 330

(b) Primarily dependent upon the policyholder or certificate holder for support and maintenance. 331 332

(B) Proof of such incapacity and dependence for purposes of division (A)(2) of this section shall be furnished by the policyholder or by the certificate holder to the insurer within thirty-one days of the child's attainment of the limiting age. Upon request, but not more frequently than annually after the two-year period following the child's attainment of the limiting age, the insurer may require proof satisfactory to it of the continuance of such incapacity and dependency. 333 334 335 336 337 338 339 340

(C) Nothing in this section shall require an insurer to cover a dependent child who is mentally retarded or physically handicapped if the contract is underwritten on evidence of insurability based on health factors set forth in the application, or if such dependent child does not satisfy the conditions of the contract as to any requirement for evidence of insurability or other provision of the contract, satisfaction of which is required for coverage thereunder to take effect. In any such case, the terms of the contract shall apply with regard to the coverage or exclusion of the dependent from such coverage. Nothing in this section shall apply to accidental death or dismemberment benefits provided by any such policy of sickness and accident insurance. 341 342 343 344 345 346 347 348 349 350 351 352

(D) Nothing in this section shall do any of the following: 353

(1) Require that any policy offer coverage for dependent 354
children or provide coverage for an unmarried dependent child's 355
children as dependents on the policy; 356

(2) Require an employer to pay for any part of the premium 357
for an unmarried dependent child that has attained the limiting 358
age for dependents, as provided in the policy; 359

(3) Require an employer to offer health insurance coverage to 360
the dependents of any employee. 361

(E) This section does not apply to any policies or 362
certificates covering only accident, credit, dental, disability 363
income, long-term care, hospital indemnity, medicare supplement, 364
specified disease, or vision care; coverage under a 365
one-time-limited-duration policy ~~of not longer~~ that is less than 366
~~six~~ twelve months; coverage issued as a supplement to liability 367
insurance; insurance arising out of a workers' compensation or 368
similar law; automobile medical-payment insurance; or insurance 369
under which benefits are payable with or without regard to fault 370
and that is statutorily required to be contained in any liability 371
insurance policy or equivalent self-insurance. 372

(F) As used in this section, "health benefit plan" has the 373
same meaning as in section 3924.01 of the Revised Code and also 374
includes both of the following: 375

(1) A public employee benefit plan; 376

(2) A health benefit plan as regulated under the "Employee 377
Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq. 378

Sec. 3923.241. (A) Notwithstanding section 3901.71 of the 379
Revised Code, any public employee benefit plan that provides that 380
coverage of an unmarried dependent child will terminate upon 381
attainment of the limiting age for dependent children specified in 382

the plan shall also provide in substance both of the following: 383

(1) Once an unmarried child has attained the limiting age for 384
dependent children, as provided in the plan, upon the request of 385
the employee, the public employee benefit plan shall offer to 386
cover the unmarried child until the child attains ~~twenty-eight~~ 387
twenty-six years of age if all of the following are true: 388

(a) The child is the natural child, stepchild, or adopted 389
child of the employee. 390

(b) The child is a resident of this state or a full-time 391
student at an accredited public or private institution of higher 392
education. 393

(c) The child is not employed by an employer that offers any 394
health benefit plan under which the child is eligible for 395
coverage. 396

(d) The child is not eligible for the medicaid program or the 397
medicare program. 398

(2) That attainment of the limiting age for dependent 399
children shall not operate to terminate the coverage of a 400
dependent child if the child is and continues to be both of the 401
following: 402

(a) Incapable of self-sustaining employment by reason of 403
mental retardation or physical handicap; 404

(b) Primarily dependent upon the plan member for support and 405
maintenance. 406

(B) Proof of incapacity and dependence for purposes of 407
division (A)(2) of this section shall be furnished to the public 408
employee benefit plan within thirty-one days of the child's 409
attainment of the limiting age. Upon request, but not more 410
frequently than annually, the public employee benefit plan may 411
require proof satisfactory to it of the continuance of such 412

incapacity and dependency. 413

(C) Nothing in this section shall do any of the following: 414

(1) Require that any public employee benefit plan offer 415
coverage for dependent children or provide coverage for an 416
unmarried dependent child's children as dependents on the public 417
employee benefit plan; 418

(2) Require an employer to pay for any part of the premium 419
for an unmarried dependent child that has attained the limiting 420
age for dependents, as provided in the plan; 421

(3) Require an employer to offer health insurance coverage to 422
the dependents of any employee. 423

(D) This section does not apply to any public employee 424
benefit plan covering only accident, credit, dental, disability 425
income, long-term care, hospital indemnity, medicare supplement, 426
specified disease, or vision care; coverage under a 427
one-time-limited-duration policy ~~of not longer~~ that is less than 428
~~six~~ twelve months; coverage issued as a supplement to liability 429
insurance; insurance arising out of a workers' compensation or 430
similar law; automobile medical-payment insurance; or insurance 431
under which benefits are payable with or without regard to fault 432
and which is statutorily required to be contained in any liability 433
insurance policy or equivalent self-insurance. 434

(E) As used in this section, "health benefit plan" has the 435
same meaning as in section 3924.01 of the Revised Code and also 436
includes both of the following: 437

(1) A public employee benefit plan; 438

(2) A health benefit plan as regulated under the "Employee 439
Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq. 440

Sec. 3923.281. (A) As used in this section: 441

(1) "Biologically based mental illness" means schizophrenia, 442
schizoaffective disorder, major depressive disorder, bipolar 443
disorder, paranoia and other psychotic disorders, 444
obsessive-compulsive disorder, and panic disorder, as these terms 445
are defined in the most recent edition of the diagnostic and 446
statistical manual of mental disorders published by the American 447
psychiatric association. 448

(2) "Policy of sickness and accident insurance" has the same 449
meaning as in section 3923.01 of the Revised Code, but excludes 450
any hospital indemnity, medicare supplement, long-term care, 451
disability income, one-time-limited-duration policy ~~of not longer~~ 452
that is less than ~~six~~ twelve months, supplemental benefit, or 453
other policy that provides coverage for specific diseases or 454
accidents only; any policy that provides coverage for workers' 455
compensation claims compensable pursuant to Chapters 4121. and 456
4123. of the Revised Code; and any policy that provides coverage 457
to medicaid recipients. 458

(B) Notwithstanding section 3901.71 of the Revised Code, and 459
subject to division (E) of this section, every policy of sickness 460
and accident insurance shall provide benefits for the diagnosis 461
and treatment of biologically based mental illnesses on the same 462
terms and conditions as, and shall provide benefits no less 463
extensive than, those provided under the policy of sickness and 464
accident insurance for the treatment and diagnosis of all other 465
physical diseases and disorders, if both of the following apply: 466

(1) The biologically based mental illness is clinically 467
diagnosed by a physician authorized under Chapter 4731. of the 468
Revised Code to practice medicine and surgery or osteopathic 469
medicine and surgery; a psychologist licensed under Chapter 4732. 470
of the Revised Code; a professional clinical counselor, 471
professional counselor, or independent social worker licensed 472
under Chapter 4757. of the Revised Code; or a clinical nurse 473

specialist licensed under Chapter 4723. of the Revised Code whose nursing specialty is mental health. 474 475

(2) The prescribed treatment is not experimental or investigational, having proven its clinical effectiveness in accordance with generally accepted medical standards. 476 477 478

(C) Division (B) of this section applies to all coverages and terms and conditions of the policy of sickness and accident insurance, including, but not limited to, coverage of inpatient hospital services, outpatient services, and medication; maximum lifetime benefits; copayments; and individual and family deductibles. 479 480 481 482 483 484

(D) Nothing in this section shall be construed as prohibiting a sickness and accident insurance company from taking any of the following actions: 485 486 487

(1) Negotiating separately with mental health care providers with regard to reimbursement rates and the delivery of health care services; 488 489 490

(2) Offering policies that provide benefits solely for the diagnosis and treatment of biologically based mental illnesses; 491 492

(3) Managing the provision of benefits for the diagnosis or treatment of biologically based mental illnesses through the use of pre-admission screening, by requiring beneficiaries to obtain authorization prior to treatment, or through the use of any other mechanism designed to limit coverage to that treatment determined to be necessary; 493 494 495 496 497 498

(4) Enforcing the terms and conditions of a policy of sickness and accident insurance. 499 500

(E) An insurer that offers any policy of sickness and accident insurance is not required to provide benefits for the diagnosis and treatment of biologically based mental illnesses 501 502 503

pursuant to division (B) of this section if all of the following apply: 504 505

(1) The insurer submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the insurer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year. 506 507 508 509 510 511 512 513

(2) The insurer submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase described in division (E)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and disorders. 514 515 516 517 518 519 520

(3) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (E)(1) and (2) of this section: 521 522 523

(a) Incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the insurer's costs for claims and administrative expenses for the coverage of all other physical diseases and disorders to increase by more than one per cent per year. 524 525 526 527 528 529

(b) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the insurer for the coverage of all other physical diseases and disorders. 530 531 532 533

Any determination made by the superintendent under this 534

division is subject to Chapter 119. of the Revised Code. 535

Sec. 3923.57. Notwithstanding any provision of this chapter, every individual policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state is subject to the following conditions, as applicable: 536 537 538 539

(A) Pre-existing conditions provisions shall not exclude or limit coverage for a period beyond twelve months following the policyholder's effective date of coverage and may only relate to conditions during the six months immediately preceding the effective date of coverage. 540 541 542 543 544

(B) In determining whether a pre-existing conditions provision applies to a policyholder or dependent, each policy shall credit the time the policyholder or dependent was covered under a previous policy, contract, or plan if the previous coverage was continuous to a date not more than thirty days prior to the effective date of the new coverage, exclusive of any applicable service waiting period under the policy. 545 546 547 548 549 550 551

(C)(1) Except as otherwise provided in division (C) of this section, an insurer that provides an individual sickness and accident insurance policy to an individual shall renew or continue in force such coverage at the option of the individual. 552 553 554 555

(2) An insurer may nonrenew or discontinue coverage of an individual in the individual market based only on one or more of the following reasons: 556 557 558

(a) The individual failed to pay premiums or contributions in accordance with the terms of the policy or the insurer has not received timely premium payments. 559 560 561

(b) The individual performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the policy. 562 563 564

(c) The insurer is ceasing to offer coverage in the individual market in accordance with division (D) of this section and the applicable laws of this state. 565 566 567

(d) If the insurer offers coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area, or in an area for which the insurer is authorized to do business; provided, however, that such coverage is terminated uniformly without regard to any health status-related factor of covered individuals. 568 569 570 571 572 573

(e) If the coverage is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association, on the basis of which the coverage is provided, ceases; provided, however, that such coverage is terminated under division (C)(2)(e) of this section uniformly without regard to any health status-related factor of covered individuals. 574 575 576 577 578 579 580

An insurer offering coverage to individuals solely through membership in a bona fide association shall not be deemed, by virtue of that offering, to be in the individual market for purposes of sections 3923.58 and 3923.581 of the Revised Code. Such an insurer shall not be required to accept applicants for coverage in the individual market pursuant to sections 3923.58 and 3923.581 of the Revised Code unless the insurer also offers coverage to individuals other than through bona fide associations. 581 582 583 584 585 586 587 588

(3) An insurer may cancel or decide not to renew the coverage of a dependent of an individual if the dependent has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage and if the cancellation or nonrenewal is not based, either directly or indirectly, on any health status-related factor in relation to the dependent. 589 590 591 592 593 594 595

(D)(1) If an insurer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the insurer if the insurer does all of the following: 596 597 598 599

(a) Provides notice to each individual provided coverage of this type in such market of the discontinuation at least ninety days prior to the date of the discontinuation of the coverage; 600 601 602

(b) Offers to each individual provided coverage of this type in such market, the option to purchase any other individual health insurance coverage currently being offered by the insurer for individuals in that market; 603 604 605 606

(c) In exercising the option to discontinue coverage of this type and in offering the option of coverage under division (D)(1)(b) of this section, acts uniformly without regard to any health status-related factor of covered individuals or of individuals who may become eligible for such coverage. 607 608 609 610 611

(2) If an insurer elects to discontinue offering all health insurance coverage in the individual market in this state, health insurance coverage may be discontinued by the insurer only if both of the following apply: 612 613 614 615

(a) The insurer provides notice to the department of insurance and to each individual of the discontinuation at least one hundred eighty days prior to the date of the expiration of the coverage. 616 617 618 619

(b) All health insurance delivered or issued for delivery in this state in such market is discontinued and coverage under that health insurance in that market is not renewed. 620 621 622

(3) In the event of a discontinuation under division (D)(2) of this section in the individual market, the insurer shall not provide for the issuance of any health insurance coverage in the market and this state during the five-year period beginning on the 623 624 625 626

date of the discontinuation of the last health insurance coverage not so renewed. 627 628

(E) Notwithstanding divisions (C) and (D) of this section, an insurer may, at the time of coverage renewal, modify the health insurance coverage for a policy form offered to individuals in the individual market if the modification is consistent with the law of this state and effective on a uniform basis among all individuals with that policy form. 629 630 631 632 633 634

(F) Such policies are subject to sections 2743 and 2747 of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-43 and 300gg-47, as amended. 635 636 637 638

(G) Sections 3924.031 and 3924.032 of the Revised Code shall apply to sickness and accident insurance policies offered in the individual market in the same manner as they apply to health benefit plans offered in the small employer market. 639 640 641 642

In accordance with 45 C.F.R. 148.102, divisions (C) to (G) of this section also apply to all group sickness and accident insurance policies that are not sold in connection with an employment-related group health plan and that provide more than short-term, limited duration coverage. 643 644 645 646 647

In applying divisions (C) to (G) of this section with respect to health insurance coverage that is made available by an insurer in the individual market to individuals only through one or more associations, the term "individual" includes the association of which the individual is a member. 648 649 650 651 652

For purposes of this section, any policy issued pursuant to division (C) of section 3923.13 of the Revised Code in connection with a public or private college or university student health insurance program is considered to be issued to a bona fide association. 653 654 655 656 657

As used in this section, "bona fide association" has the same meaning as in section 3924.03 of the Revised Code, and "health status-related factor" and "network plan" have the same meanings as in section 3924.031 of the Revised Code.

This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy ~~of no longer~~ that is less than ~~six~~ twelve months, or other policy that offers only supplemental benefits.

Sec. 3923.58. (A) As used in sections 3923.58 and 3923.59 of the Revised Code:

(1) "Base rate" means, as to any health benefit plan that is issued by a carrier in the individual market, the lowest premium rate for new or existing business prescribed by the carrier for the same or similar coverage under a plan or arrangement covering any individual with similar case characteristics.

(2) "Carrier," "health benefit plan," and "MEWA" have the same meanings as in section 3924.01 of the Revised Code.

(3) "Network plan" means a health benefit plan of a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

(4) "Ohio health care basic and standard plans" means those plans established under section 3924.10 of the Revised Code.

(5) "Pre-existing conditions provision" means a policy provision that excludes or limits coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition which, during a

specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received, or a pregnancy existing on the effective date of coverage. 688 689 690 691 692 693

(B) Beginning in January of each year, carriers in the business of issuing health benefit plans to individuals and nonemployer groups, except individual health benefit plans issued pursuant to sections 1751.16 and 3923.122 of the Revised Code, shall accept applicants for open enrollment coverage, as set forth in this division, in the order in which they apply for coverage and subject to the limitation set forth in division (G) of this section. Carriers shall accept for coverage pursuant to this section individuals to whom both of the following conditions apply: 694 695 696 697 698 699 700 701 702 703

(1) The individual is not applying for coverage as an employee of an employer, as a member of an association, or as a member of any other group. 704 705 706

(2) The individual is not covered, and is not eligible for coverage, under any other private or public health benefits arrangement, including the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or any other act of congress or law of this or any other state of the United States that provides benefits comparable to the benefits provided under this section, any medicare supplement policy, or any continuation of coverage policy under state or federal law. 707 708 709 710 711 712 713 714 715

(C) A carrier shall offer to any individual accepted under this section the Ohio health care basic and standard plans or health benefit plans that are substantially similar to the Ohio health care basic and standard plans in benefit plan design and 716 717 718 719

scope of covered services. 720

A carrier may offer other health benefit plans in addition to, but not in lieu of, the plans required to be offered under this division. A basic health benefit plan shall provide, at a minimum, the coverage provided by the Ohio health care basic plan or any health benefit plan that is substantially similar to the Ohio health care basic plan in benefit plan design and scope of covered services. A standard health benefit plan shall provide, at a minimum, the coverage provided by the Ohio health care standard plan or any health benefit plan that is substantially similar to the Ohio health care standard plan in benefit plan design and scope of covered services. 721 722 723 724 725 726 727 728 729 730 731

For purposes of this division, the superintendent of insurance shall determine whether a health benefit plan is substantially similar to the Ohio health care basic and standard plans in benefit plan design and scope of covered services. 732 733 734 735

(D)(1) Health benefit plans issued under this section may establish pre-existing conditions provisions that exclude or limit coverage for a period of up to twelve months following the individual's effective date of coverage and that may relate only to conditions during the six months immediately preceding the effective date of coverage. A health insuring corporation may apply a pre-existing condition provision for any basic health care service related to a transplant of a body organ if the transplant occurs within one year after the effective date of an enrollee's coverage under this section except with respect to a newly born child who meets the requirements for coverage under section 1751.61 of the Revised Code. 736 737 738 739 740 741 742 743 744 745 746 747

(2) In determining whether a pre-existing conditions provision applies to an insured or dependent, each policy shall credit the time the insured or dependent was covered under a previous policy, contract, or plan if the previous coverage was 748 749 750 751

continuous to a date not more than sixty-three days prior to the effective date of the new coverage, exclusive of any applicable service waiting period under the policy. 752 753 754

(E) Premiums charged to individuals under this section may not exceed the amounts specified below: 755 756

(1) For calendar years 2010 and 2011, an amount that is two times the base rate for coverage offered to any other individual to which the carrier is currently accepting new business, and for which similar copayments and deductibles are applied; 757 758 759 760

(2) For calendar year 2012 and every year thereafter, an amount that is one and one-half times the base rate for coverage offered to any other individual to which the carrier is currently accepting new business and for which similar copayments and deductibles are applied, unless the superintendent of insurance determines that the amendments by this act to this section and section 3923.581 of the Revised Code, have resulted in the market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase by more than five and one quarter percentage points during calendar year 2010. If the superintendent makes that determination, the premium limit established by division (E)(1) of this section shall remain in effect. The superintendent's determination shall be supported by a signed letter from a member of the American academy of actuaries. 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775

(F) In offering health benefit plans under this section, a carrier may require the purchase of health benefit plans that condition the reimbursement of health services upon the use of a specific network of providers. 776 777 778 779

(G)(1) A carrier shall not be required to accept new applicants under this section if the total number of the carrier's current insureds with open enrollment coverage issued under this 780 781 782

section calculated as of the immediately preceding thirty-first day of December and excluding the carrier's medicare supplement policies and conversion or continuation of coverage policies under state or federal law and any policies described in division (L) of this section meets the following limits: 783 784 785 786 787

(a) For calendar years 2010 and 2011, four per cent of the carrier's total number of individual or nonemployer group insureds in this state; 788 789 790

(b) For calendar year 2012 and every year thereafter, eight per cent of the carrier's total number of insured individuals and nonemployer group insureds in this state, unless the superintendent of insurance determines that the amendments by this act to this section and section 3923.581 of the Revised Code, have resulted in the market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase by more than five and one quarter percentage points during calendar year 2010. If the superintendent makes that determination, the enrollment limit established by division (G)(1)(a) of this section shall remain in effect. The superintendent's determination shall be supported by a signed letter from a member of the American academy of actuaries. 791 792 793 794 795 796 797 798 799 800 801 802 803 804

(2) An officer of the carrier shall certify to the department of insurance when it has met the enrollment limit set forth in division (G)(1) of this section. Upon providing such certification, the carrier shall be relieved of its open enrollment requirement under this section as long as the carrier continues to meet the open enrollment limit. If the total number of the carrier's current insureds with open enrollment coverage issued under this section falls below the enrollment limit, the carrier shall accept new applicants. A carrier may establish a waiting list if the carrier has met the open enrollment limit and 805 806 807 808 809 810 811 812 813 814

shall notify the superintendent if the carrier has a waiting list in effect. 815 816

(H) A carrier shall not be required to accept under this section applicants who, at the time of enrollment, are confined to a health care facility because of chronic illness, permanent injury, or other infirmity that would cause economic impairment to the carrier if the applicants were accepted. A carrier shall not be required to make the effective date of benefits for individuals accepted under this section earlier than ninety days after the date of acceptance, except that when the individual had prior coverage with a health benefit plan that was terminated by a carrier because the carrier exited the market and the individual was accepted for open enrollment under this section within sixty-three days of that termination, the effective date of benefits shall be the date of enrollment. 817 818 819 820 821 822 823 824 825 826 827 828 829

(I) The requirements of this section do not apply to any carrier that is currently in a state of supervision, insolvency, or liquidation. If a carrier demonstrates to the satisfaction of the superintendent that the requirements of this section would place the carrier in a state of supervision, insolvency, or liquidation, or would otherwise jeopardize the carrier's economic viability overall or in the individual market, the superintendent may waive or modify the requirements of division (B) or (G) of this section. The actions of the superintendent under this division shall be effective for a period of not more than one year. At the expiration of such time, a new showing of need for a waiver or modification by the carrier shall be made before a new waiver or modification is issued or imposed. 830 831 832 833 834 835 836 837 838 839 840 841 842

(J) No hospital, health care facility, or health care practitioner, and no person who employs any health care practitioner, shall balance bill any individual or dependent of an individual for any health care supplies or services provided to 843 844 845 846

the individual or dependent who is insured under a policy issued 847
under this section. The hospital, health care facility, or health 848
care practitioner, or any person that employs the health care 849
practitioner, shall accept payments made to it by the carrier 850
under the terms of the policy or contract insuring or covering 851
such individual as payment in full for such health care supplies 852
or services. 853

As used in this division, "hospital" has the same meaning as 854
in section 3727.01 of the Revised Code; "health care practitioner" 855
has the same meaning as in section 4769.01 of the Revised Code; 856
and "balance bill" means charging or collecting an amount in 857
excess of the amount reimbursable or payable under the policy or 858
health care service contract issued to an individual under this 859
section for such health care supply or service. "Balance bill" 860
does not include charging for or collecting copayments or 861
deductibles required by the policy or contract. 862

(K) A carrier may pay an agent a commission in the amount of 863
not more than five per cent of the premium charged for initial 864
placement or for otherwise securing the issuance of a policy or 865
contract issued to an individual under this section, and not more 866
than four per cent of the premium charged for the renewal of such 867
a policy or contract. The superintendent may adopt, in accordance 868
with Chapter 119. of the Revised Code, such rules as are necessary 869
to enforce this division. 870

(L) This section does not apply to any policy that provides 871
coverage for specific diseases or accidents only, or to any 872
hospital indemnity, medicare supplement, long-term care, 873
disability income, one-time-limited-duration policy ~~of no longer~~ 874
that is less than ~~six~~ twelve months, or other policy that offers 875
only supplemental benefits. 876

(M) If a carrier offers a health benefit plan in the 877
individual market through a network plan, the carrier may do both 878

of the following: 879

(1) Limit the individuals that may apply for such coverage to those who live, work, or reside in the service area of the network plan; 880 881 882

(2) Within the service area of the network plan, deny the coverage to individuals if the carrier has demonstrated both of the following to the superintendent: 883 884 885

(a) The carrier will not have the capacity to deliver services adequately to any additional individuals because of the carrier's obligations to existing group contract holders and individuals. 886 887 888 889

(b) The carrier is applying division (M)(2) of this section uniformly to all individuals without regard to any health status-related factors of those individuals. 890 891 892

(N) A carrier that, pursuant to division (M)(2) of this section, denies coverage to an individual in the service area of a network plan, shall not offer coverage in the individual market within that service area for at least one hundred eighty days after the date the carrier denies the coverage. 893 894 895 896 897

Sec. 3923.601. (A)(1) This section applies to both of the following: 898 899

(a) A sickness and accident insurer that issues or requires the use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims pursuant to a policy, contract, or agreement for health care services; 900 901 902 903 904

(b) A person that a sickness and accident insurer contracts with to issue a standardized identification card or an electronic technology described in division (A)(1)(a) of this section. 905 906 907

(2) Notwithstanding division (A)(1) of this section, this 908

section does not apply to the issuance or required use of a standardized identification card or an electronic technology for the submission and routing of prescription drug claims in connection with any of the following: 909-912

(a) Any individual or group policy of sickness and accident insurance covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time-limited-duration policy ~~of not longer~~ that is less than ~~six~~ twelve months; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance. 913-923

(b) Coverage provided under the medicaid program. 924

(c) Coverage provided under an employer's self-insurance plan or by any of its administrators, as defined in section 3959.01 of the Revised Code, to the extent that federal law supersedes, preempts, prohibits, or otherwise precludes the application of this section to the plan and its administrators. 925-929

(B) A standardized identification card or an electronic technology issued or required to be used as provided in division (A)(1) of this section shall contain uniform prescription drug information in accordance with either division (B)(1) or (2) of this section. 930-934

(1) The standardized identification card or the electronic technology shall be in a format and contain information fields approved by the national council for prescription drug programs or a successor organization, as specified in the council's or successor organization's pharmacy identification card 935-939

implementation guide in effect on the first day of October most immediately preceding the issuance or required use of the standardized identification card or the electronic technology. 940 941 942

(2) If the insurer or person under contract with the insurer to issue a standardized identification card or an electronic technology requires the information for the submission and routing of a claim, the standardized identification card or the electronic technology shall contain any of the following information: 943 944 945 946 947

(a) The insurer's name; 948

(b) The insured's name, group number, and identification number; 949 950

(c) A telephone number to inquire about pharmacy-related issues; 951 952

(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN"; 953 954

(e) The processor's control number, labeled as "RxPCN"; 955

(f) The insured's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp." 956 957

(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer's international identification number or the processor's control number is different for medical and pharmacy claims. 958 959 960 961 962 963 964 965

(D) Each sickness and accident insurer described in division (A) of this section shall annually file a certificate with the superintendent of insurance certifying that it or any person it contracts with to issue a standardized identification card or 966 967 968 969

electronic technology for submission and routing of prescription drug claims complies with this section. 970 971

(E)(1) Except as provided in division (E)(2) of this section, if there is a change in the information contained in the standardized identification card or the electronic technology issued to an insured, the insurer or person under contract with the insurer to issue a standardized identification card or an electronic technology shall issue a new card or electronic technology to the insured. 972 973 974 975 976 977 978

(2) An insurer or person under contract with the insurer is not required under division (E)(1) of this section to issue a new card or electronic technology to an insured more than once during a twelve-month period. 979 980 981 982

(F) Nothing in this section shall be construed as requiring an insurer to produce more than one standardized identification card or one electronic technology for use by insureds accessing health care benefits provided under a policy of sickness and accident insurance. 983 984 985 986 987

Sec. 3923.65. (A) As used in this section: 988

(1) "Emergency medical condition" means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: 989 990 991 992 993 994

(a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; 995 996 997

(b) Serious impairment to bodily functions; 998

(c) Serious dysfunction of any bodily organ or part. 999

(2) "Emergency services" means the following: 1000

(a) A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition; 1001 1002 1003 1004 1005

(b) Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital. 1006 1007 1008 1009 1010

(B) Every individual or group policy of sickness and accident insurance that provides hospital, surgical, or medical expense coverage shall cover emergency services without regard to the day or time the emergency services are rendered or to whether the policyholder, the hospital's emergency department where the services are rendered, or an emergency physician treating the policyholder, obtained prior authorization for the emergency services. 1011 1012 1013 1014 1015 1016 1017 1018

(C) Every individual policy or certificate furnished by an insurer in connection with any sickness and accident insurance policy shall provide information regarding the following: 1019 1020 1021

(1) The scope of coverage for emergency services; 1022

(2) The appropriate use of emergency services, including the use of the 9-1-1 system and any other telephone access systems utilized to access prehospital emergency services; 1023 1024 1025

(3) Any copayments for emergency services. 1026

(D) This section does not apply to any individual or group policy of sickness and accident insurance covering only accident, credit, dental, disability income, long-term care, hospital 1027 1028 1029

indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time limited duration policy ~~of no longer~~ that is less than ~~six~~ twelve months; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

Sec. 3923.83. (A)(1) This section applies to both of the following:

(a) A public employee benefit plan that issues or requires the use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims pursuant to a policy, contract, or agreement for health care services;

(b) A person or entity that a public employee benefit plan contracts with to issue a standardized identification card or an electronic technology described in division (A)(1)(a) of this section.

(2) Notwithstanding division (A)(1) of this section, this section does not apply to the issuance or required use of a standardized identification card or an electronic technology for the submission and routing of prescription drug claims in connection with either of the following:

(a) Any individual or group policy of insurance covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, medicare, tricare, specified disease, or vision care; coverage under a one-time-limited-duration policy ~~of not longer~~ that is less than ~~six~~ twelve months; coverage issued as a supplement to liability

insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance. 1061 1062 1063 1064 1065

(b) Coverage provided under the medicaid program. 1066

(B) A standardized identification card or an electronic technology issued or required to be used as provided in division (A)(1) of this section shall contain uniform prescription drug information in accordance with either division (B)(1) or (2) of this section. 1067 1068 1069 1070 1071

(1) The standardized identification card or the electronic technology shall be in a format and contain information fields approved by the national council for prescription drug programs or a successor organization, as specified in the council's or successor organization's pharmacy identification card implementation guide in effect on the first day of October most immediately preceding the issuance or required use of the standardized identification card or the electronic technology. 1072 1073 1074 1075 1076 1077 1078 1079

(2) If the public employee benefit plan or person under contract with the plan to issue a standardized identification card or an electronic technology requires the information for the submission and routing of a claim, the standardized identification card or the electronic technology shall contain any of the following information: 1080 1081 1082 1083 1084 1085

(a) The plan's name; 1086

(b) The insured's name, group number, and identification number; 1087 1088

(c) A telephone number to inquire about pharmacy-related issues; 1089 1090

(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN"; 1091 1092

(e) The processor's control number, labeled as "RxPCN"; 1093

(f) The insured's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp." 1094 1095

(C) If the standardized identification card or the electronic technology issued or required to be used as provided in division (A)(1) of this section is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels identified in divisions (B)(2)(d) and (e) of this section if the issuer's international identification number or the processor's control number is different for medical and pharmacy claims. 1096 1097 1098 1099 1100 1101 1102 1103

(D)(1) Except as provided in division (D)(2) of this section, if there is a change in the information contained in the standardized identification card or the electronic technology issued to an insured, the public employee benefit plan or person under contract with the plan to issue a standardized identification card or electronic technology shall issue a new card or electronic technology to the insured. 1104 1105 1106 1107 1108 1109 1110

(2) A public employee benefit plan or person under contract with the plan is not required under division (D)(1) of this section to issue a new card or electronic technology to an insured more than once during a twelve-month period. 1111 1112 1113 1114

(E) Nothing in this section shall be construed as requiring a public employee benefit plan to produce more than one standardized identification card or one electronic technology for use by insureds accessing health care benefits provided under a health benefit plan. 1115 1116 1117 1118 1119

Sec. 3924.01. As used in sections 3924.01 to 3924.14 of the 1120

Revised Code: 1121

(A) "Actuarial certification" means a written statement prepared by a member of the American academy of actuaries, or by any other person acceptable to the superintendent of insurance, that states that, based upon the person's examination, a carrier offering health benefit plans to small employers is in compliance with sections 3924.01 to 3924.14 of the Revised Code. "Actuarial certification" shall include a review of the appropriate records of, and the actuarial assumptions and methods used by, the carrier relative to establishing premium rates for the health benefit plans. 1122 1123 1124 1125 1126 1127 1128 1129 1130 1131

(B) "Adjusted average market premium price" means the average market premium price as determined by the board of directors of the Ohio health reinsurance program either on the basis of the arithmetic mean of all carriers' premium rates for an OHC plan sold to groups with similar case characteristics by all carriers selling OHC plans in the state, or on any other equitable basis determined by the board. 1132 1133 1134 1135 1136 1137 1138

(C) "Base premium rate" means, as to any health benefit plan that is issued by a carrier and that covers at least two but no more than fifty employees of a small employer, the lowest premium rate for a new or existing business prescribed by the carrier for the same or similar coverage under a plan or arrangement covering any small employer with similar case characteristics. 1139 1140 1141 1142 1143 1144

(D) "Carrier" means any sickness and accident insurance company or health insuring corporation authorized to issue health benefit plans in this state or a MEWA. A sickness and accident insurance company that owns or operates a health insuring corporation, either as a separate corporation or as a line of business, shall be considered as a separate carrier from that health insuring corporation for purposes of sections 3924.01 to 3924.14 of the Revised Code. 1145 1146 1147 1148 1149 1150 1151 1152

(E) "Case characteristics" means, with respect to a small 1153
employer, the geographic area in which the employees work; the age 1154
and sex of the individual employees and their dependents; the 1155
appropriate industry classification as determined by the carrier; 1156
the number of employees and dependents; and such other objective 1157
criteria as may be established by the carrier. "Case 1158
characteristics" does not include claims experience, health 1159
status, or duration of coverage from the date of issue. 1160

(F) "Dependent" means the spouse or child of an eligible 1161
employee, subject to applicable terms of the health benefits plan 1162
covering the employee. 1163

(G) "Eligible employee" means an employee who works a normal 1164
work week of ~~twenty-five~~ thirty or more hours. "Eligible employee" 1165
does not include a temporary or substitute employee, or a seasonal 1166
employee who works only part of the calendar year on the basis of 1167
natural or suitable times or circumstances. 1168

(H) "Health benefit plan" means any hospital or medical 1169
expense policy or certificate or any health plan provided by a 1170
carrier, that is delivered, issued for delivery, renewed, or used 1171
in this state on or after the date occurring six months after 1172
November 24, 1995. "Health benefit plan" does not include policies 1173
covering only accident, credit, dental, disability income, 1174
long-term care, hospital indemnity, medicare supplement, specified 1175
disease, or vision care; coverage under a 1176
one-time-limited-duration policy ~~of no longer~~ that is less than 1177
~~six~~ twelve months; coverage issued as a supplement to liability 1178
insurance; insurance arising out of a workers' compensation or 1179
similar law; automobile medical-payment insurance; or insurance 1180
under which benefits are payable with or without regard to fault 1181
and which is statutorily required to be contained in any liability 1182
insurance policy or equivalent self-insurance. 1183

(I) "Late enrollee" means an eligible employee or dependent 1184

who enrolls in a small employer's health benefit plan other than during the first period in which the employee or dependent is eligible to enroll under the plan or during a special enrollment period described in section 2701(f) of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg, as amended. 1185 1186 1187 1188 1189 1190

(J) "MEWA" means any "multiple employer welfare arrangement" as defined in section 3 of the "Federal Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended, except for any arrangement which is fully insured as defined in division (b)(6)(D) of section 514 of that act. 1191 1192 1193 1194 1195

(K) "Midpoint rate" means, for small employers with similar case characteristics and plan designs and as determined by the applicable carrier for a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate. 1196 1197 1198 1199 1200

(L) "Pre-existing conditions provision" means a policy provision that excludes or limits coverage for charges or expenses incurred during a specified period following the insured's enrollment date as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the enrollment date. Genetic information shall not be treated as such a condition in the absence of a diagnosis of the condition related to such information. 1201 1202 1203 1204 1205 1206 1207 1208 1209

For purposes of this division, "enrollment date" means, with respect to an individual covered under a group health benefit plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment. 1210 1211 1212 1213

(M) "Service waiting period" means the period of time after employment begins before an employee is eligible to be covered for 1214 1215

benefits under the terms of any applicable health benefit plan offered by the small employer. 1216 1217

(N)(1) "Small employer" means, in connection with a group health benefit plan and with respect to a calendar year and a plan year, an employer who employed an average of at least two but no more than fifty eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. 1218 1219 1220 1221 1222 1223

(2) For purposes of division (N)(1) of this section, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be considered one employer. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected the employer will employ on business days in the current calendar year. Any reference in division (N) of this section to an "employer" includes any predecessor of the employer. Except as otherwise specifically provided, provisions of sections 3924.01 to 3924.14 of the Revised Code that apply to a small employer that has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this division. 1224 1225 1226 1227 1228 1229 1230 1231 1232 1233 1234 1235 1236 1237 1238 1239

(O) "OHC plan" means an Ohio health care plan, which is the basic, standard, or carrier reimbursement plan for small employers and individuals established in accordance with section 3924.10 of the Revised Code. 1240 1241 1242 1243

Section 2. That existing sections 1739.061, 1751.14, 3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 3923.601, 3923.65, 3923.83, and 3924.01 of the Revised Code are hereby 1244 1245 1246

repealed. 1247

Section 3. Sections 1751.14, and 3924.01 as amended by this act, apply only to policies, contracts, and agreements that are delivered, issued for delivery, or renewed in this state on or after January 1, 2015. Sections 3923.24 and 3923.241 as amended by this act, apply only to policies of sickness and accident insurance delivered, issued for delivery, or renewed in this state and public or private employee benefit plans that are established or modified in this state on or after January 1, 2015. 1248 1249 1250 1251 1252 1253 1254 1255

Section 4. The General Assembly declares that the amendments made to section 3923.58 of the Revised Code by this act are not to supersede the suspension of the operation of this section enacted by Section 3 of Sub. S.B. 9 of the 130th General Assembly. Rather, it is the intent of the General Assembly to ensure consistency in Ohio Insurance Law should this suspension be nullified. 1256 1257 1258 1259 1260 1261