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Senators Kearney, Eklund

Cosponsors: Senators Cafaro, Gentile, Smith, Sawyer, Tavares, Schiavoni, Turner, Lehner, Jones, Bacon, Balderson, Beagle, Burke, Coley, Faber, Gardner, Hite, Hughes, LaRose, Manning, Obhof, Oelslager, Patton, Peterson, Schaffer, Seitz, Skindell, Uecker, Widener
Representatives Wachtmann, Brown

A B I L L

To amend sections 1739.061, 1751.14, 1751.69, 3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 3923.601, 3923.65, 3923.83, 3923.85, 3924.01, 4729.291, and 4729.541 and to enact sections 505.377, 737.082, 737.222, 3702.40, and 4731.056 of the Revised Code to require a mammography facility to include certain information in the mammography report summary sent to a patient under federal law if the patient's mammogram demonstrates the presence of dense breast tissue; to establish requirements regarding controlled substances containing buprenorphine used for the purpose of treating drug dependence or addiction; 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; to increase the duration of the health insurance considered to be short-term under certain insurance laws; and to make changes to the chemotherapy parity law.

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

Section 1. That sections 1739.061, 1751.14, 1751.69, 3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 3923.601, 3923.65, 3923.83, 3923.85, 3924.01, 4729.291, and 4729.541 be amended and sections 505.377, 737.082, 737.222, 3702.40, and 4731.056 of the Revised Code be enacted to read as follows:

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.

(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.

(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:

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

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

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

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

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

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

(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.

(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.

(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.

(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.

(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.

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

(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~~ twenty-six years of age if all of the following are true:

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

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

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

(d) The child is not eligible for coverage under the medicaid

program or the medicare program.

(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:

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

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

(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 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.

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

(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;

(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;

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

(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.

(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:

(1) A public employee benefit plan;

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

Sec. 1751.69. (A) As used in this section, "cost sharing" means the cost to an individual insured under an individual or group health insuring corporation policy, contract, or agreement according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the policy, contract, or agreement.

(B) Notwithstanding section 3901.71 of the Revised Code and subject to division (D) of this section, no individual or group health insuring corporation policy, contract, or agreement providing basic health care services or prescription drug services that is delivered, issued for delivery, or renewed in this state, if the policy, contract, or agreement provides coverage for cancer chemotherapy treatment, shall fail to comply with either of the following:

(1) The policy, contract, or agreement shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intraveneously administered or injected cancer medications.

(2) The policy, contract, or agreement shall not comply with division (B)(1) of this section by imposing an increase in cost sharing solely for orally administered, intravenously administered, or injected cancer medications.

(C) Notwithstanding any provision of this section to the contrary, an individual or group health insuring corporation policy, contract, or agreement shall be deemed to be in compliance with this section if the cost sharing imposed under such a policy, contract, or agreement for orally administered cancer treatments does not exceed one hundred dollars per prescription fill. The cost sharing limit of one hundred dollars per prescription fill shall apply to a high deductible plan, as defined in 26 U.S.C. 223, or a catastrophic plan, as defined in 42 U.S.C. 18022, only after the deductible has been met.

(D) The prohibitions in division (B) of this section do not preclude an individual or group health insuring corporation policy, contract, or agreement from requiring an enrollee to obtain prior authorization before orally administered cancer medication is dispensed to the enrollee.

(E) A health insuring corporation that offers coverage for basic health care services is not required to comply with division (B) of this section if all of the following apply:

(1) The health insuring corporation submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that compliance with division (B)(1) of this section for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(2) The health insuring corporation submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs 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 health insuring corporation for

the coverage of basic health care services.

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

(i) Compliance with division (B)(1) of this section for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(b) Any determination made by the superintendent under division (E)(3) of this section is subject to Chapter 119. of the Revised Code.

Sec. 3702.40. (A) As used in this section, "mammogram" and "facility" have the same meanings as in section 263b(a) of the "Mammography Quality Standards Act of 1992," 106 Stat. 3547 (1992), 42 U.S.C. 263b(a), as amended.

(B) As required by 21 C.F.R. 900.12(c)(2), a facility shall send to each patient who has a mammogram at the facility a summary of the written report containing the results of the patient's mammogram. If, based on the breast imaging reporting and data system established by the American college of radiology, the patient's mammogram demonstrates that the patient has dense breast tissue, the summary shall include the following statement:

"Your mammogram demonstrates that you have dense breast tissue, which could hide abnormalities. Dense breast tissue, in and of itself, is a relatively common condition. Therefore, this

information is not provided to cause undue concern; rather, it is to raise your awareness and promote discussion with your health care provider regarding the presence of dense breast tissue in addition to other risk factors."

As required by 21 C.F.R. 900.12(c)(3), the facility shall send to the patient's health care provider, if known, a copy of the written report containing the results of the patient's mammogram not later than thirty days after the mammogram was performed.

(C) This section does not do either of the following:

(1) Create a new cause of action or substantive legal right against a person, facility, or other entity.

(2) Create a standard of care, obligation, or duty for a person, facility, or other entity that would provide the basis for a cause of action or substantive legal right, other than the duty to send the summary and written report described in division (B) of this section.

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

(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 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~~ that is less than ~~six~~ twelve 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.

(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:

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

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

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

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

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

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

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

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

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

(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.

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

(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.

(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.

(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 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.

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:

(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~~ twenty-six years of age if all of the following are true:

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

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

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

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

(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:

(a) Incapable of self-sustaining employment by reason of

mental retardation or physical handicap;

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

(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.

(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.

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

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

(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;

(3) Require an employer to offer health insurance coverage to

the dependents of any employee.

(E) This section does not apply to any policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, 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 a workers' compensation or similar law; automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(F) 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:

(1) A public employee benefit plan;

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

Sec. 3923.241. (A) Notwithstanding section 3901.71 of the Revised Code, any public employee benefit plan that provides that coverage of an unmarried dependent child will terminate upon attainment of the limiting age for dependent children specified in the plan shall also provide in substance both of the following:

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

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

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

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

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

(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:

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

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

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

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

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

(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 plan;

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

(D) This section does not apply to any public employee benefit plan covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, 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 a workers' compensation or similar law; automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(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:

(1) A public employee benefit plan;

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

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

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

(2) "Policy of sickness and accident insurance" has the same meaning as in section 3923.01 of the Revised Code, but excludes

any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy ~~of not longer~~ that is less than ~~six~~ twelve months, supplemental benefit, or other policy that provides coverage for specific diseases or accidents only; any policy that provides coverage for workers' compensation claims compensable pursuant to Chapters 4121. and 4123. of the Revised Code; and any policy that provides coverage to medicaid recipients.

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

(1) The biologically based mental illness is clinically diagnosed by a physician authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery; a psychologist licensed under Chapter 4732. of the Revised Code; a licensed professional clinical counselor, licensed professional counselor, independent social worker, or independent marriage and family therapist licensed under Chapter 4757. of the Revised Code; or a clinical nurse specialist or certified nurse practitioner licensed under Chapter 4723. of the Revised Code whose nursing specialty is mental health.

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

(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.

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

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

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

(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;

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

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

(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.

(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.

(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:

(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.

(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.

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code.

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:

(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.

(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.

(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.

(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:

(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.

(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.

(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.

(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.

(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.

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.

(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.

(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:

(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;

(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;

(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.

(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:

(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.

(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.

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

(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.

(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.

(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.

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.

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.

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.

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.

(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:

(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.

(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.

(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 scope of covered services.

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.

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.

(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.

(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 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.

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

(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;

(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.

(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.

(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 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:

(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;

(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.

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

(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.

(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.

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

As used in this division, "hospital" has the same meaning as

in section 3727.01 of the Revised Code; "health care practitioner" has the same meaning as in section 4769.01 of the Revised Code; and "balance bill" means charging or collecting an amount in excess of the amount reimbursable or payable under the policy or health care service contract issued to an individual under this section for such health care supply or service. "Balance bill" does not include charging for or collecting copayments or deductibles required by the policy or contract.

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

(L) 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.

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

(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;

(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:

(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.

(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.

(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.

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

(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;

(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.

(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 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.

(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.

(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.

(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:

(a) The insurer's name;

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

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

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

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

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

(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.

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

(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.

(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.

(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.

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

(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:

(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;

(b) Serious impairment to bodily functions;

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

(2) "Emergency services" means the following:

(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;

(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.

(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.

(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:

(1) The scope of coverage for emergency services;

(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;

(3) Any copayments for emergency services.

(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 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.

(b) Coverage provided under the medicaid program.

(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.

(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.

(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:

(a) The plan's name;

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

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

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

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

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

(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.

(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.

(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.

(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.

Sec. 3923.85. (A) As used in this section, "cost sharing" means the cost to an individual insured under an individual or group policy of sickness and accident insurance or a public employee benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the policy or plan.

(B) Notwithstanding section 3901.71 of the Revised Code and subject to division (D) of this section, no individual or group

policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state and no public employee benefit plan that is established or modified in this state shall fail to comply with either of the following:

(1) The policy or plan shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intraveneously administered or injected cancer medications.

(2) The policy or plan shall not comply with division (B)(1) of this section by imposing an increase in cost sharing solely for orally administered, intravenously administered, or injected cancer medications.

(C) Notwithstanding any provision of this section to the contrary, a policy or plan shall be deemed to be in compliance with this section if the cost sharing imposed under such a policy or plan for orally administered cancer treatments does not exceed one hundred dollars per prescription fill. <u>The cost sharing limit of one hundred dollars per prescription fill shall apply to a high deductible plan, as defined in 26 U.S.C. 223, or a catastrophic plan, as defined in 42 U.S.C. 18022, only after the deductible has been met.</u>

(D)(1) The prohibitions in division (B) of this section do not preclude an individual or group policy of sickness and accident insurance or public employee benefit plan from requiring an insured or plan member to obtain prior authorization before orally administered cancer medication is dispensed to the insured or plan member.

(2) Division (B) of this section does not apply to the offer or renewal of any individual or group policy of sickness and accident insurance that provides coverage for specific diseases or

accidents only, or to any hospital indemnity, medicare supplement, disability income, or other policy that offers only supplemental benefits.

(E) An insurer that offers any sickness and accident insurance or any public employee benefit plan that offers coverage for basic health care services is not required to comply with division (B) of this section if all of the following apply:

(1) The insurer or plan submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that compliance with division (B)(1) of this section for a period of at least six months independently caused the insurer or plan's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(2) The insurer or plan submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs 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 or plan for the coverage of basic health care services.

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

(i) Compliance with division (B)(1) of this section for a period of at least six months independently caused the insurer or plan's costs for claims and administrative expenses for the coverage of basic health care services to increase more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged

by the insurer or plan for the coverage of basic health care services.

(b) Any determination made by the superintendent under division (E)(3) of this section is subject to Chapter 119. of the Revised Code.

Sec. 3924.01. As used in sections 3924.01 to 3924.14 of the Revised Code:

(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.

(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.

(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.

(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.

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

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

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

(H) "Health benefit plan" means any hospital or medical expense policy or certificate or any health plan provided by a carrier, that is delivered, issued for delivery, renewed, or used in this state on or after the date occurring six months after November 24, 1995. "Health benefit plan" does not include policies covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, 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 a workers' compensation or similar law; automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

(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.

(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.

(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.

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.

(M) "Service waiting period" means the period of time after employment begins before an employee is eligible to be covered for benefits under the terms of any applicable health benefit plan offered by the small employer.

(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.

(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.

(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.

Sec. 4729.291. (A) When a licensed health professional authorized to prescribe drugs personally furnishes drugs to a patient pursuant to division (B) of section 4729.29 of the Revised Code, the prescriber shall ensure that the drugs are labeled and packaged in accordance with state and federal drug laws and any rules and regulations adopted pursuant to those laws. Records of purchase and disposition of all drugs personally furnished to patients shall be maintained by the prescriber in accordance with state and federal drug statutes and any rules adopted pursuant to those statutes.

(B) When personally furnishing to a patient RU-486 (mifepristone), a prescriber is subject to section 2919.123 of the Revised Code. A prescription for RU-486 (mifepristone) shall be in writing and in accordance with section 2919.123 of the Revised Code.

(C)(1) Except as provided in division (D) of this section, a prescriber ~~may~~ shall not do either of the following:

(a) In any thirty-day period, personally furnish to or for patients, taken as a whole, controlled substances in an amount that exceeds a total of two thousand five hundred dosage units;

(b) In any seventy-two-hour period, personally furnish to or for a patient an amount of a controlled substance that exceeds the amount necessary for the patient's use in a seventy-two-hour period.

(2) The state board of pharmacy may impose a fine of not more than five thousand dollars on a prescriber who fails to comply

with the limits established under division (C)(1) of this section. A separate fine may be imposed for each instance of failing to comply with the limits. In imposing the fine, the board's actions shall be taken in accordance with Chapter 119. of the Revised Code.

(D)(1) None of the following shall be counted in determining whether the amounts specified in division (C)(1) of this section have been exceeded:

(a) Methadone provided to patients for the purpose of treating drug dependence or addiction, if the prescriber meets the conditions specified in 21 C.F.R. 1306.07;

(b) Buprenorphine provided to patients for the purpose of treating drug dependence or addiction~~, if the prescriber is exempt from separate registration with the United States drug enforcement administration~~ as part of an opioid treatment program that is the subject of a current, valid certification from the substance abuse and mental health services administration of the United States department of health and human services pursuant to ~~21~~ 42 C.F.R. ~~1301.28~~ 8.11 and distributes both buprenorphine and methadone;

(c) Controlled substances provided to research subjects by a facility conducting clinical research in studies approved by a hospital-based institutional review board or an institutional review board accredited by the association for the accreditation of human research protection programs.

(2) Division (C)(1) of this section does not apply to a prescriber who is a veterinarian.

Sec. 4729.541. (A) Except as provided in divisions (B) and (C) of this section, a business entity described in division (B)(1)(j) or (k) of section 4729.51 of the Revised Code may possess, have custody or control of, and distribute the dangerous

drugs in category I, category II, and category III, as defined in section 4729.54 of the Revised Code, without holding a terminal distributor of dangerous drugs license issued under that section.

(B) If a business entity described in division (B)(1)(j) or (k) of section 4729.51 of the Revised Code is a pain management clinic or is operating a pain management clinic, the entity shall hold a license as a terminal distributor of dangerous drugs with a pain management clinic classification issued under section 4729.552 of the Revised Code.

(C) Beginning April 1, 2015, a business entity described in division (B)(1)(j) or (k) of section 4729.51 of the Revised Code shall hold a license as a terminal distributor of dangerous drugs in order to possess, have custody or control of, and distribute ~~dangerous~~ either of the following:

(1) Dangerous drugs that are compounded or used for the purpose of compounding;

(2) Controlled substances containing buprenorphine that are used for the purpose of treating drug dependence or addiction.

Sec. 4731.056. (A) As used in this section:

(1) "Controlled substance," "schedule III," "schedule IV," and "schedule V" have the same meanings as in section 3719.01 of the Revised Code.

(2) "Physician" means an individual authorized by this chapter to practice medicine and surgery or osteopathic medicine and surgery.

(B) The state medical board shall adopt rules in accordance with Chapter 119. of the Revised Code that establish standards and procedures to be followed by physicians in the use of controlled substances in schedule III, IV, or V to treat opioid dependence or

addiction. The board may limit the application of the rules to treatment provided through an office-based practice or other practice type or location specified by the board.

Section 2. That existing sections 1739.061, 1751.14, 1751.69, 3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 3923.601, 3923.65, 3923.83, 3923.85, 3924.01, 4729.291, and 4729.541 of the Revised Code are hereby repealed.

Section 3. Section 1751.14 and division (G) of section 3924.01 of the Revised Code, 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, 2016. Division (A)(1) of section 3923.24 and division (A)(1) of section 3923.241 of the Revised Code, 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 employee benefit plans or multiple employer welfare arrangement contracts and certificates that are established or modified in this state on or after January 1, 2016.

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.