

As Reported by the House Health and Aging Committee

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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**

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A B I L L

To amend sections 1739.061, 1751.14, 1751.69, 1
3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 2
3923.58, 3923.601, 3923.65, 3923.83, 3923.85, 3
3924.01, 4729.291, and 4729.541 and to enact 4
sections 505.377, 737.082, 737.222, 3702.40, and 5
4731.056 of the Revised Code to require a 6
mammography facility to include certain 7
information in the mammography report summary sent 8
to a patient under federal law if the patient's 9
mammogram demonstrates the presence of dense 10
breast tissue; to establish requirements regarding 11
controlled substances containing buprenorphine 12
used for the purpose of treating drug dependence 13
or addiction; to clarify the status of volunteer 14
firefighters for purposes of the Patient 15
Protection and Affordable Care Act; to make 16
changes regarding coverage for a dependent child 17
under a parent's health insurance plan and the 18
hours of work needed to qualify for coverage under 19

a small employer health benefit plan; to increase 20
the duration of the health insurance considered to 21
be short-term under certain insurance laws; and to 22
make changes to the chemotherapy parity law. 23

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

Section 1. That sections 1739.061, 1751.14, 1751.69, 24
3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 3923.601, 25
3923.65, 3923.83, 3923.85, 3924.01, 4729.291, and 4729.541 be 26
amended and sections 505.377, 737.082, 737.222, 3702.40, and 27
4731.056 of the Revised Code be enacted to read as follows: 28

Sec. 505.377. A volunteer firefighter appointed pursuant to 29
this chapter is a bona fide volunteer and not an employee for 30
purposes of section 513 of the "Patient Protection and Affordable 31
Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for 32
providing those fire protection services, the volunteer receives 33
any of the benefits provided in Chapter 146., 4121., or 4123. or 34
section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised 35
Code. 36

Sec. 737.082. A volunteer firefighter appointed pursuant to 37
this chapter is a bona fide volunteer and not an employee for 38
purposes of section 513 of the "Patient Protection and Affordable 39
Care Act," 124 Stat. 119 (2010), 26 U.S.C. 4980H, if, for 40
providing those fire protection services, the volunteer receives 41
any of the benefits provided in Chapter 146., 4121., or 4123. or 42
section 9.65, 505.23, 3333.26, 3923.13, or 4113.41 of the Revised 43
Code. 44

Sec. 737.222. A volunteer firefighter appointed pursuant to 45
this chapter is a bona fide volunteer and not an employee for 46

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. 77
78

(b) Coverage provided under the medicaid program. 79

(c) Coverage provided under an employer's self-insurance plan 80
or by any of its administrators, as defined in section 3959.01 of 81
the Revised Code, to the extent that federal law supersedes, 82
preempts, prohibits, or otherwise precludes the application of 83
this section to the plan and its administrators. 84

(B) A standardized identification card or an electronic 85
technology issued or required to be used as provided in division 86
(A)(1) of this section shall contain uniform prescription drug 87
information in accordance with either division (B)(1) or (2) of 88
this section. 89

(1) The standardized identification card or the electronic 90
technology shall be in a format and contain information fields 91
approved by the national council for prescription drug programs or 92
a successor organization, as specified in the council's or 93
successor organization's pharmacy identification card 94
implementation guide in effect on the first day of October most 95
immediately preceding the issuance or required use of the 96
standardized identification card or the electronic technology. 97

(2) If the multiple employer welfare arrangement or person 98
under contract with it to issue a standardized identification card 99
or an electronic technology requires the information for the 100
submission and routing of a claim, the standardized identification 101
card or the electronic technology shall contain any of the 102
following information: 103

(a) The name of the multiple employer welfare arrangement; 104

(b) The individual's name, group number, and identification 105
number; 106

(c) A telephone number to inquire about pharmacy-related issues;	107 108
(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN";	109 110
(e) The processor's control number, labeled as "RxPCN";	111
(f) The individual's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp."	112 113 114
(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.	115 116 117 118 119 120 121 122
(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.	123 124 125 126 127 128
(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.	129 130 131 132 133 134 135
(2) A multiple employer welfare arrangement or person under contract with it is not required under division (E)(1) of this	136 137

section to issue a new card or electronic technology to an 138
individual more than once during a twelve-month period. 139

(F) Nothing in this section shall be construed as requiring a 140
multiple employer welfare arrangement to produce more than one 141
standardized identification card or one electronic technology for 142
use by individuals accessing health care benefits provided under a 143
multiple employer welfare arrangement. 144

Sec. 1751.14. (A) Notwithstanding section 3901.71 of the 145
Revised Code, any policy, contract, or agreement for health care 146
services authorized by this chapter that is issued, delivered, or 147
renewed in this state and that provides that coverage of an 148
unmarried dependent child will terminate upon attainment of the 149
limiting age for dependent children specified in the policy, 150
contract, or agreement, shall also provide in substance both of 151
the following: 152

(1) Once an unmarried child has attained the limiting age for 153
dependent children, as provided in the policy, contract, or 154
agreement, upon the request of the subscriber, the health insuring 155
corporation shall offer to cover the unmarried child until the 156
child attains ~~twenty-eight~~ twenty-six years of age if all of the 157
following are true: 158

(a) The child is the natural child, stepchild, or adopted 159
child of the subscriber. 160

(b) The child is a resident of this state or a full-time 161
student at an accredited public or private institution of higher 162
education. 163

(c) The child is not employed by an employer that offers any 164
health benefit plan under which the child is eligible for 165
coverage. 166

(d) The child is not eligible for coverage under the medicaid 167

program or the medicare program.	168
(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:	169 170 171 172
(a) Incapable of self-sustaining employment by reason of mental retardation or physical handicap;	173 174
(b) Primarily dependent upon the subscriber for support and maintenance.	175 176
(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.	177 178 179 180 181 182 183
(C) Nothing in this section shall do any of the following:	184
(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;	185 186 187 188
(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;	189 190 191 192
(3) Require an employer to offer health insurance coverage to the dependents of any employee.	193 194
(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	195 196 197

services.	198
(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:	199 200 201
(1) A public employee benefit plan;	202
(2) A health benefit plan as regulated under the "Employee Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq.	203 204
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.	205 206 207 208 209 210
(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:	211 212 213 214 215 216 217 218
(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 intravenously administered or injected cancer medications.	219 220 221 222 223
(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.	224 225 226 227

(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. 260

(3)(a) The superintendent of insurance makes the following 261
determinations from the documentation and opinion submitted 262
pursuant to divisions (E)(1) and (2) of this section: 263

(i) Compliance with division (B)(1) of this section for a 264
period of at least six months independently caused the health 265
insuring corporation's costs for claims and administrative 266
expenses for the coverage of basic health care services to 267
increase more than one per cent per year. 268

(ii) The increase in costs reasonably justifies an increase 269
of more than one per cent in the annual premiums or rates charged 270
by the health insuring corporation for the coverage of basic 271
health care services. 272

(b) Any determination made by the superintendent under 273
division (E)(3) of this section is subject to Chapter 119. of the 274
Revised Code. 275

Sec. 3702.40. (A) As used in this section, "mammogram" and 276
"facility" have the same meanings as in section 263b(a) of the 277
"Mammography Quality Standards Act of 1992," 106 Stat. 3547 278
(1992), 42 U.S.C. 263b(a), as amended. 279

(B) As required by 21 C.F.R. 900.12(c)(2), a facility shall 280
send to each patient who has a mammogram at the facility a summary 281
of the written report containing the results of the patient's 282
mammogram. If, based on the breast imaging reporting and data 283
system established by the American college of radiology, the 284
patient's mammogram demonstrates that the patient has dense breast 285
tissue, the summary shall include the following statement: 286

"Your mammogram demonstrates that you have dense breast 287
tissue, which could hide abnormalities. Dense breast tissue, in 288
and of itself, is a relatively common condition. Therefore, this 289

information is not provided to cause undue concern; rather, it is 290
to raise your awareness and promote discussion with your health 291
care provider regarding the presence of dense breast tissue in 292
addition to other risk factors." 293

As required by 21 C.F.R. 900.12(c)(3), the facility shall 294
send to the patient's health care provider, if known, a copy of 295
the written report containing the results of the patient's 296
mammogram not later than thirty days after the mammogram was 297
performed. 298

(C) This section does not do either of the following: 299

(1) Create a new cause of action or substantive legal right 300
against a person, facility, or other entity. 301

(2) Create a standard of care, obligation, or duty for a 302
person, facility, or other entity that would provide the basis for 303
a cause of action or substantive legal right, other than the duty 304
to send the summary and written report described in division (B) 305
of this section. 306

Sec. 3923.022. (A) As used in this section: 307

(1)(a) "Administrative expense" means the amount resulting 308
from the following: the amount of premiums earned by the insurer 309
for sickness and accident insurance business plus the amount of 310
losses recovered from reinsurance coverage minus the sum of the 311
amount of claims for losses paid; the amount of losses incurred 312
but not reported; the amount incurred for state fees, federal and 313
state taxes, and reinsurance; and the incurred costs and expenses 314
related, either directly or indirectly, to the payment of 315
commissions, measures to control fraud, and managed care. 316

(b) "Administrative expense" does not include any amounts 317
collected, or administrative expenses incurred, by an insurer for 318
the administration of an employee health benefit plan subject to 319

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 351
insurer. The statement shall itemize and separately detail all of 352
the following information with respect to the insurer's sickness 353
and accident insurance business: 354

(a) The amount of premiums earned by the insurer both before 355
and after any costs related to the insurer's purchase of 356
reinsurance coverage; 357

(b) The total amount of claims for losses paid by the insurer 358
both before and after any reimbursement from reinsurance coverage; 359

(c) The amount of any losses incurred by the insurer but not 360
reported by the insurer in the current or prior year; 361

(d) The amount of costs incurred by the insurer for state 362
fees and federal and state taxes; 363

(e) The amount of costs incurred by the insurer for 364
reinsurance coverage; 365

(f) The amount of costs incurred by the insurer that are 366
related to the insurer's payment of commissions; 367

(g) The amount of costs incurred by the insurer that are 368
related to the insurer's fraud prevention measures; 369

(h) The amount of costs incurred by the insurer that are 370
related to managed care; and 371

(i) Any other administrative expenses incurred by the 372
insurer. 373

(2) The statement also shall include all of the information 374
required under division (C)(1) of this section separately detailed 375
for the insurer's individual business, small group business, and 376
large group business. 377

(D) No insurer shall fail to comply with this section. 378

(E) If the superintendent determines that an insurer has 379

violated this section, the superintendent, pursuant to an 380
adjudication conducted in accordance with Chapter 119. of the 381
Revised Code, may order the suspension of the insurer's license to 382
do the business of sickness and accident insurance in this state 383
until the superintendent is satisfied that the insurer is in 384
compliance with this section. If the insurer continues to do the 385
business of sickness and accident insurance in this state while 386
under the suspension order, the superintendent shall order the 387
insurer to pay one thousand dollars for each day of the violation. 388

(F) Any money collected by the superintendent under division 389
(E) of this section shall be deposited by the superintendent into 390
the state treasury to the credit of the department of insurance 391
operating fund. 392

(G) The statement of aggregate expenses filed pursuant to 393
this section separately detailing an insurer's individual, small 394
group, and large group business shall be considered work papers 395
resulting from the conduct of a market analysis of an entity 396
subject to examination by the superintendent under division (C) of 397
section 3901.48 of the Revised Code, except that the 398
superintendent may share aggregated market information that 399
identifies the premiums earned as reported under division 400
(C)(1)(a) of this section, the administrative expenses reported 401
under division (C)(1)(i) of this section, the amount of 402
commissions reported under division (C)(1)(f) of this section, the 403
amount of taxes paid as reported under division (C)(1)(d) of this 404
section, the total of the remaining benefit costs as reported 405
under divisions (C)(1)(b) and (c) of this section, and the amount 406
of fraud and managed care expenses reported under divisions 407
(C)(1)(g) and (h) of this section. 408

Sec. 3923.24. (A) Notwithstanding section 3901.71 of the 409
Revised Code, every certificate furnished by an insurer in 410

connection with, or pursuant to any provision of, any group 411
sickness and accident insurance policy delivered, issued for 412
delivery, renewed, or used in this state on or after January 1, 413
1972, every policy of sickness and accident insurance delivered, 414
issued for delivery, renewed, or used in this state on or after 415
January 1, 1972, and every multiple employer welfare arrangement 416
offering an insurance program, which provides that coverage of an 417
unmarried dependent child of a parent or legal guardian will 418
terminate upon attainment of the limiting age for dependent 419
children specified in the contract shall also provide in substance 420
both of the following: 421

(1) Once an unmarried child has attained the limiting age for 422
dependent children, as provided in the policy, upon the request of 423
the insured, the insurer shall offer to cover the unmarried child 424
until the child attains ~~twenty-eight~~ twenty-six years of age if 425
all of the following are true: 426

(a) The child is the natural child, stepchild, or adopted 427
child of the insured. 428

(b) The child is a resident of this state or a full-time 429
student at an accredited public or private institution of higher 430
education. 431

(c) The child is not employed by an employer that offers any 432
health benefit plan under which the child is eligible for 433
coverage. 434

(d) The child is not eligible for the medicaid program or the 435
medicare program. 436

(2) That attainment of the limiting age for dependent 437
children shall not operate to terminate the coverage of a 438
dependent child if the child is and continues to be both of the 439
following: 440

(a) Incapable of self-sustaining employment by reason of 441

mental retardation or physical handicap; 442

(b) Primarily dependent upon the policyholder or certificate 443
holder for support and maintenance. 444

(B) Proof of such incapacity and dependence for purposes of 445
division (A)(2) of this section shall be furnished by the 446
policyholder or by the certificate holder to the insurer within 447
thirty-one days of the child's attainment of the limiting age. 448
Upon request, but not more frequently than annually after the 449
two-year period following the child's attainment of the limiting 450
age, the insurer may require proof satisfactory to it of the 451
continuance of such incapacity and dependency. 452

(C) Nothing in this section shall require an insurer to cover 453
a dependent child who is mentally retarded or physically 454
handicapped if the contract is underwritten on evidence of 455
insurability based on health factors set forth in the application, 456
or if such dependent child does not satisfy the conditions of the 457
contract as to any requirement for evidence of insurability or 458
other provision of the contract, satisfaction of which is required 459
for coverage thereunder to take effect. In any such case, the 460
terms of the contract shall apply with regard to the coverage or 461
exclusion of the dependent from such coverage. Nothing in this 462
section shall apply to accidental death or dismemberment benefits 463
provided by any such policy of sickness and accident insurance. 464

(D) Nothing in this section shall do any of the following: 465

(1) Require that any policy offer coverage for dependent 466
children or provide coverage for an unmarried dependent child's 467
children as dependents on the policy; 468

(2) Require an employer to pay for any part of the premium 469
for an unmarried dependent child that has attained the limiting 470
age for dependents, as provided in the policy; 471

(3) Require an employer to offer health insurance coverage to 472

the dependents of any employee. 473

(E) This section does not apply to any policies or 474
certificates covering only accident, credit, dental, disability 475
income, long-term care, hospital indemnity, medicare supplement, 476
specified disease, or vision care; coverage under a 477
one-time-limited-duration policy ~~of not longer~~ that is less than 478
~~six~~ twelve months; coverage issued as a supplement to liability 479
insurance; insurance arising out of a workers' compensation or 480
similar law; automobile medical-payment insurance; or insurance 481
under which benefits are payable with or without regard to fault 482
and that is statutorily required to be contained in any liability 483
insurance policy or equivalent self-insurance. 484

(F) As used in this section, "health benefit plan" has the 485
same meaning as in section 3924.01 of the Revised Code and also 486
includes both of the following: 487

(1) A public employee benefit plan; 488

(2) A health benefit plan as regulated under the "Employee 489
Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq. 490

Sec. 3923.241. (A) Notwithstanding section 3901.71 of the 491
Revised Code, any public employee benefit plan that provides that 492
coverage of an unmarried dependent child will terminate upon 493
attainment of the limiting age for dependent children specified in 494
the plan shall also provide in substance both of the following: 495

(1) Once an unmarried child has attained the limiting age for 496
dependent children, as provided in the plan, upon the request of 497
the employee, the public employee benefit plan shall offer to 498
cover the unmarried child until the child attains ~~twenty-eight~~ 499
twenty-six years of age if all of the following are true: 500

(a) The child is the natural child, stepchild, or adopted 501
child of the employee. 502

(b) The child is a resident of this state or a full-time student at an accredited public or private institution of higher education.	503 504 505
(c) The child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage.	506 507 508
(d) The child is not eligible for the medicaid program or the medicare program.	509 510
(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:	511 512 513 514
(a) Incapable of self-sustaining employment by reason of mental retardation or physical handicap;	515 516
(b) Primarily dependent upon the plan member for support and maintenance.	517 518
(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.	519 520 521 522 523 524 525
(C) Nothing in this section shall do any of the following:	526
(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;	527 528 529 530
(2) Require an employer to pay for any part of the premium for an unmarried dependent child that has attained the limiting	531 532

age for dependents, as provided in the plan; 533

(3) Require an employer to offer health insurance coverage to 534
the dependents of any employee. 535

(D) This section does not apply to any public employee 536
benefit plan covering only accident, credit, dental, disability 537
income, long-term care, hospital indemnity, medicare supplement, 538
specified disease, or vision care; coverage under a 539
one-time-limited-duration policy ~~of not longer~~ that is less than 540
~~six~~ twelve months; coverage issued as a supplement to liability 541
insurance; insurance arising out of a workers' compensation or 542
similar law; automobile medical-payment insurance; or insurance 543
under which benefits are payable with or without regard to fault 544
and which is statutorily required to be contained in any liability 545
insurance policy or equivalent self-insurance. 546

(E) As used in this section, "health benefit plan" has the 547
same meaning as in section 3924.01 of the Revised Code and also 548
includes both of the following: 549

(1) A public employee benefit plan; 550

(2) A health benefit plan as regulated under the "Employee 551
Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq. 552

Sec. 3923.281. (A) As used in this section: 553

(1) "Biologically based mental illness" means schizophrenia, 554
schizoaffective disorder, major depressive disorder, bipolar 555
disorder, paranoia and other psychotic disorders, 556
obsessive-compulsive disorder, and panic disorder, as these terms 557
are defined in the most recent edition of the diagnostic and 558
statistical manual of mental disorders published by the American 559
psychiatric association. 560

(2) "Policy of sickness and accident insurance" has the same 561
meaning as in section 3923.01 of the Revised Code, but excludes 562

any hospital indemnity, medicare supplement, long-term care, 563
disability income, one-time-limited-duration policy ~~of not longer~~ 564
that is less than ~~six~~ twelve months, supplemental benefit, or 565
other policy that provides coverage for specific diseases or 566
accidents only; any policy that provides coverage for workers' 567
compensation claims compensable pursuant to Chapters 4121. and 568
4123. of the Revised Code; and any policy that provides coverage 569
to medicaid recipients. 570

(B) Notwithstanding section 3901.71 of the Revised Code, and 571
subject to division (E) of this section, every policy of sickness 572
and accident insurance shall provide benefits for the diagnosis 573
and treatment of biologically based mental illnesses on the same 574
terms and conditions as, and shall provide benefits no less 575
extensive than, those provided under the policy of sickness and 576
accident insurance for the treatment and diagnosis of all other 577
physical diseases and disorders, if both of the following apply: 578

(1) The biologically based mental illness is clinically 579
diagnosed by a physician authorized under Chapter 4731. of the 580
Revised Code to practice medicine and surgery or osteopathic 581
medicine and surgery; a psychologist licensed under Chapter 4732. 582
of the Revised Code; a licensed professional clinical counselor, 583
licensed professional counselor, independent social worker, or 584
independent marriage and family therapist licensed under Chapter 585
4757. of the Revised Code; or a clinical nurse specialist or 586
certified nurse practitioner licensed under Chapter 4723. of the 587
Revised Code whose nursing specialty is mental health. 588

(2) The prescribed treatment is not experimental or 589
investigational, having proven its clinical effectiveness in 590
accordance with generally accepted medical standards. 591

(C) Division (B) of this section applies to all coverages and 592
terms and conditions of the policy of sickness and accident 593
insurance, including, but not limited to, coverage of inpatient 594

hospital services, outpatient services, and medication; maximum 595
lifetime benefits; copayments; and individual and family 596
deductibles. 597

(D) Nothing in this section shall be construed as prohibiting 598
a sickness and accident insurance company from taking any of the 599
following actions: 600

(1) Negotiating separately with mental health care providers 601
with regard to reimbursement rates and the delivery of health care 602
services; 603

(2) Offering policies that provide benefits solely for the 604
diagnosis and treatment of biologically based mental illnesses; 605

(3) Managing the provision of benefits for the diagnosis or 606
treatment of biologically based mental illnesses through the use 607
of pre-admission screening, by requiring beneficiaries to obtain 608
authorization prior to treatment, or through the use of any other 609
mechanism designed to limit coverage to that treatment determined 610
to be necessary; 611

(4) Enforcing the terms and conditions of a policy of 612
sickness and accident insurance. 613

(E) An insurer that offers any policy of sickness and 614
accident insurance is not required to provide benefits for the 615
diagnosis and treatment of biologically based mental illnesses 616
pursuant to division (B) of this section if all of the following 617
apply: 618

(1) The insurer submits documentation certified by an 619
independent member of the American academy of actuaries to the 620
superintendent of insurance showing that incurred claims for 621
diagnostic and treatment services for biologically based mental 622
illnesses for a period of at least six months independently caused 623
the insurer's costs for claims and administrative expenses for the 624
coverage of all other physical diseases and disorders to increase 625

by more than one per cent per year. 626

(2) The insurer submits a signed letter from an independent 627
member of the American academy of actuaries to the superintendent 628
of insurance opining that the increase described in division 629
(E)(1) of this section could reasonably justify an increase of 630
more than one per cent in the annual premiums or rates charged by 631
the insurer for the coverage of all other physical diseases and 632
disorders. 633

(3) The superintendent of insurance makes the following 634
determinations from the documentation and opinion submitted 635
pursuant to divisions (E)(1) and (2) of this section: 636

(a) Incurred claims for diagnostic and treatment services for 637
biologically based mental illnesses for a period of at least six 638
months independently caused the insurer's costs for claims and 639
administrative expenses for the coverage of all other physical 640
diseases and disorders to increase by more than one per cent per 641
year. 642

(b) The increase in costs reasonably justifies an increase of 643
more than one per cent in the annual premiums or rates charged by 644
the insurer for the coverage of all other physical diseases and 645
disorders. 646

Any determination made by the superintendent under this 647
division is subject to Chapter 119. of the Revised Code. 648

Sec. 3923.57. Notwithstanding any provision of this chapter, 649
every individual policy of sickness and accident insurance that is 650
delivered, issued for delivery, or renewed in this state is 651
subject to the following conditions, as applicable: 652

(A) Pre-existing conditions provisions shall not exclude or 653
limit coverage for a period beyond twelve months following the 654
policyholder's effective date of coverage and may only relate to 655

conditions during the six months immediately preceding the 656
effective date of coverage. 657

(B) In determining whether a pre-existing conditions 658
provision applies to a policyholder or dependent, each policy 659
shall credit the time the policyholder or dependent was covered 660
under a previous policy, contract, or plan if the previous 661
coverage was continuous to a date not more than thirty days prior 662
to the effective date of the new coverage, exclusive of any 663
applicable service waiting period under the policy. 664

(C)(1) Except as otherwise provided in division (C) of this 665
section, an insurer that provides an individual sickness and 666
accident insurance policy to an individual shall renew or continue 667
in force such coverage at the option of the individual. 668

(2) An insurer may nonrenew or discontinue coverage of an 669
individual in the individual market based only on one or more of 670
the following reasons: 671

(a) The individual failed to pay premiums or contributions in 672
accordance with the terms of the policy or the insurer has not 673
received timely premium payments. 674

(b) The individual performed an act or practice that 675
constitutes fraud or made an intentional misrepresentation of 676
material fact under the terms of the policy. 677

(c) The insurer is ceasing to offer coverage in the 678
individual market in accordance with division (D) of this section 679
and the applicable laws of this state. 680

(d) If the insurer offers coverage in the market through a 681
network plan, the individual no longer resides, lives, or works in 682
the service area, or in an area for which the insurer is 683
authorized to do business; provided, however, that such coverage 684
is terminated uniformly without regard to any health 685
status-related factor of covered individuals. 686

(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 718
individuals in that market; 719

(c) In exercising the option to discontinue coverage of this 720
type and in offering the option of coverage under division 721
(D)(1)(b) of this section, acts uniformly without regard to any 722
health status-related factor of covered individuals or of 723
individuals who may become eligible for such coverage. 724

(2) If an insurer elects to discontinue offering all health 725
insurance coverage in the individual market in this state, health 726
insurance coverage may be discontinued by the insurer only if both 727
of the following apply: 728

(a) The insurer provides notice to the department of 729
insurance and to each individual of the discontinuation at least 730
one hundred eighty days prior to the date of the expiration of the 731
coverage. 732

(b) All health insurance delivered or issued for delivery in 733
this state in such market is discontinued and coverage under that 734
health insurance in that market is not renewed. 735

(3) In the event of a discontinuation under division (D)(2) 736
of this section in the individual market, the insurer shall not 737
provide for the issuance of any health insurance coverage in the 738
market and this state during the five-year period beginning on the 739
date of the discontinuation of the last health insurance coverage 740
not so renewed. 741

(E) Notwithstanding divisions (C) and (D) of this section, an 742
insurer may, at the time of coverage renewal, modify the health 743
insurance coverage for a policy form offered to individuals in the 744
individual market if the modification is consistent with the law 745
of this state and effective on a uniform basis among all 746
individuals with that policy form. 747

(F) Such policies are subject to sections 2743 and 2747 of 748

the "Health Insurance Portability and Accountability Act of 1996," 749
Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-43 and 750
300gg-47, as amended. 751

(G) Sections 3924.031 and 3924.032 of the Revised Code shall 752
apply to sickness and accident insurance policies offered in the 753
individual market in the same manner as they apply to health 754
benefit plans offered in the small employer market. 755

In accordance with 45 C.F.R. 148.102, divisions (C) to (G) of 756
this section also apply to all group sickness and accident 757
insurance policies that are not sold in connection with an 758
employment-related group health plan and that provide more than 759
short-term, limited duration coverage. 760

In applying divisions (C) to (G) of this section with respect 761
to health insurance coverage that is made available by an insurer 762
in the individual market to individuals only through one or more 763
associations, the term "individual" includes the association of 764
which the individual is a member. 765

For purposes of this section, any policy issued pursuant to 766
division (C) of section 3923.13 of the Revised Code in connection 767
with a public or private college or university student health 768
insurance program is considered to be issued to a bona fide 769
association. 770

As used in this section, "bona fide association" has the same 771
meaning as in section 3924.03 of the Revised Code, and "health 772
status-related factor" and "network plan" have the same meanings 773
as in section 3924.031 of the Revised Code. 774

This section does not apply to any policy that provides 775
coverage for specific diseases or accidents only, or to any 776
hospital indemnity, medicare supplement, long-term care, 777
disability income, one-time-limited-duration policy ~~of no longer~~ 778
that is less than six twelve months, or other policy that offers 779

only supplemental benefits. 780

Sec. 3923.58. (A) As used in sections 3923.58 and 3923.59 of 781
the Revised Code: 782

(1) "Base rate" means, as to any health benefit plan that is 783
issued by a carrier in the individual market, the lowest premium 784
rate for new or existing business prescribed by the carrier for 785
the same or similar coverage under a plan or arrangement covering 786
any individual with similar case characteristics. 787

(2) "Carrier," "health benefit plan," and "MEWA" have the 788
same meanings as in section 3924.01 of the Revised Code. 789

(3) "Network plan" means a health benefit plan of a carrier 790
under which the financing and delivery of medical care, including 791
items and services paid for as medical care, are provided, in 792
whole or in part, through a defined set of providers under 793
contract with the carrier. 794

(4) "Ohio health care basic and standard plans" means those 795
plans established under section 3924.10 of the Revised Code. 796

(5) "Pre-existing conditions provision" means a policy 797
provision that excludes or limits coverage for charges or expenses 798
incurred during a specified period following the insured's 799
effective date of coverage as to a condition which, during a 800
specified period immediately preceding the effective date of 801
coverage, had manifested itself in such a manner as would cause an 802
ordinarily prudent person to seek medical advice, diagnosis, care, 803
or treatment or for which medical advice, diagnosis, care, or 804
treatment was recommended or received, or a pregnancy existing on 805
the effective date of coverage. 806

(B) Beginning in January of each year, carriers in the 807
business of issuing health benefit plans to individuals and 808
nonemployer groups, except individual health benefit plans issued 809

pursuant to sections 1751.16 and 3923.122 of the Revised Code, 810
shall accept applicants for open enrollment coverage, as set forth 811
in this division, in the order in which they apply for coverage 812
and subject to the limitation set forth in division (G) of this 813
section. Carriers shall accept for coverage pursuant to this 814
section individuals to whom both of the following conditions 815
apply: 816

(1) The individual is not applying for coverage as an 817
employee of an employer, as a member of an association, or as a 818
member of any other group. 819

(2) The individual is not covered, and is not eligible for 820
coverage, under any other private or public health benefits 821
arrangement, including the medicare program established under 822
Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 823
U.S.C.A. 301, as amended, or any other act of congress or law of 824
this or any other state of the United States that provides 825
benefits comparable to the benefits provided under this section, 826
any medicare supplement policy, or any continuation of coverage 827
policy under state or federal law. 828

(C) A carrier shall offer to any individual accepted under 829
this section the Ohio health care basic and standard plans or 830
health benefit plans that are substantially similar to the Ohio 831
health care basic and standard plans in benefit plan design and 832
scope of covered services. 833

A carrier may offer other health benefit plans in addition 834
to, but not in lieu of, the plans required to be offered under 835
this division. A basic health benefit plan shall provide, at a 836
minimum, the coverage provided by the Ohio health care basic plan 837
or any health benefit plan that is substantially similar to the 838
Ohio health care basic plan in benefit plan design and scope of 839
covered services. A standard health benefit plan shall provide, at 840
a minimum, the coverage provided by the Ohio health care standard 841

plan or any health benefit plan that is substantially similar to 842
the Ohio health care standard plan in benefit plan design and 843
scope of covered services. 844

For purposes of this division, the superintendent of 845
insurance shall determine whether a health benefit plan is 846
substantially similar to the Ohio health care basic and standard 847
plans in benefit plan design and scope of covered services. 848

(D)(1) Health benefit plans issued under this section may 849
establish pre-existing conditions provisions that exclude or limit 850
coverage for a period of up to twelve months following the 851
individual's effective date of coverage and that may relate only 852
to conditions during the six months immediately preceding the 853
effective date of coverage. A health insuring corporation may 854
apply a pre-existing condition provision for any basic health care 855
service related to a transplant of a body organ if the transplant 856
occurs within one year after the effective date of an enrollee's 857
coverage under this section except with respect to a newly born 858
child who meets the requirements for coverage under section 859
1751.61 of the Revised Code. 860

(2) In determining whether a pre-existing conditions 861
provision applies to an insured or dependent, each policy shall 862
credit the time the insured or dependent was covered under a 863
previous policy, contract, or plan if the previous coverage was 864
continuous to a date not more than sixty-three days prior to the 865
effective date of the new coverage, exclusive of any applicable 866
service waiting period under the policy. 867

(E) Premiums charged to individuals under this section may 868
not exceed the amounts specified below: 869

(1) For calendar years 2010 and 2011, an amount that is two 870
times the base rate for coverage offered to any other individual 871
to which the carrier is currently accepting new business, and for 872

which similar copayments and deductibles are applied; 873

(2) For calendar year 2012 and every year thereafter, an 874
amount that is one and one-half times the base rate for coverage 875
offered to any other individual to which the carrier is currently 876
accepting new business and for which similar copayments and 877
deductibles are applied, unless the superintendent of insurance 878
determines that the amendments by this act to this section and 879
section 3923.581 of the Revised Code, have resulted in the 880
market-wide average medical loss ratio for coverage sold to 881
individual insureds and nonemployer group insureds in this state, 882
including open enrollment insureds, to increase by more than five 883
and one quarter percentage points during calendar year 2010. If 884
the superintendent makes that determination, the premium limit 885
established by division (E)(1) of this section shall remain in 886
effect. The superintendent's determination shall be supported by a 887
signed letter from a member of the American academy of actuaries. 888

(F) In offering health benefit plans under this section, a 889
carrier may require the purchase of health benefit plans that 890
condition the reimbursement of health services upon the use of a 891
specific network of providers. 892

(G)(1) A carrier shall not be required to accept new 893
applicants under this section if the total number of the carrier's 894
current insureds with open enrollment coverage issued under this 895
section calculated as of the immediately preceding thirty-first 896
day of December and excluding the carrier's medicare supplement 897
policies and conversion or continuation of coverage policies under 898
state or federal law and any policies described in division (L) of 899
this section meets the following limits: 900

(a) For calendar years 2010 and 2011, four per cent of the 901
carrier's total number of individual or nonemployer group insureds 902
in this state; 903

(b) For calendar year 2012 and every year thereafter, eight 904
per cent of the carrier's total number of insured individuals and 905
nonemployer group insureds in this state, unless the 906
superintendent of insurance determines that the amendments by this 907
act to this section and section 3923.581 of the Revised Code, have 908
resulted in the market-wide average medical loss ratio for 909
coverage sold to individual insureds and nonemployer group 910
insureds in this state, including open enrollment insureds, to 911
increase by more than five and one quarter percentage points 912
during calendar year 2010. If the superintendent makes that 913
determination, the enrollment limit established by division 914
(G)(1)(a) of this section shall remain in effect. The 915
superintendent's determination shall be supported by a signed 916
letter from a member of the American academy of actuaries. 917

(2) An officer of the carrier shall certify to the department 918
of insurance when it has met the enrollment limit set forth in 919
division (G)(1) of this section. Upon providing such 920
certification, the carrier shall be relieved of its open 921
enrollment requirement under this section as long as the carrier 922
continues to meet the open enrollment limit. If the total number 923
of the carrier's current insureds with open enrollment coverage 924
issued under this section falls below the enrollment limit, the 925
carrier shall accept new applicants. A carrier may establish a 926
waiting list if the carrier has met the open enrollment limit and 927
shall notify the superintendent if the carrier has a waiting list 928
in effect. 929

(H) A carrier shall not be required to accept under this 930
section applicants who, at the time of enrollment, are confined to 931
a health care facility because of chronic illness, permanent 932
injury, or other infirmity that would cause economic impairment to 933
the carrier if the applicants were accepted. A carrier shall not 934
be required to make the effective date of benefits for individuals 935

accepted under this section earlier than ninety days after the 936
date of acceptance, except that when the individual had prior 937
coverage with a health benefit plan that was terminated by a 938
carrier because the carrier exited the market and the individual 939
was accepted for open enrollment under this section within 940
sixty-three days of that termination, the effective date of 941
benefits shall be the date of enrollment. 942

(I) The requirements of this section do not apply to any 943
carrier that is currently in a state of supervision, insolvency, 944
or liquidation. If a carrier demonstrates to the satisfaction of 945
the superintendent that the requirements of this section would 946
place the carrier in a state of supervision, insolvency, or 947
liquidation, or would otherwise jeopardize the carrier's economic 948
viability overall or in the individual market, the superintendent 949
may waive or modify the requirements of division (B) or (G) of 950
this section. The actions of the superintendent under this 951
division shall be effective for a period of not more than one 952
year. At the expiration of such time, a new showing of need for a 953
waiver or modification by the carrier shall be made before a new 954
waiver or modification is issued or imposed. 955

(J) No hospital, health care facility, or health care 956
practitioner, and no person who employs any health care 957
practitioner, shall balance bill any individual or dependent of an 958
individual for any health care supplies or services provided to 959
the individual or dependent who is insured under a policy issued 960
under this section. The hospital, health care facility, or health 961
care practitioner, or any person that employs the health care 962
practitioner, shall accept payments made to it by the carrier 963
under the terms of the policy or contract insuring or covering 964
such individual as payment in full for such health care supplies 965
or services. 966

As used in this division, "hospital" has the same meaning as 967

in section 3727.01 of the Revised Code; "health care practitioner" 968
has the same meaning as in section 4769.01 of the Revised Code; 969
and "balance bill" means charging or collecting an amount in 970
excess of the amount reimbursable or payable under the policy or 971
health care service contract issued to an individual under this 972
section for such health care supply or service. "Balance bill" 973
does not include charging for or collecting copayments or 974
deductibles required by the policy or contract. 975

(K) A carrier may pay an agent a commission in the amount of 976
not more than five per cent of the premium charged for initial 977
placement or for otherwise securing the issuance of a policy or 978
contract issued to an individual under this section, and not more 979
than four per cent of the premium charged for the renewal of such 980
a policy or contract. The superintendent may adopt, in accordance 981
with Chapter 119. of the Revised Code, such rules as are necessary 982
to enforce this division. 983

(L) This section does not apply to any policy that provides 984
coverage for specific diseases or accidents only, or to any 985
hospital indemnity, medicare supplement, long-term care, 986
disability income, one-time-limited-duration policy ~~of no longer~~ 987
that is less than six twelve months, or other policy that offers 988
only supplemental benefits. 989

(M) If a carrier offers a health benefit plan in the 990
individual market through a network plan, the carrier may do both 991
of the following: 992

(1) Limit the individuals that may apply for such coverage to 993
those who live, work, or reside in the service area of the network 994
plan; 995

(2) Within the service area of the network plan, deny the 996
coverage to individuals if the carrier has demonstrated both of 997
the following to the superintendent: 998

(a) The carrier will not have the capacity to deliver 999
services adequately to any additional individuals because of the 1000
carrier's obligations to existing group contract holders and 1001
individuals. 1002

(b) The carrier is applying division (M)(2) of this section 1003
uniformly to all individuals without regard to any health 1004
status-related factors of those individuals. 1005

(N) A carrier that, pursuant to division (M)(2) of this 1006
section, denies coverage to an individual in the service area of a 1007
network plan, shall not offer coverage in the individual market 1008
within that service area for at least one hundred eighty days 1009
after the date the carrier denies the coverage. 1010

Sec. 3923.601. (A)(1) This section applies to both of the 1011
following: 1012

(a) A sickness and accident insurer that issues or requires 1013
the use of a standardized identification card or an electronic 1014
technology for submission and routing of prescription drug claims 1015
pursuant to a policy, contract, or agreement for health care 1016
services; 1017

(b) A person that a sickness and accident insurer contracts 1018
with to issue a standardized identification card or an electronic 1019
technology described in division (A)(1)(a) of this section. 1020

(2) Notwithstanding division (A)(1) of this section, this 1021
section does not apply to the issuance or required use of a 1022
standardized identification card or an electronic technology for 1023
the submission and routing of prescription drug claims in 1024
connection with any of the following: 1025

(a) Any individual or group policy of sickness and accident 1026
insurance covering only accident, credit, dental, disability 1027
income, long-term care, hospital indemnity, medicare supplement, 1028

medicare, tricare, specified disease, or vision care; coverage 1029
under a one-time-limited-duration policy ~~of not longer~~ that is 1030
less than ~~six~~ twelve months; coverage issued as a supplement to 1031
liability insurance; insurance arising out of workers' 1032
compensation or similar law; automobile medical payment insurance; 1033
or insurance under which benefits are payable with or without 1034
regard to fault and which is statutorily required to be contained 1035
in any liability insurance policy or equivalent self-insurance. 1036

(b) Coverage provided under the medicaid program. 1037

(c) Coverage provided under an employer's self-insurance plan 1038
or by any of its administrators, as defined in section 3959.01 of 1039
the Revised Code, to the extent that federal law supersedes, 1040
preempts, prohibits, or otherwise precludes the application of 1041
this section to the plan and its administrators. 1042

(B) A standardized identification card or an electronic 1043
technology issued or required to be used as provided in division 1044
(A)(1) of this section shall contain uniform prescription drug 1045
information in accordance with either division (B)(1) or (2) of 1046
this section. 1047

(1) The standardized identification card or the electronic 1048
technology shall be in a format and contain information fields 1049
approved by the national council for prescription drug programs or 1050
a successor organization, as specified in the council's or 1051
successor organization's pharmacy identification card 1052
implementation guide in effect on the first day of October most 1053
immediately preceding the issuance or required use of the 1054
standardized identification card or the electronic technology. 1055

(2) If the insurer or person under contract with the insurer 1056
to issue a standardized identification card or an electronic 1057
technology requires the information for the submission and routing 1058
of a claim, the standardized identification card or the electronic 1059

technology shall contain any of the following information:	1060
(a) The insurer's name;	1061
(b) The insured's name, group number, and identification number;	1062 1063
(c) A telephone number to inquire about pharmacy-related issues;	1064 1065
(d) The issuer's international identification number, labeled as "ANSI BIN" or "RxBIN";	1066 1067
(e) The processor's control number, labeled as "RxPCN";	1068
(f) The insured's pharmacy benefits group number if different from the insured's medical group number, labeled as "RxGrp."	1069 1070
(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.	1071 1072 1073 1074 1075 1076 1077 1078
(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.	1079 1080 1081 1082 1083 1084
(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	1085 1086 1087 1088 1089

electronic technology shall issue a new card or electronic 1090
technology to the insured. 1091

(2) An insurer or person under contract with the insurer is 1092
not required under division (E)(1) of this section to issue a new 1093
card or electronic technology to an insured more than once during 1094
a twelve-month period. 1095

(F) Nothing in this section shall be construed as requiring 1096
an insurer to produce more than one standardized identification 1097
card or one electronic technology for use by insureds accessing 1098
health care benefits provided under a policy of sickness and 1099
accident insurance. 1100

Sec. 3923.65. (A) As used in this section: 1101

(1) "Emergency medical condition" means a medical condition 1102
that manifests itself by such acute symptoms of sufficient 1103
severity, including severe pain, that a prudent layperson with 1104
average knowledge of health and medicine could reasonably expect 1105
the absence of immediate medical attention to result in any of the 1106
following: 1107

(a) Placing the health of the individual or, with respect to 1108
a pregnant woman, the health of the woman or her unborn child, in 1109
serious jeopardy; 1110

(b) Serious impairment to bodily functions; 1111

(c) Serious dysfunction of any bodily organ or part. 1112

(2) "Emergency services" means the following: 1113

(a) A medical screening examination, as required by federal 1114
law, that is within the capability of the emergency department of 1115
a hospital, including ancillary services routinely available to 1116
the emergency department, to evaluate an emergency medical 1117
condition; 1118

(b) Such further medical examination and treatment that are 1119
required by federal law to stabilize an emergency medical 1120
condition and are within the capabilities of the staff and 1121
facilities available at the hospital, including any trauma and 1122
burn center of the hospital. 1123

(B) Every individual or group policy of sickness and accident 1124
insurance that provides hospital, surgical, or medical expense 1125
coverage shall cover emergency services without regard to the day 1126
or time the emergency services are rendered or to whether the 1127
policyholder, the hospital's emergency department where the 1128
services are rendered, or an emergency physician treating the 1129
policyholder, obtained prior authorization for the emergency 1130
services. 1131

(C) Every individual policy or certificate furnished by an 1132
insurer in connection with any sickness and accident insurance 1133
policy shall provide information regarding the following: 1134

(1) The scope of coverage for emergency services; 1135

(2) The appropriate use of emergency services, including the 1136
use of the 9-1-1 system and any other telephone access systems 1137
utilized to access prehospital emergency services; 1138

(3) Any copayments for emergency services. 1139

(D) This section does not apply to any individual or group 1140
policy of sickness and accident insurance covering only accident, 1141
credit, dental, disability income, long-term care, hospital 1142
indemnity, medicare supplement, medicare, tricare, specified 1143
disease, or vision care; coverage under a one-time limited 1144
duration policy ~~of no longer~~ that is less than ~~six~~ twelve months; 1145
coverage issued as a supplement to liability insurance; insurance 1146
arising out of workers' compensation or similar law; automobile 1147
medical payment insurance; or insurance under which benefits are 1148
payable with or without regard to fault and which is statutorily 1149

required to be contained in any liability insurance policy or 1150
equivalent self-insurance. 1151

Sec. 3923.83. (A)(1) This section applies to both of the 1152
following: 1153

(a) A public employee benefit plan that issues or requires 1154
the use of a standardized identification card or an electronic 1155
technology for submission and routing of prescription drug claims 1156
pursuant to a policy, contract, or agreement for health care 1157
services; 1158

(b) A person or entity that a public employee benefit plan 1159
contracts with to issue a standardized identification card or an 1160
electronic technology described in division (A)(1)(a) of this 1161
section. 1162

(2) Notwithstanding division (A)(1) of this section, this 1163
section does not apply to the issuance or required use of a 1164
standardized identification card or an electronic technology for 1165
the submission and routing of prescription drug claims in 1166
connection with either of the following: 1167

(a) Any individual or group policy of insurance covering only 1168
accident, credit, dental, disability income, long-term care, 1169
hospital indemnity, medicare supplement, medicare, tricare, 1170
specified disease, or vision care; coverage under a 1171
one-time-limited-duration policy ~~of not longer~~ that is less than 1172
~~six~~ twelve months; coverage issued as a supplement to liability 1173
insurance; insurance arising out of workers' compensation or 1174
similar law; automobile medical payment insurance; or insurance 1175
under which benefits are payable with or without regard to fault 1176
and which is statutorily required to be contained in any liability 1177
insurance policy or equivalent self-insurance. 1178

(b) Coverage provided under the medicaid program. 1179

(B) A standardized identification card or an electronic 1180
technology issued or required to be used as provided in division 1181
(A)(1) of this section shall contain uniform prescription drug 1182
information in accordance with either division (B)(1) or (2) of 1183
this section. 1184

(1) The standardized identification card or the electronic 1185
technology shall be in a format and contain information fields 1186
approved by the national council for prescription drug programs or 1187
a successor organization, as specified in the council's or 1188
successor organization's pharmacy identification card 1189
implementation guide in effect on the first day of October most 1190
immediately preceding the issuance or required use of the 1191
standardized identification card or the electronic technology. 1192

(2) If the public employee benefit plan or person under 1193
contract with the plan to issue a standardized identification card 1194
or an electronic technology requires the information for the 1195
submission and routing of a claim, the standardized identification 1196
card or the electronic technology shall contain any of the 1197
following information: 1198

(a) The plan's name; 1199

(b) The insured's name, group number, and identification 1200
number; 1201

(c) A telephone number to inquire about pharmacy-related 1202
issues; 1203

(d) The issuer's international identification number, labeled 1204
as "ANSI BIN" or "RxBIN"; 1205

(e) The processor's control number, labeled as "RxPCN"; 1206

(f) The insured's pharmacy benefits group number if different 1207
from the insured's medical group number, labeled as "RxGrp." 1208

(C) If the standardized identification card or the electronic 1209

technology issued or required to be used as provided in division 1210
(A)(1) of this section is also used for submission and routing of 1211
nonpharmacy claims, the designation "Rx" is required to be 1212
included as part of the labels identified in divisions (B)(2)(d) 1213
and (e) of this section if the issuer's international 1214
identification number or the processor's control number is 1215
different for medical and pharmacy claims. 1216

(D)(1) Except as provided in division (D)(2) of this section, 1217
if there is a change in the information contained in the 1218
standardized identification card or the electronic technology 1219
issued to an insured, the public employee benefit plan or person 1220
under contract with the plan to issue a standardized 1221
identification card or electronic technology shall issue a new 1222
card or electronic technology to the insured. 1223

(2) A public employee benefit plan or person under contract 1224
with the plan is not required under division (D)(1) of this 1225
section to issue a new card or electronic technology to an insured 1226
more than once during a twelve-month period. 1227

(E) Nothing in this section shall be construed as requiring a 1228
public employee benefit plan to produce more than one standardized 1229
identification card or one electronic technology for use by 1230
insureds accessing health care benefits provided under a health 1231
benefit plan. 1232

Sec. 3923.85. (A) As used in this section, "cost sharing" 1233
means the cost to an individual insured under an individual or 1234
group policy of sickness and accident insurance or a public 1235
employee benefit plan according to any coverage limit, copayment, 1236
coinsurance, deductible, or other out-of-pocket expense 1237
requirements imposed by the policy or plan. 1238

(B) Notwithstanding section 3901.71 of the Revised Code and 1239
subject to division (D) of this section, no individual or group 1240

policy of sickness and accident insurance that is delivered, 1241
issued for delivery, or renewed in this state and no public 1242
employee benefit plan that is established or modified in this 1243
state shall fail to comply with either of the following: 1244

(1) The policy or plan shall not provide coverage or impose 1245
cost sharing for a prescribed, orally administered cancer 1246
medication on a less favorable basis than the coverage it provides 1247
or cost sharing it imposes for intravenously administered or 1248
injected cancer medications. 1249

(2) The policy or plan shall not comply with division (B)(1) 1250
of this section by imposing an increase in cost sharing solely for 1251
orally administered, intravenously administered, or injected 1252
cancer medications. 1253

(C) Notwithstanding any provision of this section to the 1254
contrary, a policy or plan shall be deemed to be in compliance 1255
with this section if the cost sharing imposed under such a policy 1256
or plan for orally administered cancer treatments does not exceed 1257
one hundred dollars per prescription fill. The cost sharing limit 1258
of one hundred dollars per prescription fill shall apply to a high 1259
deductible plan, as defined in 26 U.S.C. 223, or a catastrophic 1260
plan, as defined in 42 U.S.C. 18022, only after the deductible has 1261
been met. 1262

(D)(1) The prohibitions in division (B) of this section do 1263
not preclude an individual or group policy of sickness and 1264
accident insurance or public employee benefit plan from requiring 1265
an insured or plan member to obtain prior authorization before 1266
orally administered cancer medication is dispensed to the insured 1267
or plan member. 1268

(2) Division (B) of this section does not apply to the offer 1269
or renewal of any individual or group policy of sickness and 1270
accident insurance that provides coverage for specific diseases or 1271

accidents only, or to any hospital indemnity, medicare supplement, 1272
disability income, or other policy that offers only supplemental 1273
benefits. 1274

(E) An insurer that offers any sickness and accident 1275
insurance or any public employee benefit plan that offers coverage 1276
for basic health care services is not required to comply with 1277
division (B) of this section if all of the following apply: 1278

(1) The insurer or plan submits documentation certified by an 1279
independent member of the American academy of actuaries to the 1280
superintendent of insurance showing that compliance with division 1281
(B)(1) of this section for a period of at least six months 1282
independently caused the insurer or plan's costs for claims and 1283
administrative expenses for the coverage of basic health care 1284
services to increase by more than one per cent per year. 1285

(2) The insurer or plan submits a signed letter from an 1286
independent member of the American academy of actuaries to the 1287
superintendent of insurance opining that the increase in costs 1288
described in division (E)(1) of this section could reasonably 1289
justify an increase of more than one per cent in the annual 1290
premiums or rates charged by the insurer or plan for the coverage 1291
of basic health care services. 1292

(3)(a) The superintendent of insurance makes the following 1293
determinations from the documentation and opinion submitted 1294
pursuant to divisions (E)(1) and (2) of this section: 1295

(i) Compliance with division (B)(1) of this section for a 1296
period of at least six months independently caused the insurer or 1297
plan's costs for claims and administrative expenses for the 1298
coverage of basic health care services to increase more than one 1299
per cent per year. 1300

(ii) The increase in costs reasonably justifies an increase 1301
of more than one per cent in the annual premiums or rates charged 1302

by the insurer or plan for the coverage of basic health care services. 1303
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(b) Any determination made by the superintendent under division (E)(3) of this section is subject to Chapter 119. of the Revised Code. 1305
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Sec. 3924.01. As used in sections 3924.01 to 3924.14 of the Revised Code: 1308
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(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. 1310
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(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. 1320
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(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. 1327
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(D) "Carrier" means any sickness and accident insurance 1333
company or health insuring corporation authorized to issue health 1334
benefit plans in this state or a MEWA. A sickness and accident 1335
insurance company that owns or operates a health insuring 1336
corporation, either as a separate corporation or as a line of 1337
business, shall be considered as a separate carrier from that 1338
health insuring corporation for purposes of sections 3924.01 to 1339
3924.14 of the Revised Code. 1340

(E) "Case characteristics" means, with respect to a small 1341
employer, the geographic area in which the employees work; the age 1342
and sex of the individual employees and their dependents; the 1343
appropriate industry classification as determined by the carrier; 1344
the number of employees and dependents; and such other objective 1345
criteria as may be established by the carrier. "Case 1346
characteristics" does not include claims experience, health 1347
status, or duration of coverage from the date of issue. 1348

(F) "Dependent" means the spouse or child of an eligible 1349
employee, subject to applicable terms of the health benefits plan 1350
covering the employee. 1351

(G) "Eligible employee" means an employee who works a normal 1352
work week of ~~twenty-five~~ thirty or more hours. "Eligible employee" 1353
does not include a temporary or substitute employee, or a seasonal 1354
employee who works only part of the calendar year on the basis of 1355
natural or suitable times or circumstances. 1356

(H) "Health benefit plan" means any hospital or medical 1357
expense policy or certificate or any health plan provided by a 1358
carrier, that is delivered, issued for delivery, renewed, or used 1359
in this state on or after the date occurring six months after 1360
November 24, 1995. "Health benefit plan" does not include policies 1361
covering only accident, credit, dental, disability income, 1362
long-term care, hospital indemnity, medicare supplement, specified 1363
disease, or vision care; coverage under a 1364

one-time-limited-duration policy ~~of no longer~~ that is less than 1365
~~six~~ twelve months; coverage issued as a supplement to liability 1366
insurance; insurance arising out of a workers' compensation or 1367
similar law; automobile medical-payment insurance; or insurance 1368
under which benefits are payable with or without regard to fault 1369
and which is statutorily required to be contained in any liability 1370
insurance policy or equivalent self-insurance. 1371

(I) "Late enrollee" means an eligible employee or dependent 1372
who enrolls in a small employer's health benefit plan other than 1373
during the first period in which the employee or dependent is 1374
eligible to enroll under the plan or during a special enrollment 1375
period described in section 2701(f) of the "Health Insurance 1376
Portability and Accountability Act of 1996," Pub. L. No. 104-191, 1377
110 Stat. 1955, 42 U.S.C.A. 300gg, as amended. 1378

(J) "MEWA" means any "multiple employer welfare arrangement" 1379
as defined in section 3 of the "Federal Employee Retirement Income 1380
Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended, 1381
except for any arrangement which is fully insured as defined in 1382
division (b)(6)(D) of section 514 of that act. 1383

(K) "Midpoint rate" means, for small employers with similar 1384
case characteristics and plan designs and as determined by the 1385
applicable carrier for a rating period, the arithmetic average of 1386
the applicable base premium rate and the corresponding highest 1387
premium rate. 1388

(L) "Pre-existing conditions provision" means a policy 1389
provision that excludes or limits coverage for charges or expenses 1390
incurred during a specified period following the insured's 1391
enrollment date as to a condition for which medical advice, 1392
diagnosis, care, or treatment was recommended or received during a 1393
specified period immediately preceding the enrollment date. 1394
Genetic information shall not be treated as such a condition in 1395
the absence of a diagnosis of the condition related to such 1396

information. 1397

For purposes of this division, "enrollment date" means, with 1398
respect to an individual covered under a group health benefit 1399
plan, the date of enrollment of the individual in the plan or, if 1400
earlier, the first day of the waiting period for such enrollment. 1401

(M) "Service waiting period" means the period of time after 1402
employment begins before an employee is eligible to be covered for 1403
benefits under the terms of any applicable health benefit plan 1404
offered by the small employer. 1405

(N)(1) "Small employer" means, in connection with a group 1406
health benefit plan and with respect to a calendar year and a plan 1407
year, an employer who employed an average of at least two but no 1408
more than fifty eligible employees on business days during the 1409
preceding calendar year and who employs at least two employees on 1410
the first day of the plan year. 1411

(2) For purposes of division (N)(1) of this section, all 1412
persons treated as a single employer under subsection (b), (c), 1413
(m), or (o) of section 414 of the "Internal Revenue Code of 1986," 1414
100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be considered one 1415
employer. In the case of an employer that was not in existence 1416
throughout the preceding calendar year, the determination of 1417
whether the employer is a small or large employer shall be based 1418
on the average number of eligible employees that it is reasonably 1419
expected the employer will employ on business days in the current 1420
calendar year. Any reference in division (N) of this section to an 1421
"employer" includes any predecessor of the employer. Except as 1422
otherwise specifically provided, provisions of sections 3924.01 to 1423
3924.14 of the Revised Code that apply to a small employer that 1424
has a health benefit plan shall continue to apply until the plan 1425
anniversary following the date the employer no longer meets the 1426
requirements of this division. 1427

(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. 1458
A separate fine may be imposed for each instance of failing to 1459
comply with the limits. In imposing the fine, the board's actions 1460
shall be taken in accordance with Chapter 119. of the Revised 1461
Code. 1462

(D)(1) None of the following shall be counted in determining 1463
whether the amounts specified in division (C)(1) of this section 1464
have been exceeded: 1465

(a) Methadone provided to patients for the purpose of 1466
treating drug dependence or addiction, if the prescriber meets the 1467
conditions specified in 21 C.F.R. 1306.07; 1468

(b) Buprenorphine provided to patients for the purpose of 1469
treating drug dependence or addiction, ~~if the prescriber is exempt~~ 1470
~~from separate registration with the United States drug enforcement~~ 1471
~~administration as part of an opioid treatment program that is the~~ 1472
subject of a current, valid certification from the substance abuse 1473
and mental health services administration of the United States 1474
department of health and human services pursuant to ~~21~~ 42 C.F.R. 1475
~~1301.28~~ 8.11 and distributes both buprenorphine and methadone; 1476

(c) Controlled substances provided to research subjects by a 1477
facility conducting clinical research in studies approved by a 1478
hospital-based institutional review board or an institutional 1479
review board accredited by the association for the accreditation 1480
of human research protection programs. 1481

(2) Division (C)(1) of this section does not apply to a 1482
prescriber who is a veterinarian. 1483

Sec. 4729.541. (A) Except as provided in divisions (B) and 1484
(C) of this section, a business entity described in division 1485
(B)(1)(j) or (k) of section 4729.51 of the Revised Code may 1486
possess, have custody or control of, and distribute the dangerous 1487

drugs in category I, category II, and category III, as defined in 1488
section 4729.54 of the Revised Code, without holding a terminal 1489
distributor of dangerous drugs license issued under that section. 1490

(B) If a business entity described in division (B)(1)(j) or 1491
(k) of section 4729.51 of the Revised Code is a pain management 1492
clinic or is operating a pain management clinic, the entity shall 1493
hold a license as a terminal distributor of dangerous drugs with a 1494
pain management clinic classification issued under section 1495
4729.552 of the Revised Code. 1496

(C) Beginning April 1, 2015, a business entity described in 1497
division (B)(1)(j) or (k) of section 4729.51 of the Revised Code 1498
shall hold a license as a terminal distributor of dangerous drugs 1499
in order to possess, have custody or control of, and distribute 1500
~~dangerous~~ either of the following: 1501

(1) Dangerous drugs that are compounded or used for the 1502
purpose of compounding; 1503

(2) Controlled substances containing buprenorphine that are 1504
used for the purpose of treating drug dependence or addiction. 1505

Sec. 4731.056. (A) As used in this section: 1506

(1) "Controlled substance," "schedule III," "schedule IV," 1507
and "schedule V" have the same meanings as in section 3719.01 of 1508
the Revised Code. 1509

(2) "Physician" means an individual authorized by this 1510
chapter to practice medicine and surgery or osteopathic medicine 1511
and surgery. 1512

(B) The state medical board shall adopt rules in accordance 1513
with Chapter 119. of the Revised Code that establish standards and 1514
procedures to be followed by physicians in the use of controlled 1515
substances in schedule III, IV, or V to treat opioid dependence or 1516

addiction. The board may limit the application of the rules to 1517
treatment provided through an office-based practice or other 1518
practice type or location specified by the board. 1519

Section 2. That existing sections 1739.061, 1751.14, 1751.69, 1520
3923.022, 3923.24, 3923.241, 3923.281, 3923.57, 3923.58, 3923.601, 1521
3923.65, 3923.83, 3923.85, 3924.01, 4729.291, and 4729.541 of the 1522
Revised Code are hereby repealed. 1523

Section 3. Section 1751.14 and division (G) of section 1524
3924.01 of the Revised Code, as amended by this act, apply only to 1525
policies, contracts, and agreements that are delivered, issued for 1526
delivery, or renewed in this state on or after January 1, 2016. 1527
Division (A)(1) of section 3923.24 and division (A)(1) of section 1528
3923.241 of the Revised Code, as amended by this act, apply only 1529
to policies of sickness and accident insurance delivered, issued 1530
for delivery, or renewed in this state and public employee benefit 1531
plans or multiple employer welfare arrangement contracts and 1532
certificates that are established or modified in this state on or 1533
after January 1, 2016. 1534

Section 4. The General Assembly declares that the amendments 1535
made to section 3923.58 of the Revised Code by this act are not to 1536
supersede the suspension of the operation of this section enacted 1537
by Section 3 of Sub. S.B. 9 of the 130th General Assembly. Rather, 1538
it is the intent of the General Assembly to ensure consistency in 1539
Ohio Insurance Law should this suspension be nullified. 1540