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Bill Analysis

Am. Sub. S.B. 5

126th General Assembly
(As Passed by the Senate)

Sens. Hottinger, Harris

BILL SUMMARY

- Increases the percentage that insurance premium rates may vary from the applicable midpoint rate under the Small Employer Health Benefit Plans Law.
- Increases from 150 to 500 the number of employees an employer may employ and still be considered a small employer under the Small Employer Health Care Alliances Law.
- Permits an insurer to establish one or more separate classes of business in the Small Employer Health Care Alliances Law and designates special rating and actuarial certification requirements for those classes.
- Increases the number of small employer health care alliance programs to which a 1% or 1.4% tax exemption is available.
- Creates a system to regulate discount medical plan organizations.
- Places a limit on an insured's liability for copayments and deductibles under a health benefit plan.

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CONTENT AND OPERATION

Small employer health benefit plans

An individual or group health benefit plan providing health care benefits to at least two but no more than 50 employees of a small employer is currently regulated under the Small Employer Health Benefit Plans Law (R.C. 3924.01 to 3924.14), if the health benefit plan meets either of two conditions: (1) any portion of the plan's premium or benefits is paid by the small employer, or any covered individual is reimbursed, whether through wage adjustments or otherwise, by the small employer for any portion of the plan premium, or (2) the plan is treated by the employer or any of the covered individuals as part of a plan or program for purposes of computing federally taxable income. (R.C. 3924.01 and 3924.02, both not in the bill.)

Existing law prohibits the premium rates charged or offered by any small employer health benefit plan insurer for a rating period from varying from the applicable midpoint rate by more than 35% of that midpoint rate for the same or similar coverage under a health benefit plan covering any small employer with similar case characteristics. The bill increases to 40% the percentage by which premium rates charged or offered for the same or similar coverage may vary from the applicable midpoint rate. The bill also permits an insurer to apply a low claims discount not to exceed 5% of the midpoint rate to small employers with favorable claims experience. The bill explains that a premium rate for a rating period may fall outside the 40% variance permitted by the bill as the result of a low claims discount. (R.C. 3924.04.)

Under existing law, "midpoint rate" means the arithmetic average of the applicable base premium rate and the corresponding highest premium rate as determined by the applicable insurer for a rating period for small employers with similar case characteristics and plan designs. "Base premium rate" means the lowest premium rate for a new or existing business prescribed by the insurer for the same or similar coverage under a plan or arrangement covering any small

employer with similar case characteristics. (R.C. 3924.01, not in the bill, and 3924.04.)

Under existing law, if the premium rates charged or offered for the same or similar coverage exceed the applicable midpoint rate by more than the allowable percentage, any increase in premium rates for a new rating period cannot exceed the sum of (1) any percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period and (2) any adjustment determined by the insurer due to a change in the small employer's case characteristics or plan design. Existing law applies this method for calculating premium rates that exceed the midpoint rate by more than the allowable percentage to a small employer health benefit plan that was delivered or issued for delivery prior to the effective date of this law. (R.C. 3924.04.)

The bill applies the above-described method for calculating premium rates that exceed the midpoint rate by the allowable percentage to low claims discount variations above 5%. The bill repeals the application of this method to health benefit plans delivered or issued for delivery prior to the effective date of the law. (*Id*.)

Under the bill, the changes made to existing law described above do not take effect until six months after the effective date of the bill. (Section 3.)

Small employer health care alliances

Under the existing Small Employer Health Care Alliances Law (R.C. Chapter 1731.), a small employer health care alliance may develop an "alliance program" by contracting with one or more insurers to provide one or more health benefit plans to alliance members for those members' employees, retirees, and dependents and family members of those employees and retirees. A small employer health care alliance generally is a chamber of commerce, trade association, or professional organization and must meet certain requirements, such as having members that include or are exclusively small employers and being a nonprofit corporation or association. These alliance programs differ from the small employer health benefit plans because the small employer health benefit plans are offered by an insurer directly to a small employer and not through an alliance program. (R.C. 1731.01 and 1731.03.)

Definitions

Existing law defines small employer to mean an employer that employs no more than 150 full-time employees, at least a majority of whom are employed at locations within this state. Under the bill, the maximum number of full-time

employees an employer may employ to be considered a small employer increases to 500 full-time employees. (R.C. 1731.01.)

Under existing law, the premiums or other charges an insurer receives from a small employer and that employer's employees or retirees under a health benefit plan as part of an alliance program are exempt from the 1% or 1.4% premium and franchise taxes usually placed on insurers. However, this exemption only applies if the alliance program is considered a "qualified alliance program." Existing law defines "qualified alliance program" to mean an alliance program under which health care benefits are provided to 2,500 or more employees, retirees, dependents, or family members. The bill decreases to 1,000 or more the threshold number of employees, retirees, dependents, or family members an alliance program must service in order to be considered a "qualified alliance program." (R.C. 1731.01 and 1731.07, 5725.18, and 5729.03, all not in the bill.)

Minimum number of employees

Existing law prohibits an alliance from adopting, imposing, or enforcing medical underwriting rules for the purpose of determining whether an alliance member is eligible to purchase a policy, contract, or plan of health insurance or health benefits from any insurer in connection with the alliance program. The bill adds to this prohibition that an alliance may not adopt, impose, or enforce underwriting rules requiring a small employer to have more than a minimum number of employees for the purpose of determining whether an alliance member is eligible as described above. (R.C. 1731.03.)

Existing law prohibits an alliance from rejecting any applicant for membership in the alliance based on the health status of the applicant's employees or their dependents. The bill prohibits an alliance from rejecting a membership application because the small employer does not have more than a minimum number of employees in addition to the prohibition described above. (*Id*.)

Application of the Small Employer Health Benefit Plans Law

Under existing law, the provisions in the Small Employer Health Benefit Plans Law, described above in "***Small employer health benefit plans***," apply to health benefit plans offered through alliance programs. The bill modifies the application of these provisions so that all of the provisions of Small Employer Health Benefit Plans Law apply except if a health benefit plan insurer establishes a separate class of business for one or more small employer health care alliances. If an insurer establishes such separate classes of business, the rating period and actuarial certification provisions created in the bill in the Small Employer Health Care Alliances Law apply to those classes in conjunction with the rating period and actuarial certification provisions in the Small Employer Health Benefit Plans

Law. However, the rating period and actuarial certification changes do not take effect until six months after the effective date of the bill. (R.C. 1731.03, 1731.09, 3924.04, and 3924.06, and Section 3.)

Rating periods. The bill permits an insurer to establish one or more separate classes of business solely comprised of one or more alliances. If an insurer establishes these separate classes of businesses, the following rating period provisions apply to those classes in conjunction with the rating period provisions described above in "***Small employer health benefit plans***." First, the premium rate limitations described above concerning the permitted 40% variance, low claims discount, and premium rate calculation method apply to each class of business separate and apart from the insurer's other business. Second, the base premium rate and midpoint rate must be determined with respect to each class of business separate and apart from the insurer's other business. Finally, the midpoint rate for a class of business may not exceed the midpoint rate for any other class of business or the insurer's non-alliance business by more than 15%. (R.C. 1731.03, 1731.09, and 3924.04.)

Under the bill, "base premium rate" and "midpoint rate" have the same meanings as in the Small Employer Health Benefit Plans Law described above in "***Small employer health benefit plans***." "Class of business" means a group of small employers that are enrolled employers in one or more alliances. "Small employers" means an employer who employs an average of at least two but no more than 50 employees. "Enrolled employer" means an alliance member who has obtained coverage for the employer's employees through an alliance program. (R.C. 1731.01, 1731.09, and 3924.01, not in the bill.)

Actuarial certification. Under the Small Employer Health Benefit Plans Law, an insurer must demonstrate compliance with the law through actuarial certification. The insurer must file annually with the Superintendent of Insurance an actuarial certification stating that the underwriting and rating methods of the insurer (1) comply with accepted actuarial practice, (2) are uniformly applied to health benefit plans covering small employers, and (3) comply with the applicable provisions of the Small Employer Health Benefit Plans Law. (R.C. 3924.06.)

The bill stipulates that the above-described existing provisions in the Small Employer Health Benefit Plans Law concerning actuarial certification must apply in conjunction with the bill's actuarial certification provisions if the insurer establishes separate classes of business for one or more small employer health care alliances. The bill requires an insurer annually to file with the Superintendent an actuarial certification for each class of business demonstrating that the underwriting and rating methods of the insurer (1) comply with accepted actuarial practices, (2) are uniformly applied to health benefit plans covering small employers within the class of business, and (3) comply with the applicable

provisions of the Small Employer Health Care Alliances Law and the Small Employer Health Benefit Plans Law. (R.C. 1731.03, 1731.09, and 3924.06.)

Existing law and the bill define "actuarial certification" to mean a written statement prepared by a member of the American Academy of Actuaries, or by any other person acceptable to the Superintendent, that states that, based upon the person's examination, an insurer offering health benefit plans to small employers is in compliance with the Small Employer Health Benefit Plans Law. "Actuarial certification" includes a review of the appropriate records of, and the actuarial assumptions and methods used by, the insurer relative to establishing premium rates for the health benefit plans. (R.C. 1731.09 and 3924.01, not in the bill.)

Other requirements. The bill requires an insurer to file with the Superintendent a notification identifying any alliance or alliances to be treated as a separate class of business at least 60 days prior to the date the rates for that class of business take effect. The bill also requires any application for a certificate of authority to establish a small employer health care alliance to include a disclosure as to whether the alliance will be underwritten or rated as part of a separate class of business. However, these two requirements do not take effect until six months after the effective date of the bill. (R.C. 1731.021, not in the bill, and 1731.09, and Section 3.)

Eligible employees

Existing law requires an agreement between a small employer health care alliance and an insurer to contain at least several different provisions. One provision existing law requires is a statement of the eligibility requirements that an employee or retiree must meet in order to be eligible to obtain and retain coverage under a health benefit plan offered by the insurer. If this statement requires an employee to work a minimum number of hours per week in order to obtain or retain coverage, that minimum may not exceed 17.5 hours. The bill raises to 25 hours the minimum number of hours per week an employee may be required to work to obtain and retain coverage. (R.C. 1731.04.)

Discount medical plans

Under the bill, certain organizations referred to as "discount medical plan organizations" that offer discount medical plans must adhere to several new provisions regulating agreements between the organization and a health care provider and requirements concerning disclosures, marketing, and membership. "Discount medical plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, offers access to members to providers of medical services and the right to receive discounted medical services. "Discount medical plan" does not include a plan (1) that does

not require a membership or charge a fee to use the plan's medical card, (2) that offers discounts for only pharmaceutical supplies or prescription drugs, or both, and no other medical services, (3) offered by a sickness and accident insurer, a health insuring corporation, or an affiliate of such insurer or corporation if the insurer, corporation, or affiliate discloses in writing in not less than 12-point type on any application, advertisements, marketing materials, and brochures describing the plan that the plan is not insurance. "Discount medical plan organization" or "organization" means a person who does business in this state; offers access to members to providers of medical services and the right to receive discounted medical services from those providers; contracts with providers, provider networks, or other discount medical plan organizations to offer discount medical plans to members; and determines the fee members pay to participate in the organization. "Discount medical plan organization" does not include a sickness and accident insurer or health insuring corporation. (R.C. 3961.01.)

Provider agreements

The bill prohibits an organization from offering to members, or advertising to prospective members, discounted medical services unless the services are offered pursuant to a provider agreement. "Provider agreement" means any agreement entered into between an organization and a provider or provider network to offer discounted medical services to members. "Provider" means any health care professional or facility that has contracted, directly or indirectly, with an organization to offer discounted medical services to members. "Provider network" means a person that negotiates, directly or indirectly, with an organization on behalf of more than one provider to offer discounted medical services to members. (R.C. 3961.01 and 3961.02.)

Under the bill, an organization may enter into a provider agreement directly with a provider, indirectly through a provider network to which a provider belongs, or through another organization that contracts with providers directly or through a provider network. A provider agreement between an organization and a provider must contain (1) a list of medical services and products offered at a discount, (2) the discounted rates for medical services or a fee schedule that reflects the provider's discounted rates, and (3) a statement that the provider will not charge members more than those discounted rates. (R.C. 3924.02.)

Under the bill, a provider agreement between an organization and a provider network must require the provider network to (1) maintain an up-to-date list of the network's contracted providers and supply that list to the organization on a monthly basis and (2) have a written agreement with each provider who offers discounted medical services that contains (a) the items required in a provider agreement between an organization and a provider described above and (b) a grant of authority that allows the network to contract with organizations on behalf of the

provider. A provider agreement between an organization and another organization must require the other organization to have provider agreements in place that comply with the applicable requirements for provider agreements between an organization and a provider or provider network, as described above. An organization must keep for the duration of the agreement a copy of each provider agreement into which the organization has entered. (*Id.*)

Marketers

The bill requires an organization to enter into a written agreement with a marketer prior to an organization allowing the marketer to market, promote, sell, or distribute a discount medical plan. This written agreement must prohibit the marketer from using or issuing any advertising, marketing materials, brochures, or discount medical cards without the organization's written approval. "Marketer" means a person or entity who markets, promotes, sells, or distributes a discount medical plan, including, but not limited to, a private label entity that places its name on and markets or distributes a plan pursuant to a written agreement with an organization. "Marketer" does not mean a sickness and accident insurer, a health insuring corporation, or an affiliate of such insurer or corporation if the insurer, corporation, or affiliate discloses in writing in not less than 12-point type on any application, advertisements, marketing materials, and brochures describing the plan that the plan is not insurance. (R.C. 3961.01 and 3961.03.)

Under the bill, an organization is bound by and responsible for the marketer's activities that are within the scope of the marketer's agency relationship with the organization. An organization must approve in writing all advertisements, marketing materials, brochures, and discount cards prior to a marketer using these materials to market, promote, sell, or distribute the plan. (R.C. 3961.03.)

Disclosures

The bill requires an organization or marketer to disclose all of the following information in writing in not less than 12-point type on the first content page of any advertisements, marketing materials, or brochures made available to the public relating to a discount medical plan and with any enrollment forms: (1) a statement that the plan is not insurance, (2) a statement that the range of discounts for medical services offered under the plan will vary depending on the type of provider and medical services, (3) a statement that the plan is prohibited from making members' payments to providers for medical services received under the plan, (4) a statement that the member is obligated to pay for all discounted medical services received under the plan, and (5) the organization's toll-free telephone number and internet web site address that a member or prospective member may

use to obtain additional information about and assistance with the plan and up-to-date lists of providers participating in the plan. (R.C. 3961.04.)

The bill requires an organization or marketer to disclose all of the information described above orally in addition to disclosing it in writing if the organization's or marketer's initial contact with a prospective or new member is by telephone. An organization also is required to provide to each prospective or new member a copy of the terms and conditions of the plan in a written document at the time of purchase. The written document must be clear and contain (1) the name of the member, (2) the benefits provided under the plan, (3) any processing fees and periodic charges associated with the plan, including, but not limited to, the procedures for changing the mode of payment and any accompanying additional charges if applicable, (4) any limitations, exclusions, or exceptions regarding the receipt of plan benefits, (5) any waiting periods for certain medical services under the plan, (6) the procedures for obtaining discounts under the plan, such as requiring members to contact the organization to request that the organization make an appointment with a provider on the member's behalf, (7) cancellation and refund rights described below in "***Cancellation and refund rights***," (8) membership renewal, termination, and cancellation terms and conditions, (9) the procedures for adding new family members to the plan, (10) the procedures for filing complaints under the organization's complaint system and a statement explaining that, if the member remains dissatisfied after completing the organization's complaint system, the member may contact the Department of Insurance, and (11) the name, mailing address, toll-free telephone number, and electronic mail address of the organization that a member may use to make inquiries about the plan, send cancellation notices, and file complaints. (*Id*.)

The bill requires an organization to maintain on an internet web site page an up-to-date list of the names and addresses of the providers with which the organization has contracted directly or indirectly through a provider network. The organization's internet web site address must be prominently displayed on all of the organization's advertisements, marketing materials, brochures, and discount medical plan cards. When an organization or marketer sells a plan together with any other product, the organization or marketer must give to the member, in addition to the other disclosures required under the bill, a written statement delineating the fees applicable only to the plan. (*Id*.)

Prohibitions

The bill prohibits an organization from certain acts. An organization may not use the term "insurance" in the organization's advertisements, marketing materials, brochures, or discount medical plan cards except when permitted under the bill as a disclaimer of any relationship between plan benefits and insurance or in a description of an insurance product connected with a plan. An organization

may not use in the organization's advertisements, marketing materials, brochures, or discount medical plan cards the terms "health plan," "coverage," "benefits," "copay," "copayments," "deductible," "pre-existing conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or any other terms in a manner that could mislead a person into believing that the plan is health insurance. (R.C. 3961.05.)

Under the bill, an organization may not make misleading, deceptive, or fraudulent statements or representations regarding the terms or benefits of the plan, including, but not limited to, statements or representations regarding discounts, range of discounts, or access to those discounts offered under the plan. Except for hospital services, an organization may not have restrictions on access to plan providers, including, but not limited to, waiting and notification periods. An organization may not pay providers fees for medical services or collect or accept money from a member to pay a provider for medical services received under the plan. (*Id*.)

Cancellation and refund rights

Under the bill, an organization must permit members to cancel membership in a plan at any time. If a member gives notice of cancellation within 30 days after the date the member receives the written document explaining the terms and conditions of the plan described above in "***Disclosures***," the organization, within 30 days of the member giving such notice, must fully refund any fees except for a nominal fee associated with enrollments that cannot exceed $30. (R.C. 3961.06.)

The bill prohibits an organization from charging or collecting a periodic fee after a member has returned to the organization the member's discount medical plan card or given the organization notice of cancellation. Cancellation of membership in a plan occurs when a member gives notice of cancellation to an organization or marketer by delivering the notice by hand, depositing the notice in a mailbox if the notice is properly addressed to the organization or marketer and postage is prepaid, or sending an electronic message to the organization's or marketer's electronic message address. An organization must make a pro rata reimbursement of all periodic fees charged to a member, less nominal fees associated with enrollment or discounts for annual enrollment, if the organization cancels a member's membership for any reason other than the member's failure to pay fees or if a member cancels the member's membership after the first 30 days of membership and the organization charges periodic fees for more than one month. (*Id*.)

Examination of an organization's records

Under the bill, the Superintendent may examine or investigate the business and affairs of an organization as the Superintendent deems appropriate to protect the interests of Ohio residents. The Superintendent may do both of the following when examining or investigating an organization: (1) order an organization to produce any records, files, advertising and solicitation materials, lists of providers with which the organization contracted, lists of members, provider agreements, agreements between a marketer and an organization, or other information and (2) take statements under oath to determine whether an organization has violated or is violating the discount medical plan provisions of the bill or is acting contrary to the public interest. (R.C. 3961.07.)

The bill specifies that all records and other information concerning an organization obtained by the Superintendent or the Superintendent's deputies, examiners, assistants, agents, or other employees as described above are confidential and not public records for purposes of the Public Records Law (R.C. 149.43) unless the organization is given notice and opportunity for hearing concerning the records and other information. If no administrative action is initiated with respect to a particular matter about which the Superintendent obtained records or other information, the records and other information must remain confidential for three years after the file on the matter is closed. (*Id*.)

Under the bill, four exceptions apply to the confidentiality requirement described above. First, where the Superintendent or the Superintendent's deputies, examiners, assistants, agents, or other employees appropriately take official action regarding the affairs of an organization or marketer or in connection with actual or potential criminal proceedings, the confidentiality requirements do not apply. Second, the Superintendent may share records and other information with other persons employed by or acting on behalf of the Superintendent; local, state, federal, and international regulatory and law enforcement agencies; local, state, and federal prosecutors; and the National Association of Insurance Commissioners (hereafter referred to as "NAIC") and its affiliates and subsidiaries if the recipient agrees and has authority to agree to maintain the confidential status of the records or other information. Third, the Superintendent may disclose records and other information in furtherance of any regulatory or legal action brought by or on behalf of the Superintendent or the state resulting from the exercise of the Superintendent's official duties. Finally, the Superintendent may authorize the NAIC and its affiliates and subsidiaries by agreement to share confidential records and other information with local, state, federal, and international regulatory and law enforcement agencies and local, state, and federal prosecutors if the recipient agrees and has authority to agree to maintain the confidential status of the records and other information. If records or other information is disclosed or shared as a

result of the second or last exception listed above, any applicable privilege or claim of confidentiality is not waived. (*Id*.)

The bill prohibits any Ohio court from requiring Department employees or agents to testify in a civil action if the testimony concerns any matter related to records or other information considered confidential as described above. Nothing in the above-described confidentiality provisions and the exceptions to those provisions may be construed to limit the Superintendent's enforcement powers under the insurance laws. (*Id*.)

Enforcement

The bill prohibits any person from failing to comply with the provisions of the bill concerning discount medical plans. If the Superintendent determines that any person has violated these provisions, the Superintendent may take one or more of several types of actions. The Superintendent may assess a civil penalty in an amount not to exceed $25,000 per violation if the person knew or should have known of the violation. The Superintendent may assess administrative costs to cover the expenses incurred in the administrative action, including, but not limited to, expenses incurred in the investigation and hearing process. The Superintendent may order corrective actions in lieu of or in addition to the other penalties described above, including, but not limited to, suspending civil penalties if an organization complies with the terms of the corrective action order. The Superintendent also may order restitution to members. The Superintendent must deposit any penalties or administrative assessments collected as described above into the state treasury to the credit of the Department of Insurance Operating Fund. (R.C. 3961.08.)

Before imposing one or more of the above-described penalties, the bill requires the Superintendent to give an organization notice and opportunity for hearing as described in the Administrative Procedure Act (R.C. Chapter 119.) to the extent that the provisions in that law do not conflict with several procedural provisions created under the bill. One of these provisions is that a notice of opportunity for hearing, a hearing officer's findings and recommendations, or any order issued by the Superintendent must be served by certified mail, return receipt requested, to the last known address of an organization. An organization's last known address is the address listed on the organization's disclosures described above in "***Disclosures***." If the certified mail envelope is returned to the Superintendent with an endorsement showing that service was refused or that the envelope was unclaimed, the notices, findings and recommendations, and orders and all subsequent notices required under the Administrative Procedure Act may be served by ordinary mail to the organization's last known address. The time period to request an administrative hearing described in the Administrative Procedure Act begins to run the date the ordinary mailing was sent. A certificate

of mailing must evidence any mailings sent by ordinary mail and must complete service to the organization unless the ordinary mail envelope is returned to the Superintendent with an endorsement showing failure of delivery. If service by ordinary mail as described above fails, the Superintendent may publish a summary of the substantive provisions of the notice, findings and recommendations, or orders once a week for three consecutive weeks in a newspaper of general circulation in the county of the organization's last known address. The notice is considered served on the date of the third publication. (*Id*.)

Another provision in the bill that prevails over a conflicting provision in the Administrative Procedure Act is that any notice is required to be served under the Administrative Procedure Act also must be served upon the party's attorney by ordinary mail if the party's attorney has entered an appearance in the matter. An additional provision is that in lieu of certified or ordinary mail or publication notice as described above, the Superintendent may perfect service on a party by personal delivery of the notice by the Superintendent's designee. Another provision that would prevail over a conflicting provision in the Administrative Procedure Act is that notices regarding the scheduling of hearings and all other notices not described above must be sent by ordinary mail to the party and the party's attorney. (*Id*.)

Under the bill, the final provision that is said to prevail over the Administrative Procedure Act specifies that a subpoena or subpoena duces tecum to a witness from the Superintendent, the Superintendent's designee, or an attorney for appearance at a hearing, for the production of documents or other evidence, or for taking testimony for use at a hearing must be served by certified mail, return receipt requested. These subpoenas must be enforced in the manner described in the Administrative Procedure Act. However, nothing in this provision or any other provision described above that prevails over a conflicting Administrative Procedure Act provision may be construed to limit the Superintendent's other statutory powers to issue subpoenas. (*Id*.)

The bill permits the Superintendent to issue a cease-and-desist order requiring a person to cease and desist from engaging in a violation of the provisions of the bill concerning discount medical plans if the violation has caused, is causing, or is about to cause substantial and material harm. The Superintendent must, immediately after issuing such an order, serve notice of the order by certified mail, return receipt requested, or by any other manner described above to the person subject to the order and all other persons involved in the actual or potential violation. The notice must specify the particular act, omission, practice, or transaction that is the subject of the order and set a date, not more than 15 days after the date the order was issued, for a hearing on the continuation or revocation of the order. The person subject to the order must comply with the

order immediately upon receiving it. After the notice described above is served, the Superintendent may notify all interested parties that a cease-and-desist order was issued. (*Id*.)

The bill permits the Superintendent to continue the hearing date described above concerning a cease-and-desist order upon application by the person subject to the order and for good cause. The Administrative Procedure Act applies to the hearing on the order to the extent that the Law does not conflict with the procedures described in the provisions of the bill concerning discount medical plans. The Superintendent must, within 15 days after objections are submitted concerning the hearing officer's report and recommendations, issue a final order either confirming or revoking the cease-and-desist order. The final order may be appealed as described in the Administrative Procedure Act. The remedy of issuing a cease-and-desist order is cumulative and concurrent with the other remedies described above available to the Superintendent. (*Id*.)

Under the bill, if the Superintendent has reasonable cause to believe that an order issued has been violated in whole or in part, the Superintendent may request the Attorney General to commence any appropriate action against the violator. In such an action, a court may impose (1) a civil penalty of not more than $25,000 per violation, (2) injunctive relief, (3) restitution, or (4) any other appropriate relief. The Superintendent must deposit any civil penalties collected as described above into the state treasury to the credit of the Department of Insurance Operating Fund. (*Id*.)

Rulemaking authority

Under the bill, the Superintendent may adopt rules in accordance with the Administrative Procedure Act for purposes of implementing the provisions of the bill concerning discount medical plans. (R.C. 3961.09.)

Definitions

The bill defines:

(1) "Facility" to mean an institution where medical services are performed, including, but not limited to, a hospital or other licensed inpatient center; ambulatory surgical or treatment center; skilled nursing center; residential treatment center; rehabilitation center; diagnostic, laboratory, and imaging center; and any other health care setting. (R.C. 3961.01.)

(2) "Health care professional" means a physician or other health care provider who is licensed, accredited, certified, or otherwise authorized to perform specified medical services within the scope of the person's license, accreditation,

certification, or other authorization and performs medical services consistent with Ohio laws. (*Id*.)

(3) "Medical services" means any maintenance care of the human body; preventative care for the human body; or care, service, or treatment of an illness or dysfunction of, or injury to, the human body. "Medical services" includes, but is not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, dental care services, vision care services, pharmaceutical supplies, prescription drugs, mental health services, substance abuse services, chiropractic services, podiatric services, laboratory services, and medical equipment and supplies. (*Id*.)

(4) "Member" to mean any individual who pays fees, dues, charges, or other consideration to an organization for access to providers of medical services and the right to receive the benefits of a discount medical plan. (*Id*.)

(5) "Person" means an individual, corporation, partnership, association, joint venture, joint stock company, trust, unincorporated organization, any similar entity, or any combination of these entities. (*Id*.)

Reimbursement rate for health benefit plan deductibles

The bill limits the amount that enrollees and insureds may be required to pay health care providers and pharmacies "out-of-pocket" or from savings account funds. Under the bill, if a person is covered by a health benefit plan issued by a sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement and the person is required to pay for health care costs out-of-pocket or with funds from a savings account, the amount the enrollee or insured can be required to pay to a health care provider or pharmacy is limited to the amount that the insurer, health insuring corporation, or multiple employer welfare arrangement would pay to the provider or pharmacy under applicable reimbursement rates negotiated with the provider or pharmacy. A person is not prohibited by the bill from reaching an agreement with a health care provider or pharmacy on terms that are more favorable to the person than the negotiated reimbursement rates that would otherwise apply as long as the claim submitted reflects the alternative amount negotiated, except that a health care provider or pharmacy may not waive all or part of a copay or deductible if prohibited by any other provision of law. The above requirements, however, do not apply to amounts owed to a provider or pharmacy with whom the sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement has no applicable negotiated reimbursement rate. (R.C. 3923.81.)

The bill defines, for purposes of this section, a "health benefit plan" as any policy of sickness and accident insurance, or any policy, contract, or agreement

covering one or more "basic health care services," "supplemental health care services," or "specialty health care services" as defined in section 1751.01 of the Health Insuring Corporation Law, which is offered or provided by a health insuring corporation or by a sickness and accident insurer or multiple employer welfare arrangement. "Reimbursement rates" means any rates that apply to a payment made by a sickness and accident insurer, health insuring corporation, or multiple welfare arrangement for charges covered by a health benefit plan. A "savings account" is defined as a health savings account, health reimbursement arrangement, flexible savings account, medical savings account, or similar account or arrangement. (*Id*.)

The bill requires each sickness and accident insurer, health insuring corporation, or multiple employer welfare arrangement to establish and maintain a system whereby a person covered by a health benefit plan may obtain information regarding potential out-of-pocket costs for services provided by in-network providers. However, this requirement does not take effect until six months after the effective date of the bill. (R.C. 3923.81 and Section 3.)

HISTORY

ACTION	DATE
Introduced	01-24-05
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