**As Passed by the House**

**131st General Assembly**

**Regular Session** **H. B. No. 95**

**2015-2016**

**Representative DeVitis**

**Cosponsors: Representatives Blessing, Scherer, Roegner, Duffey, Buchy, Schuring, Johnson, T., Hackett, Cera, Grossman, Amstutz, Green, Hagan, Hood, Perales, Retherford, Terhar, Young**

# A BILL

To amend sections 1753.07, 1753.09, 3901.21, 3963.01, 3963.02, and 3963.03 of the Revised Code to prohibit a health insurer from establishing a fee schedule for dental providers for services that are not covered by any contract or participating provider agreement between the health insurer and the dental provider. 1 2 3 4 5 6 7 8

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

**Section 1.** That sections 1753.07, 1753.09, 3901.21, 3963.01, 3963.02, and 3963.03 of the Revised Code be amended to read as follows: 9 10 11

**Sec. 1753.07.** (A)(1) Prior to entering into a participation contract with a provider under section 1751.13 of the Revised Code, a health insuring corporation shall disclose basic information regarding its programs and procedures to the provider. The information shall include all of the following: 12 13 14 15 16

(a) How a participating provider is reimbursed for the 17

participating provider's services, including the range and structure of any financial risk sharing arrangements, a description of any incentive plans, and, if reimbursed according to a type of fee-for-service arrangement, the level of reimbursement for the participating provider's services; 18 19 20 21 22

(b) Insofar as division (A)(1) of section 3963.03 of the Revised Code is applicable, all of the information that is described in that division and is not included in division (A)(1)(a) of this section. 23 24 25 26

(2) Prior to entering into a participation contract with a provider under section 1751.13 of the Revised Code, a health insuring corporation shall disclose the following information upon the provider's request: 27 28 29 30

(a) How referrals to other participating providers or to nonparticipating providers are made; 31 32

(b) The availability of dispute resolution procedures and the potential for cost to be incurred; 33 34

(c) How a participating provider's name and address will be used in marketing materials. 35 36

(B) A health insuring corporation shall provide all of the following to a participating provider: 37 38

(1) Any material incorporated by reference into the participation contract, that is not otherwise available as a public record, if such material affects the participating provider; 39 40 41 42

(2) Administrative manuals related to provider participation, if any; 43 44

(3) Insofar as division (B) of section 3963.03 of the 45

Revised Code is applicable, the summary disclosure form with the disclosures required under that division;

(4) A signed and dated copy of the final participation contract.

(C) ~~Nothing~~ Except as otherwise provided in division (E) of section 3963.02 of the Revised Code, nothing in this section requires a health insuring corporation providing specialty health care services or supplemental health care services to disclose the health insuring corporation's aggregate maximum allowable fee table used to determine providers' fees or fee schedules.

**Sec. 1753.09.** (A) Except as provided in division (D) of this section, prior to terminating the participation of a provider on the basis of the participating provider's failure to meet the health insuring corporation's standards for quality or utilization in the delivery of health care services, a health insuring corporation shall give the participating provider notice of the reason or reasons for its decision to terminate the provider's participation and an opportunity to take corrective action. The health insuring corporation shall develop a performance improvement plan in conjunction with the participating provider. If after being afforded the opportunity to comply with the performance improvement plan, the participating provider fails to do so, the health insuring corporation may terminate the participation of the provider.

(B)(1) A participating provider whose participation has been terminated under division (A) of this section may appeal the termination to the appropriate medical director of the health insuring corporation. The medical director shall give the participating provider an opportunity to discuss with the

medical director the reason or reasons for the termination. 76

(2) If a satisfactory resolution of a participating provider's appeal cannot be reached under division (B)(1) of this section, the participating provider may appeal the termination to a panel composed of participating providers who have comparable or higher levels of education and training than the participating provider making the appeal. A representative of the participating provider's specialty shall be a member of the panel, if possible. This panel shall hold a hearing, and shall render its recommendation in the appeal within thirty days after holding the hearing. The recommendation shall be presented to the medical director and to the participating provider. 77 78 79 80 81 82 83 84 85 86 87

(3) The medical director shall review and consider the panel's recommendation before making a decision. The decision rendered by the medical director shall be final. 88 89 90

(C) A provider's status as a participating provider shall remain in effect during the appeal process set forth in division (B) of this section unless the termination was based on any of the reasons listed in division (D) of this section. 91 92 93 94

(D) Notwithstanding division (A) of this section, a provider's participation may be immediately terminated if the participating provider's conduct presents an imminent risk of harm to an enrollee or enrollees; or if there has occurred unacceptable quality of care, fraud, patient abuse, loss of clinical privileges, loss of professional liability coverage, incompetence, or loss of authority to practice in the participating provider's field; or if a governmental action has impaired the participating provider's ability to practice. 95 96 97 98 99 100 101 102 103

(E) Divisions (A) to (D) of this section apply only to 104

providers who are natural persons. 105

(F)(1) Nothing in this section prohibits a health insuring corporation from rejecting a provider's application for participation, or from terminating a participating provider's contract, if the health insuring corporation determines that the health care needs of its enrollees are being met and no need exists for the provider's or participating provider's services. 106 107 108 109 110 111

(2) Nothing in this section shall be construed as prohibiting a health insuring corporation from terminating a participating provider who does not meet the terms and conditions of the participating provider's contract. 112 113 114 115

(3) Nothing in this section shall be construed as prohibiting a health insuring corporation from terminating a participating provider's contract pursuant to any provision of the contract described in division ~~(E)~~ (F)(2) of section 3963.02 of the Revised Code, except that, notwithstanding any provision of a contract described in that division, this section applies to the termination of a participating provider's contract for any of the causes described in divisions (A), (D), and (F)(1) and (2) of this section. 116 117 118 119 120 121 122 123 124

(G) The superintendent of insurance may adopt rules as necessary to implement and enforce sections 1753.06, 1753.07, and 1753.09 of the Revised Code. Such rules shall be adopted in accordance with Chapter 119. of the Revised Code. 125 126 127 128

**Sec. 3901.21.** The following are hereby defined as unfair and deceptive acts or practices in the business of insurance: 129 130

(A) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, or preparing with intent to so use, any estimate, illustration, circular, or statement 131 132 133

misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statements as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer as shown by the last preceding verified statement made by it to the insurance department of this state, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation or incomplete comparison to any person for the purpose of inducing or tending to induce such person to purchase, amend, lapse, forfeit, change, or surrender insurance. 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148

Any written statement concerning the premiums for a policy which refers to the net cost after credit for an assumed dividend, without an accurate written statement of the gross premiums, cash values, and dividends based on the insurer's current dividend scale, which are used to compute the net cost for such policy, and a prominent warning that the rate of dividend is not guaranteed, is a misrepresentation for the purposes of this division. 149 150 151 152 153 154 155 156

(B) Making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station, or in any other way, or preparing with intent to so use, an advertisement, announcement, or statement containing any assertion, representation, or 157 158 159 160 161 162 163 164

statement, with respect to the business of insurance or with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading. 165 166 167

(C) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating, or preparing with intent to so use, any statement, pamphlet, circular, article, or literature, which is false as to the financial condition of an insurer and which is calculated to injure any person engaged in the business of insurance. 168 169 170 171 172 173 174

(D) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer. 175 176 177 178 179 180

Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer, or mutilating, destroying, suppressing, withholding, or concealing any of its records. 181 182 183 184 185 186 187 188 189 190 191

(E) Issuing or delivering or permitting agents, officers, or employees to issue or deliver agency company stock or other capital stock or benefit certificates or shares in any common- 192 193 194

law corporation or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance. 195 196 197

(F) Making or permitting any unfair discrimination among individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract. 198 199 200 201 202

(G)(1) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing, or offering to give, sell, or purchase, as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities, or other obligations of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract. 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219

(2) Nothing in division (F) or division (G)(1) of this section shall be construed as prohibiting any of the following practices: (a) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus 220 221 222 223 224

accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders; (b) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses; (c) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year. 225 226 227 228 229 230 231 232 233 234 235 236 237

(H) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, or preparing with intent to so use, any statement to the effect that a policy of life insurance is, is the equivalent of, or represents shares of capital stock or any rights or options to subscribe for or otherwise acquire any such shares in the life insurance company issuing that policy or any other company. 238 239 240 241 242 243 244

(I) Making, issuing, circulating, or causing or permitting to be made, issued or circulated, or preparing with intent to so issue, any statement to the effect that payments to a policyholder of the principal amounts of a pure endowment are other than payments of a specific benefit for which specific premiums have been paid. 245 246 247 248 249 250

(J) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated, or preparing with intent to so use, any statement to the effect that any insurance company was required to change a policy form or related material to 251 252 253 254

comply with Title XXXIX of the Revised Code or any regulation of the superintendent of insurance, for the purpose of inducing or intending to induce any policyholder or prospective policyholder to purchase, amend, lapse, forfeit, change, or surrender insurance. 255 256 257 258 259

(K) Aiding or abetting another to violate this section. 260

(L) Refusing to issue any policy of insurance, or canceling or declining to renew such policy because of the sex or marital status of the applicant, prospective insured, insured, or policyholder. 261 262 263 264

(M) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, other than life insurance, or in the benefits payable thereunder, or in underwriting standards and practices or eligibility requirements, or in any of the terms or conditions of such contract, or in any other manner whatever. 265 266 267 268 269 270 271 272

(N) Refusing to make available disability income insurance solely because the applicant's principal occupation is that of managing a household. 273 274 275

(O) Refusing, when offering maternity benefits under any individual or group sickness and accident insurance policy, to make maternity benefits available to the policyholder for the individual or individuals to be covered under any comparable policy to be issued for delivery in this state, including family members if the policy otherwise provides coverage for family members. Nothing in this division shall be construed to prohibit an insurer from imposing a reasonable waiting period for such 276 277 278 279 280 281 282 283

benefits under an individual sickness and accident insurance policy issued to an individual who is not a federally eligible individual or a nonemployer-related group sickness and accident insurance policy, but in no event shall such waiting period exceed two hundred seventy days. 284 285 286 287 288

For purposes of division (O) of this section, "federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103. 289 290 291

(P) Using, or permitting to be used, a pattern settlement as the basis of any offer of settlement. As used in this division, "pattern settlement" means a method by which liability is routinely imputed to a claimant without an investigation of the particular occurrence upon which the claim is based and by using a predetermined formula for the assignment of liability arising out of occurrences of a similar nature. Nothing in this division shall be construed to prohibit an insurer from determining a claimant's liability by applying formulas or guidelines to the facts and circumstances disclosed by the insurer's investigation of the particular occurrence upon which a claim is based. 292 293 294 295 296 297 298 299 300 301 302 303

(Q) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent, or kind of life or sickness and accident insurance or annuity coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. With respect to all other conditions, including the underlying cause of blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated actuarial experience as are sighted persons. Refusal to insure 304 305 306 307 308 309 310 311 312 313

includes, but is not limited to, denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the eyesight of the insured is lost. However, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when such conditions existed at the time the policy was issued. To the extent that the provisions of this division may appear to conflict with any provision of section 3999.16 of the Revised Code, this division applies. 314 315 316 317 318 319 320 321 322

(R)(1) Directly or indirectly offering to sell, selling, or delivering, issuing for delivery, renewing, or using or otherwise marketing any policy of insurance or insurance product in connection with or in any way related to the grant of a student loan guaranteed in whole or in part by an agency or commission of this state or the United States, except insurance that is required under federal or state law as a condition for obtaining such a loan and the premium for which is included in the fees and charges applicable to the loan; or, in the case of an insurer or insurance agent, knowingly permitting any lender making such loans to engage in such acts or practices in connection with the insurer's or agent's insurance business. 323 324 325 326 327 328 329 330 331 332 333 334

(2) Except in the case of a violation of division (G) of this section, division (R)(1) of this section does not apply to either of the following: 335 336 337

(a) Acts or practices of an insurer, its agents, representatives, or employees in connection with the grant of a guaranteed student loan to its insured or the insured's spouse or dependent children where such acts or practices take place more than ninety days after the effective date of the insurance; 338 339 340 341 342

(b) Acts or practices of an insurer, its agents, 343

representatives, or employees in connection with the solicitation, processing, or issuance of an insurance policy or product covering the student loan borrower or the borrower's spouse or dependent children, where such acts or practices take place more than one hundred eighty days after the date on which the borrower is notified that the student loan was approved. 344 345 346 347 348 349

(S) Denying coverage, under any health insurance or health care policy, contract, or plan providing family coverage, to any natural or adopted child of the named insured or subscriber solely on the basis that the child does not reside in the household of the named insured or subscriber. 350 351 352 353 354

(T)(1) Using any underwriting standard or engaging in any other act or practice that, directly or indirectly, due solely to any health status-related factor in relation to one or more individuals, does either of the following: 355 356 357 358

(a) Terminates or fails to renew an existing individual policy, contract, or plan of health benefits, or a health benefit plan issued to an employer, for which an individual would otherwise be eligible; 359 360 361 362

(b) With respect to a health benefit plan issued to an employer, excludes or causes the exclusion of an individual from coverage under an existing employer-provided policy, contract, or plan of health benefits. 363 364 365 366

(2) The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code for purposes of implementing division (T)(1) of this section. 367 368 369

(3) For purposes of division (T)(1) of this section, "health status-related factor" means any of the following: 370 371

(a) Health status; 372

(b) Medical condition, including both physical and mental illnesses; 373 374

(c) Claims experience; 375

(d) Receipt of health care; 376

(e) Medical history; 377

(f) Genetic information; 378

(g) Evidence of insurability, including conditions arising out of acts of domestic violence; 379 380

(h) Disability. 381

(U) With respect to a health benefit plan issued to a small employer, as those terms are defined in section 3924.01 of the Revised Code, negligently or willfully placing coverage for adverse risks with a certain carrier, as defined in section 3924.01 of the Revised Code. 382 383 384 385 386

(V) Using any program, scheme, device, or other unfair act or practice that, directly or indirectly, causes or results in the placing of coverage for adverse risks with another carrier, as defined in section 3924.01 of the Revised Code. 387 388 389 390

(W) Failing to comply with section 3923.23, 3923.231, 3923.232, 3923.233, or 3923.234 of the Revised Code by engaging in any unfair, discriminatory reimbursement practice. 391 392 393

(X) Intentionally establishing an unfair premium for, or misrepresenting the cost of, any insurance policy financed under a premium finance agreement of an insurance premium finance company. 394 395 396 397

(Y)(1)(a) Limiting coverage under, refusing to issue, canceling, or refusing to renew, any individual policy or 398 399

contract of life insurance, or limiting coverage under or refusing to issue any individual policy or contract of health insurance, for the reason that the insured or applicant for insurance is or has been a victim of domestic violence; 400 401 402 403

(b) Adding a surcharge or rating factor to a premium of any individual policy or contract of life or health insurance for the reason that the insured or applicant for insurance is or has been a victim of domestic violence; 404 405 406 407

(c) Denying coverage under, or limiting coverage under, any policy or contract of life or health insurance, for the reason that a claim under the policy or contract arises from an incident of domestic violence; 408 409 410 411

(d) Inquiring, directly or indirectly, of an insured under, or of an applicant for, a policy or contract of life or health insurance, as to whether the insured or applicant is or has been a victim of domestic violence, or inquiring as to whether the insured or applicant has sought shelter or protection from domestic violence or has sought medical or psychological treatment as a victim of domestic violence. 412 413 414 415 416 417 418

(2) Nothing in division (Y)(1) of this section shall be construed to prohibit an insurer from inquiring as to, or from underwriting or rating a risk on the basis of, a person's physical or mental condition, even if the condition has been caused by domestic violence, provided that all of the following apply: 419 420 421 422 423 424

(a) The insurer routinely considers the condition in underwriting or in rating risks, and does so in the same manner for a victim of domestic violence as for an insured or applicant who is not a victim of domestic violence; 425 426 427 428

(b) The insurer does not refuse to issue any policy or contract of life or health insurance or cancel or refuse to renew any policy or contract of life insurance, solely on the basis of the condition, except where such refusal to issue, cancellation, or refusal to renew is based on sound actuarial principles or is related to actual or reasonably anticipated experience; 429 430 431 432 433 434 435

(c) The insurer does not consider a person's status as being or as having been a victim of domestic violence, in itself, to be a physical or mental condition; 436 437 438

(d) The underwriting or rating of a risk on the basis of the condition is not used to evade the intent of division (Y)(1) of this section, or of any other provision of the Revised Code. 439 440 441

(3)(a) Nothing in division (Y)(1) of this section shall be construed to prohibit an insurer from refusing to issue a policy or contract of life insurance insuring the life of a person who is or has been a victim of domestic violence if the person who committed the act of domestic violence is the applicant for the insurance or would be the owner of the insurance policy or contract. 442 443 444 445 446 447 448

(b) Nothing in division (Y)(2) of this section shall be construed to permit an insurer to cancel or refuse to renew any policy or contract of health insurance in violation of the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C.A. 300gg-41(b), as amended, or in a manner that violates or is inconsistent with any provision of the Revised Code that implements the "Health Insurance Portability and Accountability Act of 1996." 449 450 451 452 453 454 455 456

(4) An insurer is immune from any civil or criminal 457

liability that otherwise might be incurred or imposed as a result of any action taken by the insurer to comply with division (Y) of this section. 458 459 460

(5) As used in division (Y) of this section, "domestic violence" means any of the following acts: 461 462

(a) Knowingly causing or attempting to cause physical harm to a family or household member; 463 464

(b) Recklessly causing serious physical harm to a family or household member; 465 466

(c) Knowingly causing, by threat of force, a family or household member to believe that the person will cause imminent physical harm to the family or household member. 467 468 469

For the purpose of division (Y)(5) of this section, "family or household member" has the same meaning as in section 2919.25 of the Revised Code. 470 471 472

Nothing in division (Y)(5) of this section shall be construed to require, as a condition to the application of division (Y) of this section, that the act described in division (Y)(5) of this section be the basis of a criminal prosecution. 473 474 475 476

(Z) Disclosing a coroner's records by an insurer in violation of section 313.10 of the Revised Code. 477 478

(AA) Making, issuing, circulating, or causing or permitting to be made, issued, or circulated any statement or representation that a life insurance policy or annuity is a contract for the purchase of funeral goods or services. 479 480 481 482

(BB)(1) Setting or requiring the insurer's approval of fees for dental services that are not covered dental services, as defined in section 3963.01 of the Revised Code, or making 483 484 485

available any health benefit plan that sets fees for dental services that are not covered dental care services. 486 487

(2) Nothing in division (BB)(1) of this section shall be construed to apply to any health benefit plan subject to regulation by the "Employee Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq., as amended. 488 489 490 491

(CC) With respect to private passenger automobile insurance, charging premium rates that are excessive, inadequate, or unfairly discriminatory, pursuant to division (D) of section 3937.02 of the Revised Code, based solely on the location of the residence of the insured. 492 493 494 495 496

The enumeration in sections 3901.19 to 3901.26 of the Revised Code of specific unfair or deceptive acts or practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the superintendent of insurance to adopt rules to implement this section, or to take action under other sections of the Revised Code. 497 498 499 500 501 502

This section does not prohibit the sale of shares of any investment company registered under the "Investment Company Act of 1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any policies, annuities, or other contracts described in section 3907.15 of the Revised Code. 503 504 505 506 507

As used in this section, "estimate," "statement," "representation," "misrepresentation," "advertisement," or "announcement" includes oral or written occurrences. 508 509 510

**Sec. 3963.01.** As used in this chapter: 511

(A) "Affiliate" means any person or entity that has ownership or control of a contracting entity, is owned or controlled by a contracting entity, or is under common ownership 512 513 514

or control with a contracting entity. 515

(B) "Basic health care services" has the same meaning as in division (A) of section 1751.01 of the Revised Code, except that it does not include any services listed in that division that are provided by a pharmacist or nursing home. 516 517 518 519

(C) "Contracting entity" means any person that has a primary business purpose of contracting with participating providers for the delivery of health care services. 520 521 522

(D) "Covered dental services" means dental services for which a reimbursement is available under an enrollee's health benefit plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or any other limitation. 523 524 525 526 527 528 529

(E) "Credentialing" means the process of assessing and validating the qualifications of a provider applying to be approved by a contracting entity to provide basic health care services, specialty health care services, or supplemental health care services to enrollees. 530 531 532 533 534

~~(E)~~ (F) "Edit" means adjusting one or more procedure codes billed by a participating provider on a claim for payment or a practice that results in any of the following: 535 536 537

(1) Payment for some, but not all of the procedure codes originally billed by a participating provider; 538 539

(2) Payment for a different procedure code than the procedure code originally billed by a participating provider; 540 541

(3) A reduced payment as a result of services provided to 542

an enrollee that are claimed under more than one procedure code on the same service date.

~~(F)~~ (G) "Electronic claims transport" means to accept and digitize claims or to accept claims already digitized, to place those claims into a format that complies with the electronic transaction standards issued by the United States department of health and human services pursuant to the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as those electronic standards are applicable to the parties and as those electronic standards are updated from time to time, and to electronically transmit those claims to the appropriate contracting entity, payer, or third-party administrator.

~~(G)~~ (H) "Enrollee" means any person eligible for health care benefits under a health benefit plan, including an eligible recipient of medicaid, and includes all of the following terms:

(1) "Enrollee" and "subscriber" as defined by section 1751.01 of the Revised Code;

(2) "Member" as defined by section 1739.01 of the Revised Code;

(3) "Insured" and "plan member" pursuant to Chapter 3923. of the Revised Code;

(4) "Beneficiary" as defined by section 3901.38 of the Revised Code.

~~(H)~~ (I) "Health care contract" means a contract entered into, materially amended, or renewed between a contracting entity and a participating provider for the delivery of basic health care services, specialty health care services, or supplemental health care services to enrollees.

~~(I)~~ (J) "Health care services" means basic health care services, specialty health care services, and supplemental health care services.

~~(J)~~ (K) "Material amendment" means an amendment to a health care contract that decreases the participating provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expenses, or adds a new product. A material amendment does not include any of the following:

(1) A decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the contract;

(2) A decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract;

(3) An administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the contract;

(4) Changes to an existing prior authorization, precertification, notification, or referral program that do not substantially increase the provider's administrative expense;

(5) Changes to an edit program or to specific edits if the participating provider is provided notice of the changes pursuant to division (A)(1) of section 3963.04 of the Revised Code and the notice includes information sufficient for the provider to determine the effect of the change;

(6) Changes to a health care contract described in 601
division (B) of section 3963.04 of the Revised Code. 602

~~(K)~~ (L) "Participating provider" means a provider that has 603
a health care contract with a contracting entity and is entitled 604
to reimbursement for health care services rendered to an 605
enrollee under the health care contract. 606

~~(L)~~ (M) "Payer" means any person that assumes the 607
financial risk for the payment of claims under a health care 608
contract or the reimbursement for health care services provided 609
to enrollees by participating providers pursuant to a health 610
care contract. 611

~~(M)~~ (N) "Primary enrollee" means a person who is 612
responsible for making payments for participation in a health 613
care plan or an enrollee whose employment or other status is the 614
basis of eligibility for enrollment in a health care plan. 615

~~(N)~~ (O) "Procedure codes" includes the American medical 616
association's current procedural terminology code, the American 617
dental association's current dental terminology, and the centers 618
for medicare and medicaid services health care common procedure 619
coding system. 620

~~(O)~~ (P) "Product" means one of the following types of 621
categories of coverage for which a participating provider may be 622
obligated to provide health care services pursuant to a health 623
care contract: 624

(1) A health maintenance organization or other product 625
provided by a health insuring corporation; 626

(2) A preferred provider organization; 627

(3) Medicare; 628

(4) Medicaid; 629

(5) Workers' compensation. 630

~~(P)~~ (Q) "Provider" means a physician, podiatrist, dentist, chiropractor, optometrist, psychologist, physician assistant, advanced practice registered nurse, occupational therapist, massage therapist, physical therapist, licensed professional counselor, licensed professional clinical counselor, hearing aid dealer, orthotist, prosthetist, home health agency, hospice care program, pediatric respite care program, or hospital, or a provider organization or physician-hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts. "Provider" does not mean a pharmacist, pharmacy, nursing home, or a provider organization or physician-hospital organization that leases the provider organization's or physician-hospital organization's network to a third party or contracts directly with employers or health and welfare funds. 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645

~~(Q)~~ (R) "Specialty health care services" has the same meaning as in section 1751.01 of the Revised Code, except that it does not include any services listed in division (B) of section 1751.01 of the Revised Code that are provided by a pharmacist or a nursing home. 646 647 648 649 650

~~(R)~~ (S) "Supplemental health care services" has the same meaning as in division (B) of section 1751.01 of the Revised Code, except that it does not include any services listed in that division that are provided by a pharmacist or nursing home. 651 652 653 654

**Sec. 3963.02.** (A)(1) No contracting entity shall sell, rent, or give a third party the contracting entity's rights to a participating provider's services pursuant to the contracting 655 656 657

entity's health care contract with the participating provider unless one of the following applies: 658 659

(a) The third party accessing the participating provider's services under the health care contract is an employer or other entity providing coverage for health care services to its employees or members, and that employer or entity has a contract with the contracting entity or its affiliate for the administration or processing of claims for payment for services provided pursuant to the health care contract with the participating provider. 660 661 662 663 664 665 666 667

(b) The third party accessing the participating provider's services under the health care contract either is an affiliate or subsidiary of the contracting entity or is providing administrative services to, or receiving administrative services from, the contracting entity or an affiliate or subsidiary of the contracting entity. 668 669 670 671 672 673

(c) The health care contract specifically provides that it applies to network rental arrangements and states that one purpose of the contract is selling, renting, or giving the contracting entity's rights to the services of the participating provider, including other preferred provider organizations, and the third party accessing the participating provider's services is any of the following: 674 675 676 677 678 679 680

(i) A payer or a third-party administrator or other entity responsible for administering claims on behalf of the payer; 681 682

(ii) A preferred provider organization or preferred provider network that receives access to the participating provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in 683 684 685 686

a contract with the participating provider that is in compliance with division (A)(1)(c) of this section, and is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is bound under its contract with the participating provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement. 687 688 689 690 691 692 693 694

(iii) An entity that is engaged in the business of providing electronic claims transport between the contracting entity and the payer or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of the contracting entity's contract with the participating provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement. 695 696 697 698 699 700 701 702

(2) The contracting entity that sells, rents, or gives the contracting entity's rights to the participating provider's services pursuant to the contracting entity's health care contract with the participating provider as provided in division (A)(1) of this section shall do both of the following: 703 704 705 706 707

(a) Maintain a web page that contains a listing of third parties described in divisions (A)(1)(b) and (c) of this section with whom a contracting entity contracts for the purpose of selling, renting, or giving the contracting entity's rights to the services of participating providers that is updated at least every six months and is accessible to all participating providers, or maintain a toll-free telephone number accessible to all participating providers by means of which participating providers may access the same listing of third parties; 708 709 710 711 712 713 714 715 716

(b) Require that the third party accessing the participating provider's services through the participating provider's health care contract is obligated to comply with all of the applicable terms and conditions of the contract, including, but not limited to, the products for which the participating provider has agreed to provide services, except that a payer receiving administrative services from the contracting entity or its affiliate shall be solely responsible for payment to the participating provider. 717 718 719 720 721 722 723 724 725

(3) Any information disclosed to a participating provider under this section shall be considered proprietary and shall not be distributed by the participating provider. 726 727 728

(4) Except as provided in division (A)(1) of this section, no entity shall sell, rent, or give a contracting entity's rights to the participating provider's services pursuant to a health care contract. 729 730 731 732

(B)(1) No contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider provide services for all of the products offered by the contracting entity. 733 734 735 736

(2) Division (B)(1) of this section shall not be construed to do any of the following: 737 738

(a) Prohibit any participating provider from voluntarily accepting an offer by a contracting entity to provide health care services under all of the contracting entity's products; 739 740 741

(b) Prohibit any contracting entity from offering any financial incentive or other form of consideration specified in the health care contract for a participating provider to provide health care services under all of the contracting entity's 742 743 744 745

products; 746

(c) Require any contracting entity to contract with a participating provider to provide health care services for less than all of the contracting entity's products if the contracting entity does not wish to do so. 747 748 749 750

(3)(a) Notwithstanding division (B)(2) of this section, no contracting entity shall require, as a condition of contracting with the contracting entity, that the participating provider accept any future product offering that the contracting entity makes. 751 752 753 754 755

(b) If a participating provider refuses to accept any future product offering that the contracting entity makes, the contracting entity may terminate the health care contract based on the participating provider's refusal upon written notice to the participating provider no sooner than one hundred eighty days after the refusal. 756 757 758 759 760 761

(4) Once the contracting entity and the participating provider have signed the health care contract, it is presumed that the financial incentive or other form of consideration that is specified in the health care contract pursuant to division (B)(2)(b) of this section is the financial incentive or other form of consideration that was offered by the contracting entity to induce the participating provider to enter into the contract. 762 763 764 765 766 767 768

(C) No contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider waive or forego any right or benefit expressly conferred upon a participating provider by state or federal law. However, this division does not prohibit a contracting entity from restricting a participating provider's scope of practice 769 770 771 772 773 774

for the services to be provided under the contract. 775

(D) No health care contract shall do any of the following: 776

(1) Prohibit any participating provider from entering into a health care contract with any other contracting entity; 777 778

(2) Prohibit any contracting entity from entering into a health care contract with any other provider; 779 780

(3) Preclude its use or disclosure for the purpose of enforcing this chapter or other state or federal law, except that a health care contract may require that appropriate measures be taken to preserve the confidentiality of any proprietary or trade-secret information. 781 782 783 784 785

(E)(1) No contracting entity shall require in any health care contract that covers any dental services, either directly or indirectly, that a participating provider who is a dentist provide services to an enrollee at a fee set by, or a fee subject to the approval of, the contracting entity unless the dental services are covered dental services. 786 787 788 789 790 791

(2) To the extent that the provisions in division (E)(1) of this section conflict with the provisions of the federal "Employee Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq., as amended, the federal law shall control. 792 793 794 795

(F)(1) In addition to any other lawful reasons for terminating a health care contract, a health care contract may only be terminated under the circumstances described in division (A)(3) of section 3963.04 of the Revised Code. 796 797 798 799

(2) If the health care contract provides for termination for cause by either party, the health care contract shall state the reasons that may be used for termination for cause, which 800 801 802

terms shall be reasonable. Once the contracting entity and the 803
participating provider have signed the health care contract, it 804
is presumed that the reasons stated in the health care contract 805
for termination for cause by either party are reasonable. 806
Subject to division ~~(E)~~(F)(3) of this section, the health care 807
contract shall state the time by which the parties must provide 808
notice of termination for cause and to whom the parties shall 809
give the notice. 810

(3) Nothing in divisions ~~(E)~~(F)(1) and (2) of this section 811
shall be construed as prohibiting any health insuring 812
corporation from terminating a participating provider's contract 813
for any of the causes described in divisions (A), (D), and (F) 814
(1) and (2) of section 1753.09 of the Revised Code. 815
Notwithstanding any provision in a health care contract pursuant 816
to division ~~(E)~~(F)(2) of this section, section 1753.09 of the 817
Revised Code applies to the termination of a participating 818
provider's contract for any of the causes described in divisions 819
(A), (D), and (F)(1) and (2) of section 1753.09 of the Revised 820
Code. 821

(4) Subject to sections 3963.01 to 3963.11 of the Revised 822
Code, nothing in this section prohibits the termination of a 823
health care contract without cause if the health care contract 824
otherwise provides for termination without cause. 825

~~(F)~~(G)(1) Disputes among parties to a health care contract 826
that only concern the enforcement of the contract rights 827
conferred by section 3963.02, divisions (A) and (D) of section 828
3963.03, and section 3963.04 of the Revised Code are subject to 829
a mutually agreed upon arbitration mechanism that is binding on 830
all parties. The arbitrator may award reasonable attorney's fees 831
and costs for arbitration relating to the enforcement of this 832

section to the prevailing party. 833

(2) The arbitrator shall make the arbitrator's decision in an arbitration proceeding having due regard for any applicable rules, bulletins, rulings, or decisions issued by the department of insurance or any court concerning the enforcement of the contract rights conferred by section 3963.02, divisions (A) and (D) of section 3963.03, and section 3963.04 of the Revised Code. 834 835 836 837 838 839

(3) A party shall not simultaneously maintain an arbitration proceeding as described in division ~~(F)~~ (G)(1) of this section and pursue a complaint with the superintendent of insurance to investigate the subject matter of the arbitration proceeding. However, if a complaint is filed with the department of insurance, the superintendent may choose to investigate the complaint or, after reviewing the complaint, advise the complainant to proceed with arbitration to resolve the complaint. The superintendent may request to receive a copy of the results of the arbitration. If the superintendent of insurance notifies an insurer or a health insuring corporation in writing that the superintendent has initiated a market conduct examination into the specific subject matter of the arbitration proceeding pending against that insurer or health insuring corporation, the arbitration proceeding shall be stayed at the request of the insurer or health insuring corporation pending the outcome of the market conduct investigation by the superintendent. 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857

**Sec. 3963.03.** (A) Each health care contract shall include all of the following information: 858 859

(1)(a) Information sufficient for the participating provider to determine the compensation or payment terms for health care services, including all of the following, subject to 860 861 862

division (A)(1)(b) of this section:

(i) The manner of payment, such as fee-for-service, capitation, or risk;

(ii) The fee schedule of procedure codes reasonably expected to be billed by a participating provider's specialty for services provided pursuant to the health care contract and the associated payment or compensation for each procedure code. A fee schedule may be provided electronically. Upon request, a contracting entity shall provide a participating provider with the fee schedule for any other procedure codes requested and a written fee schedule, that shall not be required more frequently than twice per year excluding when it is provided in connection with any change to the schedule. This requirement may be satisfied by providing a clearly understandable, readily available mechanism, such as a specific web site address, that allows a participating provider to determine the effect of procedure codes on payment or compensation before a service is provided or a claim is submitted.

(iii) The effect, if any, on payment or compensation if more than one procedure code applies to the service also shall be stated. This requirement may be satisfied by providing a clearly understandable, readily available mechanism, such as a specific web site address, that allows a participating provider to determine the effect of procedure codes on payment or compensation before a service is provided or a claim is submitted.

(b) If the contracting entity is unable to include the information described in ~~division~~ divisions (A)(1)(a)(ii) and (iii) of this section, the contracting entity shall include both of the following types of information instead:

(i) The methodology used to calculate any fee schedule, such as relative value unit system and conversion factor or percentage of billed charges. If applicable, the methodology disclosure shall include the name of any relative value unit system, its version, edition, or publication date, any applicable conversion or geographic factor, and any date by which compensation or fee schedules may be changed by the methodology as anticipated at the time of contract. 893 894 895 896 897 898 899 900

(ii) The identity of any internal processing edits, including the publisher, product name, version, and version update of any editing software. 901 902 903

(c) If the contracting entity is not the payer and is unable to include the information described in division (A)(1)(a) or (b) of this section, then the contracting entity shall provide by telephone a readily available mechanism, such as a specific web site address, that allows the participating provider to obtain that information from the payer. 904 905 906 907 908 909

(2) Any product or network for which the participating provider is to provide services; 910 911

(3) The term of the health care contract; 912

(4) A specific web site address that contains the identity of the contracting entity or payer responsible for the processing of the participating provider's compensation or payment; 913 914 915 916

(5) Any internal mechanism provided by the contracting entity to resolve disputes concerning the interpretation or application of the terms and conditions of the contract. A contracting entity may satisfy this requirement by providing a clearly understandable, readily available mechanism, such as a 917 918 919 920 921

specific web site address or an appendix, that allows a participating provider to determine the procedures for the internal mechanism to resolve those disputes. 922 923 924

(6) A list of addenda, if any, to the contract. 925

(B)(1) Each contracting entity shall include a summary disclosure form with a health care contract that includes all of the information specified in division (A) of this section. The information in the summary disclosure form shall refer to the location in the health care contract, whether a page number, section of the contract, appendix, or other identifiable location, that specifies the provisions in the contract to which the information in the form refers. 926 927 928 929 930 931 932 933

(2) The summary disclosure form shall include all of the following statements: 934 935

(a) That the form is a guide to the health care contract and that the terms and conditions of the health care contract constitute the contract rights of the parties; 936 937 938

(b) That reading the form is not a substitute for reading the entire health care contract; 939 940

(c) That by signing the health care contract, the participating provider will be bound by the contract's terms and conditions; 941 942 943

(d) That the terms and conditions of the health care contract may be amended pursuant to section 3963.04 of the Revised Code and the participating provider is encouraged to carefully read any proposed amendments sent after execution of the contract; 944 945 946 947 948

(e) That nothing in the summary disclosure form creates 949

any additional rights or causes of action in favor of either party. 950 951

(3) No contracting entity that includes any information in the summary disclosure form with the reasonable belief that the information is truthful or accurate shall be subject to a civil action for damages or to binding arbitration based on the summary disclosure form. Division (B)(3) of this section does not impair or affect any power of the department of insurance to enforce any applicable law. 952 953 954 955 956 957 958

(4) The summary disclosure form described in divisions (B)(1) and (2) of this section shall be in substantially the following form: 959 960 961

"SUMMARY DISCLOSURE FORM 962

(1) Compensation terms 963

(a) Manner of payment 964

[ ] Fee for service 965

[ ] Capitation 966

[ ] Risk 967

[ ] Other ............... See ............... 968

(b) Fee schedule available at ............... 969

(c) Fee calculation schedule available at ............... 970

(d) Identity of internal processing edits available at ............... 971 972

(e) Information in (c) and (d) is not required if information in (b) is provided. 973 974

(2) List of products or networks covered by this contract 975

[ ] ............... 976

[ ] ............... 977

[ ] ............... 978

[ ] ............... 979

[ ] ............... 980

(3) Term of this contract ............... 981

(4) Contracting entity or payer responsible for processing payment available at ............... 982 983

(5) Internal mechanism for resolving disputes regarding contract terms available at ............... 984 985

(6) Addenda to contract 986

| | Title | Subject | |
|---|---|---|---|
| | Title | Subject | 987 |
| (a) | | | 988 |
| (b) | | | 989 |
| (c) | | | 990 |
| (d) | | | 991 |

(7) Telephone number to access a readily available mechanism, such as a specific web site address, to allow a participating provider to receive the information in (1) through (6) from the payer. 992 993 994 995

IMPORTANT INFORMATION - PLEASE READ CAREFULLY 996

The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section ~~3963.01(G)~~ 3963.01(I) of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract 997 998 999 1000

constitute the contract rights of the parties. 1001

Reading this Summary Disclosure Form is not a substitute for reading the entire Health Care Contract. When you sign the Health Care Contract, you will be bound by its terms and conditions. These terms and conditions may be amended over time pursuant to section 3963.04 of the Ohio Revised Code. You are encouraged to read any proposed amendments that are sent to you after execution of the Health Care Contract. 1002 1003 1004 1005 1006 1007 1008

Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party." 1009 1010

(C) When a contracting entity presents a proposed health care contract for consideration by a provider, the contracting entity shall provide in writing or make reasonably available the information required in division (A)(1) of this section. 1011 1012 1013 1014

(D) The contracting entity shall identify any utilization management, quality improvement, or a similar program that the contracting entity uses to review, monitor, evaluate, or assess the services provided pursuant to a health care contract. The contracting entity shall disclose the policies, procedures, or guidelines of such a program applicable to a participating provider upon request by the participating provider within fourteen days after the date of the request. 1015 1016 1017 1018 1019 1020 1021 1022

(E) Nothing in this section shall be construed as preventing or affecting the application of section 1753.07 of the Revised Code that would otherwise apply to a contract with a participating provider. 1023 1024 1025 1026

(F) The requirements of division (C) of this section do not prohibit a contracting entity from requiring a reasonable confidentiality agreement between the provider and the 1027 1028 1029

contracting entity regarding the terms of the proposed health care contract. If either party violates the confidentiality agreement, a party to the confidentiality agreement may bring a civil action to enjoin the other party from continuing any act that is in violation of the confidentiality agreement, to recover damages, to terminate the contract, or to obtain any combination of relief. 1030 1031 1032 1033 1034 1035 1036

**Section 2.** That existing sections 1753.07, 1753.09, 3901.21, 3963.01, 3963.02, and 3963.03 of the Revised Code are hereby repealed. 1037 1038 1039

**Section 3.** The following represent the General Assembly's intent and findings: 1040 1041

(A) The provisions of this act seek to prevent dental insurers, dental benefit plans, and other contracting entities from establishing fee limitations on services that are not covered dental services for enrollees under a dental insurance plan. 1042 1043 1044 1045 1046

(B) Strategies by dental insurers, dental benefit plans, or other contracting entities to adopt or impose a deductible, copayment, coinsurance, or any other requirement in such a way as to provide de minimis reimbursement for services as a method to avoid the impact of this law is contrary to the spirit and intent of the General Assembly. 1047 1048 1049 1050 1051 1052