As Introduced

131st General Assembly

Regular Session 2015-2016

H. B. No. 95

Representative DeVitis
Cosponsors: Representatives Blessing, Scherer, Roegner, Duffey, Buchy,
Schuring, Johnson, T., Hackett, Cera, Grossman

A BILL

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

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

Section 1. That sections 1753.07, 1753.09, 3901.21,	9
3963.01, 3963.02, and 3963.03 of the Revised Code be amended to	10
read as follows:	11
Sec. 1753.07. (A) (1) Prior to entering into a	12
participation contract with a provider under section 1751.13 of	13
the Revised Code, a health insuring corporation shall disclose	14
basic information regarding its programs and procedures to the	15
provider. The information shall include all of the following:	16
(a) How a participating provider is reimbursed for the	17
participating provider's services, including the range and	18

structure of any financial risk sharing arrangements, a	19
description of any incentive plans, and, if reimbursed according	20
to a type of fee-for-service arrangement, the level of	21
reimbursement for the participating provider's services;	22
(b) Insofar as division (A)(1) of section 3963.03 of the	23
Revised Code is applicable, all of the information that is	24
described in that division and is not included in division (A)	25
(1) (a) of this section.	26
(2) Prior to entering into a participation contract with a	27
provider under section 1751.13 of the Revised Code, a health	28
insuring corporation shall disclose the following information	29
upon the provider's request:	30
(a) How referrals to other participating providers or to	31
nonparticipating providers are made;	32
(b) The availability of dispute resolution procedures and	33
the potential for cost to be incurred;	34
(c) How a participating provider's name and address will	35
be used in marketing materials.	36
(B) A health insuring corporation shall provide all of the	37
following to a participating provider:	38
(1) Any material incorporated by reference into the	39
participation contract, that is not otherwise available as a	40
public record, if such material affects the participating	41
provider;	42
(2) Administrative manuals related to provider	43
participation, if any;	44
(3) Insofar as division (B) of section 3963.03 of the	45
Revised Code is applicable, the summary disclosure form with the	46

disclosures required under that division;	47
(4) A signed and dated copy of the final participation	48
contract.	49
(C) Nothing Except as otherwise provided in division (E)	50
of section 3963.02 of the Revised Code, nothing in this section	51
requires a health insuring corporation providing specialty	52
health care services or supplemental health care services to	53
disclose the health insuring corporation's aggregate maximum	54
allowable fee table used to determine providers' fees or fee	55
schedules.	56
Selledates.	30
Sec. 1753.09. (A) Except as provided in division (D) of	57
this section, prior to terminating the participation of a	58
provider on the basis of the participating provider's failure to	59
meet the health insuring corporation's standards for quality or	60
utilization in the delivery of health care services, a health	61
insuring corporation shall give the participating provider	62
notice of the reason or reasons for its decision to terminate	63
the provider's participation and an opportunity to take	64
corrective action. The health insuring corporation shall develop	65
a performance improvement plan in conjunction with the	66
participating provider. If after being afforded the opportunity	67
to comply with the performance improvement plan, the	68
participating provider fails to do so, the health insuring	69
corporation may terminate the participation of the provider.	70
(B)(1) A participating provider whose participation has	71
been terminated under division (A) of this section may appeal	72
the termination to the appropriate medical director of the	73
health insuring corporation. The medical director shall give the	74
participating provider an opportunity to discuss with the	75
medical director the reason or reasons for the termination.	76

(2) If a satisfactory resolution of a participating	77
provider's appeal cannot be reached under division (B)(1) of	78
this section, the participating provider may appeal the	79
termination to a panel composed of participating providers who	80
have comparable or higher levels of education and training than	81
the participating provider making the appeal. A representative	82
of the participating provider's specialty shall be a member of	83
the panel, if possible. This panel shall hold a hearing, and	84
shall render its recommendation in the appeal within thirty days	85
after holding the hearing. The recommendation shall be presented	86
to the medical director and to the participating provider.	87
(3) The medical director shall review and consider the	88
panel's recommendation before making a decision. The decision	89
rendered by the medical director shall be final.	90
(C) A provider's status as a participating provider shall	91
remain in effect during the appeal process set forth in division	92
(B) of this section unless the termination was based on any of	93
the reasons listed in division (D) of this section.	94
(D) Notwithstanding division (A) of this section, a	95
provider's participation may be immediately terminated if the	96
participating provider's conduct presents an imminent risk of	97
harm to an enrollee or enrollees; or if there has occurred	98
unacceptable quality of care, fraud, patient abuse, loss of	99
clinical privileges, loss of professional liability coverage,	100
incompetence, or loss of authority to practice in the	101
participating provider's field; or if a governmental action has	102
impaired the participating provider's ability to practice.	103
(E) Divisions (A) to (D) of this section apply only to	104

105

providers who are natural persons.

(F)(1) Nothing in this section prohibits a health insuring	106
corporation from rejecting a provider's application for	107
participation, or from terminating a participating provider's	108
contract, if the health insuring corporation determines that the	109
health care needs of its enrollees are being met and no need	110
exists for the provider's or participating provider's services.	111
(2) Nothing in this section shall be construed as	112
prohibiting a health insuring corporation from terminating a	113
participating provider who does not meet the terms and	114
conditions of the participating provider's contract.	115
(3) Nothing in this section shall be construed as	116
prohibiting a health insuring corporation from terminating a	117
participating provider's contract pursuant to any provision of	118
the contract described in division $\frac{(E)(F)}{(2)}$ (2) of section 3963.02	119
of the Revised Code, except that, notwithstanding any provision	120
of a contract described in that division, this section applies	121
to the termination of a participating provider's contract for	122
any of the causes described in divisions (A), (D), and (F)(1)	123
and (2) of this section.	124
(G) The superintendent of insurance may adopt rules as	125
necessary to implement and enforce sections 1753.06, 1753.07,	126
and 1753.09 of the Revised Code. Such rules shall be adopted in	127
accordance with Chapter 119. of the Revised Code.	128
Sec. 3901.21. The following are hereby defined as unfair	129
and deceptive acts or practices in the business of insurance:	130
(A) Making, issuing, circulating, or causing or permitting	131
to be made, issued, or circulated, or preparing with intent to	132
so use, any estimate, illustration, circular, or statement	133
misrepresenting the terms of any policy issued or to be issued	134

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

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

(B) Making, publishing, disseminating, circulating, or 157 placing before the public or causing, directly or indirectly, to 158 be made, published, disseminated, circulated, or placed before 159 the public, in a newspaper, magazine, or other publication, or 160 in the form of a notice, circular, pamphlet, letter, or poster, 161 or over any radio station, or in any other way, or preparing 162 with intent to so use, an advertisement, announcement, or 163 statement containing any assertion, representation, or 164 statement, with respect to the business of insurance or with 165

respect to any person in the conduct of the person's insurance	166
business, which is untrue, deceptive, or misleading.	167
(C) Making, publishing, disseminating, or circulating,	168
directly or indirectly, or aiding, abetting, or encouraging the	169
making, publishing, disseminating, or circulating, or preparing	170
with intent to so use, any statement, pamphlet, circular,	171
article, or literature, which is false as to the financial	172
condition of an insurer and which is calculated to injure any	173
person engaged in the business of insurance.	174
(D) Filing with any supervisory or other public official,	175
or making, publishing, disseminating, circulating, or delivering	176
to any person, or placing before the public, or causing directly	177
or indirectly to be made, published, disseminated, circulated,	178
delivered to any person, or placed before the public, any false	179
statement of financial condition of an insurer.	180
Making any false entry in any book, report, or statement	181
of any insurer with intent to deceive any agent or examiner	182
lawfully appointed to examine into its condition or into any of	183
its affairs, or any public official to whom such insurer is	184
required by law to report, or who has authority by law to	185
examine into its condition or into any of its affairs, or, with	186
like intent, willfully omitting to make a true entry of any	187
material fact pertaining to the business of such insurer in any	188
book, report, or statement of such insurer, or mutilating,	189
destroying, suppressing, withholding, or concealing any of its	190
records.	191
(E) Issuing or delivering or permitting agents, officers,	192
or employees to issue or deliver agency company stock or other	193

capital stock or benefit certificates or shares in any common-

law corporation or securities or any special or advisory board

194

contracts or other contracts of any kind promising returns and 196 profits as an inducement to insurance. 197

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

203

204

205

206

207

208

209

210

211

212

213

214

215

216

217

218

- (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.
- (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

 accumulated from nonparticipating insurance, provided that any

 220

such bonuses or abatement of premiums shall be fair and	226
equitable to policyholders and for the best interests of the	227
company and its policyholders; (b) in the case of life insurance	228
policies issued on the industrial debit plan, making allowance	229
to policyholders who have continuously for a specified period	230
made premium payments directly to an office of the insurer in an	231
amount which fairly represents the saving in collection	232
expenses; (c) readjustment of the rate of premium for a group	233
insurance policy based on the loss or expense experience	234
thereunder, at the end of the first or any subsequent policy	235
year of insurance thereunder, which may be made retroactive only	236
for such policy year.	237
(H) Making, issuing, circulating, or causing or permitting	238
to be made, issued, or circulated, or preparing with intent to	239
so use, any statement to the effect that a policy of life	240
insurance is, is the equivalent of, or represents shares of	241
capital stock or any rights or options to subscribe for or	242
otherwise acquire any such shares in the life insurance company	243
issuing that policy or any other company.	244
(I) Making, issuing, circulating, or causing or permitting	245
to be made, issued or circulated, or preparing with intent to so	246
issue, any statement to the effect that payments to a	247
policyholder of the principal amounts of a pure endowment are	248
other than payments of a specific benefit for which specific	249
premiums have been paid.	250
(J) Making, issuing, circulating, or causing or permitting	251
to be made, issued, or circulated, or preparing with intent to	252
so use, any statement to the effect that any insurance company	253

was required to change a policy form or related material to

comply with Title XXXIX of the Revised Code or any regulation of

254

the superintendent of insurance, for the purpose of inducing or	256
intending to induce any policyholder or prospective policyholder	257
to purchase, amend, lapse, forfeit, change, or surrender	258
insurance.	259
(K) Aiding or abetting another to violate this section.	260
(L) Refusing to issue any policy of insurance, or	261
canceling or declining to renew such policy because of the sex	262
or marital status of the applicant, prospective insured,	263
insured, or policyholder.	264
(M) Making or permitting any unfair discrimination between	265
individuals of the same class and of essentially the same hazard	266
in the amount of premium, policy fees, or rates charged for any	267
policy or contract of insurance, other than life insurance, or	268
in the benefits payable thereunder, or in underwriting standards	269
and practices or eligibility requirements, or in any of the	270
terms or conditions of such contract, or in any other manner	271
whatever.	272
(N) Refusing to make available disability income insurance	273
solely because the applicant's principal occupation is that of	274
managing a household.	275
(O) Refusing, when offering maternity benefits under any	276
individual or group sickness and accident insurance policy, to	277
make maternity benefits available to the policyholder for the	278
individual or individuals to be covered under any comparable	279
policy to be issued for delivery in this state, including family	280
members if the policy otherwise provides coverage for family	281
members. Nothing in this division shall be construed to prohibit	282
an insurer from imposing a reasonable waiting period for such	283
benefits under an individual sickness and accident insurance	284

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

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

- (P) Using, or permitting to be used, a pattern settlement 292 as the basis of any offer of settlement. As used in this 293 division, "pattern settlement" means a method by which liability 294 is routinely imputed to a claimant without an investigation of 295 the particular occurrence upon which the claim is based and by 296 using a predetermined formula for the assignment of liability 297 arising out of occurrences of a similar nature. Nothing in this 298 division shall be construed to prohibit an insurer from 299 determining a claimant's liability by applying formulas or 300 quidelines to the facts and circumstances disclosed by the 301 insurer's investigation of the particular occurrence upon which 302 a claim is based. 303
- (Q) Refusing to insure, or refusing to continue to insure, 304 or limiting the amount, extent, or kind of life or sickness and 305 accident insurance or annuity coverage available to an 306 individual, or charging an individual a different rate for the 307 same coverage solely because of blindness or partial blindness. 308 With respect to all other conditions, including the underlying 309 cause of blindness or partial blindness, persons who are blind 310 or partially blind shall be subject to the same standards of 311 sound actuarial principles or actual or reasonably anticipated 312 actuarial experience as are sighted persons. Refusal to insure 313 includes, but is not limited to, denial by an insurer of 314

disability insurance coverage on the grounds that the policy	315
defines "disability" as being presumed in the event that the	316
eyesight of the insured is lost. However, an insurer may exclude	317
from coverage disabilities consisting solely of blindness or	318
partial blindness when such conditions existed at the time the	319
policy was issued. To the extent that the provisions of this	320
division may appear to conflict with any provision of section	321
3999.16 of the Revised Code, this division applies.	322
(R)(1) Directly or indirectly offering to sell, selling,	323
or delivering, issuing for delivery, renewing, or using or	324
otherwise marketing any policy of insurance or insurance product	325
in connection with or in any way related to the grant of a	326
student loan guaranteed in whole or in part by an agency or	327
commission of this state or the United States, except insurance	328
that is required under federal or state law as a condition for	329
obtaining such a loan and the premium for which is included in	330
the fees and charges applicable to the loan; or, in the case of	331
an insurer or insurance agent, knowingly permitting any lender	332
making such loans to engage in such acts or practices in	333
connection with the insurer's or agent's insurance business.	334
(2) Except in the case of a violation of division (G) of	335
this section, division (R)(1) of this section does not apply to	336
either of the following:	337
(a) Acts or practices of an insurer, its agents,	338
representatives, or employees in connection with the grant of a	339
guaranteed student loan to its insured or the insured's spouse	340
or dependent children where such acts or practices take place	341
more than ninety days after the effective date of the insurance;	342
(b) Acts or practices of an insurer, its agents,	343

344

representatives, or employees in connection with the

solicitation, processing, or issuance of an insurance policy or	345
product covering the student loan borrower or the borrower's	346
spouse or dependent children, where such acts or practices take	347
place more than one hundred eighty days after the date on which	348
the borrower is notified that the student loan was approved.	349
(S) Denying coverage, under any health insurance or health	350
care policy, contract, or plan providing family coverage, to any	351
natural or adopted child of the named insured or subscriber	352
solely on the basis that the child does not reside in the	353
household of the named insured or subscriber.	354
(T)(1) Using any underwriting standard or engaging in any	355
other act or practice that, directly or indirectly, due solely	356
to any health status-related factor in relation to one or more	357
individuals, does either of the following:	358
(a) Terminates or fails to renew an existing individual	359
policy, contract, or plan of health benefits, or a health	360
benefit plan issued to an employer, for which an individual	361
would otherwise be eligible;	362
(b) With respect to a health benefit plan issued to an	363
employer, excludes or causes the exclusion of an individual from	364
coverage under an existing employer-provided policy, contract,	365
or plan of health benefits.	366
(2) The superintendent of insurance may adopt rules in	367
accordance with Chapter 119. of the Revised Code for purposes of	368
implementing division (T)(1) of this section.	369
(3) For purposes of division (T)(1) of this section,	370
"health status-related factor" means any of the following:	371
(a) Health status;	372

(b) Medical condition, including both physical and mental	373
illnesses;	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	379
out of acts of domestic violence;	380
(h) Disability.	381
(U) With respect to a health benefit plan issued to a	382
small employer, as those terms are defined in section 3924.01 of	383
the Revised Code, negligently or willfully placing coverage for	384
adverse risks with a certain carrier, as defined in section	385
3924.01 of the Revised Code.	386
(V) Using any program, scheme, device, or other unfair act	387
or practice that, directly or indirectly, causes or results in	388
the placing of coverage for adverse risks with another carrier,	389
as defined in section 3924.01 of the Revised Code.	390
(W) Failing to comply with section 3923.23, 3923.231,	391
3923.232, 3923.233, or 3923.234 of the Revised Code by engaging	392
in any unfair, discriminatory reimbursement practice.	393
(X) Intentionally establishing an unfair premium for, or	394
misrepresenting the cost of, any insurance policy financed under	395
a premium finance agreement of an insurance premium finance	396
company.	397
(Y)(1)(a) Limiting coverage under, refusing to issue,	398
canceling, or refusing to renew, any individual policy or	399

contract of life insurance, or limiting coverage under or	400
refusing to issue any individual policy or contract of health	401
insurance, for the reason that the insured or applicant for	402
insurance is or has been a victim of domestic violence;	403
(b) Adding a surcharge or rating factor to a premium of	404
any individual policy or contract of life or health insurance	405
for the reason that the insured or applicant for insurance is or	406
has been a victim of domestic violence;	407
(c) Denying coverage under, or limiting coverage under,	408
any policy or contract of life or health insurance, for the	409
reason that a claim under the policy or contract arises from an	410
incident of domestic violence;	411
(d) Inquiring, directly or indirectly, of an insured	412
under, or of an applicant for, a policy or contract of life or	413
health insurance, as to whether the insured or applicant is or	414
has been a victim of domestic violence, or inquiring as to	415
whether the insured or applicant has sought shelter or	416
protection from domestic violence or has sought medical or	417
psychological treatment as a victim of domestic violence.	418
(2) Nothing in division (Y)(1) of this section shall be	419
construed to prohibit an insurer from inquiring as to, or from	420
underwriting or rating a risk on the basis of, a person's	421
physical or mental condition, even if the condition has been	422
caused by domestic violence, provided that all of the following	423
apply:	424
(a) The insurer routinely considers the condition in	425
underwriting or in rating risks, and does so in the same manner	426
for a victim of domestic violence as for an insured or applicant	427
who is not a victim of domestic violence;	428

(b) The insurer does not refuse to issue any policy or	429
contract of life or health insurance or cancel or refuse to	430
renew any policy or contract of life insurance, solely on the	431
basis of the condition, except where such refusal to issue,	432
cancellation, or refusal to renew is based on sound actuarial	433
principles or is related to actual or reasonably anticipated	434
experience;	435
(c) The insurer does not consider a person's status as	436
being or as having been a victim of domestic violence, in	437
itself, to be a physical or mental condition;	438
(d) The underwriting or rating of a risk on the basis of	439
the condition is not used to evade the intent of division (Y)(1)	440
of this section, or of any other provision of the Revised Code.	441
(3)(a) Nothing in division (Y)(1) of this section shall be	442
construed to prohibit an insurer from refusing to issue a policy	443
or contract of life insurance insuring the life of a person who	444
is or has been a victim of domestic violence if the person who	445
committed the act of domestic violence is the applicant for the	446
insurance or would be the owner of the insurance policy or	447
contract.	448
(b) Nothing in division (Y)(2) of this section shall be	449
construed to permit an insurer to cancel or refuse to renew any	450
policy or contract of health insurance in violation of the	451
"Health Insurance Portability and Accountability Act of 1996,"	452
110 Stat. 1955, 42 U.S.C.A. 300gg-41(b), as amended, or in a	453
manner that violates or is inconsistent with any provision of	454
the Revised Code that implements the "Health Insurance	455
Portability and Accountability Act of 1996."	456
(4) An insurer is immune from any civil or criminal	457

liability that otherwise might be incurred or imposed as a	458
result of any action taken by the insurer to comply with	459
division (Y) of this section.	460
(5) As used in division (Y) of this section, "domestic	461
violence" means any of the following acts:	462
(a) Knowingly causing or attempting to cause physical harm	463
to a family or household member;	464
(b) Recklessly causing serious physical harm to a family	465
or household member;	466
(c) Knowingly causing, by threat of force, a family or	467
household member to believe that the person will cause imminent	468
physical harm to the family or household member.	469
	470
For the purpose of division (Y)(5) of this section,	470
"family or household member" has the same meaning as in section	471
2919.25 of the Revised Code.	472
Nothing in division (Y)(5) of this section shall be	473
construed to require, as a condition to the application of	474
division (Y) of this section, that the act described in division	475
(Y) (5) of this section be the basis of a criminal prosecution.	476
(Z) Disclosing a coroner's records by an insurer in	477
violation of section 313.10 of the Revised Code.	478
(AA) Making, issuing, circulating, or causing or	479
permitting to be made, issued, or circulated any statement or	480
representation that a life insurance policy or annuity is a	481
contract for the purchase of funeral goods or services.	482
(BB) (1) Setting or requiring the insurer's approval of	483
fees for dental services that are not covered dental services,	484
as defined in section 3963.01 of the Revised Code, or making	485

available any health benefit plan that sets fees for dental	486
services that are not covered dental care services.	487
(2) Nothing in division (BB)(1) of this section shall be	488
construed to apply to any health benefit plan subject to	489
regulation by the "Employee Retirement Income Security Act of	490
1974," 29 U.S.C. 1001, et seq., as amended.	491
(CC) With respect to private passenger automobile	492
insurance, charging premium rates that are excessive,	493
inadequate, or unfairly discriminatory, pursuant to division (D)	494
of section 3937.02 of the Revised Code, based solely on the	495
location of the residence of the insured.	496
The enumeration in sections 3901.19 to 3901.26 of the	497
Revised Code of specific unfair or deceptive acts or practices	498
in the business of insurance is not exclusive or restrictive or	499
intended to limit the powers of the superintendent of insurance	500
to adopt rules to implement this section, or to take action	501
under other sections of the Revised Code.	502
This section does not prohibit the sale of shares of any	503
investment company registered under the "Investment Company Act	504
of 1940," 54 Stat. 789, 15 U.S.C.A. 80a-1, as amended, or any	505
policies, annuities, or other contracts described in section	506
3907.15 of the Revised Code.	507
As used in this section, "estimate," "statement,"	508
"representation," "misrepresentation," "advertisement," or	509
"announcement" includes oral or written occurrences.	510
Sec. 3963.01. As used in this chapter:	511
(A) "Affiliate" means any person or entity that has	512
ownership or control of a contracting entity, is owned or	513
controlled by a contracting entity, or is under common ownership	514

or control with a contracting entity.	515
(B) "Basic health care services" has the same meaning as	516
in division (A) of section 1751.01 of the Revised Code, except	517
that it does not include any services listed in that division	518
that are provided by a pharmacist or nursing home.	519
(C) "Contracting entity" means any person that has a	520
primary business purpose of contracting with participating	521
providers for the delivery of health care services.	522
(D) "Covered dental services" means dental services for	523
which a reimbursement is available under an enrollee's health	524
benefit plan contract, or for which a reimbursement would be	525
available but for the application of contractual limitations	526
such as a deductible, copayment, coinsurance, waiting period,	527
annual or lifetime maximum, frequency limitation, alternative	528
benefit payment, or any other limitation.	529
(E) "Credentialing" means the process of assessing and	530
validating the qualifications of a provider applying to be	531
approved by a contracting entity to provide basic health care	532
services, specialty health care services, or supplemental health	533
care services to enrollees.	534
(E) (F) "Edit" means adjusting one or more procedure codes	535
billed by a participating provider on a claim for payment or a	536
practice that results in any of the following:	537
(1) Payment for some, but not all of the procedure codes	538
originally billed by a participating provider;	539
(2) Payment for a different procedure code than the	540
procedure code originally billed by a participating provider;	541
(3) A reduced payment as a result of services provided to	542

an enrollee that are claimed under more than one procedure code	543
on the same service date.	544
(F) (G) "Electronic claims transport" means to accept and	545
digitize claims or to accept claims already digitized, to place	546
those claims into a format that complies with the electronic	547
transaction standards issued by the United States department of	548
health and human services pursuant to the "Health Insurance	549
Portability and Accountability Act of 1996," 110 Stat. 1955, 42	550
U.S.C. 1320d, et seq., as those electronic standards are	551
applicable to the parties and as those electronic standards are	552
updated from time to time, and to electronically transmit those	553
claims to the appropriate contracting entity, payer, or third-	554
party administrator.	555
(G)—(H) "Enrollee" means any person eligible for health	556
care benefits under a health benefit plan, including an eligible	557
recipient of medicaid, and includes all of the following terms:	558
(1) "Enrollee" and "subscriber" as defined by section	559
1751.01 of the Revised Code;	560
(2) "Member" as defined by section 1739.01 of the Revised	561
Code;	562
(3) "Insured" and "plan member" pursuant to Chapter 3923.	563
of the Revised Code;	564
(4) "Beneficiary" as defined by section 3901.38 of the	565
Revised Code.	566
(H) (I) "Health care contract" means a contract entered	567
into, materially amended, or renewed between a contracting	568
entity and a participating provider for the delivery of basic	569
health care services, specialty health care services, or	570
supplemental health care services to enrollees.	571

(I) (J) "Health care services" means basic health care	572
services, specialty health care services, and supplemental	573
health care services.	574
(J) (K) "Material amendment" means an amendment to a	575
health care contract that decreases the participating provider's	576
payment or compensation, changes the administrative procedures	577
in a way that may reasonably be expected to significantly	578
increase the provider's administrative expenses, or adds a new	579
product. A material amendment does not include any of the	580
following:	581
(1) A decrease in payment or compensation resulting solely	582
from a change in a published fee schedule upon which the payment	583
or compensation is based and the date of applicability is	584
clearly identified in the contract;	585
	= 0.4
(2) A decrease in payment or compensation that was	586
anticipated under the terms of the contract, if the amount and	587
date of applicability of the decrease is clearly identified in	588
the contract;	589
(3) An administrative change that may significantly	590
increase the provider's administrative expense, the specific	591
applicability of which is clearly identified in the contract;	592
(4) Changes to an existing prior authorization,	593
precertification, notification, or referral program that do not	594
substantially increase the provider's administrative expense;	595
(5) Changes to an edit program or to specific edits if the	596
participating provider is provided notice of the changes	597
pursuant to division (A)(1) of section 3963.04 of the Revised	598
Code and the notice includes information sufficient for the	599
provider to determine the effect of the change;	600

(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
$\frac{(O)}{(P)}$ "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
<pre>care contract:</pre>	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,	631
chiropractor, optometrist, psychologist, physician assistant,	632
advanced practice registered nurse, occupational therapist,	633
massage therapist, physical therapist, licensed professional	634
counselor, licensed professional clinical counselor, hearing aid	635
dealer, orthotist, prosthetist, home health agency, hospice care	636
program, pediatric respite care program, or hospital, or a	637
provider organization or physician-hospital organization that is	638
acting exclusively as an administrator on behalf of a provider	639
to facilitate the provider's participation in health care	640
contracts. "Provider" does not mean a pharmacist, pharmacy,	641
nursing home, or a provider organization or physician-hospital	642
organization that leases the provider organization's or	643
physician-hospital organization's network to a third party or	644
contracts directly with employers or health and welfare funds.	645
(Q)—(R) "Specialty health care services" has the same	646
meaning as in section 1751.01 of the Revised Code, except that	647
it does not include any services listed in division (B) of	648
section 1751.01 of the Revised Code that are provided by a	649
pharmacist or a nursing home.	650
(R)—(S) "Supplemental health care services" has the same	651
meaning as in division (B) of section 1751.01 of the Revised	652
Code, except that it does not include any services listed in	653
that division that are provided by a pharmacist or nursing home.	654
Sec. 3963.02. (A) (1) No contracting entity shall sell,	655
rent, or give a third party the contracting entity's rights to a	656
participating provider's services pursuant to the contracting	657

entity's health care contract with the participating provider	658
unless one of the following applies:	659
(a) The third party accessing the participating provider's	660
services under the health care contract is an employer or other	661
entity providing coverage for health care services to its	662
employees or members, and that employer or entity has a contract	663
with the contracting entity or its affiliate for the	664
administration or processing of claims for payment for services	665
provided pursuant to the health care contract with the	666
participating provider.	667
(b) The third party accessing the participating provider's	668
services under the health care contract either is an affiliate	669
or subsidiary of the contracting entity or is providing	670
administrative services to, or receiving administrative services	671
from, the contracting entity or an affiliate or subsidiary of	672
the contracting entity.	673
(c) The health care contract specifically provides that it	674
applies to network rental arrangements and states that one	675
purpose of the contract is selling, renting, or giving the	676
contracting entity's rights to the services of the participating	677
provider, including other preferred provider organizations, and	678
the third party accessing the participating provider's services	679
is any of the following:	680
(i) A payer or a third-party administrator or other entity	681
responsible for administering claims on behalf of the payer;	682
(ii) A preferred provider organization or preferred	683
provider network that receives access to the participating	684
provider's services pursuant to an arrangement with the	685
preferred provider organization or preferred provider network in	686

a contract with the participating provider that is in compliance	687
with division (A)(1)(c) of this section, and is required to	688
comply with all of the terms, conditions, and affirmative	689
obligations to which the originally contracted primary	690
participating provider network is bound under its contract with	691
the participating provider, including, but not limited to,	692
obligations concerning patient steerage and the timeliness and	693
manner of reimbursement.	694
(iii) An entity that is engaged in the business of	695
providing electronic claims transport between the contracting	696
entity and the payer or third-party administrator and complies	697
with all of the applicable terms, conditions, and affirmative	698
obligations of the contracting entity's contract with the	699
participating provider including, but not limited to,	700
obligations concerning patient steerage and the timeliness and	701
manner of reimbursement.	702
(2) The contracting entity that sells, rents, or gives the	703
contracting entity's rights to the participating provider's	704
services pursuant to the contracting entity's health care	705
contract with the participating provider as provided in division	706
(A) (1) of this section shall do both of the following:	707
(a) Maintain a web page that contains a listing of third	708
parties described in divisions (A)(1)(b) and (c) of this section	709
with whom a contracting entity contracts for the purpose of	710
selling, renting, or giving the contracting entity's rights to	711
the services of participating providers that is updated at least	712
every six months and is accessible to all participating	713
providers, or maintain a toll-free telephone number accessible	714
to all participating providers by means of which participating	715

716

providers may access the same listing of third parties;

(b) Require that the third party accessing the	717
participating provider's services through the participating	718
provider's health care contract is obligated to comply with all	719
of the applicable terms and conditions of the contract,	720
including, but not limited to, the products for which the	721
participating provider has agreed to provide services, except	722
that a payer receiving administrative services from the	723
contracting entity or its affiliate shall be solely responsible	724
for payment to the participating provider.	725
(3) Any information disclosed to a participating provider	726
under this section shall be considered proprietary and shall not	727
be distributed by the participating provider.	728
(4) Except as provided in division (A)(1) of this section,	729
no entity shall sell, rent, or give a contracting entity's	730
rights to the participating provider's services pursuant to a	731
health care contract.	732
(B)(1) No contracting entity shall require, as a condition	733
of contracting with the contracting entity, that a participating	734
provider provide services for all of the products offered by the	735
contracting entity.	736
(2) Division (B)(1) of this section shall not be construed	737
to do any of the following:	738
(a) Prohibit any participating provider from voluntarily	739
accepting an offer by a contracting entity to provide health	740
care services under all of the contracting entity's products;	741
(b) Prohibit any contracting entity from offering any	742
financial incentive or other form of consideration specified in	743
the health care contract for a participating provider to provide	744
health care services under all of the contracting entity's	745

products;	746
(c) Require any contracting entity to contract with a	747
participating provider to provide health care services for less	748
than all of the contracting entity's products if the contracting	749
entity does not wish to do so.	750
(3)(a) Notwithstanding division (B)(2) of this section, no	751
contracting entity shall require, as a condition of contracting	752
with the contracting entity, that the participating provider	753
accept any future product offering that the contracting entity	754
makes.	755
(b) If a participating provider refuses to accept any	756
future product offering that the contracting entity makes, the	757
contracting entity may terminate the health care contract based	758
on the participating provider's refusal upon written notice to	759
the participating provider no sooner than one hundred eighty	760
days after the refusal.	761
(4) Once the contracting entity and the participating	762
provider have signed the health care contract, it is presumed	763
that the financial incentive or other form of consideration that	764
is specified in the health care contract pursuant to division	765
(B)(2)(b) of this section is the financial incentive or other	766
form of consideration that was offered by the contracting entity	767
to induce the participating provider to enter into the contract.	768
(C) No contracting entity shall require, as a condition of	769
contracting with the contracting entity, that a participating	770
provider waive or forego any right or benefit expressly	771
conferred upon a participating provider by state or federal law.	772
However, this division does not prohibit a contracting entity	773
from restricting a participating provider's scope of practice	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	777
a health care contract with any other contracting entity;	778
(2) Prohibit any contracting entity from entering into a	779
health care contract with any other provider;	780
(3) Preclude its use or disclosure for the purpose of	781
enforcing this chapter or other state or federal law, except	782
that a health care contract may require that appropriate	783
measures be taken to preserve the confidentiality of any	784
proprietary or trade-secret information.	785
(E) (1) No contracting entity shall require in any health	786
care contract that covers any dental services, either directly	787
or indirectly, that a participating provider who is a dentist	788
provide services to an enrollee at a fee set by, or a fee	789
subject to the approval of, the contracting entity unless the	790
dental services are covered dental services.	791
(2) To the extent that the provisions in division (E)(1)	792
of this section conflict with the provisions of the federal	793
"Employee Retirement Income Security Act of 1974," 29 U.S.C.	794
1001, et seq., as amended, the federal law shall control.	795
(F)(1) In addition to any other lawful reasons for	796
terminating a health care contract, a health care contract may	797
only be terminated under the circumstances described in division	798
(A) (3) of section 3963.04 of the Revised Code.	799
(2) If the health care contract provides for termination	800
for cause by either party, the health care contract shall state	801
the reasons that may be used for termination for cause, which	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 $\frac{(E)_{}(F)_{}(3)}{}$ 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 $\frac{(E)(F)}{(I)}(1)$ 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 $\frac{(E)(F)}{(2)}(2)$ 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
$\frac{F}{G}$ (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	834
an arbitration proceeding having due regard for any applicable	835
rules, bulletins, rulings, or decisions issued by the department	836
of insurance or any court concerning the enforcement of the	837
contract rights conferred by section 3963.02, divisions (A) and	838
(D) of section 3963.03, and section 3963.04 of the Revised Code.	839
(3) A party shall not simultaneously maintain an	840
arbitration proceeding as described in division $\frac{F}{G}$ (1) of	841
this section and pursue a complaint with the superintendent of	842
insurance to investigate the subject matter of the arbitration	843
proceeding. However, if a complaint is filed with the department	844
of insurance, the superintendent may choose to investigate the	845
complaint or, after reviewing the complaint, advise the	846
complainant to proceed with arbitration to resolve the	847
complaint. The superintendent may request to receive a copy of	848
the results of the arbitration. If the superintendent of	849
insurance notifies an insurer or a health insuring corporation	850
in writing that the superintendent has initiated a market	851
conduct examination into the specific subject matter of the	852
arbitration proceeding pending against that insurer or health	853
insuring corporation, the arbitration proceeding shall be stayed	854
at the request of the insurer or health insuring corporation	855
pending the outcome of the market conduct investigation by the	856
superintendent.	857
Sec. 3963.03. (A) Each health care contract shall include	858
all of the following information:	859
(1)(a) Information sufficient for the participating	860
provider to determine the compensation or payment terms for	861

health care services, including all of the following, subject to

division (A)(1)(b) of this section:	863
(i) The manner of payment, such as fee-for-service,	864
capitation, or risk;	865
(ii) The fee schedule of procedure codes reasonably	866
expected to be billed by a participating provider's specialty	867
for services provided pursuant to the health care contract and	868
the associated payment or compensation for each procedure code.	869
A fee schedule may be provided electronically. Upon request, a	870
contracting entity shall provide a participating provider with	871
the fee schedule for any other procedure codes requested and a	872
written fee schedule, that shall not be required more frequently	873
than twice per year excluding when it is provided in connection	874
with any change to the schedule. This requirement may be	875
satisfied by providing a clearly understandable, readily	876
available mechanism, such as a specific web site address, that	877
allows a participating provider to determine the effect of	878
procedure codes on payment or compensation before a service is	879
provided or a claim is submitted.	880
(iii) The effect, if any, on payment or compensation if	881
more than one procedure code applies to the service also shall	882
be stated. This requirement may be satisfied by providing a	883
clearly understandable, readily available mechanism, such as a	884
specific web site address, that allows a participating provider	885
to determine the effect of procedure codes on payment or	886
compensation before a service is provided or a claim is	887
submitted.	888
(b) If the contracting entity is unable to include the	889
information described in-division divisions (A)(1)(a)(ii) and	890
(iii) of this section, the contracting entity shall include both	891
of the following types of information instead:	892

(i) The methodology used to calculate any fee schedule,	893
such as relative value unit system and conversion factor or	894
percentage of billed charges. If applicable, the methodology	895
disclosure shall include the name of any relative value unit	896
system, its version, edition, or publication date, any	897
applicable conversion or geographic factor, and any date by	898
which compensation or fee schedules may be changed by the	899
methodology as anticipated at the time of contract.	900
(ii) The identity of any internal processing edits,	901
including the publisher, product name, version, and version	902
update of any editing software.	903
(c) If the contracting entity is not the payer and is	904
unable to include the information described in division (A)(1)	905
(a) or (b) of this section, then the contracting entity shall	906
provide by telephone a readily available mechanism, such as a	907
specific web site address, that allows the participating	908
provider to obtain that information from the payer.	909
(2) Any product or network for which the participating	910
provider is to provide services;	911
(3) The term of the health care contract;	912
(4) A specific web site address that contains the identity	913
of the contracting entity or payer responsible for the	914
processing of the participating provider's compensation or	915
payment;	916
(5) Any internal mechanism provided by the contracting	917
entity to resolve disputes concerning the interpretation or	918
application of the terms and conditions of the contract. A	919
contracting entity may satisfy this requirement by providing a	920
clearly understandable, readily available mechanism, such as a	921

specific web site address or an appendix, that allows a	922
participating provider to determine the procedures for the	923
internal mechanism to resolve those disputes.	924
(6) A list of addenda, if any, to the contract.	925
(0) A list of addenda, if any, to the contract.	923
(B)(1) Each contracting entity shall include a summary	926
disclosure form with a health care contract that includes all of	927
the information specified in division (A) of this section. The	928
information in the summary disclosure form shall refer to the	929
location in the health care contract, whether a page number,	930
section of the contract, appendix, or other identifiable	931
location, that specifies the provisions in the contract to which	932
the information in the form refers.	933
(2) The summary disclosure form shall include all of the	934
following statements:	935
TOTIOWING Statements.	955
(a) That the form is a guide to the health care contract	936
and that the terms and conditions of the health care contract	937
constitute the contract rights of the parties;	938
(b) That reading the form is not a substitute for reading	939
the entire health care contract;	940
(c) That by signing the health care contract, the	941
participating provider will be bound by the contract's terms and	942
conditions;	943
(d) That the terms and conditions of the health care	944
contract may be amended pursuant to section 3963.04 of the	945
Revised Code and the participating provider is encouraged to	946
carefully read any proposed amendments sent after execution of	947
the contract;	948
(e) That nothing in the summary disclosure form creates	949
(e) that nothing in the adminary discreases	243

H. B. No. 95	Page 34
As Introduced	

any additional rights or causes of action in favor of either	950 951
party.	931
(3) No contracting entity that includes any information in	952
the summary disclosure form with the reasonable belief that the	953
information is truthful or accurate shall be subject to a civil	954
action for damages or to binding arbitration based on the	955
summary disclosure form. Division (B)(3) of this section does	956
not impair or affect any power of the department of insurance to	957
enforce any applicable law.	958
(4) The summary disclosure form described in divisions (B)	959
(1) and (2) of this section shall be in substantially the	960
following form:	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	971
at	972
(e) Information in (c) and (d) is not required if	973
information in (b) is provided.	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	982
payment available at	983
(5) Internal mechanism for resolving disputes regarding	984
contract terms available at	985
(6) Addenda to contract	986
Title Subject	987
(a)	988
(b)	989
(c)	990
(d)	991
(7) Telephone number to access a readily available	992
mechanism, such as a specific web site address, to allow a	993
participating provider to receive the information in (1) through	994
(6) from the payer.	995
IMPORTANT INFORMATION - PLEASE READ CAREFULLY	996
The information provided in this Summary Disclosure Form	997
is a guide to the attached Health Care Contract as defined in	998
section $\frac{3963.01(G)}{3963.01(I)}$ of the Ohio Revised Code. The	999
terms and conditions of the attached Health Care Contract	1000

constitute the contract rights of the parties.	1001
Reading this Summary Disclosure Form is not a substitute	1002
for reading the entire Health Care Contract. When you sign the	1003
Health Care Contract, you will be bound by its terms and	1004
conditions. These terms and conditions may be amended over time	1005
pursuant to section 3963.04 of the Ohio Revised Code. You are	1006
encouraged to read any proposed amendments that are sent to you	1007
after execution of the Health Care Contract.	1008
Nothing in this Summary Disclosure Form creates any	1009
additional rights or causes of action in favor of either party."	1010
(C) When a contracting entity presents a proposed health	1011
care contract for consideration by a provider, the contracting	1012
entity shall provide in writing or make reasonably available the	1013
information required in division (A)(1) of this section.	1014
(D) The contracting entity shall identify any utilization	1015
management, quality improvement, or a similar program that the	1016
contracting entity uses to review, monitor, evaluate, or assess	1017
the services provided pursuant to a health care contract. The	1018
contracting entity shall disclose the policies, procedures, or	1019
guidelines of such a program applicable to a participating	1020
provider upon request by the participating provider within	1021
fourteen days after the date of the request.	1022
(E) Nothing in this section shall be construed as	1023
preventing or affecting the application of section 1753.07 of	1024
the Revised Code that would otherwise apply to a contract with a	1025
participating provider.	1026
(F) The requirements of division (C) of this section do	1027
not prohibit a contracting entity from requiring a reasonable	1028
confidentiality agreement between the provider and the	1029

contracting entity regarding the terms of the proposed health	1030
care contract. If either party violates the confidentiality	1031
agreement, a party to the confidentiality agreement may bring a	1032
civil action to enjoin the other party from continuing any act	1033
that is in violation of the confidentiality agreement, to	1034
recover damages, to terminate the contract, or to obtain any	1035
combination of relief.	1036
Section 2. That existing sections 1753.07, 1753.09,	1037
3901.21, 3963.01, 3963.02, and 3963.03 of the Revised Code are	1038
hereby repealed.	1039
Section 3. The following represent the General Assembly's	1040
<pre>intent and findings:</pre>	1041
(A) The provisions of this act seek to prevent dental	1042
insurers, dental benefit plans, and other contracting entities	1043
from establishing fee limitations on services that are not	1044
covered dental services for enrollees under a dental insurance	1045
plan.	1046
(B) Strategies by dental insurers, dental benefit plans,	1047
or other contracting entities to adopt or impose a deductible,	1048
copayment, coinsurance, or any other requirement in such a way	1049
as to provide de minimis reimbursement for services as a method	1050
to avoid the impact of this law is contrary to the spirit and	1051
intent of the General Assembly.	1052