As Introduced

133rd General Assembly

Regular Session **H. B. No. 443**

2019-2020

Representatives Plummer, Russo

Cosponsors: Representatives Seitz, Boggs, Blair, Miranda, Leland, Sobecki, Strahorn, Skindell, Lepore-Hagan, Manning, D., Smith, K., Upchurch, Crossman, Lightbody, Robinson, Brent, Liston, Sweeney, Clites, Weinstein, Miller, A., Scherer, West, Boyd

A BILL

To amend sections 1739.05, 1751.01, 1751.92, 3901.83, 3902.30, 3922.01, 3923.51, 3923.87, 3959.20, 4723.94, 4731.2910, 4766.01, and 5168.75; to enact sections 3901.57, 3902.50, 3902.51, 5162.137, and 5167.47; and to repeal sections 3923.27, 3923.28, 3923.281, 3923.282, 3923.29, and 3923.30 of the Revised Code regarding mental health and substance use disorder benefit parity.

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

Section 1. That sections 1739.05, 1751.01, 1751.92, 3901.83, 3902.30, 3922.01, 3923.51, 3923.87, 3959.20, 4723.94, 4731.2910, 4766.01, and 5168.75 be amended and sections 3901.57, 3902.50, 3902.51, 5162.137, and 5167.47 of the Revised Code be enacted to read as follows:

Sec. 1739.05. (A) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the

Revised Code and that operates a group self-insurance program may be established only if any of the following applies:

(1) The arrangement has and maintains a minimum enrollment of three hundred employees of two or more employers.

(2) The arrangement has and maintains a minimum enrollment of three hundred self-employed individuals.

(3) The arrangement has and maintains a minimum enrollment of three hundred employees or self-employed individuals in any combination of divisions (A)(1) and (2) of this section.

(B) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program shall comply with all laws applicable to self-funded programs in this state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 3901.491, 3902.01 to 3902.14, 3923.041, 3923.24, ~~3923.282, 3923.30,~~ 3923.301, 3923.38, 3923.581, 3923.602, 3923.63, 3923.80, 3923.84, 3923.85, 3923.851, 3923.86, 3923.87, 3923.89, 3923.90, 3924.031, 3924.032, and 3924.27 of the Revised Code.

(C) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall solicit enrollments only through agents or solicitors licensed pursuant to Chapter 3905. of the Revised Code to sell or solicit sickness and accident insurance.

(D) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall provide benefits only to individuals who are members, employees of members, or the dependents of members or employees, or are eligible for continuation of coverage under section

1751.53 or 3923.38 of the Revised Code or under Title X of the "Consolidated Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 U.S.C.A. 1161, as amended.

(E) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code is subject to, and shall comply with, sections 3903.81 to 3903.93 of the Revised Code in the same manner as other life or health insurers, as defined in section 3903.81 of the Revised Code.

Sec. 1751.01. As used in this chapter:

(A) ~~(1)~~ "Basic health care services" means the following services when medically necessary:

~~(a)~~ (1) Physician's services, except when such services are supplemental under division (B) of this section;

~~(b)~~ (2) Inpatient hospital services;

~~(c)~~ (3) Outpatient medical services;

~~(d)~~ (4) Emergency health services;

~~(e)~~ (5) Urgent care services;

~~(f)~~ (6) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;

~~(g)~~ (7) Diagnostic and treatment services, other than prescription drug services, for ~~biologically based~~ mental ~~illnesses~~health and substance use disorders;

~~(h)~~ (8) Preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care;

~~(i)~~ (9) Routine patient care for patients enrolled in an

eligible cancer clinical trial pursuant to section 3923.80 of the Revised Code.

"Basic health care services" does not include experimental procedures.

~~Except as provided by divisions (A)(2) and (3) of this section in connection with the offering of coverage for diagnostic and treatment services for biologically based mental illnesses, a~~ A health insuring corporation shall not offer coverage for a health care service, defined as a basic health care service by this division, unless it offers coverage for all listed basic health care services. However, this requirement does not apply to the coverage of beneficiaries enrolled in medicare pursuant to a medicare contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage of medicaid recipients, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services.

~~(2) A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses without offering coverage for all other basic health care services. A health insuring corporation may offer coverage for diagnostic and treatment services for biologically based mental illnesses alone or in combination with one or more supplemental health care services. However, a health insuring corporation that offers coverage for any other basic health care service shall offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination~~

~~with the offer of coverage for all other listed basic health care services.~~

~~(3) A health insuring corporation that offers coverage for basic health care services is not required to offer coverage for diagnostic and treatment services for biologically based mental illnesses in combination with the offer of coverage for all other listed basic health care services if all of the following apply:~~

~~(a) The health insuring corporation submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for diagnostic and treatment services for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.~~

~~(b) The health insuring corporation submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (A)(3)(a) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.~~

~~(c) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (A)(3)(a) and (b) of this section:~~

~~(i) Incurred claims for diagnostic and treatment services~~

~~for biologically based mental illnesses for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.~~

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

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

(B)(1) "Supplemental health care services" means any health care services other than basic health care services that a health insuring corporation may offer, alone or in combination with either basic health care services or other supplemental health care services, and includes:

(a) Services of facilities for intermediate or long-term care, or both;

(b) Dental care services;

(c) Vision care and optometric services including lenses and frames;

(d) Podiatric care or foot care services;

(e) Mental health services, excluding diagnostic and treatment services ~~for biologically based mental illnesses~~;

(f) Short-term outpatient evaluative and crisis-intervention mental health services;

(g) Medical or psychological treatment and referral

services for alcohol and drug abuse or addiction;

(h) Home health services;

(i) Prescription drug services;

(j) Nursing services;

(k) Services of a dietitian licensed under Chapter 4759. of the Revised Code;

(l) Physical therapy services;

(m) Chiropractic services;

(n) Any other category of services approved by the superintendent of insurance.

(2) If a health insuring corporation offers prescription drug services under this division, the coverage shall include prescription drug services for the treatment of ~~biologically based~~ mental ~~illnesses~~ health and substance use disorders on the same terms and conditions as other physical diseases and disorders.

(C) "Specialty health care services" means one of the supplemental health care services listed in division (B) of this section, when provided by a health insuring corporation on an outpatient-only basis and not in combination with other supplemental health care services.

(D) ~~"Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published~~

~~by the American psychiatric association.~~

~~(E)~~ "Closed panel plan" means a health care plan that requires enrollees to use participating providers.

~~(F)~~ (E) "Compensation" means remuneration for the provision of health care services, determined on other than a fee-for-service or discounted-fee-for-service basis.

~~(G)~~ (F) "Contractual periodic prepayment" means the formula for determining the premium rate for all subscribers of a health insuring corporation.

~~(H)~~ (G) "Corporation" means a corporation formed under Chapter 1701. or 1702. of the Revised Code or the similar laws of another state.

~~(I)~~ (H) "Emergency health services" means those health care services that must be available on a seven-days-per-week, twenty-four-hours-per-day basis in order to prevent jeopardy to an enrollee's health status that would occur if such services were not received as soon as possible, and includes, where appropriate, provisions for transportation and indemnity payments or service agreements for out-of-area coverage.

~~(J)~~ (I) "Enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation.

~~(K)~~ (J) "Evidence of coverage" means any certificate, agreement, policy, or contract issued to a subscriber that sets out the coverage and other rights to which such person is entitled under a health care plan.

~~(L)~~ (K) "Health care facility" means any facility, except a health care practitioner's office, that provides preventive,

diagnostic, therapeutic, acute convalescent, rehabilitation, mental health, intellectual disability, intermediate care, or skilled nursing services.

~~(M)~~ (L) "Health care services" means basic, supplemental, and specialty health care services.

~~(N)~~ (M) "Health delivery network" means any group of providers or health care facilities, or both, or any representative thereof, that have entered into an agreement to offer health care services in a panel rather than on an individual basis.

~~(O)~~ (N) "Health insuring corporation" means a corporation, as defined in division ~~(H)~~ (G) of this section, that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.

"Health insuring corporation" does not include a limited liability company formed pursuant to Chapter 1705. of the Revised Code, an insurer licensed under Title XXXIX of the Revised Code if that insurer offers only open panel plans under which all providers and health care facilities participating receive their compensation directly from the insurer, a corporation formed by or on behalf of a political subdivision or a department, office, or institution of the state, or a public entity formed by or on behalf of a board of county commissioners, a county board of developmental disabilities, an

alcohol and drug addiction services board, a board of alcohol, drug addiction, and mental health services, or a community mental health board, as those terms are used in Chapters 340. and 5126. of the Revised Code. Except as provided by division (D) of section 1751.02 of the Revised Code, or as otherwise provided by law, no board, commission, agency, or other entity under the control of a political subdivision may accept insurance risk in providing for health care services. However, nothing in this division shall be construed as prohibiting such entities from purchasing the services of a health insuring corporation or a third-party administrator licensed under Chapter 3959. of the Revised Code.

~~(P)~~ (O) "Intermediary organization" means a health delivery network or other entity that contracts with licensed health insuring corporations or self-insured employers, or both, to provide health care services, and that enters into contractual arrangements with other entities for the provision of health care services for the purpose of fulfilling the terms of its contracts with the health insuring corporations and self-insured employers.

~~(Q)~~ (P) "Intermediate care" means residential care above the level of room and board for patients who require personal assistance and health-related services, but who do not require skilled nursing care.

~~(R)~~ (Q) "Medical record" means the personal information that relates to an individual's physical or mental condition, medical history, or medical treatment.

~~(S)(1)~~ (R)(1) "Open panel plan" means a health care plan that provides incentives for enrollees to use participating providers and that also allows enrollees to use providers that

are not participating providers.

(2) No health insuring corporation may offer an open panel plan, unless the health insuring corporation is also licensed as an insurer under Title XXXIX of the Revised Code, the health insuring corporation, on June 4, 1997, holds a certificate of authority or license to operate under Chapter 1736. or 1740. of the Revised Code, or an insurer licensed under Title XXXIX of the Revised Code is responsible for the out-of-network risk as evidenced by both an evidence of coverage filing under section 1751.11 of the Revised Code and a policy and certificate filing under section 3923.02 of the Revised Code.

~~(T)~~ (S) "Osteopathic hospital" means a hospital registered under section 3701.07 of the Revised Code that advocates osteopathic principles and the practice and perpetuation of osteopathic medicine by doing any of the following:

(1) Maintaining a department or service of osteopathic medicine or a committee on the utilization of osteopathic principles and methods, under the supervision of an osteopathic physician;

(2) Maintaining an active medical staff, the majority of which is comprised of osteopathic physicians;

(3) Maintaining a medical staff executive committee that has osteopathic physicians as a majority of its members.

~~(U)~~ (T) "Panel" means a group of providers or health care facilities that have joined together to deliver health care services through a contractual arrangement with a health insuring corporation, employer group, or other payor.

~~(V)~~ (U) "Person" has the same meaning as in section 1.59 of the Revised Code, and, unless the context otherwise requires,

includes any insurance company holding a certificate of authority under Title XXXIX of the Revised Code, any subsidiary and affiliate of an insurance company, and any government agency.

~~(W)~~ (V) "Premium rate" means any set fee regularly paid by a subscriber to a health insuring corporation. A "premium rate" does not include a one-time membership fee, an annual administrative fee, or a nominal access fee, paid to a managed health care system under which the recipient of health care services remains solely responsible for any charges accessed for those services by the provider or health care facility.

~~(X)~~ (W) "Primary care provider" means a provider that is designated by a health insuring corporation to supervise, coordinate, or provide initial care or continuing care to an enrollee, and that may be required by the health insuring corporation to initiate a referral for specialty care and to maintain supervision of the health care services rendered to the enrollee.

~~(Y)~~ (X) "Provider" means any natural person or partnership of natural persons who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services, or any professional association organized under Chapter 1785. of the Revised Code, provided that nothing in this chapter or other provisions of law shall be construed to preclude a health insuring corporation, health care practitioner, or organized health care group associated with a health insuring corporation from employing certified nurse practitioners, certified nurse anesthetists, clinical nurse specialists, certified nurse-midwives, pharmacists, dietitians, physician assistants, dental assistants, dental hygienists,

optometric technicians, or other allied health personnel who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services.

~~(Z)~~ (Y) "Provider sponsored organization" means a corporation, as defined in division ~~(H)~~ (G) of this section, that is at least eighty per cent owned or controlled by one or more hospitals, as defined in section 3727.01 of the Revised Code, or one or more physicians licensed to practice medicine or surgery or osteopathic medicine and surgery under Chapter 4731. of the Revised Code, or any combination of such physicians and hospitals. Such control is presumed to exist if at least eighty per cent of the voting rights or governance rights of a provider sponsored organization are directly or indirectly owned, controlled, or otherwise held by any combination of the physicians and hospitals described in this division.

~~(AA)~~ (Z) "Solicitation document" means the written materials provided to prospective subscribers or enrollees, or both, and used for advertising and marketing to induce enrollment in the health care plans of a health insuring corporation.

~~(BB)~~ (AA) "Subscriber" means a person who is responsible for making payments to a health insuring corporation for participation in a health care plan, or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health insuring corporation.

~~(CC)~~ (BB) "Urgent care services" means those health care services that are appropriately provided for an unforeseen condition of a kind that usually requires medical attention without delay but that does not pose a threat to the life, limb, or permanent health of the injured or ill person, and may

include such health care services provided out of the health insuring corporation's approved service area pursuant to indemnity payments or service agreements.

Sec. 1751.92. Each health insuring corporation shall comply with the requirements of section 3959.20 of the Revised Code as they pertain to health plan issuers.

As used in this section, "health plan issuer" has the same meaning as in section ~~3922.01~~ 3902.50 of the Revised Code.

Sec. 3901.57. (A) As used in this section:

(1) "Generally recognized independent standards of current practice" has the same meaning as in section 3902.50 of the Revised Code.

(2) "Health benefit plan" and "health plan issuer" have the same meanings as in section 3902.50 of the Revised Code.

(3) "Mental health benefits" means benefits with respect to items or services for mental health conditions, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law. Any condition defined by a health benefit plan as being or as not being a mental health condition shall be defined to be consistent with generally recognized independent standards of current practice.

(4) "Mental Health Parity and Addiction Equity Act" means the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, as amended, and any federal regulations implementing that act.

(5) "Substance use disorder benefits" means benefits with respect to items or services for substance use disorders, as defined under the terms of a health benefit plan and in

accordance with applicable federal and state law. Any condition defined by a health benefit plan as being or as not being a substance use disorder shall be defined to be consistent with generally recognized independent standards of current practice.

(B) The superintendent of insurance shall implement and enforce applicable provisions of the Mental Health Parity and Addiction Equity Act and section 3902.51 of the Revised Code, including all of the following:

(1) Proactively ensuring compliance by health plan issuers;

(2) Evaluating all consumer or provider complaints regarding mental health and substance use disorder benefits for possible parity violations;

(3) Performing parity compliance market conduct examinations of health plan issuers, particularly market conduct examinations that focus on nonquantitative treatment limitations;

(4) Requiring that health plan issuers submit the analyses described in division (B) of section 3902.51 of the Revised Code during the form review process;

(5) Adopting rules in accordance with Chapter 119. of the Revised Code as necessary to do both of the following:

(a) Effectuate any provisions of the Mental Health Parity and Addiction Equity Act that relate to the business of insurance;

(b) Enforce, monitor compliance with, and ensure continued compliance with section 3902.51 of the Revised Code.

(C) The superintendent shall issue an annual report that

is written in nontechnical, readily understandable language and shall make the report available to the public by, among such other means as the superintendent considers appropriate, posting the report on the web site of the department of insurance. The report shall do all of the following:

(1) Cover the methodology the superintendent is using to check for compliance with the Mental Health Parity and Addiction Equity Act and section 3902.51 of the Revised Code;

(2) Identify market conduct examinations conducted or completed during the preceding twelve-month period regarding compliance with parity in mental health and substance use disorder benefits under state and federal laws and summarize the results of such market conduct examinations;

(3) Detail any educational or corrective actions the superintendent has taken to ensure health plan issuer compliance with the Mental Health Parity and Addiction Equity Act and section 3902.51 of the Revised Code.

Sec. 3901.83. As used in sections 3901.83 to 3901.833 of the Revised Code:

(A) "Clinical practice guidelines" means a systematically developed statement to assist health care provider and patient decisions with regard to appropriate health care for specific clinical circumstances and conditions.

(B) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by a health plan issuer or utilization review organization to determine whether or not health care services or drugs are appropriate and consistent with medical or scientific evidence.

(C) "Health benefit plan" and "health plan issuer" have the same meanings as in section ~~3922.01~~ 3902.50 of the Revised Code.

(D) "Medical or scientific evidence" has the same meaning as in section 3922.01 of the Revised Code.

(E) "Step therapy exemption" means an overriding of a step therapy protocol in favor of immediate coverage of the health care provider's selected prescription drug.

(F) "Step therapy protocol" means a protocol or program that establishes a specific sequence in which prescription drugs that are for a specified medical condition and that are consistent with medical or scientific evidence for a particular patient are covered, under either a medical or prescription drug benefit, by a health benefit plan, including both self-administered and physician-administered drugs.

(G) "Urgent care services" has the same meaning as in section 3923.041 of the Revised Code.

(H) "Utilization review organization" has the same meaning as in section 1751.77 of the Revised Code.

Sec. 3902.30. (A) As used in this section:

(1) "Health benefit plan," "health care services," and "health plan issuer" have the same meanings as in section ~~3922.01~~ 3902.50 of the Revised Code.

(2) "Health care professional" means any of the following:

(a) A physician licensed under Chapter 4731. of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery;

(b) A physician assistant licensed under Chapter 4731. of the Revised Code;

(c) An advanced practice registered nurse as defined in section 4723.01 of the Revised Code.

(3) "In-person health care services" means health care services delivered by a health care professional through the use of any communication method where the professional and patient are simultaneously present in the same geographic location.

(4) "Recipient" means a patient receiving health care services or a health care professional with whom the provider of health care services is consulting regarding the patient.

(5) "Telemedicine services" means a mode of providing health care services through synchronous or asynchronous information and communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where the recipient is located.

(B)(1) A health benefit plan shall provide coverage for telemedicine services on the same basis and to the same extent that the plan provides coverage for the provision of in-person health care services.

(2) A health benefit plan shall not exclude coverage for a service solely because it is provided as a telemedicine service.

(C) A health benefit plan shall not impose any annual or lifetime benefit maximum in relation to telemedicine services other than such a benefit maximum imposed on all benefits offered under the plan.

(D) This section shall not be construed as doing any of

the following:

(1) Prohibiting a health benefit plan from assessing cost-sharing requirements to a covered individual for telemedicine services, provided that such cost-sharing requirements for telemedicine services are not greater than those for comparable in-person health care services;

(2) Requiring a health plan issuer to reimburse a health care professional for any costs or fees associated with the provision of telemedicine services that would be in addition to or greater than the standard reimbursement for comparable in-person health care services;

(3) Requiring a health plan issuer to reimburse a telemedicine provider for telemedicine services at the same rate as in-person services.

(E) This section applies to all health benefit plans issued, offered, or renewed on or after January 1, 2021.

Sec. 3902.50. As used in sections 3902.50 and 3902.51 of the Revised Code:

(A) "Benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(B) "Covered person" means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan.

(C) "Facility" means an institution providing health care services, or a health care setting, including hospitals and other licensed inpatient centers, ambulatory, surgical, treatment, skilled nursing, residential treatment, diagnostic,

laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

(D) "Generally recognized independent standards of current practice" includes the most current standards set out in or established by the diagnostic and statistical manual of mental disorders, the international classification of diseases, the American society of addiction medicine, and state guidelines.

(E) "Health benefit plan" means a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including benefit plans marketed in the individual or group market by all associations, whether bona fide or non-bona fide. "Health benefit plan" also means a limited benefit plan, except as follows. "Health benefit plan" does not mean any of the following types of coverage: a policy, contract, certificate, or agreement that covers only a specified accident, accident only, credit, dental, disability income, long-term care, hospital indemnity, supplemental coverage, as described in section 3923.37 of the Revised Code, specified disease, or vision care; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; a medicare supplement policy of insurance, as defined by the superintendent of insurance by rule, coverage under a plan through medicare, medicaid, or the federal employees benefit program; any coverage issued under Chapter 55 of Title 10 of the United States Code and any coverage issued as a supplement to that coverage.

(F) "Health care professional" means a physician, psychologist, nurse practitioner, or other health care practitioner licensed, accredited, or certified to perform health care services consistent with state law.

(G) "Health care provider" means a health care professional or facility.

(H) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(I) "Health plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health plan issuer" includes a third-party administrator licensed under Chapter 3959. of the Revised Code to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.

(J) "Medical and surgical benefits" means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of a health benefit plan and in accordance with applicable federal and state law, but does not include mental health or substance use disorder benefits. Any condition defined by a health benefit plan as being or as not being a medical or surgical condition shall be

defined to be consistent with generally recognized independent standards of current practice.

(K) "Mental health benefits" has the same meaning as in section 3901.57 of the Revised Code.

(L) "Mental Health Parity and Addiction Equity Act" has the same meaning as in section 3901.57 of the Revised Code.

(M) "Substance use disorder benefits" has the same meaning as in section 3901.57 of the Revised Code.

(N) "Treatment limitations" means limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. "Treatment limitations" includes all of the following:

(1) Financial restrictions;

(2) Quantitative treatment limitations, which are expressed numerically, such as fifty outpatient visits per year;

(3) Nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan.

"Treatment limitations" does not include a permanent exclusion of all benefits for a particular condition or disorder.

Sec. 3902.51. (A)(1) Each health plan issuer and health benefit plan subject to the Mental Health Parity and Addiction Equity Act, other than an employee benefit plan exempt from state regulation under 29 U.S.C. 1144, shall meet the requirements of that act. The requirements of this section do not apply to a health plan issuer or a health benefit plan that

is exempt from the requirements of that act.

(2) Any disorder defined by a health benefit plan subject to the Mental Health Parity and Addiction Equity Act, other than an employee benefit plan exempt from state regulation under 29 U.S.C. 1144, as being or as not being a substance use disorder shall be defined to be consistent with generally recognized independent standards of current practice.

(3) There shall be no separate nonquantitative treatment limitations that apply to mental health and substance use disorder benefits but not to medical and surgical benefits within any classification of benefits.

(B) A health plan issuer subject to the Mental Health Parity and Addiction Equity Act, other than an employee benefit plan exempt from state regulation under 29 U.S.C. 1144, shall submit an annual report to the superintendent of insurance containing all of the following:

(1) A description of the process used to develop or select the medical and clinical necessity criteria, including any criteria established by the American society of addiction medicine, for mental health benefits, substance use disorder benefits, and medical and surgical benefits;

(2) Identification of all nonquantitative treatment limitations that are applied to both mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits.

(3)(a) The results of an analysis demonstrating whether, as written and in operation:

(i) The processes, strategies, evidentiary standards, and other factors used in applying medical and clinical necessity

criteria to mental health and substance use disorder benefits within each classification of benefits are comparable to, and applied not more stringently than, those used in applying medical and clinical necessity criteria to medical and surgical benefits within the corresponding classification of benefits;

(ii) The processes, strategies, evidentiary standards, and other factors used in applying nonquantitative treatment limitations to mental health and substance use disorder benefits within each classification of benefits are comparable to, and applied not more stringently than, those used in applying nonquantitative treatment limitations to medical and surgical benefits within the corresponding classification of benefits.

(b) At a minimum, the results shall do all of the following:

(i) Identify all factors used to determine whether each nonquantitative treatment limitation applies to a benefit, including factors that were considered but rejected;

(ii) Identify and define the specific evidentiary standards used to determine the factors described in division (B)(3)(a)(ii) of this section and any evidence relied upon in applying each nonquantitative treatment limitation;

(iii) Provide all analyses and results of all analyses that were performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, as written, for mental health and substance use disorder benefits are comparable to, and applied not more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, as written, for medical and surgical benefits;

(iv) Provide all analyses and results of all analyses that were performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental health and substance use disorder benefits are comparable to, and applied not more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits;

(v) Disclose the specific findings and conclusions reached by the health plan issuer regarding compliance with this section and the Mental Health Parity and Addiction Equity Act.

(C) In relation to any prescription medication prescribed for the treatment of a substance use disorder, a health benefit plan subject to the Mental Health Parity and Addiction Equity Act, other than an employee benefit plan exempt from state regulation under 29 U.S.C. 1144, is subject to all of the following requirements:

(1) Except as otherwise provided in sections 1751.691 and 3923.851 of the Revised Code, the health benefit plan shall not impose any prior authorization requirements on any such prescription medication.

(2) Notwithstanding any contrary provision of sections 3901.83 to 3901.833 of the Revised Code, the health benefit plan shall not impose any step therapy requirements before the health plan issuer will authorize coverage for such a prescription medication.

(3) The health benefit plan shall place all such prescription medications on the lowest tier of the plan's drug formulary.

(4) The health benefit plan shall not exclude coverage for any such prescription medication or for any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

(D) Nothing in division (C) of this section is subject to the requirements of section 3901.71 of the Revised Code.

(E) A covered person affected by a health plan issuer's or health benefit plan's failure to provide parity as required by this section and the Mental Health Parity and Addiction Equity Act, or a health care provider on the covered person's behalf, may file a complaint with the consumer services division of the department of insurance.

Sec. 3922.01. As used in this chapter:

(A) "Adverse benefit determination" means a decision by a health plan issuer:

(1) To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:

(a) A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;

(b) A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a nonemployer group, to participate in a plan or health insurance coverage;

(c) A determination that a health care service is not a

covered benefit;

(d) The imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.

(2) Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a nonemployer group;

(3) To rescind coverage on a health benefit plan.

(B) "Ambulatory review" has the same meaning as in section 1751.77 of the Revised Code.

(C) "Authorized representative" means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

(1) A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;

(2) A person authorized by law to provide substituted consent for a covered individual;

(3) A family member or a treating health care professional, but only when the covered person is unable to provide consent.

(D) "Best evidence" means evidence based on all of the following sources, listed according to priority, as they are available:

(1) Randomized clinical trials;

(2) Cohort studies or case-control studies;

(3) Case series;

(4) Expert opinion.

(E) "Covered person" means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "Covered person" does include the covered person's authorized representative with regard to an internal appeal or external review in accordance with division (C) of this section. "Covered person" does not include the covered person's representative in any other context.

(F) "Covered benefits" or "benefits" means ~~those health care services to which a covered person is entitled under the terms of a health benefit plan~~"benefits" as defined in section 3902.50 of the Revised Code.

(G) "Emergency medical condition" has the same meaning as in section 1753.28 of the Revised Code.

(H) "Emergency services" has the same meaning as in section 1753.28 of the Revised Code.

(I) "Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence, based on a systematic review of the relevant research, in making decisions about the care of individuals.

(J) "Facility" ~~means an institution providing health care services, or a health care setting, including hospitals and other licensed inpatient centers, ambulatory, surgical, treatment, skilled nursing, residential treatment, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings~~has the same meaning as in section

3902.50 of the Revised Code.

(K) "Final adverse benefit determination" means an adverse benefit determination that is upheld at the completion of a health plan issuer's internal appeals process.

(L) "Health benefit plan," ~~means a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including benefit plans marketed in the individual or group market by all associations, whether bona fide or non-bona fide. "Health benefit plan" also means a limited benefit plan, except as follows. "Health benefit plan" does not mean any of the following types of coverage: a policy, contract, certificate, or agreement that covers only a specified accident, accident only, credit, dental, disability income, long-term care, hospital indemnity, supplemental coverage, as described in section 3923.37 of the Revised Code, specified disease, or vision care; coverage issued as a supplement to liability insurance; insurance arising out of workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; a medicare supplement policy of insurance, as defined by the superintendent of insurance by rule, coverage under a plan through medicare, medicaid, or the federal employees benefit program; any coverage issued under Chapter 55 of Title 10 of the United States Code and any coverage issued as a supplement to that coverage.~~

~~(M) "Health care professional" means a physician, psychologist, nurse practitioner, or other health care~~

~~practitioner licensed, accredited, or certified to perform health care services consistent with state law.~~

~~(N) "Health care provider" or "provider" means a health care professional or facility.~~

~~(O) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.~~

~~(P) "Health plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health plan issuer" includes a third party administrator licensed under Chapter 3959. of the Revised Code to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent~~"health care professional," "health care services," and "health plan issuer" have the same meanings as in section 3902.50 of the Revised Code.

~~(Q)~~ (M) "Health care provider" or "provider" means "health care provider" as defined in section 3902.50 of the Revised Code.

(N) "Health information" means information or data, whether oral or recorded in any form or medium, and personal

facts or information about events or relationships that relates to all of the following:

(1) The past, present, or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family;

(2) The provision of health care services or health-related benefits to a covered person;

(3) Payment for the provision of health care services to or for a covered person.

~~(R)~~ (O) "Independent review organization" means an entity that is accredited to conduct independent external reviews of adverse benefit determinations pursuant to section 3922.13 of the Revised Code.

~~(S)~~ (P) "Medical or scientific evidence" means evidence found in any of the following sources:

(1) Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the national institutes of health's library of medicine for indexing in index medicus and elsevier science ltd. for indexing in excerpta medicus;

(3) Medical journals recognized by the secretary of health

and human services under section 1861(t)(2) of the federal social security act;

(4) The following standard reference compendia:

(a) The American hospital formulary service drug information;

(b) Drug facts and comparisons;

(c) The American dental association accepted dental therapeutics;

(d) The United States pharmacopoeia drug information.

(5) Findings, studies or research conducted by or under the auspices of a federal government agency or nationally recognized federal research institute, including any of the following:

(a) The federal agency for health care research and quality;

(b) The national institutes of health;

(c) The national cancer institute;

(d) The national academy of sciences;

(e) The centers for medicare and medicaid services;

(f) The federal food and drug administration;

(g) Any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services.

(6) Any other medical or scientific evidence that is comparable.

~~(T)~~ (Q) "Person" has the same meaning as in section 3901.19 of the Revised Code.

~~(U)~~ (R) "Protected health information" means health information related to the identity of an individual, or information that could reasonably be used to determine the identity of an individual.

~~(V)~~ (S) "Rescind" means to retroactively cancel or discontinue coverage. "Rescind" does not include canceling or discontinuing coverage that only has a prospective effect or canceling or discontinuing coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

~~(W)~~ (T) "Retrospective review" means a review conducted after services have been provided to a covered person.

~~(X)~~ (U) "Superintendent" means the superintendent of insurance.

~~(Y)~~ (V) "Utilization review" has the same meaning as in section 1751.77 of the Revised Code.

~~(Z)~~ (W) "Utilization review organization" has the same meaning as in section 1751.77 of the Revised Code.

Sec. 3923.51. (A) As used in this section, "official poverty line" means the poverty line as defined by the United States office of management and budget and revised by the secretary of health and human services under 95 Stat. 511, 42 U.S.C.A. 9902, as amended.

(B) Every insurer that is authorized to write sickness and accident insurance in this state may offer group contracts of

sickness and accident insurance to any charitable foundation that is certified as exempt from taxation under section 501(c)(3) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, and that has the sole purpose of issuing certificates of coverage under these contracts to persons under the age of nineteen who are members of families that have incomes that are no greater than three hundred per cent of the official poverty line.

(C) Contracts offered pursuant to division (B) of this section are not subject to any of the following:

(1) Sections 3923.122~~,~~ and 3923.24~~, 3923.28, 3923.281, and 3923.29~~ of the Revised Code;

(2) Any other sickness and accident insurance coverage required under this chapter on August 3, 1989. Any requirement of sickness and accident insurance coverage enacted after that date applies to this section only if the subsequent enactment specifically refers to this section.

(3) Chapter 1751. of the Revised Code.

Sec. 3923.87. Each sickness and accident insurer or public employee benefit plan shall comply with the requirements of section 3959.20 of the Revised Code as they pertain to health plan issuers.

As used in this section, "health plan issuer" has the same meaning as in section ~~3922.01~~ 3902.50 of the Revised Code.

Sec. 3959.20. (A) As used in this section:

(1) "Cost-sharing" means the cost to an individual insured under a health benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket

expense requirements imposed by the plan.

(2) "Health benefit plan" and "health plan issuer" have the same meanings as in section ~~3922.01~~ 3902.50 of the Revised Code.

(3) "Pharmacy audit" has the same meaning as in section 3901.81 of the Revised Code.

(4) "Pharmacy benefit manager" and "administrator" have the same meanings as in section 3959.01 of the Revised Code.

(B) No health plan issuer, pharmacy benefit manager, or any other administrator shall require cost-sharing in an amount, or direct a pharmacy to collect cost-sharing in an amount, greater than the lesser of either of the following from an individual purchasing a prescription drug:

(1) The amount an individual would pay for the drug if the drug were to be purchased without coverage under a health benefit plan;

(2) The net reimbursement paid to the pharmacy for the prescription drug by the health plan issuer, pharmacy benefit manager, or administrator.

(C)(1) No health plan issuer, pharmacy benefit manager, or administrator shall retroactively adjust a pharmacy claim for reimbursement for a prescription drug unless the adjustment is the result of either of the following:

(a) A pharmacy audit conducted in accordance with sections 3901.811 to 3901.814 of the Revised Code;

(b) A technical billing error.

(2) No health plan issuer, pharmacy benefit manager, or

administrator shall charge a fee related to a claim unless the amount of the fee can be determined at the time of claim adjudication.

(D) The department of insurance shall create a web form that consumers can use to submit complaints relating to violations of this section.

Sec. 4723.94. (A) As used in this section:

(1) "Facility fee" means any fee charged or billed for telemedicine services provided in a facility that is intended to compensate the facility for its operational expenses and is separate and distinct from a professional fee.

(2) "Health plan issuer" has the same meaning as in section ~~3922.01~~ 3902.50 of the Revised Code.

(3) "Telemedicine services" has the same meaning as in section 3902.30 of the Revised Code.

(B) An advanced practice registered nurse providing telemedicine services shall not charge a facility fee, an origination fee, or any fee associated with the cost of the equipment used to provide telemedicine services to a health plan issuer covering telemedicine services under section 3902.30 of the Revised Code.

Sec. 4731.2910. (A) As used in this section:

(1) "Facility fee" has the same meaning as in section 4723.94 of the Revised Code.

(2) "Health care professional" means:

(a) A physician licensed under this chapter to practice medicine and surgery, osteopathic medicine and surgery, or

podiatric medicine and surgery;

(b) A physician assistant licensed under Chapter 4730. of the Revised Code.

(3) "Health plan issuer" has the same meaning as in section ~~3922.01~~ 3902.50 of the Revised Code.

(4) "Telemedicine services" has the same meaning as in section 3902.30 of the Revised Code.

(B) A health care professional providing telemedicine services shall not charge a facility fee, an origination fee, or any fee associated with the cost of the equipment used to provide telemedicine services to a health plan issuer covering telemedicine services under section 3902.30 of the Revised Code.

Sec. 4766.01. As used in this chapter:

(A) "Advanced life support" means treatment described in section 4765.39 of the Revised Code that a paramedic is certified to perform.

(B) "Air medical service organization" means an organization that furnishes, conducts, maintains, advertises, promotes, or otherwise engages in providing medical services with a rotorcraft air ambulance or fixed wing air ambulance.

(C) "Air medical transportation" means the transporting of a patient by rotorcraft air ambulance or fixed wing air ambulance with appropriately licensed and certified medical personnel.

(D) "Ambulance" means any motor vehicle that is specifically designed, constructed, or modified and equipped and is intended to be used to provide basic life support, intermediate life support, advanced life support, or mobile

intensive care unit services and transportation upon the streets or highways of this state of persons who are seriously ill, injured, wounded, or otherwise incapacitated or helpless. "Ambulance" does not include air medical transportation or a vehicle designed and used solely for the transportation of nonstretcher-bound persons, whether hospitalized or handicapped or whether ambulatory or confined to a wheelchair.

(E) "Ambulette" means a motor vehicle that is specifically designed, constructed, or modified and equipped and is intended to be used for transportation upon the streets or highways of this state of persons who require use of a wheelchair or other mobility aid.

(F) "Basic life support" means treatment described in section 4765.37 of the Revised Code that an EMT is certified to perform.

(G) "Disaster situation" means any condition or situation described by rule of the state board of emergency medical, fire, and transportation services as a mass casualty, major emergency, natural disaster, or national emergency.

(H) "Emergency medical service organization" means an organization that uses EMTs, AEMTs, or paramedics, or a combination of EMTs, AEMTs, and paramedics, to provide medical care to victims of illness or injury. An emergency medical service organization includes, but is not limited to, a commercial ambulance service organization, a hospital, and a funeral home.

(I) "EMT," "AEMT," and "paramedic" have the same meanings as in sections 4765.01 and 4765.011 of the Revised Code.

(J) "Fixed wing air ambulance" means a fixed wing aircraft

that is specifically designed, constructed, or modified and equipped and is intended to be used as a means of air medical transportation.

(K) "Health care practitioner" has the same meaning as in section 3701.74 of the Revised Code.

(L) "Health care services" has the same meaning as in section ~~3922.01~~ 3902.50 of the Revised Code.

(M) "Intermediate life support" means treatment described in section 4765.38 of the Revised Code that an AEMT is certified to perform.

(N) "Major emergency" means any emergency event that cannot be resolved through the use of locally available emergency resources.

(O) "Mass casualty" means an emergency event that results in ten or more persons being injured, incapacitated, made ill, or killed.

(P) "Medical emergency" means an unforeseen event affecting an individual in such a manner that a need for immediate care is created.

(Q) "Mobile intensive care unit" means an ambulance used only for maintaining specialized or intensive care treatment and used primarily for interhospital transports of patients whose conditions require care beyond the scope of a paramedic as provided in section 4765.39 of the Revised Code.

(R)(1) "Nonemergency medical service organization" means a person that does both of the following:

(a) Provides services to the public on a regular basis for the purpose of transporting individuals who require the use of a

wheelchair or other mobility aid to receive health care services in nonemergency circumstances;

(b) Provides the services for a fee, regardless of whether the fee is paid by the person being transported, a third party payer, as defined in section 3702.51 of the Revised Code, or any other person or government entity.

(2) "Nonemergency medical service organization" does not include a health care facility, as defined in section 1751.01 of the Revised Code, that provides ambulette services only to patients of that facility.

(S) "Nontransport vehicle" means a motor vehicle operated by a licensed emergency medical service organization not as an ambulance, but as a vehicle for providing services in conjunction with the ambulances operated by the organization or other emergency medical service organizations.

(T) "Patient" means any individual who as a result of illness or injury needs medical attention, whose physical or mental condition is such that there is imminent danger of loss of life or significant health impairment, or who may be otherwise incapacitated or helpless as a result of a physical or mental condition, or any individual whose physical condition requires the use of a wheelchair or other mobility aid.

(U) "Rotorcraft air ambulance" means a helicopter or other aircraft capable of vertical takeoffs, vertical landings, and hovering that is specifically designed, constructed, or modified and equipped and is intended to be used as a means of air medical transportation.

(V) "Taxicab" means a taxicab vehicle operated by a taxicab service company, provided the company is not a

nonemergency medical service organization.

(W) "Transportation network company driver" has the same meaning as in section 3942.01 of the Revised Code.

(X) "Transportation network company services" has the same meaning as in section 3942.01 of the Revised Code.

Sec. 5162.137. The medicaid director shall issue a biennial report about medicaid managed care organizations and parity in mental health and substance use disorder benefits provided to medicaid enrollees. The report shall be written in nontechnical, readily understandable language and shall be made available to the public by, among such other means as the director considers appropriate, posting the report on the department of medicaid's web site. The report shall do all of the following:

(A) Cover the methodology the director is using to check for compliance with section 5167.47 of the Revised Code;

(B) Identify market conduct examinations conducted or completed during the preceding two years regarding compliance with parity in mental health and substance use disorder benefits under state and federal laws and summarize the results of such market conduct examinations;

(C) Detail any educational or corrective actions the director has taken to ensure medicaid managed care organization compliance with section 5167.47 of the Revised Code.

Sec. 5167.47. (A) When contracting with a managed care organization, the department of medicaid shall require the managed care organization to provide to medicaid enrollees the same benefits and rights as required under section 3902.51 of the Revised Code.

(B) Annually each medicaid managed care organization shall submit to the department a report that contains the information required by division (B) of section 3902.51 of the Revised Code as it pertains to medicaid enrollees.

(C) A medicaid enrollee who is affected by the managed care organization's failure to provide parity as required by section 3902.51 of the Revised Code, or a health care provider on the enrollee's behalf, may file a complaint through the medicaid managed care organization's grievance process provided under section 5167.11 of the Revised Code.

(D) The medicaid director shall do both of the following:

(1) Implement and enforce section 3901.51 of the Revised Code with respect to medicaid managed care organizations;

(2) Enforce, monitor compliance with, and ensure continued compliance with this section.

(E) The director may adopt rules under section 5167.02 of the Revised Code as necessary to carry out the provisions of this section.

Sec. 5168.75. As used in sections 5168.75 to 5168.86 of the Revised Code:

(A) "Basic health care services" means all of the services listed in division ~~(A)(1)~~ (A) of section 1751.01 of the Revised Code.

(B) "Care management system" has the same meaning as in section 5167.01 of the Revised Code.

(C) "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.

(D) "Franchise fee" means the fee imposed on health insuring corporation plans under section 5168.76 of the Revised Code.

(E) "Health insuring corporation" has the same meaning as in section 1751.01 of the Revised Code, except it does not mean a corporation that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, only supplemental health care services or only specialty health care services.

(F) "Health insuring corporation plan" means a policy, contract, certificate, or agreement of a health insuring corporation under which the corporation pays for, reimburses, provides, delivers, arranges for, or otherwise makes available basic health care services. "Health insuring corporation plan" does not mean any of the following:

(1) A policy, contract, certificate, or agreement under which a health insuring corporation pays for, reimburses, provides, delivers, arranges for, or otherwise makes available only supplemental health care services or only specialty health care services;

(2) An approved health benefits plan described in 5 U.S.C. 8903 or 8903a, if imposing the franchise fee on the plan would violate 5 U.S.C. 8909(f);

(3) A medicare advantage plan authorized by Part C of Title XVIII of the "Social Security Act," 42 U.S.C. 1395w-21 et seq.

(G) "Indirect guarantee percentage" means the percentage specified in section 1903(w)(4)(C)(ii) of the "Social Security Act," 42 U.S.C. 1396b(w)(4)(C)(ii), that is to be used in

determining whether a health care class is indirectly held harmless for any portion of the costs of a broad-based health-care-related tax. If the indirect guarantee percentage changes during a fiscal year, the indirect guarantee percentage is the following:

(1) For the part of the fiscal year before the change takes effect, the percentage in effect before the change;

(2) For the part of the fiscal year beginning with the date the indirect guarantee percentage changes, the new percentage.

(H) "Medicaid managed care organization" has the same meaning as in section 5167.01 of the Revised Code.

(I) "Medicaid provider" has the same meaning as in section 5164.01 of the Revised Code.

(J) "Ohio medicaid member month" means a month in which a medicaid recipient residing in this state is enrolled in a health insuring corporation plan.

(K) "Other Ohio member month" means a month in which a resident of this state who is not a medicaid recipient is enrolled in a health insuring corporation plan.

(L) "Rate year" means the fiscal year for which a franchise fee is imposed.

Section 2. That existing sections 1739.05, 1751.01, 1751.92, 3901.83, 3902.30, 3922.01, 3923.51, 3923.87, 3959.20, 4723.94, 4731.2910, 4766.01, and 5168.75 of the Revised Code are hereby repealed.

Section 3. That sections 3923.27, 3923.28, 3923.281, 3923.282, 3923.29, and 3923.30 of the Revised Code are hereby

repealed.

Section 4. This act shall apply to health benefit plans, as defined in section 3902.50 of the Revised Code, as enacted in this act, delivered, issued for delivery, modified, or renewed on or after the effective date of this act.