

As Introduced

133rd General Assembly

Regular Session

2019-2020

S. B. No. 254

Senators Gavarone, O'Brien

Cosponsors: Senators Thomas, Antonio

A BILL

To amend sections 1739.05, 1751.01, 1751.92, 1
3901.83, 3902.30, 3922.01, 3923.51, 3923.87, 2
3959.20, 4723.94, 4731.2910, 4766.01, and 3
5168.75; to enact sections 3901.57, 3902.50, 4
3902.51, 5162.137, and 5167.47; and to repeal 5
sections 3923.27, 3923.28, 3923.281, 3923.282, 6
3923.29, and 3923.30 of the Revised Code 7
regarding mental health and substance use 8
disorder benefit parity. 9

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

Section 1. That sections 1739.05, 1751.01, 1751.92, 10
3901.83, 3902.30, 3922.01, 3923.51, 3923.87, 3959.20, 4723.94, 11
4731.2910, 4766.01, and 5168.75 be amended and sections 3901.57, 12
3902.50, 3902.51, 5162.137, and 5167.47 of the Revised Code be 13
enacted to read as follows: 14

Sec. 1739.05. (A) A multiple employer welfare arrangement 15
that is created pursuant to sections 1739.01 to 1739.22 of the 16
Revised Code and that operates a group self-insurance program 17
may be established only if any of the following applies: 18

(1) The arrangement has and maintains a minimum enrollment 19
of three hundred employees of two or more employers. 20

(2) The arrangement has and maintains a minimum enrollment 21
of three hundred self-employed individuals. 22

(3) The arrangement has and maintains a minimum enrollment 23
of three hundred employees or self-employed individuals in any 24
combination of divisions (A) (1) and (2) of this section. 25

(B) A multiple employer welfare arrangement that is 26
created pursuant to sections 1739.01 to 1739.22 of the Revised 27
Code and that operates a group self-insurance program shall 28
comply with all laws applicable to self-funded programs in this 29
state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 30
3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 31
3901.491, 3902.01 to 3902.14, 3923.041, 3923.24, ~~3923.282,~~ 32
~~3923.30,~~ 3923.301, 3923.38, 3923.581, 3923.602, 3923.63, 33
3923.80, 3923.84, 3923.85, 3923.851, 3923.86, 3923.87, 3923.89, 34
3923.90, 3924.031, 3924.032, and 3924.27 of the Revised Code. 35

(C) A multiple employer welfare arrangement created 36
pursuant to sections 1739.01 to 1739.22 of the Revised Code 37
shall solicit enrollments only through agents or solicitors 38
licensed pursuant to Chapter 3905. of the Revised Code to sell 39
or solicit sickness and accident insurance. 40

(D) A multiple employer welfare arrangement created 41
pursuant to sections 1739.01 to 1739.22 of the Revised Code 42
shall provide benefits only to individuals who are members, 43
employees of members, or the dependents of members or employees, 44
or are eligible for continuation of coverage under section 45
1751.53 or 3923.38 of the Revised Code or under Title X of the 46
"Consolidated Omnibus Budget Reconciliation Act of 1985," 100 47

Stat. 227, 29 U.S.C.A. 1161, as amended. 48

(E) A multiple employer welfare arrangement created 49
pursuant to sections 1739.01 to 1739.22 of the Revised Code is 50
subject to, and shall comply with, sections 3903.81 to 3903.93 51
of the Revised Code in the same manner as other life or health 52
insurers, as defined in section 3903.81 of the Revised Code. 53

Sec. 1751.01. As used in this chapter: 54

(A)~~(1)~~ "Basic health care services" means the following 55
services when medically necessary: 56

~~(a)~~ (1) Physician's services, except when such services 57
are supplemental under division (B) of this section; 58

~~(b)~~ (2) Inpatient hospital services; 59

~~(c)~~ (3) Outpatient medical services; 60

~~(d)~~ (4) Emergency health services; 61

~~(e)~~ (5) Urgent care services; 62

~~(f)~~ (6) Diagnostic laboratory services and diagnostic and 63
therapeutic radiologic services; 64

~~(g)~~ (7) Diagnostic and treatment services, other than 65
prescription drug services, for ~~biologically based mental~~ 66
~~illnesses~~ health and substance use disorders; 67

~~(h)~~ (8) Preventive health care services, including, but 68
not limited to, voluntary family planning services, infertility 69
services, periodic physical examinations, prenatal obstetrical 70
care, and well-child care; 71

~~(i)~~ (9) Routine patient care for patients enrolled in an 72
eligible cancer clinical trial pursuant to section 3923.80 of 73
the Revised Code. 74

"Basic health care services" does not include experimental 75
procedures. 76

~~Except as provided by divisions (A) (2) and (3) of this~~ 77
~~section in connection with the offering of coverage for~~ 78
~~diagnostic and treatment services for biologically based mental~~ 79
~~illnesses, a~~ A health insuring corporation shall not offer 80
coverage for a health care service, defined as a basic health 81
care service by this division, unless it offers coverage for all 82
listed basic health care services. However, this requirement 83
does not apply to the coverage of beneficiaries enrolled in 84
medicare pursuant to a medicare contract, or to the coverage of 85
beneficiaries enrolled in the federal employee health benefits 86
program pursuant to 5 U.S.C.A. 8905, or to the coverage of 87
medicaid recipients, or to the coverage of beneficiaries under 88
any federal health care program regulated by a federal 89
regulatory body, or to the coverage of beneficiaries under any 90
contract covering officers or employees of the state that has 91
been entered into by the department of administrative services. 92

~~(2) A health insuring corporation may offer coverage for~~ 93
~~diagnostic and treatment services for biologically based mental~~ 94
~~illnesses without offering coverage for all other basic health~~ 95
~~care services. A health insuring corporation may offer coverage~~ 96
~~for diagnostic and treatment services for biologically based~~ 97
~~mental illnesses alone or in combination with one or more~~ 98
~~supplemental health care services. However, a health insuring~~ 99
~~corporation that offers coverage for any other basic health care~~ 100
~~service shall offer coverage for diagnostic and treatment~~ 101
~~services for biologically based mental illnesses in combination~~ 102
~~with the offer of coverage for all other listed basic health~~ 103
~~care services.~~ 104

~~(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.~~ 135
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~~(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.~~ 137
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~~Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code.~~ 141
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(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: 143
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(a) Services of facilities for intermediate or long-term care, or both; 148
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(b) Dental care services; 150

(c) Vision care and optometric services including lenses and frames; 151
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(d) Podiatric care or foot care services; 153

(e) Mental health services, excluding diagnostic and treatment services ~~for biologically based mental illnesses;~~ 154
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(f) Short-term outpatient evaluative and crisis-intervention mental health services; 156
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(g) Medical or psychological treatment and referral services for alcohol and drug abuse or addiction; 158
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(h) Home health services; 160

(i) Prescription drug services; 161

(j) Nursing services; 162

(k) Services of a dietitian licensed under Chapter 4759. 163
of the Revised Code; 164

(l) Physical therapy services; 165

(m) Chiropractic services; 166

(n) Any other category of services approved by the 167
superintendent of insurance. 168

(2) If a health insuring corporation offers prescription 169
drug services under this division, the coverage shall include 170
prescription drug services for the treatment of ~~biologically-~~ 171
~~based mental illnesses~~ health and substance use disorders on the 172
same terms and conditions as other physical diseases and 173
disorders. 174

(C) "Specialty health care services" means one of the 175
supplemental health care services listed in division (B) of this 176
section, when provided by a health insuring corporation on an 177
outpatient-only basis and not in combination with other 178
supplemental health care services. 179

(D) ~~"Biologically based mental illnesses" means-~~ 180
~~schizophrenia, schizoaffective disorder, major depressive~~ 181
~~disorder, bipolar disorder, paranoia and other psychotic~~ 182
~~disorders, obsessive compulsive disorder, and panic disorder, as~~ 183
~~these terms are defined in the most recent edition of the~~ 184
~~diagnostic and statistical manual of mental disorders published~~ 185
~~by the American psychiatric association.~~ 186

~~(E)~~ "Closed panel plan" means a health care plan that 187
requires enrollees to use participating providers. 188

~~(F)~~ (E) "Compensation" means remuneration for the 189

provision of health care services, determined on other than a 190
fee-for-service or discounted-fee-for-service basis. 191

~~(G)~~ (F) "Contractual periodic prepayment" means the 192
formula for determining the premium rate for all subscribers of 193
a health insuring corporation. 194

~~(H)~~ (G) "Corporation" means a corporation formed under 195
Chapter 1701. or 1702. of the Revised Code or the similar laws 196
of another state. 197

~~(I)~~ (H) "Emergency health services" means those health 198
care services that must be available on a seven-days-per-week, 199
twenty-four-hours-per-day basis in order to prevent jeopardy to 200
an enrollee's health status that would occur if such services 201
were not received as soon as possible, and includes, where 202
appropriate, provisions for transportation and indemnity 203
payments or service agreements for out-of-area coverage. 204

~~(J)~~ (I) "Enrollee" means any natural person who is 205
entitled to receive health care benefits provided by a health 206
insuring corporation. 207

~~(K)~~ (J) "Evidence of coverage" means any certificate, 208
agreement, policy, or contract issued to a subscriber that sets 209
out the coverage and other rights to which such person is 210
entitled under a health care plan. 211

~~(L)~~ (K) "Health care facility" means any facility, except 212
a health care practitioner's office, that provides preventive, 213
diagnostic, therapeutic, acute convalescent, rehabilitation, 214
mental health, intellectual disability, intermediate care, or 215
skilled nursing services. 216

~~(M)~~ (L) "Health care services" means basic, supplemental, 217
and specialty health care services. 218

~~(N)~~ (M) "Health delivery network" means any group of 219
providers or health care facilities, or both, or any 220
representative thereof, that have entered into an agreement to 221
offer health care services in a panel rather than on an 222
individual basis. 223

~~(O)~~ (N) "Health insuring corporation" means a corporation, 224
as defined in division ~~(H)~~ (G) of this section, that, pursuant 225
to a policy, contract, certificate, or agreement, pays for, 226
reimburses, or provides, delivers, arranges for, or otherwise 227
makes available, basic health care services, supplemental health 228
care services, or specialty health care services, or a 229
combination of basic health care services and either 230
supplemental health care services or specialty health care 231
services, through either an open panel plan or a closed panel 232
plan. 233

"Health insuring corporation" does not include a limited 234
liability company formed pursuant to Chapter 1705. of the 235
Revised Code, an insurer licensed under Title XXXIX of the 236
Revised Code if that insurer offers only open panel plans under 237
which all providers and health care facilities participating 238
receive their compensation directly from the insurer, a 239
corporation formed by or on behalf of a political subdivision or 240
a department, office, or institution of the state, or a public 241
entity formed by or on behalf of a board of county 242
commissioners, a county board of developmental disabilities, an 243
alcohol and drug addiction services board, a board of alcohol, 244
drug addiction, and mental health services, or a community 245
mental health board, as those terms are used in Chapters 340. 246
and 5126. of the Revised Code. Except as provided by division 247
(D) of section 1751.02 of the Revised Code, or as otherwise 248
provided by law, no board, commission, agency, or other entity 249

under the control of a political subdivision may accept 250
insurance risk in providing for health care services. However, 251
nothing in this division shall be construed as prohibiting such 252
entities from purchasing the services of a health insuring 253
corporation or a third-party administrator licensed under 254
Chapter 3959. of the Revised Code. 255

~~(P)~~ (O) "Intermediary organization" means a health 256
delivery network or other entity that contracts with licensed 257
health insuring corporations or self-insured employers, or both, 258
to provide health care services, and that enters into 259
contractual arrangements with other entities for the provision 260
of health care services for the purpose of fulfilling the terms 261
of its contracts with the health insuring corporations and self- 262
insured employers. 263

~~(Q)~~ (P) "Intermediate care" means residential care above 264
the level of room and board for patients who require personal 265
assistance and health-related services, but who do not require 266
skilled nursing care. 267

~~(R)~~ (Q) "Medical record" means the personal information 268
that relates to an individual's physical or mental condition, 269
medical history, or medical treatment. 270

~~(S)~~ ~~(1)~~ (R) (1) "Open panel plan" means a health care plan 271
that provides incentives for enrollees to use participating 272
providers and that also allows enrollees to use providers that 273
are not participating providers. 274

(2) No health insuring corporation may offer an open panel 275
plan, unless the health insuring corporation is also licensed as 276
an insurer under Title XXXIX of the Revised Code, the health 277
insuring corporation, on June 4, 1997, holds a certificate of 278

authority or license to operate under Chapter 1736. or 1740. of 279
the Revised Code, or an insurer licensed under Title XXXIX of 280
the Revised Code is responsible for the out-of-network risk as 281
evidenced by both an evidence of coverage filing under section 282
1751.11 of the Revised Code and a policy and certificate filing 283
under section 3923.02 of the Revised Code. 284

~~(T)~~ (S) "Osteopathic hospital" means a hospital registered 285
under section 3701.07 of the Revised Code that advocates 286
osteopathic principles and the practice and perpetuation of 287
osteopathic medicine by doing any of the following: 288

(1) Maintaining a department or service of osteopathic 289
medicine or a committee on the utilization of osteopathic 290
principles and methods, under the supervision of an osteopathic 291
physician; 292

(2) Maintaining an active medical staff, the majority of 293
which is comprised of osteopathic physicians; 294

(3) Maintaining a medical staff executive committee that 295
has osteopathic physicians as a majority of its members. 296

~~(U)~~ (T) "Panel" means a group of providers or health care 297
facilities that have joined together to deliver health care 298
services through a contractual arrangement with a health 299
insuring corporation, employer group, or other payor. 300

~~(V)~~ (U) "Person" has the same meaning as in section 1.59 301
of the Revised Code, and, unless the context otherwise requires, 302
includes any insurance company holding a certificate of 303
authority under Title XXXIX of the Revised Code, any subsidiary 304
and affiliate of an insurance company, and any government 305
agency. 306

~~(W)~~ (V) "Premium rate" means any set fee regularly paid by 307

a subscriber to a health insuring corporation. A "premium rate" 308
does not include a one-time membership fee, an annual 309
administrative fee, or a nominal access fee, paid to a managed 310
health care system under which the recipient of health care 311
services remains solely responsible for any charges accessed for 312
those services by the provider or health care facility. 313

~~(X)~~ (W) "Primary care provider" means a provider that is 314
designated by a health insuring corporation to supervise, 315
coordinate, or provide initial care or continuing care to an 316
enrollee, and that may be required by the health insuring 317
corporation to initiate a referral for specialty care and to 318
maintain supervision of the health care services rendered to the 319
enrollee. 320

~~(Y)~~ (X) "Provider" means any natural person or partnership 321
of natural persons who are licensed, certified, accredited, or 322
otherwise authorized in this state to furnish health care 323
services, or any professional association organized under 324
Chapter 1785. of the Revised Code, provided that nothing in this 325
chapter or other provisions of law shall be construed to 326
preclude a health insuring corporation, health care 327
practitioner, or organized health care group associated with a 328
health insuring corporation from employing certified nurse 329
practitioners, certified nurse anesthetists, clinical nurse 330
specialists, certified nurse-midwives, pharmacists, dietitians, 331
physician assistants, dental assistants, dental hygienists, 332
optometric technicians, or other allied health personnel who are 333
licensed, certified, accredited, or otherwise authorized in this 334
state to furnish health care services. 335

~~(Z)~~ (Y) "Provider sponsored organization" means a 336
corporation, as defined in division ~~(H)~~ (G) of this section, 337

that is at least eighty per cent owned or controlled by one or 338
more hospitals, as defined in section 3727.01 of the Revised 339
Code, or one or more physicians licensed to practice medicine or 340
surgery or osteopathic medicine and surgery under Chapter 4731. 341
of the Revised Code, or any combination of such physicians and 342
hospitals. Such control is presumed to exist if at least eighty 343
per cent of the voting rights or governance rights of a provider 344
sponsored organization are directly or indirectly owned, 345
controlled, or otherwise held by any combination of the 346
physicians and hospitals described in this division. 347

~~(AA)~~ (Z) "Solicitation document" means the written 348
materials provided to prospective subscribers or enrollees, or 349
both, and used for advertising and marketing to induce 350
enrollment in the health care plans of a health insuring 351
corporation. 352

~~(BB)~~ (AA) "Subscriber" means a person who is responsible 353
for making payments to a health insuring corporation for 354
participation in a health care plan, or an enrollee whose 355
employment or other status is the basis of eligibility for 356
enrollment in a health insuring corporation. 357

~~(CC)~~ (BB) "Urgent care services" means those health care 358
services that are appropriately provided for an unforeseen 359
condition of a kind that usually requires medical attention 360
without delay but that does not pose a threat to the life, limb, 361
or permanent health of the injured or ill person, and may 362
include such health care services provided out of the health 363
insuring corporation's approved service area pursuant to 364
indemnity payments or service agreements. 365

Sec. 1751.92. Each health insuring corporation shall 366
comply with the requirements of section 3959.20 of the Revised 367

Code as they pertain to health plan issuers. 368

As used in this section, "health plan issuer" has the same 369
meaning as in section ~~3922.01~~3902.50 of the Revised Code. 370

Sec. 3901.57. (A) As used in this section: 371

(1) "Generally recognized independent standards of current 372
practice" has the same meaning as in section 3902.50 of the 373
Revised Code. 374

(2) "Health benefit plan" and "health plan issuer" have 375
the same meanings as in section 3902.50 of the Revised Code. 376

(3) "Mental health benefits" means benefits with respect 377
to items or services for mental health conditions, as defined 378
under the terms of a health benefit plan and in accordance with 379
applicable federal and state law. Any condition defined by a 380
health benefit plan as being or as not being a mental health 381
condition shall be defined to be consistent with generally 382
recognized independent standards of current practice. 383

(4) "Mental Health Parity and Addiction Equity Act" means 384
the federal Paul Wellstone and Pete Domenici Mental Health 385
Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, as 386
amended, and any federal regulations implementing that act. 387

(5) "Substance use disorder benefits" means benefits with 388
respect to items or services for substance use disorders, as 389
defined under the terms of a health benefit plan and in 390
accordance with applicable federal and state law. Any condition 391
defined by a health benefit plan as being or as not being a 392
substance use disorder shall be defined to be consistent with 393
generally recognized independent standards of current practice. 394

(B) The superintendent of insurance shall implement and 395

enforce applicable provisions of the Mental Health Parity and 396
Addiction Equity Act and section 3902.51 of the Revised Code, 397
including all of the following: 398

(1) Proactively ensuring compliance by health plan 399
issuers; 400

(2) Evaluating all consumer or provider complaints 401
regarding mental health and substance use disorder benefits for 402
possible parity violations; 403

(3) Performing parity compliance market conduct 404
examinations of health plan issuers, particularly market conduct 405
examinations that focus on nonquantitative treatment 406
limitations; 407

(4) Requiring that health plan issuers submit the analyses 408
described in division (B) of section 3902.51 of the Revised Code 409
during the form review process; 410

(5) Adopting rules in accordance with Chapter 119. of the 411
Revised Code as necessary to do both of the following: 412

(a) Effectuate any provisions of the Mental Health Parity 413
and Addiction Equity Act that relate to the business of 414
insurance; 415

(b) Enforce, monitor compliance with, and ensure continued 416
compliance with section 3902.51 of the Revised Code. 417

(C) The superintendent shall issue an annual report that 418
is written in nontechnical, readily understandable language and 419
shall make the report available to the public by, among such 420
other means as the superintendent considers appropriate, posting 421
the report on the web site of the department of insurance. The 422
report shall do all of the following: 423

(1) Cover the methodology the superintendent is using to 424
check for compliance with the Mental Health Parity and Addiction 425
Equity Act and section 3902.51 of the Revised Code; 426

(2) Identify market conduct examinations conducted or 427
completed during the preceding twelve-month period regarding 428
compliance with parity in mental health and substance use 429
disorder benefits under state and federal laws and summarize the 430
results of such market conduct examinations; 431

(3) Detail any educational or corrective actions the 432
superintendent has taken to ensure health plan issuer compliance 433
with the Mental Health Parity and Addiction Equity Act and 434
section 3902.51 of the Revised Code. 435

Sec. 3901.83. As used in sections 3901.83 to 3901.833 of 436
the Revised Code: 437

(A) "Clinical practice guidelines" means a systematically 438
developed statement to assist health care provider and patient 439
decisions with regard to appropriate health care for specific 440
clinical circumstances and conditions. 441

(B) "Clinical review criteria" means the written screening 442
procedures, decision abstracts, clinical protocols, and clinical 443
practice guidelines used by a health plan issuer or utilization 444
review organization to determine whether or not health care 445
services or drugs are appropriate and consistent with medical or 446
scientific evidence. 447

(C) "Health benefit plan" and "health plan issuer" have 448
the same meanings as in section ~~3922.01~~3902.50 of the Revised 449
Code. 450

(D) "Medical or scientific evidence" has the same meaning 451
as in section 3922.01 of the Revised Code. 452

(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 480
of any communication method where the professional and patient 481
are simultaneously present in the same geographic location. 482

(4) "Recipient" means a patient receiving health care 483
services or a health care professional with whom the provider of 484
health care services is consulting regarding the patient. 485

(5) "Telemedicine services" means a mode of providing 486
health care services through synchronous or asynchronous 487
information and communication technology by a health care 488
professional, within the professional's scope of practice, who 489
is located at a site other than the site where the recipient is 490
located. 491

(B) (1) A health benefit plan shall provide coverage for 492
telemedicine services on the same basis and to the same extent 493
that the plan provides coverage for the provision of in-person 494
health care services. 495

(2) A health benefit plan shall not exclude coverage for a 496
service solely because it is provided as a telemedicine service. 497

(C) A health benefit plan shall not impose any annual or 498
lifetime benefit maximum in relation to telemedicine services 499
other than such a benefit maximum imposed on all benefits 500
offered under the plan. 501

(D) This section shall not be construed as doing any of 502
the following: 503

(1) Prohibiting a health benefit plan from assessing cost- 504
sharing requirements to a covered individual for telemedicine 505
services, provided that such cost-sharing requirements for 506
telemedicine services are not greater than those for comparable 507
in-person health care services; 508

(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, 538
certificate, or agreement offered by a health plan issuer to 539
provide, deliver, arrange for, pay for, or reimburse any of the 540
costs of health care services, including benefit plans marketed 541
in the individual or group market by all associations, whether 542
bona fide or non-bona fide. "Health benefit plan" also means a 543
limited benefit plan, except as follows. "Health benefit plan" 544
does not mean any of the following types of coverage: a policy, 545
contract, certificate, or agreement that covers only a specified 546
accident, accident only, credit, dental, disability income, 547
long-term care, hospital indemnity, supplemental coverage, as 548
described in section 3923.37 of the Revised Code, specified 549
disease, or vision care; coverage issued as a supplement to 550
liability insurance; insurance arising out of workers' 551
compensation or similar law; automobile medical payment 552
insurance; or insurance under which benefits are payable with or 553
without regard to fault and which is statutorily required to be 554
contained in any liability insurance policy or equivalent self- 555
insurance; a medicare supplement policy of insurance, as defined 556
by the superintendent of insurance by rule, coverage under a 557
plan through medicare, medicaid, or the federal employees 558
benefit program; any coverage issued under Chapter 55 of Title 559
10 of the United States Code and any coverage issued as a 560
supplement to that coverage. 561

(F) "Health care professional" means a physician, 562
psychologist, nurse practitioner, or other health care 563
practitioner licensed, accredited, or certified to perform 564
health care services consistent with state law. 565

(G) "Health care provider" means a health care 566
professional or facility. 567

(H) "Health care services" means services for the 568
diagnosis, prevention, treatment, cure, or relief of a health 569
condition, illness, injury, or disease. 570

(I) "Health plan issuer" means an entity subject to the 571
insurance laws and rules of this state, or subject to the 572
jurisdiction of the superintendent of insurance, that contracts, 573
or offers to contract to provide, deliver, arrange for, pay for, 574
or reimburse any of the costs of health care services under a 575
health benefit plan, including a sickness and accident insurance 576
company, a health insuring corporation, a fraternal benefit 577
society, a self-funded multiple employer welfare arrangement, or 578
a nonfederal, government health plan. "Health plan issuer" 579
includes a third-party administrator licensed under Chapter 580
3959. of the Revised Code to the extent that the benefits that 581
such an entity is contracted to administer under a health 582
benefit plan are subject to the insurance laws and rules of this 583
state or subject to the jurisdiction of the superintendent. 584

(J) "Medical and surgical benefits" means benefits with 585
respect to items or services for medical conditions or surgical 586
procedures, as defined under the terms of a health benefit plan 587
and in accordance with applicable federal and state law, but 588
does not include mental health or substance use disorder 589
benefits. Any condition defined by a health benefit plan as 590
being or as not being a medical or surgical condition shall be 591
defined to be consistent with generally recognized independent 592
standards of current practice. 593

(K) "Mental health benefits" has the same meaning as in 594
section 3901.57 of the Revised Code. 595

(L) "Mental Health Parity and Addiction Equity Act" has 596
the same meaning as in section 3901.57 of the Revised Code. 597

(M) "Substance use disorder benefits" has the same meaning 598
as in section 3901.57 of the Revised Code. 599

(N) "Treatment limitations" means limits on benefits based 600
on the frequency of treatment, number of visits, days of 601
coverage, days in a waiting period, or other similar limits on 602
the scope or duration of treatment. "Treatment limitations" 603
includes all of the following: 604

(1) Financial restrictions; 605

(2) Quantitative treatment limitations, which are 606
expressed numerically, such as fifty outpatient visits per year; 607

(3) Nonquantitative treatment limitations, which otherwise 608
limit the scope or duration of benefits for treatment under a 609
plan. 610

"Treatment limitations" does not include a permanent 611
exclusion of all benefits for a particular condition or 612
disorder. 613

Sec. 3902.51. (A) (1) Each health plan issuer and health 614
benefit plan subject to the Mental Health Parity and Addiction 615
Equity Act, other than an employee benefit plan exempt from 616
state regulation under 29 U.S.C. 1144, shall meet the 617
requirements of that act. The requirements of this section do 618
not apply to a health plan issuer or a health benefit plan that 619
is exempt from the requirements of that act. 620

(2) Any disorder defined by a health benefit plan subject 621
to the Mental Health Parity and Addiction Equity Act, other than 622
an employee benefit plan exempt from state regulation under 29 623
U.S.C. 1144, as being or as not being a substance use disorder 624
shall be defined to be consistent with generally recognized 625
independent standards of current practice. 626

(3) There shall be no separate nonquantitative treatment 627
limitations that apply to mental health and substance use 628
disorder benefits but not to medical and surgical benefits 629
within any classification of benefits. 630

(B) A health plan issuer subject to the Mental Health 631
Parity and Addiction Equity Act, other than an employee benefit 632
plan exempt from state regulation under 29 U.S.C. 1144, shall 633
submit an annual report to the superintendent of insurance 634
containing all of the following: 635

(1) A description of the process used to develop or select 636
the medical and clinical necessity criteria, including any 637
criteria established by the American society of addiction 638
medicine, for mental health benefits, substance use disorder 639
benefits, and medical and surgical benefits; 640

(2) Identification of all nonquantitative treatment 641
limitations that are applied to both mental health and substance 642
use disorder benefits and medical and surgical benefits within 643
each classification of benefits. 644

(3) (a) The results of an analysis demonstrating whether, 645
as written and in operation: 646

(i) The processes, strategies, evidentiary standards, and 647
other factors used in applying medical and clinical necessity 648
criteria to mental health and substance use disorder benefits 649
within each classification of benefits are comparable to, and 650
applied not more stringently than, those used in applying 651
medical and clinical necessity criteria to medical and surgical 652
benefits within the corresponding classification of benefits; 653

(ii) The processes, strategies, evidentiary standards, and 654
other factors used in applying nonquantitative treatment 655

limitations to mental health and substance use disorder benefits 656
within each classification of benefits are comparable to, and 657
applied not more stringently than, those used in applying 658
nonquantitative treatment limitations to medical and surgical 659
benefits within the corresponding classification of benefits. 660

(b) At a minimum, the results shall do all of the 661
following: 662

(i) Identify all factors used to determine whether each 663
nonquantitative treatment limitation applies to a benefit, 664
including factors that were considered but rejected; 665

(ii) Identify and define the specific evidentiary 666
standards used to determine the factors described in division 667
(B) (3) (a) (ii) of this section and any evidence relied upon in 668
applying each nonquantitative treatment limitation; 669

(iii) Provide all analyses and results of all analyses 670
that were performed to determine that the processes and 671
strategies used to apply each nonquantitative treatment 672
limitation, as written, for mental health and substance use 673
disorder benefits are comparable to, and applied not more 674
stringently than, the processes and strategies used to apply 675
each nonquantitative treatment limitation, as written, for 676
medical and surgical benefits; 677

(iv) Provide all analyses and results of all analyses that 678
were performed to determine that the processes and strategies 679
used to apply each nonquantitative treatment limitation, in 680
operation, for mental health and substance use disorder benefits 681
are comparable to, and applied not more stringently than, the 682
processes and strategies used to apply each nonquantitative 683
treatment limitation, in operation, for medical and surgical 684

benefits; 685

(v) Disclose the specific findings and conclusions reached 686
by the health plan issuer regarding compliance with this section 687
and the Mental Health Parity and Addiction Equity Act. 688

(C) In relation to any prescription medication prescribed 689
for the treatment of a substance use disorder, a health benefit 690
plan subject to the Mental Health Parity and Addiction Equity 691
Act, other than an employee benefit plan exempt from state 692
regulation under 29 U.S.C. 1144, is subject to all of the 693
following requirements: 694

(1) Except as otherwise provided in sections 1751.691 and 695
3923.851 of the Revised Code, the health benefit plan shall not 696
impose any prior authorization requirements on any such 697
prescription medication. 698

(2) Notwithstanding any contrary provision of sections 699
3901.83 to 3901.833 of the Revised Code, the health benefit plan 700
shall not impose any step therapy requirements before the health 701
plan issuer will authorize coverage for such a prescription 702
medication. 703

(3) The health benefit plan shall place all such 704
prescription medications on the lowest tier of the plan's drug 705
formulary. 706

(4) The health benefit plan shall not exclude coverage for 707
any such prescription medication or for any associated 708
counseling or wraparound services on the grounds that such 709
medications and services were court ordered. 710

(D) Nothing in division (C) of this section is subject to 711
the requirements of section 3901.71 of the Revised Code. 712

(E) A covered person affected by a health plan issuer's or 713
health benefit plan's failure to provide parity as required by 714
this section and the Mental Health Parity and Addiction Equity 715
Act, or a health care provider on the covered person's behalf, 716
may file a complaint with the consumer services division of the 717
department of insurance. 718

Sec. 3922.01. As used in this chapter: 719

(A) "Adverse benefit determination" means a decision by a 720
health plan issuer: 721

(1) To deny, reduce, or terminate a requested health care 722
service or payment in whole or in part, including all of the 723
following: 724

(a) A determination that the health care service does not 725
meet the health plan issuer's requirements for medical 726
necessity, appropriateness, health care setting, level of care, 727
or effectiveness, including experimental or investigational 728
treatments; 729

(b) A determination of an individual's eligibility for 730
individual health insurance coverage, including coverage offered 731
to individuals through a nonemployer group, to participate in a 732
plan or health insurance coverage; 733

(c) A determination that a health care service is not a 734
covered benefit; 735

(d) The imposition of an exclusion, including exclusions 736
for pre-existing conditions, source of injury, network, or any 737
other limitation on benefits that would otherwise be covered. 738

(2) Not to issue individual health insurance coverage to 739
an applicant, including coverage offered to individuals through 740

a nonemployer group; 741

(3) To rescind coverage on a health benefit plan. 742

(B) "Ambulatory review" has the same meaning as in section 743
1751.77 of the Revised Code. 744

(C) "Authorized representative" means an individual who 745
represents a covered person in an internal appeal or external 746
review process of an adverse benefit determination who is any of 747
the following: 748

(1) A person to whom a covered individual has given 749
express, written consent to represent that individual in an 750
internal appeals process or external review process of an 751
adverse benefit determination; 752

(2) A person authorized by law to provide substituted 753
consent for a covered individual; 754

(3) A family member or a treating health care 755
professional, but only when the covered person is unable to 756
provide consent. 757

(D) "Best evidence" means evidence based on all of the 758
following sources, listed according to priority, as they are 759
available: 760

(1) Randomized clinical trials; 761

(2) Cohort studies or case-control studies; 762

(3) Case series; 763

(4) Expert opinion. 764

(E) "Covered person" means a policyholder, subscriber, 765
enrollee, member, or individual covered by a health benefit 766
plan. "Covered person" does include the covered person's 767

authorized representative with regard to an internal appeal or 768
external review in accordance with division (C) of this section. 769
"Covered person" does not include the covered person's 770
representative in any other context. 771

(F) "Covered benefits" or "benefits" means ~~those health~~ 772
~~care services to which a covered person is entitled under the~~ 773
~~terms of a health benefit plan~~ "benefits" as defined in section 774
3902.50 of the Revised Code. 775

(G) "Emergency medical condition" has the same meaning as 776
in section 1753.28 of the Revised Code. 777

(H) "Emergency services" has the same meaning as in 778
section 1753.28 of the Revised Code. 779

(I) "Evidence-based standard" means the conscientious, 780
explicit, and judicious use of the current best evidence, based 781
on a systematic review of the relevant research, in making 782
decisions about the care of individuals. 783

(J) "Facility" ~~means an institution providing health care~~ 784
~~services, or a health care setting, including hospitals and~~ 785
~~other licensed inpatient centers, ambulatory, surgical,~~ 786
~~treatment, skilled nursing, residential treatment, diagnostic,~~ 787
~~laboratory, and imaging centers, and rehabilitation and other~~ 788
~~therapeutic health settings~~ has the same meaning as in section 789
3902.50 of the Revised Code. 790

(K) "Final adverse benefit determination" means an adverse 791
benefit determination that is upheld at the completion of a 792
health plan issuer's internal appeals process. 793

(L) "Health benefit plan," ~~means a policy, contract,~~ 794
~~certificate, or agreement offered by a health plan issuer to~~ 795
~~provide, deliver, arrange for, pay for, or reimburse any of the~~ 796

~~costs of health care services, including benefit plans marketed 797~~
~~in the individual or group market by all associations, whether 798~~
~~bona fide or non-bona fide. "Health benefit plan" also means a 799~~
~~limited benefit plan, except as follows. "Health benefit plan" 800~~
~~does not mean any of the following types of coverage: a policy, 801~~
~~contract, certificate, or agreement that covers only a specified 802~~
~~accident, accident only, credit, dental, disability income, 803~~
~~long term care, hospital indemnity, supplemental coverage, as 804~~
~~described in section 3923.37 of the Revised Code, specified 805~~
~~disease, or vision care; coverage issued as a supplement to 806~~
~~liability insurance; insurance arising out of workers' 807~~
~~compensation or similar law; automobile medical payment 808~~
~~insurance; or insurance under which benefits are payable with or 809~~
~~without regard to fault and which is statutorily required to be 810~~
~~contained in any liability insurance policy or equivalent self- 811~~
~~insurance; a medicare supplement policy of insurance, as defined 812~~
~~by the superintendent of insurance by rule, coverage under a 813~~
~~plan through medicare, medicaid, or the federal employees 814~~
~~benefit program; any coverage issued under Chapter 55 of Title 815~~
~~10 of the United States Code and any coverage issued as a 816~~
~~supplement to that coverage. 817~~

~~(M) "Health care professional" means a physician, 818~~
~~psychologist, nurse practitioner, or other health care 819~~
~~practitioner licensed, accredited, or certified to perform 820~~
~~health care services consistent with state law. 821~~

~~(N) "Health care provider" or "provider" means a health 822~~
~~care professional or facility. 823~~

~~(O) "Health care services" means services for the 824~~
~~diagnosis, prevention, treatment, cure, or relief of a health 825~~
~~condition, illness, injury, or disease. 826~~

~~(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 856
or for a covered person. 857

~~(R)~~ (O) "Independent review organization" means an entity 858
that is accredited to conduct independent external reviews of 859
adverse benefit determinations pursuant to section 3922.13 of 860
the Revised Code. 861

~~(S)~~ (P) "Medical or scientific evidence" means evidence 862
found in any of the following sources: 863

(1) Peer-reviewed scientific studies published in, or 864
accepted for publication by, medical journals that meet 865
nationally recognized requirements for scientific manuscripts 866
and that submit most of their published articles for review by 867
experts who are not part of the editorial staff; 868

(2) Peer-reviewed medical literature, including literature 869
relating to therapies reviewed and approved by a qualified 870
institutional review board, biomedical compendia and other 871
medical literature that meet the criteria of the national 872
institutes of health's library of medicine for indexing in index 873
medicus and elsevier science ltd. for indexing in excerpta 874
medicus; 875

(3) Medical journals recognized by the secretary of health 876
and human services under section 1861(t)(2) of the federal 877
social security act; 878

(4) The following standard reference compendia: 879

(a) The American hospital formulary service drug 880
information; 881

(b) Drug facts and comparisons; 882

(c) The American dental association accepted dental 883

therapeutics; 884

(d) The United States pharmacopoeia drug information. 885

(5) Findings, studies or research conducted by or under 886
the auspices of a federal government agency or nationally 887
recognized federal research institute, including any of the 888
following: 889

(a) The federal agency for health care research and 890
quality; 891

(b) The national institutes of health; 892

(c) The national cancer institute; 893

(d) The national academy of sciences; 894

(e) The centers for medicare and medicaid services; 895

(f) The federal food and drug administration; 896

(g) Any national board recognized by the national 897
institutes of health for the purpose of evaluating the medical 898
value of health care services. 899

(6) Any other medical or scientific evidence that is 900
comparable. 901

~~(T)~~ (Q) "Person" has the same meaning as in section 902
3901.19 of the Revised Code. 903

~~(U)~~ (R) "Protected health information" means health 904
information related to the identity of an individual, or 905
information that could reasonably be used to determine the 906
identity of an individual. 907

~~(V)~~ (S) "Rescind" means to retroactively cancel or 908
discontinue coverage. "Rescind" does not include canceling or 909

discontinuing coverage that only has a prospective effect or 910
canceling or discontinuing coverage that is effective 911
retroactively to the extent it is attributable to a failure to 912
timely pay required premiums or contributions towards the cost 913
of coverage. 914

~~(W)~~ (T) "Retrospective review" means a review conducted 915
after services have been provided to a covered person. 916

~~(X)~~ (U) "Superintendent" means the superintendent of 917
insurance. 918

~~(Y)~~ (V) "Utilization review" has the same meaning as in 919
section 1751.77 of the Revised Code. 920

~~(Z)~~ (W) "Utilization review organization" has the same 921
meaning as in section 1751.77 of the Revised Code. 922

Sec. 3923.51. (A) As used in this section, "official 923
poverty line" means the poverty line as defined by the United 924
States office of management and budget and revised by the 925
secretary of health and human services under 95 Stat. 511, 42 926
U.S.C.A. 9902, as amended. 927

(B) Every insurer that is authorized to write sickness and 928
accident insurance in this state may offer group contracts of 929
sickness and accident insurance to any charitable foundation 930
that is certified as exempt from taxation under section 501(c) 931
(3) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 932
U.S.C.A. 1, as amended, and that has the sole purpose of issuing 933
certificates of coverage under these contracts to persons under 934
the age of nineteen who are members of families that have 935
incomes that are no greater than three hundred per cent of the 936
official poverty line. 937

(C) Contracts offered pursuant to division (B) of this 938

section are not subject to any of the following: 939

(1) Sections 3923.122, and 3923.24, ~~3923.28, 3923.281, and~~ 940
~~3923.29~~ of the Revised Code; 941

(2) Any other sickness and accident insurance coverage 942
required under this chapter on August 3, 1989. Any requirement 943
of sickness and accident insurance coverage enacted after that 944
date applies to this section only if the subsequent enactment 945
specifically refers to this section. 946

(3) Chapter 1751. of the Revised Code. 947

Sec. 3923.87. Each sickness and accident insurer or public 948
employee benefit plan shall comply with the requirements of 949
section 3959.20 of the Revised Code as they pertain to health 950
plan issuers. 951

As used in this section, "health plan issuer" has the same 952
meaning as in section ~~3922.01~~ 3902.50 of the Revised Code. 953

Sec. 3959.20. (A) As used in this section: 954

(1) "Cost-sharing" means the cost to an individual insured 955
under a health benefit plan according to any coverage limit, 956
copayment, coinsurance, deductible, or other out-of-pocket 957
expense requirements imposed by the plan. 958

(2) "Health benefit plan" and "health plan issuer" have 959
the same meanings as in section ~~3922.01~~ 3902.50 of the Revised 960
Code. 961

(3) "Pharmacy audit" has the same meaning as in section 962
3901.81 of the Revised Code. 963

(4) "Pharmacy benefit manager" and "administrator" have 964
the same meanings as in section 3959.01 of the Revised Code. 965

(B) No health plan issuer, pharmacy benefit manager, or 966
any other administrator shall require cost-sharing in an amount, 967
or direct a pharmacy to collect cost-sharing in an amount, 968
greater than the lesser of either of the following from an 969
individual purchasing a prescription drug: 970

(1) The amount an individual would pay for the drug if the 971
drug were to be purchased without coverage under a health 972
benefit plan; 973

(2) The net reimbursement paid to the pharmacy for the 974
prescription drug by the health plan issuer, pharmacy benefit 975
manager, or administrator. 976

(C) (1) No health plan issuer, pharmacy benefit manager, or 977
administrator shall retroactively adjust a pharmacy claim for 978
reimbursement for a prescription drug unless the adjustment is 979
the result of either of the following: 980

(a) A pharmacy audit conducted in accordance with sections 981
3901.811 to 3901.814 of the Revised Code; 982

(b) A technical billing error. 983

(2) No health plan issuer, pharmacy benefit manager, or 984
administrator shall charge a fee related to a claim unless the 985
amount of the fee can be determined at the time of claim 986
adjudication. 987

(D) The department of insurance shall create a web form 988
that consumers can use to submit complaints relating to 989
violations of this section. 990

Sec. 4723.94. (A) As used in this section: 991

(1) "Facility fee" means any fee charged or billed for 992
telemedicine services provided in a facility that is intended to 993

compensate the facility for its operational expenses and is 994
separate and distinct from a professional fee. 995

(2) "Health plan issuer" has the same meaning as in 996
section ~~3922.01~~ 3902.50 of the Revised Code. 997

(3) "Telemedicine services" has the same meaning as in 998
section 3902.30 of the Revised Code. 999

(B) An advanced practice registered nurse providing 1000
telemedicine services shall not charge a facility fee, an 1001
origination fee, or any fee associated with the cost of the 1002
equipment used to provide telemedicine services to a health plan 1003
issuer covering telemedicine services under section 3902.30 of 1004
the Revised Code. 1005

Sec. 4731.2910. (A) As used in this section: 1006

(1) "Facility fee" has the same meaning as in section 1007
4723.94 of the Revised Code. 1008

(2) "Health care professional" means: 1009

(a) A physician licensed under this chapter to practice 1010
medicine and surgery, osteopathic medicine and surgery, or 1011
podiatric medicine and surgery; 1012

(b) A physician assistant licensed under Chapter 4730. of 1013
the Revised Code. 1014

(3) "Health plan issuer" has the same meaning as in 1015
section ~~3922.01~~ 3902.50 of the Revised Code. 1016

(4) "Telemedicine services" has the same meaning as in 1017
section 3902.30 of the Revised Code. 1018

(B) A health care professional providing telemedicine 1019
services shall not charge a facility fee, an origination fee, or 1020

any fee associated with the cost of the equipment used to 1021
provide telemedicine services to a health plan issuer covering 1022
telemedicine services under section 3902.30 of the Revised Code. 1023

Sec. 4766.01. As used in this chapter: 1024

(A) "Advanced life support" means treatment described in 1025
section 4765.39 of the Revised Code that a paramedic is 1026
certified to perform. 1027

(B) "Air medical service organization" means an 1028
organization that furnishes, conducts, maintains, advertises, 1029
promotes, or otherwise engages in providing medical services 1030
with a rotorcraft air ambulance or fixed wing air ambulance. 1031

(C) "Air medical transportation" means the transporting of 1032
a patient by rotorcraft air ambulance or fixed wing air 1033
ambulance with appropriately licensed and certified medical 1034
personnel. 1035

(D) "Ambulance" means any motor vehicle that is 1036
specifically designed, constructed, or modified and equipped and 1037
is intended to be used to provide basic life support, 1038
intermediate life support, advanced life support, or mobile 1039
intensive care unit services and transportation upon the streets 1040
or highways of this state of persons who are seriously ill, 1041
injured, wounded, or otherwise incapacitated or helpless. 1042
"Ambulance" does not include air medical transportation or a 1043
vehicle designed and used solely for the transportation of 1044
nonstretcher-bound persons, whether hospitalized or handicapped 1045
or whether ambulatory or confined to a wheelchair. 1046

(E) "Ambulette" means a motor vehicle that is specifically 1047
designed, constructed, or modified and equipped and is intended 1048
to be used for transportation upon the streets or highways of 1049

this state of persons who require use of a wheelchair or other 1050
mobility aid. 1051

(F) "Basic life support" means treatment described in 1052
section 4765.37 of the Revised Code that an EMT is certified to 1053
perform. 1054

(G) "Disaster situation" means any condition or situation 1055
described by rule of the state board of emergency medical, fire, 1056
and transportation services as a mass casualty, major emergency, 1057
natural disaster, or national emergency. 1058

(H) "Emergency medical service organization" means an 1059
organization that uses EMTs, AEMTs, or paramedics, or a 1060
combination of EMTs, AEMTs, and paramedics, to provide medical 1061
care to victims of illness or injury. An emergency medical 1062
service organization includes, but is not limited to, a 1063
commercial ambulance service organization, a hospital, and a 1064
funeral home. 1065

(I) "EMT," "AEMT," and "paramedic" have the same meanings 1066
as in sections 4765.01 and 4765.011 of the Revised Code. 1067

(J) "Fixed wing air ambulance" means a fixed wing aircraft 1068
that is specifically designed, constructed, or modified and 1069
equipped and is intended to be used as a means of air medical 1070
transportation. 1071

(K) "Health care practitioner" has the same meaning as in 1072
section 3701.74 of the Revised Code. 1073

(L) "Health care services" has the same meaning as in 1074
section ~~3922.01~~3902.50 of the Revised Code. 1075

(M) "Intermediate life support" means treatment described 1076
in section 4765.38 of the Revised Code that an AEMT is certified 1077

to perform. 1078

(N) "Major emergency" means any emergency event that 1079
cannot be resolved through the use of locally available 1080
emergency resources. 1081

(O) "Mass casualty" means an emergency event that results 1082
in ten or more persons being injured, incapacitated, made ill, 1083
or killed. 1084

(P) "Medical emergency" means an unforeseen event 1085
affecting an individual in such a manner that a need for 1086
immediate care is created. 1087

(Q) "Mobile intensive care unit" means an ambulance used 1088
only for maintaining specialized or intensive care treatment and 1089
used primarily for interhospital transports of patients whose 1090
conditions require care beyond the scope of a paramedic as 1091
provided in section 4765.39 of the Revised Code. 1092

(R) (1) "Nonemergency medical service organization" means a 1093
person that does both of the following: 1094

(a) Provides services to the public on a regular basis for 1095
the purpose of transporting individuals who require the use of a 1096
wheelchair or other mobility aid to receive health care services 1097
in nonemergency circumstances; 1098

(b) Provides the services for a fee, regardless of whether 1099
the fee is paid by the person being transported, a third party 1100
payer, as defined in section 3702.51 of the Revised Code, or any 1101
other person or government entity. 1102

(2) "Nonemergency medical service organization" does not 1103
include a health care facility, as defined in section 1751.01 of 1104
the Revised Code, that provides ambulette services only to 1105

patients of that facility. 1106

(S) "Nontransport vehicle" means a motor vehicle operated 1107
by a licensed emergency medical service organization not as an 1108
ambulance, but as a vehicle for providing services in 1109
conjunction with the ambulances operated by the organization or 1110
other emergency medical service organizations. 1111

(T) "Patient" means any individual who as a result of 1112
illness or injury needs medical attention, whose physical or 1113
mental condition is such that there is imminent danger of loss 1114
of life or significant health impairment, or who may be 1115
otherwise incapacitated or helpless as a result of a physical or 1116
mental condition, or any individual whose physical condition 1117
requires the use of a wheelchair or other mobility aid. 1118

(U) "Rotorcraft air ambulance" means a helicopter or other 1119
aircraft capable of vertical takeoffs, vertical landings, and 1120
hovering that is specifically designed, constructed, or modified 1121
and equipped and is intended to be used as a means of air 1122
medical transportation. 1123

(V) "Taxicab" means a taxicab vehicle operated by a 1124
taxicab service company, provided the company is not a 1125
nonemergency medical service organization. 1126

(W) "Transportation network company driver" has the same 1127
meaning as in section 3942.01 of the Revised Code. 1128

(X) "Transportation network company services" has the same 1129
meaning as in section 3942.01 of the Revised Code. 1130

Sec. 5162.137. The medicaid director shall issue a 1131
biennial report about medicaid managed care organizations and 1132
parity in mental health and substance use disorder benefits 1133
provided to medicaid enrollees. The report shall be written in 1134

nontechnical, readily understandable language and shall be made 1135
available to the public by, among such other means as the 1136
director considers appropriate, posting the report on the 1137
department of medicaid's web site. The report shall do all of 1138
the following: 1139

(A) Cover the methodology the director is using to check 1140
for compliance with section 5167.47 of the Revised Code; 1141

(B) Identify market conduct examinations conducted or 1142
completed during the preceding two years regarding compliance 1143
with parity in mental health and substance use disorder benefits 1144
under state and federal laws and summarize the results of such 1145
market conduct examinations; 1146

(C) Detail any educational or corrective actions the 1147
director has taken to ensure medicaid managed care organization 1148
compliance with section 5167.47 of the Revised Code. 1149

Sec. 5167.47. (A) When contracting with a managed care 1150
organization, the department of medicaid shall require the 1151
managed care organization to provide to medicaid enrollees the 1152
same benefits and rights as required under section 3902.51 of 1153
the Revised Code. 1154

(B) Annually each medicaid managed care organization shall 1155
submit to the department a report that contains the information 1156
required by division (B) of section 3902.51 of the Revised Code 1157
as it pertains to medicaid enrollees. 1158

(C) A medicaid enrollee who is affected by the managed 1159
care organization's failure to provide parity as required by 1160
section 3902.51 of the Revised Code, or a health care provider 1161
on the enrollee's behalf, may file a complaint through the 1162
medicaid managed care organization's grievance process provided 1163

under section 5167.11 of the Revised Code. 1164

(D) The medicaid director shall do both of the following: 1165

(1) Implement and enforce section 3901.51 of the Revised 1166
Code with respect to medicaid managed care organizations; 1167

(2) Enforce, monitor compliance with, and ensure continued 1168
compliance with this section. 1169

(E) The director may adopt rules under section 5167.02 of 1170
the Revised Code as necessary to carry out the provisions of 1171
this section. 1172

Sec. 5168.75. As used in sections 5168.75 to 5168.86 of 1173
the Revised Code: 1174

(A) "Basic health care services" means all of the services 1175
listed in division ~~(A)(1)~~ (A) of section 1751.01 of the Revised 1176
Code. 1177

(B) "Care management system" has the same meaning as in 1178
section 5167.01 of the Revised Code. 1179

(C) "Dual eligible individual" has the same meaning as in 1180
section 5160.01 of the Revised Code. 1181

(D) "Franchise fee" means the fee imposed on health 1182
insuring corporation plans under section 5168.76 of the Revised 1183
Code. 1184

(E) "Health insuring corporation" has the same meaning as 1185
in section 1751.01 of the Revised Code, except it does not mean 1186
a corporation that, pursuant to a policy, contract, certificate, 1187
or agreement, pays for, reimburses, or provides, delivers, 1188
arranges for, or otherwise makes available, only supplemental 1189
health care services or only specialty health care services. 1190

(F) "Health insuring corporation plan" means a policy, 1191
contract, certificate, or agreement of a health insuring 1192
corporation under which the corporation pays for, reimburses, 1193
provides, delivers, arranges for, or otherwise makes available 1194
basic health care services. "Health insuring corporation plan" 1195
does not mean any of the following: 1196

(1) A policy, contract, certificate, or agreement under 1197
which a health insuring corporation pays for, reimburses, 1198
provides, delivers, arranges for, or otherwise makes available 1199
only supplemental health care services or only specialty health 1200
care services; 1201

(2) An approved health benefits plan described in 5 U.S.C. 1202
8903 or 8903a, if imposing the franchise fee on the plan would 1203
violate 5 U.S.C. 8909(f); 1204

(3) A medicare advantage plan authorized by Part C of 1205
Title XVIII of the "Social Security Act," 42 U.S.C. 1395w-21 et 1206
seq. 1207

(G) "Indirect guarantee percentage" means the percentage 1208
specified in section 1903(w) (4) (C) (ii) of the "Social Security 1209
Act," 42 U.S.C. 1396b(w) (4) (C) (ii), that is to be used in 1210
determining whether a health care class is indirectly held 1211
harmless for any portion of the costs of a broad-based health- 1212
care-related tax. If the indirect guarantee percentage changes 1213
during a fiscal year, the indirect guarantee percentage is the 1214
following: 1215

(1) For the part of the fiscal year before the change 1216
takes effect, the percentage in effect before the change; 1217

(2) For the part of the fiscal year beginning with the 1218
date the indirect guarantee percentage changes, the new 1219

percentage. 1220

(H) "Medicaid managed care organization" has the same 1221
meaning as in section 5167.01 of the Revised Code. 1222

(I) "Medicaid provider" has the same meaning as in section 1223
5164.01 of the Revised Code. 1224

(J) "Ohio medicaid member month" means a month in which a 1225
medicaid recipient residing in this state is enrolled in a 1226
health insuring corporation plan. 1227

(K) "Other Ohio member month" means a month in which a 1228
resident of this state who is not a medicaid recipient is 1229
enrolled in a health insuring corporation plan. 1230

(L) "Rate year" means the fiscal year for which a 1231
franchise fee is imposed. 1232

Section 2. That existing sections 1739.05, 1751.01, 1233
1751.92, 3901.83, 3902.30, 3922.01, 3923.51, 3923.87, 3959.20, 1234
4723.94, 4731.2910, 4766.01, and 5168.75 of the Revised Code are 1235
hereby repealed. 1236

Section 3. That sections 3923.27, 3923.28, 3923.281, 1237
3923.282, 3923.29, and 3923.30 of the Revised Code are hereby 1238
repealed. 1239

Section 4. This act shall apply to health benefit plans, 1240
as defined in section 3902.50 of the Revised Code, as enacted in 1241
this act, delivered, issued for delivery, modified, or renewed 1242
on or after the effective date of this act. 1243