

**As Introduced**

**131st General Assembly**

**Regular Session**

**2015-2016**

**H. B. No. 109**

**Representatives Stinziano, Antonio**

**Cosponsors: Representatives Celebrezze, Lepore-Hagan, Patterson, Ramos**

---

**A BILL**

To amend sections 124.14, 3905.01, 3905.473, and 1  
3924.01 and to enact sections 3965.01 to 3965.14 2  
of the Revised Code to create the Ohio Health 3  
Benefit Exchange. 4

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

**Section 1.** That sections 124.14, 3905.01, 3905.473, and 5  
3924.01 be amended and sections 3965.01, 3965.02, 3965.03, 6  
3965.04, 3965.05, 3965.06, 3965.07, 3965.08, 3965.09, 3965.10, 7  
3965.11, 3965.12, 3965.13, and 3965.14 of the Revised Code be 8  
enacted to read as follows: 9

**Sec. 124.14.** (A) (1) The director of administrative 10  
services shall establish, and may modify or rescind, by rule, a 11  
job classification plan for all positions, offices, and 12  
employments in the service of the state. The director shall 13  
group jobs within a classification so that the positions are 14  
similar enough in duties and responsibilities to be described by 15  
the same title, to have the same pay assigned with equity, and 16  
to have the same qualifications for selection applied. The 17  
director shall, by rule, assign a classification title to each 18  
classification within the classification plan. However, the 19

director shall consider in establishing classifications, 20  
including classifications with parenthetical titles, and 21  
assigning pay ranges such factors as duties performed only on 22  
one shift, special skills in short supply in the labor market, 23  
recruitment problems, separation rates, comparative salary 24  
rates, the amount of training required, and other conditions 25  
affecting employment. The director shall describe the duties and 26  
responsibilities of the class, establish the qualifications for 27  
being employed in each position in the class, and file with the 28  
secretary of state a copy of specifications for all of the 29  
classifications. The director shall file new, additional, or 30  
revised specifications with the secretary of state before they 31  
are used. 32

The director shall, by rule, assign each classification, 33  
either on a statewide basis or in particular counties or state 34  
institutions, to a pay range established under section 124.15 or 35  
section 124.152 of the Revised Code. The director may assign a 36  
classification to a pay range on a temporary basis for a period 37  
of six months. The director may establish, by rule adopted under 38  
Chapter 119. of the Revised Code, experimental classification 39  
plans for some or all employees paid directly by warrant of the 40  
director of budget and management. The rule shall include 41  
specifications for each classification within the plan and shall 42  
specifically address compensation ranges, and methods for 43  
advancing within the ranges, for the classifications, which may 44  
be assigned to pay ranges other than the pay ranges established 45  
under section 124.15 or 124.152 of the Revised Code. 46

(2) The director of administrative services may reassign 47  
to a proper classification those positions that have been 48  
assigned to an improper classification. If the compensation of 49  
an employee in such a reassigned position exceeds the maximum 50

rate of pay for the employee's new classification, the employee 51  
shall be placed in pay step X and shall not receive an increase 52  
in compensation until the maximum rate of pay for that 53  
classification exceeds the employee's compensation. 54

(3) The director may reassign an exempt employee, as 55  
defined in section 124.152 of the Revised Code, to a bargaining 56  
unit classification if the director determines that the 57  
bargaining unit classification is the proper classification for 58  
that employee. Notwithstanding Chapter 4117. of the Revised Code 59  
or instruments and contracts negotiated under it, these 60  
placements are at the director's discretion. 61

(4) The director shall, by rule, assign related 62  
classifications, which form a career progression, to a 63  
classification series. The director shall, by rule, assign each 64  
classification in the classification plan a five-digit number, 65  
the first four digits of which shall denote the classification 66  
series to which the classification is assigned. When a career 67  
progression encompasses more than ten classifications, the 68  
director shall, by rule, identify the additional classifications 69  
belonging to a classification series. The additional 70  
classifications shall be part of the classification series, 71  
notwithstanding the fact that the first four digits of the 72  
number assigned to the additional classifications do not 73  
correspond to the first four digits of the numbers assigned to 74  
other classifications in the classification series. 75

(B) Division (A) of this section and sections 124.15 and 76  
124.152 of the Revised Code do not apply to the following 77  
persons, positions, offices, and employments: 78

(1) Elected officials; 79

(2) Legislative employees, employees of the legislative service commission, employees in the office of the governor, employees who are in the unclassified civil service and exempt from collective bargaining coverage in the office of the secretary of state, auditor of state, treasurer of state, and attorney general, and employees of the supreme court;	80 81 82 83 84 85
(3) Any position for which the authority to determine compensation is given by law to another individual or entity;	86 87
(4) Employees of the bureau of workers' compensation whose compensation the administrator of workers' compensation establishes under division (B) of section 4121.121 of the Revised Code;	88 89 90 91
<u>(5) Employees of the Ohio health benefit exchange program whose compensation the board of the Ohio health benefit exchange agency establishes under division (H) of section 3965.03 of the Revised Code.</u>	92 93 94 95
(C) The director may employ a consulting agency to aid and assist the director in carrying out this section.	96 97
(D) (1) When the director proposes to modify a classification or the assignment of classes to appropriate pay ranges, the director shall send written notice of the proposed rule to the appointing authorities of the affected employees thirty days before a hearing on the proposed rule. The appointing authorities shall notify the affected employees regarding the proposed rule. The director also shall send those appointing authorities notice of any final rule that is adopted within ten days after adoption.	98 99 100 101 102 103 104 105 106
(2) When the director proposes to reclassify any employee in the service of the state so that the employee is adversely	107 108

affected, the director shall give to the employee affected and 109  
to the employee's appointing authority a written notice setting 110  
forth the proposed new classification, pay range, and salary. 111  
Upon the request of any classified employee in the service of 112  
the state who is not serving in a probationary period, the 113  
director shall perform a job audit to review the classification 114  
of the employee's position to determine whether the position is 115  
properly classified. The director shall give to the employee 116  
affected and to the employee's appointing authority a written 117  
notice of the director's determination whether or not to 118  
reclassify the position or to reassign the employee to another 119  
classification. An employee or appointing authority desiring a 120  
hearing shall file a written request for the hearing with the 121  
state personnel board of review within thirty days after 122  
receiving the notice. The board shall set the matter for a 123  
hearing and notify the employee and appointing authority of the 124  
time and place of the hearing. The employee, the appointing 125  
authority, or any authorized representative of the employee who 126  
wishes to submit facts for the consideration of the board shall 127  
be afforded reasonable opportunity to do so. After the hearing, 128  
the board shall consider anew the reclassification and may order 129  
the reclassification of the employee and require the director to 130  
assign the employee to such appropriate classification as the 131  
facts and evidence warrant. As provided in division (A) (1) of 132  
section 124.03 of the Revised Code, the board may determine the 133  
most appropriate classification for the position of any employee 134  
coming before the board, with or without a job audit. The board 135  
shall disallow any reclassification or reassignment 136  
classification of any employee when it finds that changes have 137  
been made in the duties and responsibilities of any particular 138  
employee for political, religious, or other unjust reasons. 139

(E) (1) Employees of each county department of job and family services shall be paid a salary or wage established by the board of county commissioners. The provisions of section 124.18 of the Revised Code concerning the standard work week apply to employees of county departments of job and family services. A board of county commissioners may do either of the following:

(a) Notwithstanding any other section of the Revised Code, supplement the sick leave, vacation leave, personal leave, and other benefits of any employee of the county department of job and family services of that county, if the employee is eligible for the supplement under a written policy providing for the supplement;

(b) Notwithstanding any other section of the Revised Code, establish alternative schedules of sick leave, vacation leave, personal leave, or other benefits for employees not inconsistent with the provisions of a collective bargaining agreement covering the affected employees.

(2) Division (E) (1) of this section does not apply to employees for whom the state employment relations board establishes appropriate bargaining units pursuant to section 4117.06 of the Revised Code, except in either of the following situations:

(a) The employees for whom the state employment relations board establishes appropriate bargaining units elect no representative in a board-conducted representation election.

(b) After the state employment relations board establishes appropriate bargaining units for such employees, all employee organizations withdraw from a representation election.

(F) (1) Notwithstanding any contrary provision of sections 169  
124.01 to 124.64 of the Revised Code, the board of trustees of 170  
each state university or college, as defined in section 3345.12 171  
of the Revised Code, shall carry out all matters of governance 172  
involving the officers and employees of the university or 173  
college, including, but not limited to, the powers, duties, and 174  
functions of the department of administrative services and the 175  
director of administrative services specified in this chapter. 176  
Officers and employees of a state university or college shall 177  
have the right of appeal to the state personnel board of review 178  
as provided in this chapter. 179

(2) Each board of trustees shall adopt rules under section 180  
111.15 of the Revised Code to carry out the matters of 181  
governance described in division (F) (1) of this section. Until 182  
the board of trustees adopts those rules, a state university or 183  
college shall continue to operate pursuant to the applicable 184  
rules adopted by the director of administrative services under 185  
this chapter. 186

(G) (1) Each board of county commissioners may, by a 187  
resolution adopted by a majority of its members, establish a 188  
county personnel department to exercise the powers, duties, and 189  
functions specified in division (G) of this section. As used in 190  
division (G) of this section, "county personnel department" 191  
means a county personnel department established by a board of 192  
county commissioners under division (G) (1) of this section. 193

(2) (a) Each board of county commissioners, by a resolution 194  
adopted by a majority of its members, may designate the county 195  
personnel department of the county to exercise the powers, 196  
duties, and functions specified in sections 124.01 to 124.64 and 197  
Chapter 325. of the Revised Code with regard to employees in the 198

service of the county, except for the powers and duties of the state personnel board of review, which powers and duties shall not be construed as having been modified or diminished in any manner by division (G) (2) of this section, with respect to the employees for whom the board of county commissioners is the appointing authority or co-appointing authority.

(b) Nothing in division (G) (2) of this section shall be construed to limit the right of any employee who possesses the right of appeal to the state personnel board of review to continue to possess that right of appeal.

(c) Any board of county commissioners that has established a county personnel department may contract with the department of administrative services, in accordance with division (H) of this section, another political subdivision, or an appropriate public or private entity to provide competitive testing services or other appropriate services.

(3) After the county personnel department of a county has been established as described in division (G) (2) of this section, any elected official, board, agency, or other appointing authority of that county, upon written notification to the county personnel department, may elect to use the services and facilities of the county personnel department. Upon receipt of the notification by the county personnel department, the county personnel department shall exercise the powers, duties, and functions as described in division (G) (2) of this section with respect to the employees of that elected official, board, agency, or other appointing authority.

(4) Each board of county commissioners, by a resolution adopted by a majority of its members, may disband the county personnel department.



(5) Any elected official, board, agency, or appointing authority of a county may end its involvement with a county personnel department upon actual receipt by the department of a certified copy of the notification that contains the decision to no longer participate.

(6) A county personnel department, in carrying out its duties, shall adhere to merit system principles with regard to employees of county departments of job and family services, child support enforcement agencies, and public child welfare agencies so that there is no threatened loss of federal funding for these agencies, and the county is financially liable to the state for any loss of federal funds due to the action or inaction of the county personnel department.

(H) County agencies may contract with the department of administrative services for any human resources services, including, but not limited to, establishment and modification of job classification plans, competitive testing services, and periodic audits and reviews of the county's uniform application of the powers, duties, and functions specified in sections 124.01 to 124.64 and Chapter 325. of the Revised Code with regard to employees in the service of the county. Nothing in this division modifies the powers and duties of the state personnel board of review with respect to employees in the service of the county. Nothing in this division limits the right of any employee who possesses the right of appeal to the state personnel board of review to continue to possess that right of appeal.

(I) The director of administrative services shall establish the rate and method of compensation for all employees who are paid directly by warrant of the director of budget and

management and who are serving in positions that the director of 259  
administrative services has determined impracticable to include 260  
in the state job classification plan. This division does not 261  
apply to elected officials, legislative employees, employees of 262  
the legislative service commission, employees who are in the 263  
unclassified civil service and exempt from collective bargaining 264  
coverage in the office of the secretary of state, auditor of 265  
state, treasurer of state, and attorney general, employees of 266  
the courts, employees of the bureau of workers' compensation 267  
whose compensation the administrator of workers' compensation 268  
establishes under division (B) of section 4121.121 of the 269  
Revised Code, or employees of an appointing authority authorized 270  
by law to fix the compensation of those employees. 271

(J) The director of administrative services shall set the 272  
rate of compensation for all intermittent, seasonal, temporary, 273  
emergency, and casual employees in the service of the state who 274  
are not considered public employees under section 4117.01 of the 275  
Revised Code. Those employees are not entitled to receive 276  
employee benefits. This rate of compensation shall be equitable 277  
in terms of the rate of employees serving in the same or similar 278  
classifications. This division does not apply to elected 279  
officials, legislative employees, employees of the legislative 280  
service commission, employees who are in the unclassified civil 281  
service and exempt from collective bargaining coverage in the 282  
office of the secretary of state, auditor of state, treasurer of 283  
state, and attorney general, employees of the courts, employees 284  
of the bureau of workers' compensation whose compensation the 285  
administrator establishes under division (B) of section 4121.121 286  
of the Revised Code, or employees of an appointing authority 287  
authorized by law to fix the compensation of those employees. 288

**Sec. 3905.01.** As used in this chapter: 289

(A) "Affordable Care Act" means the "Patient Protection and Affordable Care Act," 124 Stat. 119, 42 U.S.C. 18031 (2011). 290  
291

(B) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity. 292  
293  
294

(C) "Home state" means the state or territory of the United States, including the District of Columbia, in which an insurance agent maintains the insurance agent's principal place of residence or principal place of business and is licensed to act as an insurance agent. 295  
296  
297  
298  
299

~~(D) "In-person assister" means any person, other than a navigator, who receives any funding from, or who is selected or designated by, an exchange, the state, or the federal government to perform any of the activities and duties identified in division (i) of section 1311 of the Affordable Care Act. "In-person assister" includes any individual that is employed by, supervised by, or affiliated with an in-person assister and performs any of the activities and duties identified in division (i) of section 1311 of the Affordable Care Act, any non-navigator assistance personnel, and any other person deemed as such by rules adopted by the superintendent under division (L) of section 3905.471 of the Revised Code.~~ 300  
301  
302  
303  
304  
305  
306  
307  
308  
309  
310  
311

~~(E)~~ "Insurance" means any of the lines of authority set forth in Chapter 1739., 1751., or 1761. or Title XXXIX of the Revised Code, or as additionally determined by the superintendent of insurance. 312  
313  
314  
315

~~(F)~~ (E) "Insurance agent" or "agent" means any person that, in order to sell, solicit, or negotiate insurance, is required to be licensed under the laws of this state, including 316  
317  
318

limited lines insurance agents and surplus line brokers. 319

~~(G)~~ (F) "Insurer" has the same meaning as in section 3901.32 of the Revised Code. 320  
321

~~(H)~~ (G) "License" means the authority issued by the superintendent to a person to act as an insurance agent for the lines of authority specified, but that does not create any actual, apparent, or inherent authority in the person to represent or commit an insurer. 322  
323  
324  
325  
326

~~(I)~~ (H) "Limited line credit insurance" means credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance, or any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation and that is designated by the superintendent as limited line credit insurance. 327  
328  
329  
330  
331  
332  
333  
334

~~(J)~~ (I) "Limited line credit insurance agent" means a person that sells, solicits, or negotiates one or more forms of limited line credit insurance to individuals through a master, corporate, group, or individual policy. 335  
336  
337  
338

~~(K)~~ (J) "Limited lines insurance" means those lines of authority set forth in divisions (B) (7) to (11) of section 3905.06 of the Revised Code or in rules adopted by the superintendent, or any lines of authority the superintendent considers necessary to recognize for purposes of complying with section 3905.072 of the Revised Code. 339  
340  
341  
342  
343  
344

~~(L)~~ (K) "Limited lines insurance agent" means a person authorized by the superintendent to sell, solicit, or negotiate limited lines insurance. 345  
346  
347

~~(M)~~(L) "NAIC" means the national association of insurance  
commissioners. 348  
349

~~(N)~~(M) "Insurance navigator" means a person selected to 350  
perform the activities and duties identified in division (i) of 351  
section 1311 of the Affordable Care Act that is certified by the 352  
~~superintendent of insurance under section 3905.471 of the~~ 353  
~~Revised Code Ohio health benefit exchange agency.~~ "Insurance 354  
navigator" refers to a navigator specified in section 1311 of 355  
the Affordable Care Act, 42 U.S.C. 13031. 356

~~(O)~~(N) "Negotiate" means to confer directly with, or 357  
offer advice directly to, a purchaser or prospective purchaser 358  
of a particular contract of insurance with respect to the 359  
substantive benefits, terms, or conditions of the contract, 360  
provided the person that is conferring or offering advice either 361  
sells insurance or obtains insurance from insurers for 362  
purchasers. 363

~~(P)~~(O) "Person" means an individual or a business entity. 364

~~(Q)~~(P) "Sell" means to exchange a contract of insurance 365  
by any means, for money or its equivalent, on behalf of an 366  
insurer. 367

~~(R)~~(Q) "Solicit" means to attempt to sell insurance, or 368  
to ask or urge a person to apply for a particular kind of 369  
insurance from a particular insurer. 370

~~(S)~~(R) "Superintendent" or "superintendent of insurance" 371  
means the superintendent of insurance of this state. 372

~~(T)~~(S) "Terminate" means to cancel the relationship 373  
between an insurance agent and the insurer or to terminate an 374  
insurance agent's authority to transact insurance. 375

~~(U)~~ (T) "Uniform application" means the NAIC uniform application for resident and nonresident agent licensing, as amended by the NAIC from time to time.

~~(V)~~ (U) "Uniform business entity application" means the NAIC uniform business entity application for resident and nonresident business entities, as amended by the NAIC from time to time.

~~(W)~~ (V) "Exchange" means a health benefit exchange established by the state government of Ohio or an exchange established by the United States department of health and human services in accordance with the "Patient Protection and Affordable Care Act," 124 Stat. 119, 42 U.S.C. 18031 (2011).

**Sec. 3905.473.** (A) An exchange operating in this state shall maintain a current list of both of the following:

(1) Licensed insurance agents that have met all of the requirements necessary to offer or sell insurance through an exchange;

(2) Individuals and business entities that have been certified by the superintendent as an insurance navigator.

(B) An exchange shall make available a list of insurance agents operating near the individual's residence address that are certified to sell a health benefit plan through an exchange ~~and insurance navigators that are certified under section 3905.471 of the Revised Code.~~ An exchange operating in this state shall maintain a means of communication by which an individual may make such a request.

(C) Any web site, software application, or other electronic medium, or an exchange-sanctioned outreach event that enables a consumer to determine eligibility for and to purchase

a qualified health plan through an exchange shall include 405  
information on how an individual can obtain from an exchange the 406  
contact information of insurance agents operating near the 407  
individual's residence address that are certified to sell health 408  
benefit plans through an exchange ~~and insurance navigators that~~ 409  
~~are certified under section 3905.471 of the Revised Code.~~ 410

**Sec. 3924.01.** As used in sections 3924.01 to 3924.14 of 411  
the Revised Code: 412

(A) "Actuarial certification" means a written statement 413  
prepared by a member of the American academy of actuaries, or by 414  
any other person acceptable to the superintendent of insurance, 415  
that states that, based upon the person's examination, a carrier 416  
offering health benefit plans to small employers is in 417  
compliance with sections 3924.01 to 3924.14 of the Revised Code. 418  
"Actuarial certification" shall include a review of the 419  
appropriate records of, and the actuarial assumptions and 420  
methods used by, the carrier relative to establishing premium 421  
rates for the health benefit plans. 422

(B) "Adjusted average market premium price" means the 423  
average market premium price as determined by the board of 424  
directors of the Ohio health reinsurance program either on the 425  
basis of the arithmetic mean of all carriers' premium rates for 426  
an OHC plan sold to groups with similar case characteristics by 427  
all carriers selling OHC plans in the state, or on any other 428  
equitable basis determined by the board. 429

(C) "Base premium rate" means, as to any health benefit 430  
plan that is issued by a carrier and that covers at least two 431  
but no more than fifty employees of a small employer, the lowest 432  
premium rate for a new or existing business prescribed by the 433  
carrier for the same or similar coverage under a plan or 434

arrangement covering any small employer with similar case 435  
characteristics. 436

(D) "Carrier" means any sickness and accident insurance 437  
company or health insuring corporation authorized to issue 438  
health benefit plans in this state or a MEWA. A sickness and 439  
accident insurance company that owns or operates a health 440  
insuring corporation, either as a separate corporation or as a 441  
line of business, shall be considered as a separate carrier from 442  
that health insuring corporation for purposes of sections 443  
3924.01 to 3924.14 of the Revised Code. 444

(E) "Case characteristics" means, with respect to a small 445  
employer, the geographic area in which the employees work; the 446  
age and sex of the individual employees and their dependents; 447  
the appropriate industry classification as determined by the 448  
carrier; the number of employees and dependents; and such other 449  
objective criteria as may be established by the carrier. "Case 450  
characteristics" does not include claims experience, health 451  
status, or duration of coverage from the date of issue. 452

(F) "Dependent" means the spouse or child of an eligible 453  
employee, subject to applicable terms of the health benefits 454  
plan covering the employee. 455

(G) "Eligible employee" means an employee who works a 456  
normal work week of twenty-five or more hours. "Eligible 457  
employee" does not include a temporary or substitute employee, 458  
or a seasonal employee who works only part of the calendar year 459  
on the basis of natural or suitable times or circumstances. 460

(H) "Health benefit plan" means any hospital or medical 461  
expense policy or certificate or any health plan provided by a 462  
carrier, that is delivered, issued for delivery, renewed, or 463



used in this state on or after the date occurring six months 464  
after November 24, 1995. "Health benefit plan" does not include 465  
policies covering only accident, credit, dental, disability 466  
income, long-term care, hospital indemnity, medicare supplement, 467  
specified disease, or vision care; coverage under a one-time- 468  
limited-duration policy of no longer than six months; coverage 469  
issued as a supplement to liability insurance; insurance arising 470  
out of a workers' compensation or similar law; automobile 471  
medical-payment insurance; or insurance under which benefits are 472  
payable with or without regard to fault and which is statutorily 473  
required to be contained in any liability insurance policy or 474  
equivalent self-insurance. 475

(I) "Late enrollee" means an eligible employee or 476  
dependent who enrolls in a small employer's health benefit plan 477  
other than during the first period in which the employee or 478  
dependent is eligible to enroll under the plan or during a 479  
special enrollment period described in section 2701(f) of the 480  
"Health Insurance Portability and Accountability Act of 1996," 481  
Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg, as 482  
amended. 483

(J) "MEWA" means any "multiple employer welfare 484  
arrangement" as defined in section 3 of the "Federal Employee 485  
Retirement Income Security Act of 1974," 88 Stat. 832, 29 486  
U.S.C.A. 1001, as amended, except for any arrangement which is 487  
fully insured as defined in division (b)(6)(D) of section 514 of 488  
that act. 489

(K) "Midpoint rate" means, for small employers with 490  
similar case characteristics and plan designs and as determined 491  
by the applicable carrier for a rating period, the arithmetic 492  
average of the applicable base premium rate and the 493

corresponding highest premium rate. 494

(L) "Pre-existing conditions provision" means a policy 495  
provision that excludes or limits coverage for charges or 496  
expenses incurred during a specified period following the 497  
insured's enrollment date as to a condition for which medical 498  
advice, diagnosis, care, or treatment was recommended or 499  
received during a specified period immediately preceding the 500  
enrollment date. Genetic information shall not be treated as 501  
such a condition in the absence of a diagnosis of the condition 502  
related to such information. 503

For purposes of this division, "enrollment date" means, 504  
with respect to an individual covered under a group health 505  
benefit plan, the date of enrollment of the individual in the 506  
plan or, if earlier, the first day of the waiting period for 507  
such enrollment. 508

(M) "Service waiting period" means the period of time 509  
after employment begins before an employee is eligible to be 510  
covered for benefits under the terms of any applicable health 511  
benefit plan offered by the small employer. 512

(N) (1) "Small employer" means, until January 1, 2016, in 513  
connection with a group health benefit plan and with respect to 514  
a calendar year and a plan year, an employer who employed an 515  
average of at least two but no more than fifty eligible 516  
employees on business days during the preceding calendar year 517  
and who employs at least two employees on the first day of the 518  
plan year and, on or after January 1, 2016, an employer that 519  
employed an average of not more than one hundred employees 520  
during the preceding calendar year. 521

(2) For purposes of division (N) (1) of this section, all 522

persons treated as a single employer under subsection (b), (c), 523  
(m), or (o) of section 414 of the "Internal Revenue Code of 524  
1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be 525  
considered one employer. In the case of an employer that was not 526  
in existence throughout the preceding calendar year, the 527  
determination of whether the employer is a small or large 528  
employer shall be based on the average number of eligible 529  
employees that it is reasonably expected the employer will 530  
employ on business days in the current calendar year. Any 531  
reference in division (N) of this section to an "employer" 532  
includes any predecessor of the employer. Except as otherwise 533  
specifically provided, provisions of sections 3924.01 to 3924.14 534  
of the Revised Code that apply to a small employer that has a 535  
health benefit plan shall continue to apply until the plan 536  
anniversary following the date the employer no longer meets the 537  
requirements of this division. 538

(O) "OHC plan" means an Ohio health care plan, which is 539  
the basic, standard, or carrier reimbursement plan for small 540  
employers and individuals established in accordance with section 541  
3924.10 of the Revised Code. 542

Sec. 3965.01. (A) The purpose of this chapter is to 543  
provide for the establishment of an Ohio health benefit exchange 544  
agency and an Ohio health benefit exchange program to facilitate 545  
the purchase and sale of qualified health plans in the 546  
individual market in this state, and to provide for the 547  
establishment of a small business health options program as a 548  
part of the Ohio health benefit exchange program to assist 549  
qualified small employers in this state in facilitating the 550  
enrollment of their employees in qualified health plans offered 551  
in the small group market. 552

(B) The Ohio general assembly declares that the following objectives are to be served by this chapter: 553  
554

(1) Extend access to high quality, affordable health plans to all Ohioans; 555  
556

(2) Reduce the number of uninsured Ohioans by creating a cost-effective, user-friendly, and transparent marketplace to help consumers and employers select high quality, affordable health plans and claim available federal tax credits and cost-sharing subsidies; 557  
558  
559  
560  
561

(3) Strengthen the health care delivery system; 562

(4) Guarantee the availability and renewability of health care coverage through the private health insurance market to qualified individuals and qualified small employers; 563  
564  
565

(5) Require that health care service plans and health insurers issuing coverage in the individual and small employer markets compete on the basis of price, quality, and service, not on risk selection; 566  
567  
568  
569

(6) Meet the requirements of the federal act and applicable federal guidance and regulations. 570  
571

(C) The Ohio health benefit exchange established under this chapter may be modeled, as closely as is practicable, on the federal health insurance marketplace through which Ohioans were purchasing health insurance, as of January 1, 2015. 572  
573  
574  
575

**Sec. 3965.02. As used in this chapter:** 576

(A) "Carrier" means any sickness and accident insurance company or health insuring corporation authorized to issue health benefit plans in this state. 577  
578  
579

(B) "Exchange" or "exchange program" means the Ohio health benefit exchange program established in section 3965.05 of the Revised Code. 580  
581  
582

(C) "Exchange agency" means the Ohio health benefit exchange agency established in section 3965.03 of the Revised Code. 583  
584  
585

(D) "Federal act" means the federal "Patient Protection and Affordable Care Act of 2010," 124 Stat. 119, as amended by the federal "Health Care and Education Reconciliation Act of 2010," 124 Stat. 1029, and any amendments to those acts, or regulations or guidance issued under those acts. 586  
587  
588  
589  
590

(E) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" does not include any of the following: 591  
592  
593  
594  
595

(1) Policies covering only accident or disability income; 596

(2) Coverage issued as a supplement to liability insurance; 597  
598

(3) Liability insurance, including general liability insurance and automobile liability insurance; 599  
600

(4) Workers' compensation or similar insurance; 601

(5) Automobile medical payment insurance; 602

(6) Credit-only insurance; 603

(7) Coverage for on-site medical clinics; 604

(8) Other similar insurance coverage under which benefits for health care services are secondary or incidental to other 605  
606

insurance benefits; 607

(9) Any plan offering the benefits or coverage described 608  
in division (D) of section 3965.06 of the Revised Code. 609

(F) "Qualified dental plan" means a limited scope dental 610  
plan that has been certified in accordance with section 3965.07 611  
of the Revised Code. 612

(G) "Qualified employer" means a small employer that meets 613  
the criteria for a qualified employer established in section 614  
3965.11 of the Revised Code. 615

(H) "Qualified health plan" means a health benefit plan 616  
that has been certified pursuant to section 3965.06 of the 617  
Revised Code. 618

(I) "Qualified individual" means an individual who meets 619  
the criteria for a qualified individual established in section 620  
3965.10 of the Revised Code. 621

(J) "Secretary" means the secretary of the United States 622  
department of health and human services. 623

(K) "SHOP exchange" means the small business health 624  
options program established in section 3965.11 of the Revised 625  
Code. 626

(L) (1) "Small employer" means, until January 1, 2016, an 627  
employer that employed an average of not more than fifty 628  
employees during the preceding calendar year and, on and after 629  
January 1, 2016, an employer that employed an average of not 630  
more than one hundred employees during the preceding calendar 631  
year. 632

(2) For the purposes of division (L) (1) of this section, 633  
all persons treated as a single employer under subsection (b), 634

(c), (m), or (o) of section 414 of the "Internal Revenue Code of 1986," 26 U.S.C. 1, as amended, shall be treated as a single employer. Any reference in division (L) of this section to an "employer" includes any predecessor of the employer. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that the employer is reasonably expected to employ on business days in the current calendar year. All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer.

**Sec. 3965.03.** (A) The Ohio health benefit exchange agency is hereby created. The agency shall have a board of directors consisting of the following members:

(1) The following individuals, as part of their appointed roles:

(a) The superintendent of insurance, or the superintendent's designee;

(b) The director of medicaid, or the director's designee;

(c) The director of health, or the director's designee.

(2) The following members appointed by the governor following the nomination process described in section 3965.04 of the Revised Code. Not more than half shall be members of the same political party, none shall have been employed by or worked as an insurance agent or health care provider in the three years prior to appointment, and all shall be residents of this state. At least one of the six appointed members of the board shall have knowledge of best practices used to address disparities in

quality, access, and affordability of health care. 664

(a) One individual who, on account of the individual's 665  
present or previous vocation, employment, or affiliations, can 666  
be classified as a union representative; 667

(b) One individual who, on account of the individual's 668  
present or previous vocation, employment, or affiliations, can 669  
be classified as a consumer representative; 670

(c) One individual who, on account of the individual's 671  
present or previous vocation, employment, or affiliations, can 672  
be classified as a small business representative; 673

(d) One individual who, on account of the individual's 674  
present or previous vocation, employment, or affiliations, can 675  
be classified as an actuary; 676

(e) One individual who, on account of the individual's 677  
present or previous vocation, employment, or affiliations, can 678  
be classified as an economist; 679

(f) One individual who, on account of the individual's 680  
present or previous vocation, employment, or affiliations, can 681  
be classified as an employee benefits specialist. 682

(B) The board shall not include health care providers or 683  
their representatives, or insurers or their representatives, 684  
brokers, or agents. 685

(C) (1) Of the initial appointments made to the board under 686  
division (A) (2) of this section, the governor shall appoint two 687  
members to a term ending on June 30, 2016, two members to a term 688  
ending on June 30, 2017, and two members to a term ending on 689  
June 30, 2018. Thereafter, terms of office shall be for three 690  
years, with each term ending on the same day of the same month 691



as did the term that it succeeds. Each member shall hold office 692  
from the date of the member's appointment until the end of the 693  
term for which the member was appointed. 694

(2) The governor shall not appoint any person to more than 695  
two full terms of office on the board. This restriction does not 696  
prevent the governor from appointing a person to fill a vacancy 697  
caused by the death, resignation, or removal of a board member 698  
and also appointing that person twice to full terms on the 699  
board, or from appointing a person previously appointed to fill 700  
less than a full term twice to full terms on the board. 701

(3) Vacancies shall be filled in accordance with division 702  
(F) of section 3965.04 of the Revised Code. Any member appointed 703  
to fill a vacancy occurring prior to the expiration date of the 704  
term for which the member's predecessor was appointed shall hold 705  
office as a member for the remainder of that term. A member 706  
shall continue in office subsequent to the expiration date of 707  
the member's term until a successor takes office or until a 708  
period of sixty days has elapsed, whichever occurs first. 709

(D) All members of the board shall receive their 710  
reasonable and necessary expenses pursuant to section 126.31 of 711  
the Revised Code while engaged in the performance of their 712  
duties as members and all members described in division (A) (2) 713  
of this section also shall receive an annual salary not to 714  
exceed sixty thousand dollars in total, payable on the following 715  
basis: 716

(1) Except as provided in division (D) (2) of this section, 717  
a member shall receive five thousand dollars during a month in 718  
which the member attends one or more meetings of the board and 719  
shall receive no payment during a month in which the member 720  
attends no meeting of the board. 721

(2) A member may receive not more than sixty thousand 722  
dollars per year to compensate the member for attending meetings 723  
of the board, regardless of the number of meetings held by the 724  
board during a year or the number of meetings in excess of 725  
twelve within a year that the member attends. 726

(E) The board shall set meeting dates as necessary to 727  
perform the duties of the board under this chapter. The board 728  
shall meet at least twelve times per year. A majority of the 729  
members shall constitute a quorum. 730

(F) Before entering the duties of office, each appointed 731  
member to the board described in division (A)(2) of this section 732  
shall take an oath of office as required by sections 3.22 and 733  
3.23 of the Revised Code. 734

(G) The board may appoint an advisory committee to the 735  
board that shall consist of ten, eleven, or twelve individuals 736  
who represent stakeholders, but who shall not vote on the 737  
matters before the board. The advisory committee may include all 738  
of the following individuals: 739

(1) Representatives of health insuring corporations; 740

(2) Insurance brokers; 741

(3) Health care providers; 742

(4) Consumers, including persons with disabilities; 743

(5) Small business owners; 744

(6) Representatives of organizations or community members 745  
that represent ethnic, racial, and rural communities; 746

(7) Others as the board sees fit. 747

(H) The board is responsible for the effective operation 748

of all exchange agency responsibilities and the compliance of 749  
the exchange agency and the exchange program with all federal 750  
and state rules and regulations. The board shall do all of the 751  
following: 752

(1) Exercise all powers reasonably necessary to carry out 753  
and comply with the duties, responsibilities, and requirements 754  
of this chapter and the federal act; 755

(2) Hire an executive director who shall be in the 756  
unclassified civil service. The executive director shall be 757  
responsible for the operation of the exchange program. 758

(3) Set the salaries for staff hired by the executive 759  
director pursuant to section 3965.05 of the Revised Code that 760  
are in amounts reasonably necessary to attract and retain 761  
individuals of superior qualifications, publish those salaries 762  
in the board's annual budget, and post the board's annual budget 763  
on the web site of the exchange agency. 764

(4) Consult with stakeholders relevant to carrying out the 765  
activities applicable to the board under this chapter, including 766  
all of the following: 767

(a) Health care consumers who are enrolled in health 768  
plans; 769

(b) Individuals and entities with experience in 770  
facilitating enrollment in health plans; 771

(c) Representatives of small businesses and self-employed 772  
individuals; 773

(d) Advocates for enrolling hard-to-reach populations. 774

(5) Develop standardized quality measures to evaluate 775  
health benefit plans pursuant to division (A) (7) (g) of section 776

<u>3965.06 of the Revised Code;</u>	777
<u>(6) Establish a navigator program in accordance with</u>	778
<u>section 3965.09 of the Revised Code and select individuals and</u>	779
<u>entities for the navigator program using the criteria listed in</u>	780
<u>that section;</u>	781
<u>(7) Develop privacy policies in accordance with relevant</u>	782
<u>federal and state law, rule, and regulation to protect sensitive</u>	783
<u>applicant and enrollee information;</u>	784
<u>(8) Adopt bylaws for the regulation of its affairs and the</u>	785
<u>conduct of its business.</u>	786
<u>(I) The board may sue and be sued in the name of the</u>	787
<u>exchange agency.</u>	788
<b><u>Sec. 3965.04. (A) There is hereby created an exchange</u></b>	789
<b><u>agency board of directors nominating council consisting of the</u></b>	790
<b><u>following individuals:</u></b>	791
<u>(1) The chief executive officer of AARP, or that officer's</u>	792
<u>designee;</u>	793
<u>(2) The executive director of the Ohio developmental</u>	794
<u>disabilities council, or the executive director's designee;</u>	795
<u>(3) The director or equivalent representative of the Ohio</u>	796
<u>small business council of the Ohio chamber of commerce, or the</u>	797
<u>director or equivalent representative's designee;</u>	798
<u>(4) The chairperson of the board of directors of the</u>	799
<u>council of smaller enterprises, or the chairperson's designee;</u>	800
<u>(5) The executive director of the universal health care</u>	801
<u>action network of Ohio, or the executive director's designee;</u>	802
<u>(6) The president of the Ohio AFL-CIO, or the president's</u>	803

designee; 804

(7) The president or equivalent representative of the 805  
largest public employee organization in this state, or the 806  
president or equivalent representative's designee; 807

(8) The president of the health policy institute of Ohio, 808  
or the president's designee; 809

(9) The executive director of the Ohio commission on 810  
minority health, or the executive director's designee; 811

(10) The chairperson of the department of economics at the 812  
Ohio state university, or the chairperson's designee; 813

(11) The president of the Ohio association of health 814  
plans, or the president's designee; 815

(12) The president of the Ohio state medical association, 816  
or the president's designee; 817

(13) The chief executive officer of the Ohio hospital 818  
association, or that officer's designee; 819

(14) An individual selected by the president of the 820  
senate; 821

(15) An individual selected by the speaker of the house of 822  
representatives. 823

(B) At its first meeting each calendar year, the council 824  
shall select from among its members a chairperson and secretary. 825  
The council may adopt bylaws governing its proceedings. 826

(C) The council shall keep a record of its proceedings. 827  
Special meetings may be called by the chairperson, and shall be 828  
called by the chairperson upon receipt of a written request for 829  
a meeting signed by two or more members of the council. Written 830

notice of the time and place of each meeting shall be sent to 831  
each member of the council. Eight members, or their alternates, 832  
constitute a quorum. 833

(D) The council shall: 834

(1) Review and evaluate possible appointees for the office 835  
of exchange board director of the Ohio health benefit exchange 836  
agency; 837

(2) Consistent with section 3965.03 of the Revised Code, 838  
not more than eighty-five nor less than sixty days prior to the 839  
expiration of the term of an exchange board director or not more 840  
than thirty days after the death of, resignation of, or 841  
termination of service by, an exchange board director, provide 842  
the governor with a list of four individuals who are, in the 843  
judgment of the council, the most fully qualified to accede to 844  
the office of exchange board director. The council shall not 845  
include the name of an individual upon the list, if the 846  
appointment of that individual by the governor would result in 847  
more than three appointed members of the board of directors 848  
belonging to or being affiliated with the same political party. 849

(E) In reviewing and evaluating possible appointees for 850  
the office of exchange board director, the council may accept 851  
comments from, cooperate with, and request information from any 852  
person. The council may make recommendations to the general 853  
assembly concerning changes in legislation to assist the council 854  
in the performance of its duties. 855

(F) Within thirty days of receipt of the council's 856  
recommendations, the governor shall fill a vacancy occurring in 857  
the office of exchange board director by appointment of one of 858  
the persons recommended by the council. Nothing in this section 859

shall prevent the governor in the governor's discretion from 860  
rejecting all of the nominees of the council and reconvening the 861  
council in order to select four additional nominees. However, 862  
when the governor has reconvened the council and the council has 863  
provided the governor with a second list of four names, the 864  
governor shall make the appointment from one of the names on the 865  
first list or the second list. Each appointment by the governor 866  
shall be subject to the advice and consent of the senate. 867

(G) Members of the council shall be compensated on a per 868  
diem basis pursuant to the procedures set forth in section 869  
124.14 of the Revised Code plus reasonable travel expenses. All 870  
the expenses of the nominating council shall be paid from moneys 871  
appropriated to the exchange agency for that purpose. 872

**Sec. 3965.05.** (A) There is hereby created the Ohio health 873  
benefit exchange program within the Ohio health benefit exchange 874  
agency consisting of an exchange for individual coverage and a 875  
SHOP exchange. The executive director of the exchange agency 876  
shall be responsible for operating the exchange and shall hire 877  
all necessary staff to meet the responsibilities of the 878  
executive director as described in this section. All staff hired 879  
by the executive director shall be in the classified civil 880  
service. 881

(B) The executive director shall do all of the following: 882

(1) Make qualified health plans available to qualified 883  
individuals and qualified employers beginning on January 1, 884  
2016; 885

(2) Establish procedures by rule for the certification, 886  
recertification, and decertification of health benefit plans as 887  
qualified health plans pursuant to section 3965.06 of the 888

Revised Code and consistent with guidelines developed by the 889  
secretary under section 1311(c) of the federal act; 890

(3) Provide for the operation of a toll-free telephone 891  
hotline to respond to requests for assistance regarding the 892  
exchange; 893

(4) Establish enrollment periods, consistent with the 894  
requirements of section 1311(c) (6) of the federal act; 895

(5) Maintain a web site through which individuals can 896  
enroll in qualified health plans, and through which enrollees 897  
and applicants can obtain standardized comparative information 898  
on such plans; 899

(6) Assign a rating to each qualified health plan offered 900  
through the exchange in accordance with the criteria developed 901  
by the secretary under section 1311(c) (3) of the federal act, 902  
and determine the level of coverage of each qualified health 903  
plan in accordance with regulations issued by the secretary 904  
under section 1302(d) (2) (A) of the federal act; 905

(7) Ensure that throughout the state a choice of qualified 906  
health plans are provided at the catastrophic, bronze, silver, 907  
gold, and platinum levels of coverage as those levels are 908  
described in sections 1302(d) and (e) of the federal act. A 909  
particular plan may be available in one region of the state and 910  
not others so long as throughout the state there is a comparable 911  
selection of options at each coverage level. 912

(8) Use a standardized format for presenting health 913  
benefit options in the exchange, including the use of the 914  
uniform outline of coverage established under section 2715 of 915  
the "Public Health Service Act," 42 U.S.C. 300gg-15 ; 916

(9) Inform individuals of eligibility requirements for the 917



programs listed in division (B) of section 3965.10 of the 918  
Revised Code and enroll all eligible individuals in those 919  
programs; 920

(10) Grant certifications attesting that individuals are 921  
exempt from the individual responsibility requirement and 922  
penalty under section 5000A of the "Internal Revenue Code of 923  
1986," if individuals meet the criteria listed in division (C) 924  
of section 3965.10 of the Revised Code; 925

(11) Establish and make available by electronic means a 926  
calculator to determine the actual cost of coverage after 927  
application of any premium tax credit under section 36B of the 928  
"Internal Revenue Code of 1986," and any cost-sharing reduction 929  
under section 1402 of the federal act; 930

(12) Transfer to the United States secretary of the 931  
treasury all of the following: 932

(a) A list of the individuals who are issued a 933  
certification under division (B) (10) of this section, including 934  
the name and taxpayer identification number of each individual; 935

(b) The name and taxpayer identification number of each 936  
individual who was an employee of an employer but who was 937  
determined to be eligible for the premium tax credit under 938  
section 36B of the "Internal Revenue Code of 1986," because of 939  
either of the following reasons: 940

(i) The employer did not provide minimum essential 941  
coverage. 942

(ii) The employer provided the minimum essential coverage, 943  
but it was determined under section 36B(c) (2) (C) of the 944  
"Internal Revenue Code of 1986," to either be unaffordable to 945  
the employee or not to provide the required minimum actuarial 946

value. 947

(c) The name and taxpayer identification number of both of 948  
the following: 949

(i) Each individual who notifies the executive director 950  
pursuant to section 1411(b)(4) of the federal act that the 951  
individual has changed employers; 952

(ii) Each individual who ceases coverage under a qualified 953  
health plan during a plan year and the effective date of that 954  
cessation. 955

(13) Provide to each employer the name of each employee of 956  
the employer described in division (B) (12) (c) (ii) of this 957  
section who ceases coverage under a qualified health plan during 958  
a plan year and the effective date of the cessation; 959

(14) Review the rate of premium growth within the exchange 960  
and outside the exchange, and consider the information in making 961  
recommendations to the board of the exchange agency on whether 962  
to continue limiting qualified employer status to small 963  
employers; 964

(15) Meet the following financial integrity requirements: 965

(a) Keep an accurate accounting of all activities, 966  
receipts, and expenditures, and annually submit to the secretary 967  
an accounting report as required by section 1313 of the federal 968  
act; 969

(b) Conduct an annual fiscal audit; 970

(c) Annually prepare a written report on the 971  
implementation and performance of the exchange functions during 972  
the preceding fiscal year, including, at a minimum, the manner 973  
in which funds were expended and the progress toward, and the 974

achievement of, the requirements of this chapter. This report 975  
shall be transmitted to the general assembly and the governor 976  
and shall be made available to the public on the web site of the 977  
exchange. 978

(d) Fully cooperate with any investigation conducted by 979  
the secretary pursuant to the secretary's authority under the 980  
federal act and allow the secretary, in coordination with the 981  
inspector general of the United States department of health and 982  
human services, to do all of the following: 983

(i) Investigate the affairs of the exchange; 984

(ii) Examine the properties and records of the exchange; 985

(iii) Require periodic reports in relation to the 986  
activities undertaken by the exchange. 987

(e) In carrying out the activities of the exchange under 988  
this chapter, not use any funds intended for the administrative 989  
and operational expenses of the exchange for staff retreats, 990  
promotional giveaways, excessive executive compensation, or 991  
promotion of federal or state legislative and regulatory 992  
modifications. 993

(16) Provide referrals to any applicable office of health 994  
insurance consumer assistance or health insurance ombudsman 995  
established under section 2793 of the "Public Health Service 996  
Act," 42 U.S.C. 300gg-93, or the department of insurance for any 997  
enrollee with a grievance, complaint, or question regarding the 998  
enrollee's health plan, coverage, or a determination under that 999  
plan or coverage; 1000

(17) Market and publicize the availability of health care 1001  
coverage and federal subsidies through the exchange including 1002  
efforts to reach hard-to-reach populations; 1003

(18) Before January 1, 2021, conduct an ongoing study of exchange activities and the enrollees in qualified health plans offered through the exchange, including all of the following: 1004  
1005  
1006

(a) A survey of the cost and affordability of insurance provided under both the exchange for individual coverage and the SHOP exchange; 1007  
1008  
1009

(b) The number of physicians by area and specialty who are not taking or accepting new patients who are enrolled in qualified health plans through the exchange; 1010  
1011  
1012

(c) The adequacy of provider networks of qualified health plans. 1013  
1014

(19) Collaborate with agencies and departments of this state, including the department of job and family services and the department of insurance, to allow an individual to remain enrolled with the individual's carrier and provider network if the individual loses eligibility for premium tax credits and becomes eligible for medicaid, or loses eligibility for medicaid and becomes eligible for premium tax credits through the exchange; 1015  
1016  
1017  
1018  
1019  
1020  
1021  
1022

(20) Ensure that the privacy of applicants and enrollees in the exchange is protected by enforcing the privacy policies developed by the board of the exchange agency pursuant to division (H) (7) of section 3965.03 of the Revised Code. 1023  
1024  
1025  
1026

(C) The executive director may do any of the following: 1027

(1) Contract with an eligible entity for any of the functions of the exchange described in this chapter, including the department of job and family services or an entity that has experience in individual and small group health insurance, benefit administration or other experience relevant to the 1028  
1029  
1030  
1031  
1032

responsibilities to be assumed by the entity. A carrier or an 1033  
affiliate of a carrier is not an eligible entity. 1034

(2) Enter into information-sharing agreements with federal 1035  
and state agencies and departments and other state health 1036  
benefit exchange agencies to carry out the responsibilities of 1037  
the exchange under this chapter, provided those agreements 1038  
include adequate protections with respect to the confidentiality 1039  
of the information to be shared and comply with all state and 1040  
federal laws, rules, and regulations. 1041

(3) Make available supplemental coverage for enrollees of 1042  
the exchange to the extent permitted by the federal act, 1043  
provided that funds in the Ohio health benefit exchange 1044  
operating fund established in section 3965.12 of the Revised 1045  
Code are not used to pay the cost of that coverage. Any 1046  
supplemental coverage offered in the exchange shall be subject 1047  
to the charge imposed on qualified health plans under section 1048  
3965.12 of the Revised Code. 1049

(D) Neither the executive director nor any carrier 1050  
offering a health benefit plan through the exchange shall do 1051  
either of the following: 1052

(1) Make available on the exchange any health plan that is 1053  
not a qualified health plan; 1054

(2) Charge an individual a fee or penalty for termination 1055  
of coverage if the individual enrolls in another type of minimum 1056  
essential coverage because the individual has become newly 1057  
eligible for that coverage or because the individual's employer- 1058  
sponsored coverage has become affordable under the standards of 1059  
section 36B(c) (2) (C) of the "Internal Revenue Code of 1986." 1060

(E) All data collection performed by the executive 1061

director pursuant to this chapter shall include demographic 1062  
information, including racial and ethnic information as 1063  
specified by the executive director in rules adopted in 1064  
accordance with section 3965.13 of the Revised Code. 1065

**Sec. 3965.06.** (A) The executive director of the exchange 1066  
may certify a health benefit plan as a qualified health plan if 1067  
all of the following conditions are met: 1068

(1) The plan provides the essential health benefits 1069  
package described in section 1302(a) of the federal act, except 1070  
that the plan is not required to provide essential benefits that 1071  
duplicate the minimum benefits of qualified dental plans, as 1072  
provided in section 3965.07 of the Revised Code, if both of the 1073  
following are true: 1074

(a) The executive director has determined that at least 1075  
one qualified dental plan is available to supplement the 1076  
qualified health plan's coverage. 1077

(b) The carrier makes prominent disclosure at the time it 1078  
offers the plan, in a form approved by the executive director, 1079  
that the plan does not provide the full range of essential 1080  
pediatric benefits, and that qualified dental plans providing 1081  
those benefits and other dental benefits not covered by the plan 1082  
are offered through the exchange. 1083

(2) The premium rates and contract language have been 1084  
approved by the superintendent of insurance. 1085

(3) The plan provides at least a bronze level of coverage, 1086  
as determined pursuant to division (B)(6) of section 3965.05 of 1087  
the Revised Code unless the plan is certified as a qualified 1088  
catastrophic plan, which will only be offered to individuals 1089  
eligible for catastrophic coverage. 1090

(4) The plan's cost-sharing requirements do not exceed the 1091  
limits established under section 1302(c)(1) of the federal act, 1092  
and, if the plan is offered through the SHOP exchange, the 1093  
plan's deductible does not exceed the limits established under 1094  
section 1302(c)(2) of the federal act. 1095

(5) The carrier offering the plan meets all of the 1096  
following criteria: 1097

(a) The carrier is licensed and in good standing to offer 1098  
health insurance coverage in this state. 1099

(b) The carrier offers at least one qualified catastrophic 1100  
health plan, at least one qualified health plan in the bronze 1101  
level, at least one qualified health plan in the silver level, 1102  
at least one qualified health plan in the gold level, and at 1103  
least one qualified health plan in the platinum level, as 1104  
determined by the executive director pursuant to division (B)(6) 1105  
of section 3965.05 of the Revised Code, through the SHOP 1106  
exchange or the exchange for individual coverage or both if the 1107  
carrier participates in both the SHOP exchange and the exchange 1108  
for individual coverage. 1109

(c) The carrier charges the same premium rate for each 1110  
qualified health plan without regard to whether the plan is 1111  
offered through the exchange and without regard to whether the 1112  
plan is offered directly from the carrier or through an 1113  
insurance agent. 1114

(d) The carrier does not charge any fee or penalty for 1115  
termination of coverage in violation of division (D)(2) of 1116  
section 3965.05 of the Revised Code. 1117

(e) The carrier complies with the regulations developed by 1118  
the secretary under section 1311(d) of the federal act and such 1119

other requirements as the executive director may establish. 1120

(6) The plan meets the requirements of certification as 1121  
established by rule pursuant to division (B)(2) of section 1122  
3965.05 of the Revised Code and by the secretary under section 1123  
1311(c) of the federal act. 1124

(7) The executive director determines that making the plan 1125  
available through the exchange is in the interest of qualified 1126  
individuals and qualified employers in this state. In making 1127  
such a determination, the executive director shall consider all 1128  
of the following: 1129

(a) Plans should not make use of marketing practices that 1130  
would discourage enrollment by people with significant health 1131  
needs. 1132

(b) Plans must provide a sufficient choice of providers 1133  
and, where available, must include essential community providers 1134  
that serve low-income, medically underserved individuals. 1135

(c) Plans must be accredited by a recognized accreditation 1136  
organization, or achieve accreditation from a recognized 1137  
accreditation organization within a time period defined by the 1138  
board of the exchange agency, based on a review of their 1139  
clinical quality, patient experience, access, utilization 1140  
management, quality assurance, provider credentialing, 1141  
complaints and appeals processes, network adequacy and access, 1142  
and patient information programs. 1143

(d) Plans must have a quality improvement strategy. 1144

(e) Plans must use a uniform enrollment form for 1145  
individuals and small employers. 1146

(f) Plans must use a standard format for presenting plan 1147



options. 1148

(g) Plans must provide information about their performance 1149  
on standardized quality measures as determined by the board of 1150  
the exchange agency under division (H) (5) of section 3965.03 of 1151  
the Revised Code to enrollees and prospective enrollees. 1152

(h) Plans must report annually to the federal government 1153  
on the quality of their pediatric care. 1154

(8) The plan does not offer benefits or coverage described 1155  
in division (D) of this section. 1156

(B) The executive director shall not exclude a health 1157  
benefit plan from certification for any of the following 1158  
reasons: 1159

(1) On the basis that the plan is a fee-for-service plan; 1160

(2) Through the imposition of premium price controls by 1161  
the exchange; 1162

(3) On the basis that the health benefit plan provides 1163  
treatments necessary to prevent patients' deaths in 1164  
circumstances the executive director determines are 1165  
inappropriate or too costly. 1166

(C) The executive director shall require each carrier 1167  
seeking certification of a plan as a qualified health plan to do 1168  
all of the following: 1169

(1) Submit a justification to the executive director for 1170  
any premium increase before implementation of that increase; 1171

(2) Prominently post any information regarding a premium 1172  
increase on its web site. The executive director shall take this 1173  
information, along with the information and the recommendations 1174

provided to the exchange by the secretary under section 2794(b) 1175  
of the "Public Health Service Act," 42 U.S.C. 300gg-94, into 1176  
consideration when determining whether to allow the carrier to 1177  
make plans available through the exchange. 1178

(3) Make available to the public, in language that the 1179  
intended audience, including individuals with limited English 1180  
proficiency, can readily understand, and submit to the exchange, 1181  
the secretary, and the superintendent of insurance, accurate and 1182  
timely disclosure of all of the following information: 1183

(a) Claims payment policies and practices; 1184

(b) Periodic financial disclosures; 1185

(c) Data on enrollment, disenrollment, the number of 1186  
claims that are denied, and rating practices; 1187

(d) Information on cost-sharing and payments with respect 1188  
to any out-of-network coverage; 1189

(e) Information on enrollee and participant rights under 1190  
Title I of the federal act; 1191

(f) Other information as determined appropriate by the 1192  
secretary pursuant to section 1303 of the federal act. 1193

(4) Permit individuals to learn, in a timely manner upon 1194  
the request of the individual, the amount of cost-sharing, 1195  
including deductibles, copayments, and coinsurance, under the 1196  
individual's plan or coverage that the individual would be 1197  
responsible for paying with respect to the furnishing of a 1198  
specific item or service by a participating provider. At a 1199  
minimum, this information shall be made available to the 1200  
individual through a web site and through other means for 1201  
individuals without access to the internet. 1202

(D) The executive director shall not consider any health benefit plan for certification as a qualified health plan if the health benefit plan includes any of the following: 1203  
1204  
1205

(1) Any of the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan: 1206  
1207  
1208

(a) Limited scope dental or vision benefits; 1209

(b) Benefits for long-term care, nursing home care, home health care, or community-based care; 1210  
1211

(c) Other similar, limited benefits specified in federal regulations issued pursuant to the "Health Insurance Portability and Accountability Act of 1996." 1212  
1213  
1214

(2) Either of the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any health benefit plan maintained by the same carrier, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any health benefit plan maintained by the same carrier: 1215  
1216  
1217  
1218  
1219  
1220  
1221  
1222

(a) Coverage only for a specified disease or illness; 1223

(b) Hospital indemnity or other fixed indemnity insurance. 1224

(3) Any of the following if offered as a separate policy, certificate, or contract of insurance: 1225  
1226

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the "Social Security Act," 42 U.S.C. 1395ss; 1227  
1228  
1229

<u>(b) Coverage supplemental to the coverage provided under</u>	1230
<u>Chapter 55 of Title 10 of the United States Code;</u>	1231
<u>(c) Similar supplemental coverage provided to coverage</u>	1232
<u>under a group health plan.</u>	1233
<u>(E) The executive director shall not exempt any carrier</u>	1234
<u>seeking certification of a qualified health plan, regardless of</u>	1235
<u>the type or size of the carrier, from state licensure or</u>	1236
<u>solvency requirements and shall apply the criteria of this</u>	1237
<u>section in a manner that assures a level playing field between</u>	1238
<u>or among carriers participating in the exchange.</u>	1239
<b><u>Sec. 3965.07. (A) The executive director may certify a</u></b>	1240
<b><u>dental plan as a qualified dental plan if all of the following</u></b>	1241
<b><u>conditions are met:</u></b>	1242
<u>(1) The plan provides limited scope dental benefits that</u>	1243
<u>are offered separately from any qualified health plan.</u>	1244
<u>(2) The plan does not substantially duplicate the benefits</u>	1245
<u>typically offered by health benefit plans without dental</u>	1246
<u>coverage.</u>	1247
<u>(3) The plan includes, at a minimum, the essential</u>	1248
<u>pediatric dental benefits prescribed by the secretary pursuant</u>	1249
<u>to section 1302(b)(1)(J) of the federal act, and such other</u>	1250
<u>dental benefits as the executive director or the secretary may</u>	1251
<u>specify by rule or regulation.</u>	1252
<u>(B) The provisions of this chapter that are applicable to</u>	1253
<u>qualified health plans shall also apply to qualified dental</u>	1254
<u>plans to the extent relevant with the following exceptions:</u>	1255
<u>(1) A carrier that is licensed to offer dental coverage</u>	1256
<u>need not be licensed to offer other health benefits.</u>	1257

(2) Carriers may jointly offer a comprehensive plan 1258  
through the exchange in which the dental benefits are provided 1259  
by a carrier through a qualified dental plan and the other 1260  
benefits are provided by a carrier through a qualified health 1261  
plan, provided that the plans are priced separately and are also 1262  
made available for purchase separately at the same price. 1263

(C) The executive director may adopt additional rules 1264  
concerning qualified dental health plans. 1265

**Sec. 3965.08.** (A) Health plans that are certified as 1266  
qualified health plans pursuant to section 3965.06 of the 1267  
Revised Code and dental plans that are certified as qualified 1268  
dental plans pursuant to section 3965.07 of the Revised Code may 1269  
bid to participate in the exchange for individual coverage and 1270  
the SHOP exchange. Bidding plans will be scored by the executive 1271  
director of the exchange based on the following criteria: 1272

(1) The cost of the plan to individuals in terms of 1273  
premiums and typical out-of-pocket expenses; 1274

(2) The carrier's overall offering and plan design. 1275  
Preferred features of health benefit plans include the 1276  
following: 1277

(a) Use of a select, high-performance network; 1278

(b) Centers of excellence for complex conditions or 1279  
procedures; 1280

(c) Innovative pharmacy management; 1281

(d) Active consumer engagement; 1282

(e) Wellness incentives and management; 1283

(f) Preventive and flex benefits for chronic conditions. 1284

<u>(3) Use of multilingual community outreach or</u>	1285
<u>nontraditional media outlets to reach hard-to-reach communities</u>	1286
<u>for marketing purposes;</u>	1287
<u>(4) The ability of the plan to confirm its compliance with</u>	1288
<u>various program rules and reporting requirements;</u>	1289
<u>(5) The design of the plan's enrollment process, including</u>	1290
<u>the following considerations:</u>	1291
<u>(a) Level of burden to the consumer;</u>	1292
<u>(b) Ease of use with regard to populations that may</u>	1293
<u>experience barriers to enrollment such as the disabled and those</u>	1294
<u>with limited English language proficiency.</u>	1295
<u>(6) A determination of whether including a given plan in</u>	1296
<u>the exchange will encourage a robust system of regional plans.</u>	1297
<u>(B) After consideration of the criteria listed in division</u>	1298
<u>(A) of this section, the executive director shall select</u>	1299
<u>qualified health plans and qualified dental plans to participate</u>	1300
<u>in the exchange. There shall not be a set minimum or maximum</u>	1301
<u>number of qualified health or dental plans that are required to</u>	1302
<u>exist in the exchange.</u>	1303
<u>(C) In the course of selectively contracting for health</u>	1304
<u>care coverage, the executive director shall do both of the</u>	1305
<u>following:</u>	1306
<u>(1) Seek to contract with carriers so as to provide health</u>	1307
<u>care coverage choices that offer the optimal combination of</u>	1308
<u>choice, value, quality, and service;</u>	1309
<u>(2) Maintain a robust system of regional plans.</u>	1310
<b><u>Sec. 3965.09. (A) The board of the exchange agency shall</u></b>	1311

establish a navigator program in accordance with section 1311(i) 1312  
of the federal act, designed to advise individual consumers and 1313  
employers on the use of the exchange. 1314

(B) The board shall select individuals and entities to be 1315  
part of the navigator program. To be considered for a grant 1316  
under the navigator program, an individual or entity shall meet 1317  
all of the following criteria: 1318

(1) The individual or entity shall demonstrate to the 1319  
board that the individual or entity has existing relationships 1320  
or could readily establish relationships with consumers, 1321  
employers and employees, or self-employed individuals, likely to 1322  
be qualified to enroll in a qualified health plan; 1323

(2) The individual or entity shall not be a health 1324  
insurance issuer or receive any compensation, either directly or 1325  
indirectly, from any health insurance issuer in connection with 1326  
the enrollment of any qualified individuals or employees of a 1327  
qualified employer in a qualified health plan; 1328

(3) The individual or entity shall be capable of carrying 1329  
out the duties listed in division (C) of this section. 1330

(C) Navigators shall do all of the following: 1331

(1) Conduct public education activities to raise awareness 1332  
of the availability of qualified health plans; 1333

(2) Distribute fair and impartial information concerning 1334  
enrollment in qualified health plans, and the availability of 1335  
premium tax credits under section 36B of the "Internal Revenue 1336  
Code of 1986," and cost-sharing reductions under section 1402 of 1337  
the federal act; 1338

(3) Facilitate enrollment in qualified health plans; 1339

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the "Public Health Service Act," 42 U.S.C. 300gg-93, or the department of insurance, for any enrollee with a grievance, complaint, or question regarding their health benefit plan or coverage or a determination under that plan or coverage; 1340  
1341  
1342  
1343  
1344  
1345  
1346

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange. 1347  
1348  
1349

(D) The board shall award grants to individuals and entities approved by the board to perform work as navigators in order to fund the required duties described in division (C) of this section. Funds for grants shall be withdrawn from the Ohio health benefit exchange operating fund established in section 3965.12 of the Revised Code. 1350  
1351  
1352  
1353  
1354  
1355

**Sec. 3965.10.** (A) Only qualified individuals shall be permitted to purchase health insurance through the exchange. A qualified individual is an individual, including a minor, who meets all of the following criteria: 1356  
1357  
1358  
1359

(1) The individual is seeking to enroll in a qualified health plan offered to individuals through the exchange. 1360  
1361

(2) The individual resides in this state. 1362

(3) The individual is not incarcerated at the time of enrollment, other than incarceration pending the disposition of charges. 1363  
1364  
1365

(4) The individual is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States, or an alien lawfully present 1366  
1367  
1368



in the United States. 1369

(B) If the executive director of the exchange program 1370  
determines that an individual seeking to purchase health 1371  
insurance through the exchange is eligible for the medicaid 1372  
program under Title XIX of the "Social Security Act," 42 U.S.C. 1373  
1396, the children's health insurance program under Title XXI of 1374  
the "Social Security Act," 42 U.S.C. 1397aa, or any applicable 1375  
state or local public program, the executive director shall 1376  
enroll the individual in that program. 1377

(C) An individual shall be exempt from the individual 1378  
responsibility requirement under section 5000A of the "Internal 1379  
Revenue Code of 1986," or from the penalty imposed by that 1380  
section for either of the following reasons: 1381

(1) There is no affordable qualified health plan available 1382  
through the exchange, or the individual's employer, covering the 1383  
individual. 1384

(2) The individual meets the requirements for any other 1385  
such exemption from the individual responsibility requirement or 1386  
penalty. 1387

**Sec. 3965.11.** (A) As a part of the exchange there shall 1388  
exist a SHOP exchange through which qualified employers may 1389  
access coverage for their employees, and that shall enable any 1390  
qualified employer to specify a level of coverage so that any of 1391  
its employees may enroll in any qualified health plan offered 1392  
through the SHOP exchange at the specified level of coverage. 1393

(B) Only qualified employers shall be permitted to 1394  
participate in the SHOP exchange. A qualified employer is a 1395  
small employer that elects to make its full-time employees 1396  
eligible for one or more qualified health plans offered through 1397

the SHOP exchange, and at the option of the employer, some or 1398  
all of its part-time employees, provided that the employer meets 1399  
either of the following criteria: 1400

(1) The employer has its principal place of business in 1401  
this state and elects to provide coverage through the SHOP 1402  
exchange to all of its eligible employees, wherever employed; 1403

(2) The employer elects to provide coverage through the 1404  
SHOP exchange to all of its eligible employees who are 1405  
principally employed in this state. 1406

(C) If an employer that makes enrollment in qualified 1407  
health plans available to its employees through the SHOP 1408  
exchange would cease to be a small employer by reason of an 1409  
increase in the number of its employees, the employer shall 1410  
continue to be treated as a small employer for purposes of this 1411  
chapter as long as it continuously makes enrollment through the 1412  
SHOP exchange available to its employees. 1413

**Sec. 3965.12.** (A) (1) The exchange agency may charge 1414  
assessments or user fees to carriers or otherwise may generate 1415  
funding necessary to support its operations and the operations 1416  
of the exchange. 1417

(2) All funds collected by the exchange agency pursuant to 1418  
division (A) (1) of this section shall be paid into the state 1419  
treasury to the credit of the Ohio health benefit exchange 1420  
operating fund, which is hereby created. 1421

(B) The exchange agency shall publish the average costs of 1422  
licensing, regulatory fees, and any other payments required by 1423  
the exchange agency and the exchange, and the administrative 1424  
costs of the exchange agency and the exchange, on a web site to 1425  
educate consumers on such costs. This information shall include 1426

information on moneys lost to waste, fraud, and abuse. 1427

(C) The state shall provide funds to be used for the 1428  
purpose of educating the public on the existence and purpose of 1429  
the Ohio health benefit exchange, which funds shall include a 1430  
portion of the funds collected under this section. 1431

Sec. 3965.13. The board of the exchange agency and the 1432  
executive director of the exchange may adopt rules to implement 1433  
the provisions of this chapter. Rules adopted pursuant to this 1434  
section shall not conflict with or prevent the application of 1435  
regulations promulgated by the secretary under the federal act. 1436

Sec. 3965.14. Nothing in this chapter, and no action taken 1437  
by the board of the exchange agency or the executive director of 1438  
the exchange pursuant to this chapter, shall be construed to 1439  
preempt or supersede the authority of the superintendent of 1440  
insurance to regulate the business of insurance within this 1441  
state. Except as expressly provided to the contrary in this 1442  
chapter, all carriers offering qualified health plans in this 1443  
state shall comply fully with all applicable health insurance 1444  
laws of this state and rules adopted and orders issued by the 1445  
superintendent. 1446

**Section 2.** That existing sections 124.14, 3905.01, 1447  
3905.473, and 3924.01 of the Revised Code are hereby repealed. 1448

**Section 3.** Within ninety days after the effective date of 1449  
this act, the exchange agency board of directors nominating 1450  
council established in section 3965.04 of the Revised Code as 1451  
enacted in this act shall produce two, three, or four nominees 1452  
for each position described in division (A) (2) of section 1453  
3965.03 of the Revised Code. Following nomination, the Governor 1454  
shall appoint the members described in that division to the 1455

board of the Ohio Health Benefit Exchange Agency in accordance 1456  
with division (F) of section 3965.04 of the Revised Code as 1457  
enacted in this act. At the time of appointment, the Governor 1458  
shall determine which members of the board shall serve the terms 1459  
described in division (C) (1) of section 3965.03 of the Revised 1460  
Code. For each subsequent nomination period, the nominating 1461  
council shall produce four nominees for each position as 1462  
required by division (D) (2) of section 3965.04 of the Revised 1463  
Code. 1464