

As Introduced

131st General Assembly

Regular Session

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S. B. No. 132

Senators Skindell, Tavares

Cosponsors: Senators Cafaro, Yuko, Williams, Brown

A BILL

To amend sections 124.14, 3905.01, 3905.473, and 1
3924.01, to enact sections 3965.01 to 3965.14, 2
and to repeal sections 3905.471, 3905.472, and 3
3905.474 of the Revised Code to establish the 4
Ohio Health Benefit Exchange Program consisting 5
of an exchange for individual coverage and a 6
Small Business Health Options Program. 7

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

Section 1. That sections 124.14, 3905.01, 3905.473, and 8
3924.01 be amended and sections 3965.01, 3965.02, 3965.03, 9
3965.04, 3965.05, 3965.06, 3965.07, 3965.08, 3965.09, 3965.10, 10
3965.11, 3965.12, 3965.13, and 3965.14 of the Revised Code be 11
enacted to read as follows: 12

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

to have the same qualifications for selection applied. The 20
director shall, by rule, assign a classification title to each 21
classification within the classification plan. However, the 22
director shall consider in establishing classifications, 23
including classifications with parenthetical titles, and 24
assigning pay ranges such factors as duties performed only on 25
one shift, special skills in short supply in the labor market, 26
recruitment problems, separation rates, comparative salary 27
rates, the amount of training required, and other conditions 28
affecting employment. The director shall describe the duties and 29
responsibilities of the class, establish the qualifications for 30
being employed in each position in the class, and file with the 31
secretary of state a copy of specifications for all of the 32
classifications. The director shall file new, additional, or 33
revised specifications with the secretary of state before they 34
are used. 35

The director shall, by rule, assign each classification, 36
either on a statewide basis or in particular counties or state 37
institutions, to a pay range established under section 124.15 or 38
section 124.152 of the Revised Code. The director may assign a 39
classification to a pay range on a temporary basis for a period 40
of six months. The director may establish, by rule adopted under 41
Chapter 119. of the Revised Code, experimental classification 42
plans for some or all employees paid directly by warrant of the 43
director of budget and management. The rule shall include 44
specifications for each classification within the plan and shall 45
specifically address compensation ranges, and methods for 46
advancing within the ranges, for the classifications, which may 47
be assigned to pay ranges other than the pay ranges established 48
under section 124.15 or 124.152 of the Revised Code. 49

(2) The director of administrative services may reassign 50

to a proper classification those positions that have been 51
assigned to an improper classification. If the compensation of 52
an employee in such a reassigned position exceeds the maximum 53
rate of pay for the employee's new classification, the employee 54
shall be placed in pay step X and shall not receive an increase 55
in compensation until the maximum rate of pay for that 56
classification exceeds the employee's compensation. 57

(3) The director may reassign an exempt employee, as 58
defined in section 124.152 of the Revised Code, to a bargaining 59
unit classification if the director determines that the 60
bargaining unit classification is the proper classification for 61
that employee. Notwithstanding Chapter 4117. of the Revised Code 62
or instruments and contracts negotiated under it, these 63
placements are at the director's discretion. 64

(4) The director shall, by rule, assign related 65
classifications, which form a career progression, to a 66
classification series. The director shall, by rule, assign each 67
classification in the classification plan a five-digit number, 68
the first four digits of which shall denote the classification 69
series to which the classification is assigned. When a career 70
progression encompasses more than ten classifications, the 71
director shall, by rule, identify the additional classifications 72
belonging to a classification series. The additional 73
classifications shall be part of the classification series, 74
notwithstanding the fact that the first four digits of the 75
number assigned to the additional classifications do not 76
correspond to the first four digits of the numbers assigned to 77
other classifications in the classification series. 78

(B) Division (A) of this section and sections 124.15 and 79
124.152 of the Revised Code do not apply to the following 80

persons, positions, offices, and employments:	81
(1) Elected officials;	82
(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;	83 84 85 86 87 88
(3) Any position for which the authority to determine compensation is given by law to another individual or entity;	89 90
(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;	91 92 93 94
<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>	95 96 97 98
(C) The director may employ a consulting agency to aid and assist the director in carrying out this section.	99 100
(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.	101 102 103 104 105 106 107 108 109

(2) When the director proposes to reclassify any employee 110
in the service of the state so that the employee is adversely 111
affected, the director shall give to the employee affected and 112
to the employee's appointing authority a written notice setting 113
forth the proposed new classification, pay range, and salary. 114
Upon the request of any classified employee in the service of 115
the state who is not serving in a probationary period, the 116
director shall perform a job audit to review the classification 117
of the employee's position to determine whether the position is 118
properly classified. The director shall give to the employee 119
affected and to the employee's appointing authority a written 120
notice of the director's determination whether or not to 121
reclassify the position or to reassign the employee to another 122
classification. An employee or appointing authority desiring a 123
hearing shall file a written request for the hearing with the 124
state personnel board of review within thirty days after 125
receiving the notice. The board shall set the matter for a 126
hearing and notify the employee and appointing authority of the 127
time and place of the hearing. The employee, the appointing 128
authority, or any authorized representative of the employee who 129
wishes to submit facts for the consideration of the board shall 130
be afforded reasonable opportunity to do so. After the hearing, 131
the board shall consider anew the reclassification and may order 132
the reclassification of the employee and require the director to 133
assign the employee to such appropriate classification as the 134
facts and evidence warrant. As provided in division (A) (1) of 135
section 124.03 of the Revised Code, the board may determine the 136
most appropriate classification for the position of any employee 137
coming before the board, with or without a job audit. The board 138
shall disallow any reclassification or reassignment 139
classification of any employee when it finds that changes have 140
been made in the duties and responsibilities of any particular 141

employee for political, religious, or other unjust reasons. 142

(E) (1) Employees of each county department of job and 143
family services shall be paid a salary or wage established by 144
the board of county commissioners. The provisions of section 145
124.18 of the Revised Code concerning the standard work week 146
apply to employees of county departments of job and family 147
services. A board of county commissioners may do either of the 148
following: 149

(a) Notwithstanding any other section of the Revised Code, 150
supplement the sick leave, vacation leave, personal leave, and 151
other benefits of any employee of the county department of job 152
and family services of that county, if the employee is eligible 153
for the supplement under a written policy providing for the 154
supplement; 155

(b) Notwithstanding any other section of the Revised Code, 156
establish alternative schedules of sick leave, vacation leave, 157
personal leave, or other benefits for employees not inconsistent 158
with the provisions of a collective bargaining agreement 159
covering the affected employees. 160

(2) Division (E) (1) of this section does not apply to 161
employees for whom the state employment relations board 162
establishes appropriate bargaining units pursuant to section 163
4117.06 of the Revised Code, except in either of the following 164
situations: 165

(a) The employees for whom the state employment relations 166
board establishes appropriate bargaining units elect no 167
representative in a board-conducted representation election. 168

(b) After the state employment relations board establishes 169
appropriate bargaining units for such employees, all employee 170

organizations withdraw from a representation election. 171

(F) (1) Notwithstanding any contrary provision of sections 172
124.01 to 124.64 of the Revised Code, the board of trustees of 173
each state university or college, as defined in section 3345.12 174
of the Revised Code, shall carry out all matters of governance 175
involving the officers and employees of the university or 176
college, including, but not limited to, the powers, duties, and 177
functions of the department of administrative services and the 178
director of administrative services specified in this chapter. 179
Officers and employees of a state university or college shall 180
have the right of appeal to the state personnel board of review 181
as provided in this chapter. 182

(2) Each board of trustees shall adopt rules under section 183
111.15 of the Revised Code to carry out the matters of 184
governance described in division (F) (1) of this section. Until 185
the board of trustees adopts those rules, a state university or 186
college shall continue to operate pursuant to the applicable 187
rules adopted by the director of administrative services under 188
this chapter. 189

(G) (1) Each board of county commissioners may, by a 190
resolution adopted by a majority of its members, establish a 191
county personnel department to exercise the powers, duties, and 192
functions specified in division (G) of this section. As used in 193
division (G) of this section, "county personnel department" 194
means a county personnel department established by a board of 195
county commissioners under division (G) (1) of this section. 196

(2) (a) Each board of county commissioners, by a resolution 197
adopted by a majority of its members, may designate the county 198
personnel department of the county to exercise the powers, 199
duties, and functions specified in sections 124.01 to 124.64 and 200

Chapter 325. of the Revised Code with regard to employees in the 201
service of the county, except for the powers and duties of the 202
state personnel board of review, which powers and duties shall 203
not be construed as having been modified or diminished in any 204
manner by division (G)(2) of this section, with respect to the 205
employees for whom the board of county commissioners is the 206
appointing authority or co-appointing authority. 207

(b) Nothing in division (G)(2) of this section shall be 208
construed to limit the right of any employee who possesses the 209
right of appeal to the state personnel board of review to 210
continue to possess that right of appeal. 211

(c) Any board of county commissioners that has established 212
a county personnel department may contract with the department 213
of administrative services, in accordance with division (H) of 214
this section, another political subdivision, or an appropriate 215
public or private entity to provide competitive testing services 216
or other appropriate services. 217

(3) After the county personnel department of a county has 218
been established as described in division (G)(2) of this 219
section, any elected official, board, agency, or other 220
appointing authority of that county, upon written notification 221
to the county personnel department, may elect to use the 222
services and facilities of the county personnel department. Upon 223
receipt of the notification by the county personnel department, 224
the county personnel department shall exercise the powers, 225
duties, and functions as described in division (G)(2) of this 226
section with respect to the employees of that elected official, 227
board, agency, or other appointing authority. 228

(4) Each board of county commissioners, by a resolution 229
adopted by a majority of its members, may disband the county 230

personnel department. 231

(5) Any elected official, board, agency, or appointing 232
authority of a county may end its involvement with a county 233
personnel department upon actual receipt by the department of a 234
certified copy of the notification that contains the decision to 235
no longer participate. 236

(6) A county personnel department, in carrying out its 237
duties, shall adhere to merit system principles with regard to 238
employees of county departments of job and family services, 239
child support enforcement agencies, and public child welfare 240
agencies so that there is no threatened loss of federal funding 241
for these agencies, and the county is financially liable to the 242
state for any loss of federal funds due to the action or 243
inaction of the county personnel department. 244

(H) County agencies may contract with the department of 245
administrative services for any human resources services, 246
including, but not limited to, establishment and modification of 247
job classification plans, competitive testing services, and 248
periodic audits and reviews of the county's uniform application 249
of the powers, duties, and functions specified in sections 250
124.01 to 124.64 and Chapter 325. of the Revised Code with 251
regard to employees in the service of the county. Nothing in 252
this division modifies the powers and duties of the state 253
personnel board of review with respect to employees in the 254
service of the county. Nothing in this division limits the right 255
of any employee who possesses the right of appeal to the state 256
personnel board of review to continue to possess that right of 257
appeal. 258

(I) The director of administrative services shall 259
establish the rate and method of compensation for all employees 260

who are paid directly by warrant of the director of budget and management and who are serving in positions that the director of administrative services has determined impracticable to include in the state job classification plan. This division does not apply to elected officials, legislative employees, employees of the legislative service commission, 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, employees of the courts, 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, or employees of an appointing authority authorized by law to fix the compensation of those employees.

(J) The director of administrative services shall set the rate of compensation for all intermittent, seasonal, temporary, emergency, and casual employees in the service of the state who are not considered public employees under section 4117.01 of the Revised Code. Those employees are not entitled to receive employee benefits. This rate of compensation shall be equitable in terms of the rate of employees serving in the same or similar classifications. This division does not apply to elected officials, legislative employees, employees of the legislative service commission, 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, employees of the courts, employees of the bureau of workers' compensation whose compensation the administrator establishes under division (B) of section 4121.121 of the Revised Code, or employees of an appointing authority authorized by law to fix the compensation of those employees.

Sec. 3905.01. As used in this chapter:	292
(A) "Affordable Care Act" means the "Patient Protection and Affordable Care Act," 124 Stat. 119, 42 U.S.C. 18031 (2011).	293 294
(B) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.	295 296 297
(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.	298 299 300 301 302
(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.	303 304 305 306 307 308 309 310 311 312 313 314
(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.	315 316 317 318
(F) <u>(E)</u> "Insurance agent" or "agent" means any person that, in order to sell, solicit, or negotiate insurance, is	319 320

required to be licensed under the laws of this state, including 321
limited lines insurance agents and surplus line brokers. 322

~~(G)~~ (F) "Insurer" has the same meaning as in section 323
3901.32 of the Revised Code. 324

~~(H)~~ (G) "License" means the authority issued by the 325
superintendent to a person to act as an insurance agent for the 326
lines of authority specified, but that does not create any 327
actual, apparent, or inherent authority in the person to 328
represent or commit an insurer. 329

~~(I)~~ (H) "Limited line credit insurance" means credit life, 330
credit disability, credit property, credit unemployment, 331
involuntary unemployment, mortgage life, mortgage guaranty, 332
mortgage disability, guaranteed automobile protection insurance, 333
or any other form of insurance offered in connection with an 334
extension of credit that is limited to partially or wholly 335
extinguishing that credit obligation and that is designated by 336
the superintendent as limited line credit insurance. 337

~~(J)~~ (I) "Limited line credit insurance agent" means a 338
person that sells, solicits, or negotiates one or more forms of 339
limited line credit insurance to individuals through a master, 340
corporate, group, or individual policy. 341

~~(K)~~ (J) "Limited lines insurance" means those lines of 342
authority set forth in divisions (B) (7) to (11) of section 343
3905.06 of the Revised Code or in rules adopted by the 344
superintendent, or any lines of authority the superintendent 345
considers necessary to recognize for purposes of complying with 346
section 3905.072 of the Revised Code. 347

~~(L)~~ (K) "Limited lines insurance agent" means a person 348
authorized by the superintendent to sell, solicit, or negotiate 349

limited lines insurance. 350

~~(M)~~ (L) "NAIC" means the national association of insurance 351
commissioners. 352

~~(N)~~ (M) "Insurance navigator" means a person selected to 353
perform the activities and duties identified in division (i) of 354
section 1311 of the Affordable Care Act that is certified by the 355
~~superintendent of insurance under section 3905.471 of the~~ 356
~~Revised Code~~ Ohio health benefit exchange agency. "Insurance 357
navigator" refers to a navigator specified in section 1311 of 358
the Affordable Care Act, 42 U.S.C. 13031. 359

~~(O)~~ (N) "Negotiate" means to confer directly with, or 360
offer advice directly to, a purchaser or prospective purchaser 361
of a particular contract of insurance with respect to the 362
substantive benefits, terms, or conditions of the contract, 363
provided the person that is conferring or offering advice either 364
sells insurance or obtains insurance from insurers for 365
purchasers. 366

~~(P)~~ (O) "Person" means an individual or a business entity. 367

~~(Q)~~ (P) "Sell" means to exchange a contract of insurance 368
by any means, for money or its equivalent, on behalf of an 369
insurer. 370

~~(R)~~ (Q) "Solicit" means to attempt to sell insurance, or 371
to ask or urge a person to apply for a particular kind of 372
insurance from a particular insurer. 373

~~(S)~~ (R) "Superintendent" or "superintendent of insurance" 374
means the superintendent of insurance of this state. 375

~~(T)~~ (S) "Terminate" means to cancel the relationship 376
between an insurance agent and the insurer or to terminate an 377

insurance agent's authority to transact insurance. 378

~~(U)~~ (T) "Uniform application" means the NAIC uniform 379
application for resident and nonresident agent licensing, as 380
amended by the NAIC from time to time. 381

~~(V)~~ (U) "Uniform business entity application" means the 382
NAIC uniform business entity application for resident and 383
nonresident business entities, as amended by the NAIC from time 384
to time. 385

~~(W)~~ (V) "Exchange" means a health benefit exchange 386
established by the state government of Ohio or an exchange 387
established by the United States department of health and human 388
services in accordance with the "Patient Protection and 389
Affordable Care Act," 124 Stat. 119, 42 U.S.C. 18031 (2011). 390

Sec. 3905.473. (A) An exchange operating in this state 391
shall maintain a current list of both of the following: 392

(1) Licensed insurance agents that have met all of the 393
requirements necessary to offer or sell insurance through an 394
exchange; 395

(2) Individuals and business entities that have been 396
certified by the superintendent as an insurance navigator. 397

(B) An exchange shall make available a list of insurance 398
agents operating near the individual's residence address that 399
are certified to sell a health benefit plan through an exchange 400
~~and insurance navigators that are certified under section~~ 401
~~3905.471 of the Revised Code.~~ An exchange operating in this 402
state shall maintain a means of communication by which an 403
individual may make such a request. 404

(C) Any web site, software application, or other 405

electronic medium, or an exchange-sanctioned outreach event that 406
enables a consumer to determine eligibility for and to purchase 407
a qualified health plan through an exchange shall include 408
information on how an individual can obtain from an exchange the 409
contact information of insurance agents operating near the 410
individual's residence address that are certified to sell health 411
benefit plans through an exchange ~~and insurance navigators that~~ 412
~~are certified under section 3905.471 of the Revised Code.~~ 413

Sec. 3924.01. As used in sections 3924.01 to 3924.14 of 414
the Revised Code: 415

(A) "Actuarial certification" means a written statement 416
prepared by a member of the American academy of actuaries, or by 417
any other person acceptable to the superintendent of insurance, 418
that states that, based upon the person's examination, a carrier 419
offering health benefit plans to small employers is in 420
compliance with sections 3924.01 to 3924.14 of the Revised Code. 421
"Actuarial certification" shall include a review of the 422
appropriate records of, and the actuarial assumptions and 423
methods used by, the carrier relative to establishing premium 424
rates for the health benefit plans. 425

(B) "Adjusted average market premium price" means the 426
average market premium price as determined by the board of 427
directors of the Ohio health reinsurance program either on the 428
basis of the arithmetic mean of all carriers' premium rates for 429
an OHC plan sold to groups with similar case characteristics by 430
all carriers selling OHC plans in the state, or on any other 431
equitable basis determined by the board. 432

(C) "Base premium rate" means, as to any health benefit 433
plan that is issued by a carrier and that covers at least two 434
but no more than fifty employees of a small employer, the lowest 435

premium rate for a new or existing business prescribed by the 436
carrier for the same or similar coverage under a plan or 437
arrangement covering any small employer with similar case 438
characteristics. 439

(D) "Carrier" means any sickness and accident insurance 440
company or health insuring corporation authorized to issue 441
health benefit plans in this state or a MEWA. A sickness and 442
accident insurance company that owns or operates a health 443
insuring corporation, either as a separate corporation or as a 444
line of business, shall be considered as a separate carrier from 445
that health insuring corporation for purposes of sections 446
3924.01 to 3924.14 of the Revised Code. 447

(E) "Case characteristics" means, with respect to a small 448
employer, the geographic area in which the employees work; the 449
age and sex of the individual employees and their dependents; 450
the appropriate industry classification as determined by the 451
carrier; the number of employees and dependents; and such other 452
objective criteria as may be established by the carrier. "Case 453
characteristics" does not include claims experience, health 454
status, or duration of coverage from the date of issue. 455

(F) "Dependent" means the spouse or child of an eligible 456
employee, subject to applicable terms of the health benefits 457
plan covering the employee. 458

(G) "Eligible employee" means an employee who works a 459
normal work week of twenty-five or more hours. "Eligible 460
employee" does not include a temporary or substitute employee, 461
or a seasonal employee who works only part of the calendar year 462
on the basis of natural or suitable times or circumstances. 463

(H) "Health benefit plan" means any hospital or medical 464

expense policy or certificate or any health plan provided by a 465
carrier, that is delivered, issued for delivery, renewed, or 466
used in this state on or after the date occurring six months 467
after November 24, 1995. "Health benefit plan" does not include 468
policies covering only accident, credit, dental, disability 469
income, long-term care, hospital indemnity, medicare supplement, 470
specified disease, or vision care; coverage under a one-time- 471
limited-duration policy of no longer than six months; coverage 472
issued as a supplement to liability insurance; insurance arising 473
out of a workers' compensation or similar law; automobile 474
medical-payment insurance; or insurance under which benefits are 475
payable with or without regard to fault and which is statutorily 476
required to be contained in any liability insurance policy or 477
equivalent self-insurance. 478

(I) "Late enrollee" means an eligible employee or 479
dependent who enrolls in a small employer's health benefit plan 480
other than during the first period in which the employee or 481
dependent is eligible to enroll under the plan or during a 482
special enrollment period described in section 2701(f) of the 483
"Health Insurance Portability and Accountability Act of 1996," 484
Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg, as 485
amended. 486

(J) "MEWA" means any "multiple employer welfare 487
arrangement" as defined in section 3 of the "Federal Employee 488
Retirement Income Security Act of 1974," 88 Stat. 832, 29 489
U.S.C.A. 1001, as amended, except for any arrangement which is 490
fully insured as defined in division (b) (6) (D) of section 514 of 491
that act. 492

(K) "Midpoint rate" means, for small employers with 493
similar case characteristics and plan designs and as determined 494

by the applicable carrier for a rating period, the arithmetic 495
average of the applicable base premium rate and the 496
corresponding highest premium rate. 497

(L) "Pre-existing conditions provision" means a policy 498
provision that excludes or limits coverage for charges or 499
expenses incurred during a specified period following the 500
insured's enrollment date as to a condition for which medical 501
advice, diagnosis, care, or treatment was recommended or 502
received during a specified period immediately preceding the 503
enrollment date. Genetic information shall not be treated as 504
such a condition in the absence of a diagnosis of the condition 505
related to such information. 506

For purposes of this division, "enrollment date" means, 507
with respect to an individual covered under a group health 508
benefit plan, the date of enrollment of the individual in the 509
plan or, if earlier, the first day of the waiting period for 510
such enrollment. 511

(M) "Service waiting period" means the period of time 512
after employment begins before an employee is eligible to be 513
covered for benefits under the terms of any applicable health 514
benefit plan offered by the small employer. 515

(N) (1) "Small employer" means, until January 1, 2016, in 516
connection with a group health benefit plan and with respect to 517
a calendar year and a plan year, an employer who employed an 518
average of at least two but no more than fifty eligible 519
employees on business days during the preceding calendar year 520
and who employs at least two employees on the first day of the 521
plan year and, on or after January 1, 2016, an employer that 522
employed an average of not more than one hundred employees 523
during the preceding calendar year. 524

(2) For purposes of division (N)(1) of this section, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be considered one 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 it is reasonably expected the employer will employ on business days in the current calendar year. Any reference in division (N) of this section to an "employer" includes any predecessor of the employer. Except as otherwise specifically provided, provisions of sections 3924.01 to 3924.14 of the Revised Code that apply to a small employer that has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this division.

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

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

(B) The Ohio general assembly declares that the following objectives are to be served by this chapter: 556
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(1) Extend access to high quality, affordable health plans to all Ohioans; 558
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(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; 560
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(3) Strengthen the health care delivery system; 565

(4) Guarantee the availability and renewability of health care coverage through the private health insurance market to qualified individuals and qualified small employers; 566
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(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; 569
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(6) Meet the requirements of the federal act and applicable federal guidance and regulations. 573
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Sec. 3965.02. As used in this chapter: 575

(A) "Carrier" means any sickness and accident insurance company or health insuring corporation authorized to issue health benefit plans in this state. 576
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(B) "Exchange" or "exchange program" means the Ohio health benefit exchange program established in section 3965.05 of the Revised Code. 579
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(C) "Exchange agency" means the Ohio health benefit 582

exchange agency established in section 3965.03 of the Revised Code. 583
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(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. 585
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(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: 590
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(1) Policies covering only accident or disability income; 595

(2) Coverage issued as a supplement to liability insurance; 596
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(3) Liability insurance, including general liability insurance and automobile liability insurance; 598
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(4) Workers' compensation or similar insurance; 600

(5) Automobile medical payment insurance; 601

(6) Credit-only insurance; 602

(7) Coverage for on-site medical clinics; 603

(8) Other similar insurance coverage under which benefits for health care services are secondary or incidental to other insurance benefits; 604
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(9) Any plan offering the benefits or coverage described in division (D) of section 3965.06 of the Revised Code. 607
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(F) "Qualified dental plan" means a limited scope dental 609

plan that has been certified in accordance with section 3965.07 610
of the Revised Code. 611

(G) "Qualified employer" means a small employer that meets 612
the criteria for a qualified employer established in section 613
3965.11 of the Revised Code. 614

(H) "Qualified health plan" means a health benefit plan 615
that has been certified pursuant to section 3965.06 of the 616
Revised Code. 617

(I) "Qualified individual" means an individual who meets 618
the criteria for a qualified individual established in section 619
3965.10 of the Revised Code. 620

(J) "Secretary" means the secretary of the United States 621
department of health and human services. 622

(K) "SHOP exchange" means the small business health 623
options program established in section 3965.11 of the Revised 624
Code. 625

(L) (1) "Small employer" means, until January 1, 2016, an 626
employer that employed an average of not more than fifty 627
employees during the preceding calendar year and, on and after 628
January 1, 2016, an employer that employed an average of not 629
more than one hundred employees during the preceding calendar 630
year. 631

(2) For the purposes of division (L) (1) of this section, 632
all persons treated as a single employer under subsection (b), 633
(c), (m), or (o) of section 414 of the "Internal Revenue Code of 634
1986," 26 U.S.C. 1, as amended, shall be treated as a single 635
employer. Any reference in division (L) of this section to an 636
"employer" includes any predecessor of the employer. In the case 637
of an employer that was not in existence throughout the 638

preceding calendar year, the determination of whether the 639
employer is a small or large employer shall be based on the 640
average number of eligible employees that the employer is 641
reasonably expected to employ on business days in the current 642
calendar year. All employees shall be counted, including part- 643
time employees and employees who are not eligible for coverage 644
through the employer. 645

Sec. 3965.03. (A) The Ohio health benefit exchange agency 646
is hereby created. The agency shall have a board of directors 647
consisting of the following members: 648

(1) The following individuals, as part of their appointed 649
roles: 650

(a) The superintendent of insurance, or the 651
superintendent's designee; 652

(b) The director of medicaid, or the director's designee; 653

(c) The director of health, or the director's designee. 654

(2) The following members appointed by the governor 655
following the nomination process described in section 3965.04 of 656
the Revised Code. Not more than half shall be members of the 657
same political party, none shall have been employed by or worked 658
as an insurance agent or health care provider in the three years 659
prior to appointment, and all shall be residents of this state. 660
At least one of the six appointed members of the board shall 661
have knowledge of best practices used to address disparities in 662
quality, access, and affordability of health care. 663

(a) One individual who, on account of the individual's 664
present or previous vocation, employment, or affiliations, can 665
be classified as a union representative; 666

(b) One individual who, on account of the individual's present or previous vocation, employment, or affiliations, can be classified as a consumer representative; 667
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(c) One individual who, on account of the individual's present or previous vocation, employment, or affiliations, can be classified as a small business representative; 670
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(d) One individual who, on account of the individual's present or previous vocation, employment, or affiliations, can be classified as an actuary; 673
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(e) One individual who, on account of the individual's present or previous vocation, employment, or affiliations, can be classified as an economist; 676
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(f) One individual who, on account of the individual's present or previous vocation, employment, or affiliations, can be classified as an employee benefits specialist. 679
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(B) The board shall not include health care providers or their representatives, or insurers or their representatives, brokers, or agents. 682
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(C) (1) Of the initial appointments made to the board under division (A) (2) of this section, the governor shall appoint two members to a term ending on June 30, 2016, two members to a term ending on June 30, 2017, and two members to a term ending on June 30, 2018. Thereafter, terms of office shall be for three years, with each term ending on the same day of the same month as did the term that it succeeds. Each member shall hold office from the date of the member's appointment until the end of the term for which the member was appointed. 685
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(2) The governor shall not appoint any person to more than two full terms of office on the board. This restriction does not 694
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prevent the governor from appointing a person to fill a vacancy 696
caused by the death, resignation, or removal of a board member 697
and also appointing that person twice to full terms on the 698
board, or from appointing a person previously appointed to fill 699
less than a full term twice to full terms on the board. 700

(3) Vacancies shall be filled in accordance with division 701
(F) of section 3965.04 of the Revised Code. Any member appointed 702
to fill a vacancy occurring prior to the expiration date of the 703
term for which the member's predecessor was appointed shall hold 704
office as a member for the remainder of that term. A member 705
shall continue in office subsequent to the expiration date of 706
the member's term until a successor takes office or until a 707
period of sixty days has elapsed, whichever occurs first. 708

(D) All members of the board shall receive their 709
reasonable and necessary expenses pursuant to section 126.31 of 710
the Revised Code while engaged in the performance of their 711
duties as members and all members described in division (A) (2) 712
of this section also shall receive an annual salary not to 713
exceed sixty thousand dollars in total, payable on the following 714
basis: 715

(1) Except as provided in division (D) (2) of this section, 716
a member shall receive five thousand dollars during a month in 717
which the member attends one or more meetings of the board and 718
shall receive no payment during a month in which the member 719
attends no meeting of the board. 720

(2) A member may receive not more than sixty thousand 721
dollars per year to compensate the member for attending meetings 722
of the board, regardless of the number of meetings held by the 723
board during a year or the number of meetings in excess of 724
twelve within a year that the member attends. 725

(E) The board shall set meeting dates as necessary to perform the duties of the board under this chapter. The board shall meet at least twelve times per year. A majority of the members shall constitute a quorum. 726
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(F) Before entering the duties of office, each appointed member to the board described in division (A) (2) of this section shall take an oath of office as required by sections 3.22 and 3.23 of the Revised Code. 730
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(G) The board may appoint an advisory committee to the board that shall consist of ten, eleven, or twelve individuals who represent stakeholders, but who shall not vote on the matters before the board. The advisory committee may include all of the following individuals: 734
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(1) Representatives of health insuring corporations; 739

(2) Insurance brokers; 740

(3) Health care providers; 741

(4) Consumers, including persons with disabilities; 742

(5) Small business owners; 743

(6) Representatives of organizations or community members that represent ethnic, racial, and rural communities; 744
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(7) Others as the board sees fit. 746

(H) The board is responsible for the effective operation of all exchange agency responsibilities and the compliance of the exchange agency and the exchange program with all federal and state rules and regulations. The board shall do all of the following: 747
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(1) Exercise all powers reasonably necessary to carry out 752

and comply with the duties, responsibilities, and requirements 753
of this chapter and the federal act; 754

(2) Hire an executive director who shall be in the 755
unclassified civil service. The executive director shall be 756
responsible for the operation of the exchange program. 757

(3) Set the salaries for staff hired by the executive 758
director pursuant to section 3965.05 of the Revised Code that 759
are in amounts reasonably necessary to attract and retain 760
individuals of superior qualifications, publish those salaries 761
in the board's annual budget, and post the board's annual budget 762
on the web site of the exchange agency. 763

(4) Consult with stakeholders relevant to carrying out the 764
activities applicable to the board under this chapter, including 765
all of the following: 766

(a) Health care consumers who are enrolled in health 767
plans; 768

(b) Individuals and entities with experience in 769
facilitating enrollment in health plans; 770

(c) Representatives of small businesses and self-employed 771
individuals; 772

(d) Advocates for enrolling hard-to-reach populations. 773

(5) Develop standardized quality measures to evaluate 774
health benefit plans pursuant to division (A) (7) (g) of section 775
3965.06 of the Revised Code; 776

(6) Establish a navigator program in accordance with 777
section 3965.09 of the Revised Code and select individuals and 778
entities for the navigator program using the criteria listed in 779
that section; 780

(7) Develop privacy policies in accordance with relevant federal and state law, rule, and regulation to protect sensitive applicant and enrollee information; 781
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(8) Adopt bylaws for the regulation of its affairs and the conduct of its business. 784
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(I) The board may sue and be sued in the name of the exchange agency. 786
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Sec. 3965.04. (A) There is hereby created an exchange agency board of directors nominating council consisting of the following individuals: 788
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(1) The chief executive officer of AARP, or that officer's designee; 791
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(2) The executive director of the Ohio developmental disabilities council, or the executive director's designee; 793
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(3) The director or equivalent representative of the Ohio small business council of the Ohio chamber of commerce, or the director or equivalent representative's designee; 795
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(4) The chairperson of the board of directors of the council of smaller enterprises, or the chairperson's designee; 798
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(5) The executive director of the universal health care action network of Ohio, or the executive director's designee; 800
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(6) The president of the Ohio AFL-CIO, or the president's designee; 802
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(7) The president or equivalent representative of the largest public employee organization in this state, or the president or equivalent representative's designee; 804
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(8) The president of the health policy institute of Ohio, 807

- or the president's designee; 808
- (9) The executive director of the Ohio commission on 809
minority health, or the executive director's designee; 810
- (10) The chairperson of the department of economics at the 811
Ohio state university, or the chairperson's designee; 812
- (11) The president of the Ohio association of health 813
plans, or the president's designee; 814
- (12) The president of the Ohio state medical association, 815
or the president's designee; 816
- (13) The chief executive officer of the Ohio hospital 817
association, or that officer's designee; 818
- (14) An individual selected by the president of the 819
senate; 820
- (15) An individual selected by the speaker of the house of 821
representatives. 822
- (B) At its first meeting each calendar year, the council 823
shall select from among its members a chairperson and secretary. 824
The council may adopt bylaws governing its proceedings. 825
- (C) The council shall keep a record of its proceedings. 826
Special meetings may be called by the chairperson, and shall be 827
called by the chairperson upon receipt of a written request for 828
a meeting signed by two or more members of the council. Written 829
notice of the time and place of each meeting shall be sent to 830
each member of the council. Eight members, or their alternates, 831
constitute a quorum. 832
- (D) The council shall: 833
- (1) Review and evaluate possible appointees for the office 834

of exchange board director of the Ohio health benefit exchange 835
agency; 836

(2) Consistent with section 3965.03 of the Revised Code, 837
not more than eighty-five nor less than sixty days prior to the 838
expiration of the term of an exchange board director or not more 839
than thirty days after the death of, resignation of, or 840
termination of service by, an exchange board director, provide 841
the governor with a list of four individuals who are, in the 842
judgment of the council, the most fully qualified to accede to 843
the office of exchange board director. The council shall not 844
include the name of an individual upon the list, if the 845
appointment of that individual by the governor would result in 846
more than three appointed members of the board of directors 847
belonging to or being affiliated with the same political party. 848

(E) In reviewing and evaluating possible appointees for 849
the office of exchange board director, the council may accept 850
comments from, cooperate with, and request information from any 851
person. The council may make recommendations to the general 852
assembly concerning changes in legislation to assist the council 853
in the performance of its duties. 854

(F) Within thirty days of receipt of the council's 855
recommendations, the governor shall fill a vacancy occurring in 856
the office of exchange board director by appointment of one of 857
the persons recommended by the council. Nothing in this section 858
shall prevent the governor in the governor's discretion from 859
rejecting all of the nominees of the council and reconvening the 860
council in order to select four additional nominees. However, 861
when the governor has reconvened the council and the council has 862
provided the governor with a second list of four names, the 863
governor shall make the appointment from one of the names on the 864

first list or the second list. Each appointment by the governor 865
shall be subject to the advice and consent of the senate. 866

(G) Members of the council shall be compensated on a per 867
diem basis pursuant to the procedures set forth in section 868
124.14 of the Revised Code plus reasonable travel expenses. All 869
the expenses of the nominating council shall be paid from moneys 870
appropriated to the exchange agency for that purpose. 871

Sec. 3965.05. (A) There is hereby created the Ohio health 872
benefit exchange program within the Ohio health benefit exchange 873
agency consisting of an exchange for individual coverage and a 874
SHOP exchange. The executive director of the exchange agency 875
shall be responsible for operating the exchange and shall hire 876
all necessary staff to meet the responsibilities of the 877
executive director as described in this section. All staff hired 878
by the executive director shall be in the classified civil 879
service. 880

(B) The executive director shall do all of the following: 881

(1) Make qualified health plans available to qualified 882
individuals and qualified employers beginning on January 1, 883
2016; 884

(2) Establish procedures by rule for the certification, 885
recertification, and decertification of health benefit plans as 886
qualified health plans pursuant to section 3965.06 of the 887
Revised Code and consistent with guidelines developed by the 888
secretary under section 1311(c) of the federal act; 889

(3) Provide for the operation of a toll-free telephone 890
hotline to respond to requests for assistance regarding the 891
exchange; 892

(4) Establish enrollment periods, consistent with the 893

requirements of section 1311(c)(6) of the federal act; 894

(5) Maintain a web site through which individuals can 895
enroll in qualified health plans, and through which enrollees 896
and applicants can obtain standardized comparative information 897
on such plans; 898

(6) Assign a rating to each qualified health plan offered 899
through the exchange in accordance with the criteria developed 900
by the secretary under section 1311(c)(3) of the federal act, 901
and determine the level of coverage of each qualified health 902
plan in accordance with regulations issued by the secretary 903
under section 1302(d)(2)(A) of the federal act; 904

(7) Ensure that throughout the state a choice of qualified 905
health plans are provided at the catastrophic, bronze, silver, 906
gold, and platinum levels of coverage as those levels are 907
described in sections 1302(d) and (e) of the federal act. A 908
particular plan may be available in one region of the state and 909
not others so long as throughout the state there is a comparable 910
selection of options at each coverage level. 911

(8) Use a standardized format for presenting health 912
benefit options in the exchange, including the use of the 913
uniform outline of coverage established under section 2715 of 914
the "Public Health Service Act," 42 U.S.C. 300gg-15 ; 915

(9) Inform individuals of eligibility requirements for the 916
programs listed in division (B) of section 3965.10 of the 917
Revised Code and enroll all eligible individuals in those 918
programs; 919

(10) Grant certifications attesting that individuals are 920
exempt from the individual responsibility requirement and 921
penalty under section 5000A of the "Internal Revenue Code of 922

1986," if individuals meet the criteria listed in division (C) 923
of section 3965.10 of the Revised Code; 924

(11) Establish and make available by electronic means a 925
calculator to determine the actual cost of coverage after 926
application of any premium tax credit under section 36B of the 927
"Internal Revenue Code of 1986," and any cost-sharing reduction 928
under section 1402 of the federal act; 929

(12) Transfer to the United States secretary of the 930
treasury all of the following: 931

(a) A list of the individuals who are issued a 932
certification under division (B) (10) of this section, including 933
the name and taxpayer identification number of each individual; 934

(b) The name and taxpayer identification number of each 935
individual who was an employee of an employer but who was 936
determined to be eligible for the premium tax credit under 937
section 36B of the "Internal Revenue Code of 1986," because of 938
either of the following reasons: 939

(i) The employer did not provide minimum essential 940
coverage. 941

(ii) The employer provided the minimum essential coverage, 942
but it was determined under section 36B(c) (2) (C) of the 943
"Internal Revenue Code of 1986," to either be unaffordable to 944
the employee or not to provide the required minimum actuarial 945
value. 946

(c) The name and taxpayer identification number of both of 947
the following: 948

(i) Each individual who notifies the executive director 949
pursuant to section 1411(b) (4) of the federal act that the 950

- individual has changed employers; 951
- (ii) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation. 952
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- (13) Provide to each employer the name of each employee of the employer described in division (B) (12) (c) (ii) of this section who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation; 955
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- (14) Review the rate of premium growth within the exchange and outside the exchange, and consider the information in making recommendations to the board of the exchange agency on whether to continue limiting qualified employer status to small employers; 959
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- (15) Meet the following financial integrity requirements: 964
- (a) Keep an accurate accounting of all activities, receipts, and expenditures, and annually submit to the secretary an accounting report as required by section 1313 of the federal act; 965
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- (b) Conduct an annual fiscal audit; 969
- (c) Annually prepare a written report on the implementation and performance of the exchange functions during the preceding fiscal year, including, at a minimum, the manner in which funds were expended and the progress toward, and the achievement of, the requirements of this chapter. This report shall be transmitted to the general assembly and the governor and shall be made available to the public on the web site of the exchange. 970
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- (d) Fully cooperate with any investigation conducted by 978

the secretary pursuant to the secretary's authority under the 979
federal act and allow the secretary, in coordination with the 980
inspector general of the United States department of health and 981
human services, to do all of the following: 982

(i) Investigate the affairs of the exchange; 983

(ii) Examine the properties and records of the exchange; 984

(iii) Require periodic reports in relation to the 985
activities undertaken by the exchange. 986

(e) In carrying out the activities of the exchange under 987
this chapter, not use any funds intended for the administrative 988
and operational expenses of the exchange for staff retreats, 989
promotional giveaways, excessive executive compensation, or 990
promotion of federal or state legislative and regulatory 991
modifications. 992

(16) Provide referrals to any applicable office of health 993
insurance consumer assistance or health insurance ombudsman 994
established under section 2793 of the "Public Health Service 995
Act," 42 U.S.C. 300gg-93 , or the department of insurance for 996
any enrollee with a grievance, complaint, or question regarding 997
the enrollee's health plan, coverage, or a determination under 998
that plan or coverage; 999

(17) Market and publicize the availability of health care 1000
coverage and federal subsidies through the exchange including 1001
efforts to reach hard-to-reach populations; 1002

(18) Before January 1, 2021, conduct an ongoing study of 1003
exchange activities and the enrollees in qualified health plans 1004
offered through the exchange, including all of the following: 1005

(a) A survey of the cost and affordability of insurance 1006

provided under both the exchange for individual coverage and the SHOP exchange; 1007
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(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; 1009
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(c) The adequacy of provider networks of qualified health plans. 1012
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(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; 1014
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(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. 1022
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(C) The executive director may do any of the following: 1026

(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 responsibilities to be assumed by the entity. A carrier or an affiliate of a carrier is not an eligible entity. 1027
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(2) Enter into information-sharing agreements with federal and state agencies and departments and other state health 1034
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benefit exchange agencies to carry out the responsibilities of 1036
the exchange under this chapter, provided those agreements 1037
include adequate protections with respect to the confidentiality 1038
of the information to be shared and comply with all state and 1039
federal laws, rules, and regulations. 1040

(3) Make available supplemental coverage for enrollees of 1041
the exchange to the extent permitted by the federal act, 1042
provided that funds in the Ohio health benefit exchange 1043
operating fund established in section 3965.12 of the Revised 1044
Code are not used to pay the cost of that coverage. Any 1045
supplemental coverage offered in the exchange shall be subject 1046
to the charge imposed on qualified health plans under section 1047
3965.12 of the Revised Code. 1048

(D) Neither the executive director nor any carrier 1049
offering a health benefit plan through the exchange shall do 1050
either of the following: 1051

(1) Make available on the exchange any health plan that is 1052
not a qualified health plan; 1053

(2) Charge an individual a fee or penalty for termination 1054
of coverage if the individual enrolls in another type of minimum 1055
essential coverage because the individual has become newly 1056
eligible for that coverage or because the individual's employer- 1057
sponsored coverage has become affordable under the standards of 1058
section 36B(c)(2)(C) of the "Internal Revenue Code of 1986." 1059

(E) All data collection performed by the executive 1060
director pursuant to this chapter shall include demographic 1061
information, including racial and ethnic information as 1062
specified by the executive director in rules adopted in 1063
accordance with section 3965.13 of the Revised Code. 1064

Sec. 3965.06. (A) The executive director of the exchange 1065
may certify a health benefit plan as a qualified health plan if 1066
all of the following conditions are met: 1067

(1) The plan provides the essential health benefits 1068
package described in section 1302(a) of the federal act, except 1069
that the plan is not required to provide essential benefits that 1070
duplicate the minimum benefits of qualified dental plans, as 1071
provided in section 3965.07 of the Revised Code, if both of the 1072
following are true: 1073

(a) The executive director has determined that at least 1074
one qualified dental plan is available to supplement the 1075
qualified health plan's coverage. 1076

(b) The carrier makes prominent disclosure at the time it 1077
offers the plan, in a form approved by the executive director, 1078
that the plan does not provide the full range of essential 1079
pediatric benefits, and that qualified dental plans providing 1080
those benefits and other dental benefits not covered by the plan 1081
are offered through the exchange. 1082

(2) The premium rates and contract language have been 1083
approved by the superintendent of insurance. 1084

(3) The plan provides at least a bronze level of coverage, 1085
as determined pursuant to division (B)(6) of section 3965.05 of 1086
the Revised Code unless the plan is certified as a qualified 1087
catastrophic plan, which will only be offered to individuals 1088
eligible for catastrophic coverage. 1089

(4) The plan's cost-sharing requirements do not exceed the 1090
limits established under section 1302(c)(1) of the federal act, 1091
and, if the plan is offered through the SHOP exchange, the 1092
plan's deductible does not exceed the limits established under 1093

section 1302(c)(2) of the federal act. 1094

(5) The carrier offering the plan meets all of the 1095
following criteria: 1096

(a) The carrier is licensed and in good standing to offer 1097
health insurance coverage in this state. 1098

(b) The carrier offers at least one qualified catastrophic 1099
health plan, at least one qualified health plan in the bronze 1100
level, at least one qualified health plan in the silver level, 1101
at least one qualified health plan in the gold level, and at 1102
least one qualified health plan in the platinum level, as 1103
determined by the executive director pursuant to division (B)(6) 1104
of section 3965.05 of the Revised Code, through the SHOP 1105
exchange or the exchange for individual coverage or both if the 1106
carrier participates in both the SHOP exchange and the exchange 1107
for individual coverage. 1108

(c) The carrier charges the same premium rate for each 1109
qualified health plan without regard to whether the plan is 1110
offered through the exchange and without regard to whether the 1111
plan is offered directly from the carrier or through an 1112
insurance agent. 1113

(d) The carrier does not charge any fee or penalty for 1114
termination of coverage in violation of division (D)(2) of 1115
section 3965.05 of the Revised Code. 1116

(e) The carrier complies with the regulations developed by 1117
the secretary under section 1311(d) of the federal act and such 1118
other requirements as the executive director may establish. 1119

(6) The plan meets the requirements of certification as 1120
established by rule pursuant to division (B)(2) of section 1121
3965.05 of the Revised Code and by the secretary under section 1122

<u>1311(c) of the federal act.</u>	1123
<u>(7) The executive director determines that making the plan available through the exchange is in the interest of qualified individuals and qualified employers in this state. In making such a determination, the executive director shall consider all of the following:</u>	1124
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<u>(a) Plans should not make use of marketing practices that would discourage enrollment by people with significant health needs.</u>	1129
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<u>(b) Plans must provide a sufficient choice of providers and, where available, must include essential community providers that serve low-income, medically underserved individuals.</u>	1132
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<u>(c) Plans must be accredited by a recognized accreditation organization, or achieve accreditation from a recognized accreditation organization within a time period defined by the board of the exchange agency, based on a review of their clinical quality, patient experience, access, utilization management, quality assurance, provider credentialing, complaints and appeals processes, network adequacy and access, and patient information programs.</u>	1135
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<u>(d) Plans must have a quality improvement strategy.</u>	1143
<u>(e) Plans must use a uniform enrollment form for individuals and small employers.</u>	1144
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<u>(f) Plans must use a standard format for presenting plan options.</u>	1146
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<u>(g) Plans must provide information about their performance on standardized quality measures as determined by the board of the exchange agency under division (H) (5) of section 3965.03 of</u>	1148
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the Revised Code to enrollees and prospective enrollees. 1151

(h) Plans must report annually to the federal government 1152
on the quality of their pediatric care. 1153

(8) The plan does not offer benefits or coverage described 1154
in division (D) of this section. 1155

(B) The executive director shall not exclude a health 1156
benefit plan from certification for any of the following 1157
reasons: 1158

(1) On the basis that the plan is a fee-for-service plan; 1159

(2) Through the imposition of premium price controls by 1160
the exchange; 1161

(3) On the basis that the health benefit plan provides 1162
treatments necessary to prevent patients' deaths in 1163
circumstances the executive director determines are 1164
inappropriate or too costly. 1165

(C) The executive director shall require each carrier 1166
seeking certification of a plan as a qualified health plan to do 1167
all of the following: 1168

(1) Submit a justification to the executive director for 1169
any premium increase before implementation of that increase; 1170

(2) Prominently post any information regarding a premium 1171
increase on its web site. The executive director shall take this 1172
information, along with the information and the recommendations 1173
provided to the exchange by the secretary under section 2794(b) 1174
of the "Public Health Service Act," 42 U.S.C. 300gg-94 , into 1175
consideration when determining whether to allow the carrier to 1176
make plans available through the exchange. 1177

(3) Make available to the public, in language that the intended audience, including individuals with limited English proficiency, can readily understand, and submit to the exchange, the secretary, and the superintendent of insurance, accurate and timely disclosure of all of the following information: 1178
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(a) Claims payment policies and practices; 1183

(b) Periodic financial disclosures; 1184

(c) Data on enrollment, disenrollment, the number of claims that are denied, and rating practices; 1185
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(d) Information on cost-sharing and payments with respect to any out-of-network coverage; 1187
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(e) Information on enrollee and participant rights under Title I of the federal act; 1189
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(f) Other information as determined appropriate by the secretary pursuant to section 1303 of the federal act. 1191
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(4) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through a web site and through other means for individuals without access to the internet. 1193
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(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: 1202
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(1) Any of the following benefits if they are provided 1205

<u>under a separate policy, certificate, or contract of insurance</u>	1206
<u>or are otherwise not an integral part of the plan:</u>	1207
<u>(a) Limited scope dental or vision benefits;</u>	1208
<u>(b) Benefits for long-term care, nursing home care, home</u>	1209
<u>health care, or community-based care;</u>	1210
<u>(c) Other similar, limited benefits specified in federal</u>	1211
<u>regulations issued pursuant to the "Health Insurance Portability</u>	1212
<u>and Accountability Act of 1996."</u>	1213
<u>(2) Either of the following benefits if the benefits are</u>	1214
<u>provided under a separate policy, certificate, or contract of</u>	1215
<u>insurance, there is no coordination between the provision of the</u>	1216
<u>benefits and any exclusion of benefits under any health benefit</u>	1217
<u>plan maintained by the same carrier, and the benefits are paid</u>	1218
<u>with respect to an event without regard to whether benefits are</u>	1219
<u>provided with respect to such an event under any health benefit</u>	1220
<u>plan maintained by the same carrier:</u>	1221
<u>(a) Coverage only for a specified disease or illness;</u>	1222
<u>(b) Hospital indemnity or other fixed indemnity insurance.</u>	1223
<u>(3) Any of the following if offered as a separate policy,</u>	1224
<u>certificate, or contract of insurance:</u>	1225
<u>(a) Medicare supplemental health insurance as defined</u>	1226
<u>under section 1882(g)(1) of the "Social Security Act," 42 U.S.C.</u>	1227
<u>1395ss;</u>	1228
<u>(b) Coverage supplemental to the coverage provided under</u>	1229
<u>chapter 55 of Title 10 of the United States Code;</u>	1230
<u>(c) Similar supplemental coverage provided to coverage</u>	1231
<u>under a group health plan.</u>	1232

(E) The executive director shall not exempt any carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from state licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among carriers participating in the exchange. 1233
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Sec. 3965.07. (A) The executive director may certify a dental plan as a qualified dental plan if all of the following conditions are met: 1239
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(1) The plan provides limited scope dental benefits that are offered separately from any qualified health plan. 1242
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(2) The plan does not substantially duplicate the benefits typically offered by health benefit plans without dental coverage. 1244
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(3) The plan includes, at a minimum, the essential pediatric dental benefits prescribed by the secretary pursuant to section 1302(b)(1)(J) of the federal act, and such other dental benefits as the executive director or the secretary may specify by rule or regulation. 1247
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(B) The provisions of this chapter that are applicable to qualified health plans shall also apply to qualified dental plans to the extent relevant with the following exceptions: 1252
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(1) A carrier that is licensed to offer dental coverage need not be licensed to offer other health benefits. 1255
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(2) Carriers may jointly offer a comprehensive plan through the exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, provided that the plans are priced separately and are also 1257
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<u>made available for purchase separately at the same price.</u>	1262
<u>(C) The executive director may adopt additional rules concerning qualified dental health plans.</u>	1263
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<u>Sec. 3965.08. (A) Health plans that are certified as qualified health plans pursuant to section 3965.06 of the Revised Code and dental plans that are certified as qualified dental plans pursuant to section 3965.07 of the Revised Code may bid to participate in the exchange for individual coverage and the SHOP exchange. Bidding plans will be scored by the executive director of the exchange based on the following criteria:</u>	1265
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<u>(1) The cost of the plan to individuals in terms of premiums and typical out-of-pocket expenses;</u>	1272
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<u>(2) The carrier's overall offering and plan design. Preferred features of health benefit plans include the following:</u>	1274
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<u>(a) Use of a select, high-performance network;</u>	1277
<u>(b) Centers of excellence for complex conditions or procedures;</u>	1278
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<u>(c) Innovative pharmacy management;</u>	1280
<u>(d) Active consumer engagement;</u>	1281
<u>(e) Wellness incentives and management;</u>	1282
<u>(f) Preventive and flex benefits for chronic conditions.</u>	1283
<u>(3) Use of multilingual community outreach or nontraditional media outlets to reach hard-to-reach communities for marketing purposes;</u>	1284
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<u>(4) The ability of the plan to confirm its compliance with various program rules and reporting requirements;</u>	1287
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<u>(5) The design of the plan's enrollment process, including</u>	1289
<u>the following considerations:</u>	1290
<u>(a) Level of burden to the consumer;</u>	1291
<u>(b) Ease of use with regard to populations that may</u>	1292
<u>experience barriers to enrollment such as the disabled and those</u>	1293
<u>with limited English language proficiency.</u>	1294
<u>(6) A determination of whether including a given plan in</u>	1295
<u>the exchange will encourage a robust system of regional plans.</u>	1296
<u>(B) After consideration of the criteria listed in division</u>	1297
<u>(A) of this section, the executive director shall select</u>	1298
<u>qualified health plans and qualified dental plans to participate</u>	1299
<u>in the exchange. There shall not be a set minimum or maximum</u>	1300
<u>number of qualified health or dental plans that are required to</u>	1301
<u>exist in the exchange.</u>	1302
<u>(C) In the course of selectively contracting for health</u>	1303
<u>care coverage, the executive director shall do both of the</u>	1304
<u>following:</u>	1305
<u>(1) Seek to contract with carriers so as to provide health</u>	1306
<u>care coverage choices that offer the optimal combination of</u>	1307
<u>choice, value, quality, and service;</u>	1308
<u>(2) Maintain a robust system of regional plans.</u>	1309
<u>Sec. 3965.09. (A) The board of the exchange agency shall</u>	1310
<u>establish a navigator program in accordance with section 1311(i)</u>	1311
<u>of the federal act, designed to advise individual consumers and</u>	1312
<u>employers on the use of the exchange.</u>	1313
<u>(B) The board shall select individuals and entities to be</u>	1314
<u>part of the navigator program. To be considered for a grant</u>	1315
<u>under the navigator program, an individual or entity shall meet</u>	1316

all of the following criteria: 1317

(1) The individual or entity shall demonstrate to the 1318
board that the individual or entity has existing relationships 1319
or could readily establish relationships with consumers, 1320
employers and employees, or self-employed individuals, likely to 1321
be qualified to enroll in a qualified health plan; 1322

(2) The individual or entity shall not be a health 1323
insurance issuer or receive any compensation, either directly or 1324
indirectly, from any health insurance issuer in connection with 1325
the enrollment of any qualified individuals or employees of a 1326
qualified employer in a qualified health plan; 1327

(3) The individual or entity shall be capable of carrying 1328
out the duties listed in division (C) of this section. 1329

(C) Navigators shall do all of the following: 1330

(1) Conduct public education activities to raise awareness 1331
of the availability of qualified health plans; 1332

(2) Distribute fair and impartial information concerning 1333
enrollment in qualified health plans, and the availability of 1334
premium tax credits under section 36B of the "Internal Revenue 1335
Code of 1986," and cost-sharing reductions under section 1402 of 1336
the federal act; 1337

(3) Facilitate enrollment in qualified health plans; 1338

(4) Provide referrals to any applicable office of health 1339
insurance consumer assistance or health insurance ombudsman 1340
established under section 2793 of the "Public Health Service 1341
Act," 42 U.S.C. 300gg-93, or the department of insurance, for 1342
any enrollee with a grievance, complaint, or question regarding 1343
their health benefit plan or coverage or a determination under 1344

that plan or coverage; 1345

(5) Provide information in a manner that is culturally and 1346
linguistically appropriate to the needs of the population being 1347
served by the exchange. 1348

(D) The board shall award grants to individuals and 1349
entities approved by the board to perform work as navigators in 1350
order to fund the required duties described in division (C) of 1351
this section. Funds for grants shall be withdrawn from the Ohio 1352
health benefit exchange operating fund established in section 1353
3965.12 of the Revised Code. 1354

Sec. 3965.10. (A) Only qualified individuals shall be 1355
permitted to purchase health insurance through the exchange. A 1356
qualified individual is an individual, including a minor, who 1357
meets all of the following criteria: 1358

(1) The individual is seeking to enroll in a qualified 1359
health plan offered to individuals through the exchange. 1360

(2) The individual resides in this state. 1361

(3) The individual is not incarcerated at the time of 1362
enrollment, other than incarceration pending the disposition of 1363
charges. 1364

(4) The individual is, and is reasonably expected to be, 1365
for the entire period for which enrollment is sought, a citizen 1366
or national of the United States, or an alien lawfully present 1367
in the United States. 1368

(B) If the executive director of the exchange program 1369
determines that an individual seeking to purchase health 1370
insurance through the exchange is eligible for the medicaid 1371
program under Title XIX of the "Social Security Act," 42 U.S.C. 1372

1396 , the children's health insurance program under Title XXI 1373
of the "Social Security Act," 42 U.S.C. 1397aa, or any 1374
applicable state or local public program, the executive director 1375
shall enroll the individual in that program. 1376

(C) An individual shall be exempt from the individual 1377
responsibility requirement under section 5000A of the "Internal 1378
Revenue Code of 1986," or from the penalty imposed by that 1379
section for either of the following reasons: 1380

(1) There is no affordable qualified health plan available 1381
through the exchange, or the individual's employer, covering the 1382
individual. 1383

(2) The individual meets the requirements for any other 1384
such exemption from the individual responsibility requirement or 1385
penalty. 1386

Sec. 3965.11. (A) As a part of the exchange there shall 1387
exist a SHOP exchange through which qualified employers may 1388
access coverage for their employees, and that shall enable any 1389
qualified employer to specify a level of coverage so that any of 1390
its employees may enroll in any qualified health plan offered 1391
through the SHOP exchange at the specified level of coverage. 1392

(B) Only qualified employers shall be permitted to 1393
participate in the SHOP exchange. A qualified employer is a 1394
small employer that elects to make its full-time employees 1395
eligible for one or more qualified health plans offered through 1396
the SHOP exchange, and at the option of the employer, some or 1397
all of its part-time employees, provided that the employer meets 1398
either of the following criteria: 1399

(1) The employer has its principal place of business in 1400
this state and elects to provide coverage through the SHOP 1401

exchange to all of its eligible employees, wherever employed; 1402

(2) The employer elects to provide coverage through the 1403
SHOP exchange to all of its eligible employees who are 1404
principally employed in this state. 1405

(C) If an employer that makes enrollment in qualified 1406
health plans available to its employees through the SHOP 1407
exchange would cease to be a small employer by reason of an 1408
increase in the number of its employees, the employer shall 1409
continue to be treated as a small employer for purposes of this 1410
chapter as long as it continuously makes enrollment through the 1411
SHOP exchange available to its employees. 1412

Sec. 3965.12. (A) (1) The exchange agency may charge 1413
assessments or user fees to carriers or otherwise may generate 1414
funding necessary to support its operations and the operations 1415
of the exchange. 1416

(2) All funds collected by the exchange agency pursuant to 1417
division (A) (1) of this section shall be paid into the state 1418
treasury to the credit of the Ohio health benefit exchange 1419
operating fund, which is hereby created. 1420

(B) The exchange agency shall publish the average costs of 1421
licensing, regulatory fees, and any other payments required by 1422
the exchange agency and the exchange, and the administrative 1423
costs of the exchange agency and the exchange, on a web site to 1424
educate consumers on such costs. This information shall include 1425
information on monies lost to waste, fraud, and abuse. 1426

Sec. 3965.13. The board of the exchange agency and the 1427
executive director of the exchange may adopt rules to implement 1428
the provisions of this chapter. Rules adopted pursuant to this 1429
section shall not conflict with or prevent the application of 1430

regulations promulgated by the secretary under the federal act. 1431

Sec. 3965.14. Nothing in this chapter, and no action taken 1432
by the board of the exchange agency or the executive director of 1433
the exchange pursuant to this chapter, shall be construed to 1434
preempt or supersede the authority of the superintendent of 1435
insurance to regulate the business of insurance within this 1436
state. Except as expressly provided to the contrary in this 1437
chapter, all carriers offering qualified health plans in this 1438
state shall comply fully with all applicable health insurance 1439
laws of this state and rules adopted and orders issued by the 1440
superintendent. 1441

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Section 2. That existing sections 124.14, 3905.01, 1443
3905.473, and 3924.01 and sections 3905.471, 3905.472, and 1444
3905.474 of the Revised Code are hereby repealed. 1445

Section 3. Within ninety days after the effective date of 1446
this act, the exchange agency board of directors nominating 1447
council established in section 3965.04 of the Revised Code as 1448
enacted in this act shall produce two, three, or four nominees 1449
for each position described in division (A) (2) of section 1450
3965.03 of the Revised Code. Following nomination, the Governor 1451
shall appoint the members described in that division to the 1452
board of the Ohio Health Benefit Exchange Agency in accordance 1453
with division (F) of section 3965.04 of the Revised Code as 1454
enacted in this act. At the time of appointment, the Governor 1455
shall determine which members of the board shall serve the terms 1456
described in division (C) (1) of section 3965.03 of the Revised 1457
Code. For each subsequent nomination period, the nominating 1458
council shall produce four nominees for each position as 1459
required by division (D) (2) of section 3965.04 of the Revised 1460

Code .

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