BULLETIN NO. 2009-05

RESCISSION OF BULLETINS 14, 90-7, 90-8, 94-8, 94-9, 97-1

(Effective February 10, 2009)

The purpose of this bulletin is to rescind the following attached Ohio Department of Insurance Bulletins that are outdated or are covered by subsequent statutes or rules.

1. Bulletin 14, entitled Health, Accident and Hospitalization Insurance.

2. Bulletin 90-7, entitled Urinalysis as Preliminary Screen Before Applying HIV Blood Test and Related Confidentiality Requirements.

3. Bulletin 90-8, entitled Rescission of Bulletin 88-2 (Superseded by rule 3901-1-41 effective 10/19/90).

4. Bulletin 94-8, entitled Disclosure and Use of Provider Discounts. This bulletin is being updated as to citations and terminology in Bulletin 2009-06, and to add a reference to Revised Code Section 3923.81 concerning negotiated discounted rates and their effect on out of pocket costs.

5. Bulletin 94-9, entitled Disclosure and Use of Provider Discounts.

6. Bulletin 97-1, entitled Basic Health Services and Infertility Services. This bulletin is being updated as to terminology and language in the statute described in Bulletin 2009-07.

Mary Jo Hudson
Superintendent of Insurance

Ohio Miscellaneous Regulatory Material
DEPARTMENT OF INSURANCE
BULLETINS

Bulletin 14 Health, accident and hospitalization insurance

Effective Date
November 19, 1957

This bulletin is applicable only to individual sickness and accident policies, riders and endorsements issued or delivered after July 1, 1956 in the State of Ohio.

Section 1: (a) As used herein the word "shall" is mandatory, and the word "may" is permissive.

(b) The words "policy" or "policies" as used herein include riders and endorsements.

Section 2: Sections 3923.03 to 3923.07, inclusive, Revised Code, do not apply to sickness and accident group and blanket insurance as defined in Section 3923.12 and 3923.13 except as provided in Section 3923.20.

Section 3: All individual policies issued on the Industrial basis shall comply with the requirements of Sections 3923.01 to 3923.22, inclusive and with this bulletin.

Section 4: any policy now in use subject to the provisions of Sections 3923.011 to 3923.09 as effective July 1, 1956, heretofore filed by or on behalf of an insurer and approved by the Department of Insurance need not solely on account of this bulletin, be refiled; however, policies which do not conform with the applicable provisions of such sections as effective July 1, 1956, and which are issued after July 1, 1956, shall be brought into compliance with the requirements of such sections, as amended, and with this bulletin by the use of rider or endorsement duly filed and approved by the Department of Insurance.

Section 5: A policy may contain language to the effect that its renewal is subject to timely payment of premiums when due.

Section 6: The certificates referred to in the last sentence of the second paragraph of Section 3923.02 are those which are used in the State of Ohio in connection with or pursuant to the provisions of any group sickness and accident insurance policy which is not delivered or issued in the State of Ohio but which insures residents of Ohio. The purpose of such sentence is to provide a method whereby the Superintendent of Insurance may request the filing of a particular form of certificate for informational purposes. When the Superintendent desires such information he will request it.

Section 7: The second paragraph of Division (A) of Section 3923.04 need not be made a part of the required "Entire Contract; Changes" policy provision and may be omitted therefrom.

Section 8: The last paragraph of Division (B)(2) of Section 3923.04 which provides that no chronic disease or chronic physical condition may be excluded from the coverage except by

name or specific description need not be made a part of the required policy provision. The purpose of this last paragraph in Division (B) is to make it clear that the words "chronic disease" or "chronic physical condition" are not terms sufficiently descriptive to constitute exceptions to the policy coverage.

Section 9: (a) The last paragraph of Division (C) of Section 3923.04 does not apply to a policy in which the insured has the right to continue the policy in force subject to its terms by the timely payment of premiums until (1) at least age 50, or (2), in case of a policy issued after age 44, for a period of at least five years from its date of issue; except that, if the insurer in such policy provides that the policy may continue in force after the specified age or specified period of time but that the insurer may refuse to renew the policy after such age or such period, a rider or endorsement shall be issued on the date when such policy becomes renewable at the option of the insurer and the rider or endorsement shall comply with Division (C) of Section 3923.04.

(b) The last paragraph of Division (C) of Section 3923.04 applies only to a policy issued to an individual on an individual basis in which the insurer reserves the right to refuse to renew. It does not apply to individual policies issued to members of an association, labor union, or to employees of an employer when (1) the policy provides that the insurer shall not refuse to renew any individual policyholder in a particular group unless the insurer gives at least 60 days notice of intention to non-renew all policyholders in that group, or (2) the policy provides that the insurer may terminate or refuse to renew an individual after the individual attains a specified age, retires, or ceases to engage in the duties of his profession or occupation (except by reason of disability covered under the terms of the policy), or ceases to be a member of the association, labor union or to be an employee of the employer. If, after the occurrence of one of the conditions on which individual termination or refusal to renew is permitted by the terms of the policy, the insurer elects to keep such policy in force but reserves the right to refuse to renew the policy on its anniversary date thereafter, a rider or endorsement shall be issued to the insured individual on the date the insurer so elects to keep such policy in force. The rider or endorsement shall not be attached to the policy until such date unless such rider or endorsement specifically provides that it shall not become effective until after the occurrence of the conditions on which individual termination or refusal to renew is permitted by the terms of the policy. The rider or endorsement shall comply with Division (C) of Section 3923.04.

(c) The word "anniversary" as used in the last paragraph of Division (C) of Section 3923.04 means that date which is one year after the effective date of the policy. All subsequent anniversary dates shall be measured from the effective date of the policy.

(d) The use of words "first anniversary, or between anniversaries, of its date of issue" which appear in the last paragraph of Division (c) of Section 3923.04, mean that the insurer may issue a policy, rider or endorsement containing language providing for a premium renewal date which occurs on, or after and nearest, but not before, the anniversary date of the policy. Certain policies are issued wherein the premium renewal date does not coincide with but does not precede the anniversary date. If the premium renewal date coincides with the anniversary date, a reference in the policy to the anniversary date occurring "after and nearest each anniversary date of issue," is not required and, in such case, a reference to the right to refuse to renew on each anniversary is sufficient. Policy or rider language more favorable to the insured may be used at the option of the insurer. For example, establishing the premium due date in such manner as to provide coverage for a few days or a few weeks longer than the required one year, would be more favorable to the insured and, therefore,

permissible.

(e) In the event of reinstatement after lapse the policy shall retain its original anniversary date, unless by rider or endorsement the insurer elects to establish a new anniversary date.

Section 10: (a) Division (M) of Section 3923.04 requires a provision for cancellation by the insured. Each policy issued to an individual on an individual basis, except those described in paragraph (d) of this section of this bulletin, shall contain such a cancellation provision.

(b) In the event of cancellation by the insured of any policy, other than policies specified in paragraph (d) of this section of this bulletin, the insurer shall return promptly the unearned portions of any premium paid. Section 3923.04 provides that the earned premium shall be computed by the use of the short rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. An insurer, however, may use the pro rata method of returning premiums, if it desires to do so. This department will accept for filing the short rate table commonly in use by fire and casualty companies, or any other table which is more favorable to the insured.

(c) The last sentence of Division (M) of Section 3923.04, which nullifies any other cancellation provision, may be omitted from a policy which does not contain any provision permitting cancellation by the insurer or permitting the insurer to refuse to renew.

(d) Division (M) of Section 3923.04 does not apply to travel or trip accident-only policies which are issued for a single premium on a non-renewable basis for a term not to exceed 180 days covering a hazardous period of time selected by the insured.

Section 11: Under the provisions of Section 3923.07, and with the approval of the Superintendent of Insurance, the caption or wording of the text of any provision of any policy designed to comply with either Division (C) or (M) of Section 3923.04 may be drafted in a manner which varies from the wording used in the statute, if the wording of the policy is not less favorable to the insured or the beneficiary than the statutory wording, and clarifies the meaning of either the caption or text of the policy.

Section 12: (a) Section 3923.12(A)(3) and Section 3923.13(E) of the Revised Code provides that the Superintendent of Insurance may approve a policy for issuance to any group which is substantially similar to the groups listed in said sections.

(b) Under Section 3923.12 employees or members of associations may be covered, whether such employees are members of the association or not.

(c) A blanket policy issued under Section 3923.13 may be issued to a school board or a school district to cover one or more schools. Such blanket school policies may provide coverage for all bona fide employees of the school, school board and school district. (These examples are not intended to be exclusive, but are only an indication of permissible eligible groups substantially similar to the groups listed in Sections 3923.12 and 3923.13.) Policies submitted under the "substantially similar" portions of Sections 3923.12 and 3923.13 shall be considered by the department of Insurance only when submitted in exactly the same language and form in which they will be issued.

Section 13: As used in Sickness and Accident policies in this State, unless otherwise clearly

defined in the policy, the word "hospital" shall mean: any institution which maintains an establishment for the medical or surgical care of bed patients for a continuous period longer than twenty-four hours, which is open to the general public twenty-four hours each day for emergency care, which has a minimum of ten patient beds, which has an average of two thousand patient days per annum, and which has on duty a registered nurse twenty-four hours each day.

Section 14: All policies submitted to the Department of Insurance for approval must be completed in "John Doe" fashion. Only one copy of each form need be filed.

CROSS REFERENCE 3923.03; 3923.07; 3923.12; 3923.13; 3923.20; 3923.01; 3923.22; 3923.011; 3923.09; 3923.02; 3923.04

Arthur I. Vorys
Director of Insurance

SUBJECT CATEGORY 060 - Health insurance / insurers 080 - Group insurance (all lines) 300 - The policy 360 - Filing and reporting requirements

DEFINITIONS Anniversary; First anniversary, or between anniversaries, of its date of issue; Hospital

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URINALYSIS AS PRELIMINARY SCREEN BEFORE APPLYING HIV BLOOD TEST AND RELATED CONFIDENTIALITY REQUIREMENTS

BULLETIN 90-7

December 18, 1990

This Bulletin is intended to provide guidance in interpreting and applying the provisions of Section 3901.46 of the Ohio Revised Code with respect to the use by insurers of urinalysis procedures as a preliminary screen before the use of HIV blood tests and with respect to related confidentiality requirements.

Urinalysis procedures may be utilized by insurers as a screen to determine whether particular applicants should undergo an HIV blood test, provided the urinalysis procedure satisfies the following four conditions:

1. That such procedures are utilized only as a preliminary screen to determine whether an HIV blood test should be requested;

2. That a positive indication from such urinalysis procedures of the presence of HIV antibodies is not accepted by insurers as an ultimate determination of the presence of such infection;

3. That before urine samples are obtained such insurers provide written notice to applicants that urinalysis procedures will be utilized as a preliminary screen for HIV antibodies. The written notice shall inform the applicant of the purpose of the urinalysis. The notice must explain the procedure for notifying the applicant of the results, that the result will be confidential, and that if the result of the urinalysis screen is positive, an HIV blood test must be taken before an ultimate determination of the presence of such infection may be made by the insurer. The written notice must also provide a reference for further information concerning AIDS. (e.g., for more information about AIDS call the Columbus AIDS Hotline at 1-800-332-2437);

4. That such insurers apply the same confidentiality protections to the results of such procedures as are imposed by Section 3901.46(C) 1, 2, 3 of the Ohio Revised Code. Insurers may not disclose the results of a urinalysis to any medical information exchange, including the Medical Information Bureau.

Accordingly, insurers doing business in Ohio may utilize such urinalysis procedures as a screen to determine whether particular applicants should undergo an HIV blood test, provided that each of the four conditions specified in the foregoing paragraph of this Bulletin is fully satisfied.

George Fabe,
Superintendent of Insurance

RICHARD F. CELESTE
Governor

STATE OF OHIO
DEPARTMENT OF INSURANCE
2100 STELLA COURT
COLUMBUS 43266-0566

BULLETIN 90-8
RESCISSION OF BULLETIN 88-2

This Bulletin rescinds and supersedes existing Department of Insurance Bulletin 88-2, dated March 29, 1988, entitled Medicare Supplement Advertising Requirements.

Bulletin 88-2 has been superseded by Ohio Administrative Code Rule 3901-1-41, entitled Medicare Supplement, effective date October 19, 1990. In addition, Ohio Administrative Code Rule 3901-1-35, entitled Solicitation and Sale of Medicare Supplement Accident and Health Policies, contains certain rules regarding the solicitation and sale of medicare supplement policies.

12-19-90
Date

George Fabe
Superintendent of Insurance

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State Of Ohio
Department of Insurance
2100 Stella Court Columbus, Ohio 43266-0566

George V. Voinovich
Governor
Harold T. Duryee
Director

BULLETIN 94 - 8

TO: Health Insurance Companies And Other Third Party Payers
FROM: Harold T. Duryee, Director of Insurance
SUBJECT: Disclosure and Use of Provider Discounts
DATE: November 23, 1994

This bulletin addresses the claim payment practices of insurance companies and regulated third party payers that have negotiated discount prices for health services with health care providers, primarily hospitals. This bulletin does not apply to Health Maintenance Organizations licensed pursuant to Chapter 1742 of the Ohio Revised Code.

The Department administers Ohio Revised Code 3901.21, the Unfair and Deceptive Trade Practice Act. That statute defines as an unfair and deceptive act the making of a statement that is untrue, deceptive or misleading. Accordingly, misrepresenting the terms of an insurance policy is subject to an enforcement action as an unfair and deceptive trade practice.

The Department considers it to be an unfair and deceptive act to not calculate the co-payment to be paid by an individual entitled to coverage under an insurance policy on the basis set forth in that insurance policy. It is also an unfair and deceptive act for the insurance company or other third party payer, whose contract provides for a calculation of a covered individual's co-payment, not to disclose such method of calculation in the certificate or evidence of coverage provided to individuals entitled to coverage. Such disclosure may also be made with the use of explanations of benefits or other similar non-contractual communications with individuals entitled to coverage. Licensees of the Department are subject to a market conduct examination should they fail to provide disclosure.

Next, health insurers and other third party payers typically have provisions in their health contracts that set limits on payments. Where such provisions set limits for an annual or lifetime maximum payment to an individual entitled to coverage, the Department considers it to be an unfair and deceptive practice to calculate such limit on a basis other than actual payments unless such calculation is in accordance with a specific provision within the contract. When the policy has a limit based on other than actual cash payments, that provision must be disclosed in any certificate or evidence of coverage. Such disclosure may also be made with the use of explanations of benefits or other similar non-contractual communications with individuals entitled to coverage.

The Department instructs all health insurers and other third party payers to conduct an audit of claims denied for the reason that the annual or lifetime maximum has been provided. Based on the preceding paragraph each health insurer or other third party payer shall make additional payments as appropriate for each claim. All health insurers and other third party payers shall submit a report of all affected accounts including any payments to the Department within 120 days of the date of this bulletin. Further if a health insurer or other third party payer has no accounts or payments to report, that information should be sent to the Department within the time period set forth above. Failure to report may be cause for a market conduct examination. Send the report to the Office of Life and Health Services at the Department.

State Of Ohio
Department of Insurance
2100 Stella Court Columbus, Ohio 43266-0566

George V. Voinovich
Governor
Harold T. Duryee
Director

BULLETIN 94 - 9

TO: Health Maintenance Organizations Licensed Pursuant To Chapter 1742 of the Ohio Revised Code
FROM: Harold T. Duryee, Director of Insurance
SUBJECT: Disclosure and Use of Provider Discounts
DATE: November 23, 1994

This bulletin addresses the claim payment practices of Health Maintenance Organizations (HMO) licensed pursuant to Ohio Revised Code Chapter 1742, which have negotiated prices with health care providers, primarily hospitals for basic health care services.

The Department administers Ohio Revised Code 3901.21, the Unfair and Deceptive Trade Practice Act. That statute defines as an unfair and deceptive act the making of a statement that is untrue, deceptive or misleading. Accordingly, misrepresenting the terms of an HMO contract is subject to an enforcement action as an unfair and deceptive trade practice.

The Department considers it to be an unfair and deceptive act to not calculate the co-payment to be paid by an individual entitled to coverage under an HMO contract on the basis set forth in that contract. It is also an unfair and deceptive act for the HMO whose contract provides for a different method of calculation of a covered individual's co-payment not to disclose such method of calculation in the certificate or evidence of coverage provided to individuals entitled to coverage. Such disclosure may also be made with the use of solicitation materials or other similar non-contractual communications with enrollees entitled to coverage.

Also, HMOs are governed by Section 1742.09(B)(2) of the Ohio Revised Code. That section states in part: "(An HMO)...may not impose co-payment charges on basic health care services that exceed thirty per cent of the total cost of providing to its enrollees any single covered service...".

The Department position is that "total cost" as used in that statute means the payments actually made to providers of basic health services rendered to an individual entitled to services, and does not include administrative costs or additional expenses incurred by the HMO. Next, "any single covered service" includes all health services rendered for a specific health condition covered by the HMO contract.

If an HMO and its providers negotiate a discount so the HMO does not have to pay the provider the billed charges, the benefit of the negotiated payment must be considered in the calculation of an enrollee's co-payment. The total cost of a service, is the amount the HMO has agreed to pay the provider, not the billed charges.

HMOs are instructed to report to the Department that they are in compliance with the position stated in this bulletin. Noncompliance with these laws could result in a market conduct examination and other administrative actions against the licensee. Send the report to the Office of Life and Health Services at the Department.

State Of Ohio
Department of Insurance
2100 Stella Court Columbus, Ohio 43215-1067

George V. Voinovich
Governor
Harold T. Duryee
Director

Bulletin 97-1

November 13, 1997

To: Health Insuring Corporations
From: Harold T. Duryee
Re: Basic Health Services and Infertility Services

This bulletin addresses coverage of infertility services as a basic health care service under Chapter 1751 of the Revised Code. This bulletin is consistent with the standards promulgated by the United States Department of Health and Human Services, Health Care Financing Administration (HCFA) at 58 Federal Register 51632 for federally qualified health maintenance organizations.

Basic health care services, as defined at section 1751.01 (A) include the following services when medically necessary:

(1) Physician services;
(2) Inpatient hospital services;
(3) Outpatient medical services;
(4) Emergency health services;
(5) Urgent care services;
(6) Diagnostic laboratory services and diagnostic and therapeutic radiologic services;
(7) Preventative health care services, including but not limited to, voluntary family planning services, *infertility services*, periodic physical examinations, prenatal obstetrical care, and well-child care (emphasis added).

Although infertility services are referenced, such services are subject to the general qualification that they be medically necessary. The department interprets basic health care services with regard to infertility services to mean diagnostic and exploratory procedures to determine infertility including surgical procedures to correct the medically diagnosed disease or condition of the reproductive organs including but not limited to, endometriosis, collapsed/clogged fallopian tubes or testicular failure.

Procedures such as in vitro fertilization ("IVF"), gamete intrafallopian transfer ("GIFT") and zygote intrafallopian transfer ("ZIFT") are not essential for the protection of an individual's health and are therefore not mandated benefits as basic health care services. This does not preclude coverage for these services, it merely states that coverage for these services is not mandatory by law.

Harold T. Duryee
Superintendent