



# Ohio Legislative Service Commission

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## Synopsis of Senate Committee Amendments\*

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### **Sub. H.B. 218**

129th General Assembly  
(S. Insurance, Commerce and Labor)

The Senate Committee added provisions to the bill that made the following changes:

- Consolidates the process of disputing a denied benefit claim and submitting the claim for external review under one chapter and makes conforming changes to bring Ohio law into compliance with federal law and regulations related to external reviews.
- Expands the definition of adverse determination to encompass a larger class of claim denials, including the imposition of exclusions, decisions not to issue health insurance, and decisions to rescind coverage.
- Expands the express requirement for health issuers to have an internal appeal process from health insuring corporations only to sickness and accident insurers and public employee benefit plans.
- Permits an independent review organization to overturn an adverse benefit determination if the health plan issuer does not timely provide specified information.
- Stipulates that the new processes and requirements related to external reviews are effective for those adverse benefit determinations provided on or after January 1, 2012.
- Increases the situations under which health plan issuers must provide notifications to covered individuals and specifies what must be included in these notifications.
- Authorizes de minimis violation of the 30-day, internal appeal exhaustion deadline if it can be demonstrated that the violation does no serious harm to the covered

\* This synopsis does not address amendments that may have been adopted on the Senate Floor.

person and is part of ongoing, good faith communications between the covered person and the health plan issuer.

- Prohibits health plan issuers offering individual health insurance coverage from requiring more than one level of internal review before an external review may be requested.
- Specifies that independent review organizations are not bound by any conclusions reached by the health plan issuer during a utilization review or an internal appeal.
- Enables non-terminal cases involving an experimental or investigational review to be eligible for external review.
- Requires health plan issuers to record data related to requests for external reviews and to report this information to the Superintendent of Insurance upon request.
- Specifies that health plan issuers are required to pay for the costs of an external review, including any secondary external reviews initiated by the Superintendent of Insurance.
- Removes the external review cost threshold of \$500, enabling claims to be eligible for external review, regardless of cost.