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H.B. 133
136th General Assembly

Bill Analysis

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Version: As Reported by House Ways & Means

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SUMMARY

Income tax credit for health reimbursement arrangements

- Authorizes a nonrefundable income tax credit for a small employer that offers an individual coverage health reimbursement arrangement to its employees.

Unfair and deceptive practices

- Modifies and expands the list of prohibited unfair and deceptive insurance practices to include certain underwriting practices that may induce or steer individuals away from an employer-provided health benefit plan.
- Specifies that providing information on tax credits available under the bill related to individual coverage health reimbursement arrangements and assisting an employer in setting up such an arrangement are not unfair and deceptive practices.
- Authorizes the Department of Insurance to impose a civil penalty up to $25,000 plus administrative costs for unfair and deceptive practices that may induce or steer individuals away from an employer-provided health benefit plan.
- Modifies terminology in a continuing unfair and deceptive practice prohibition related to placing coverage for adverse risks with insurers.

DETAILED ANALYSIS

Income tax credit for health reimbursement arrangements

The bill authorizes a nonrefundable income tax credit for certain small employers that offer to their employees an individual coverage health reimbursement arrangement.

An individual coverage health reimbursement arrangement is an employer provided plan that provides employees with a fixed amount that can be used to pay for medical care expenses

rather than providing a traditional health care plan. Expenses that are eligible for reimbursement include health insurance premiums, co-payments, or other out-of-pocket costs.[1] Under the bill, a qualifying taxpayer is an employer of between two and 50 employees that provides an individual coverage health reimbursement arrangement to some or all of those employees, contributing at least $400 annually to the arrangement per employee.

The amount of the credit is calculated by multiplying the number of benefitted employees by $400. The Tax Commissioner may require an employer to provide information necessary to support a claim for the credit. An owner of a pass-through entity that is an employer qualifying for the credit may claim the owner's proportionate share of the credit.[2] Qualifying employers may claim the credit starting in the first taxable year that ends on or after the bill's 90-day effective date.[3]

Unfair and deceptive practices

Employer-provided plans

The bill modifies and expands the list of unfair and deceptive insurance practices prohibited by state law. Under continuing law, changed in part by the bill, the Superintendent of Insurance may impose a variety of sanctions on an insurer that engages in unfair and deceptive practices. Possible sanctions include suspending or revoking the insurer's license, ordering the insurer to make restitution, and imposing a civil penalty. The changes made by the bill are addressed in the table below.

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Prohibits terminating or failing to renew an existing individual policy, contract, or plan of health benefits or a health benefit plan issued to an employer, for which an individual would otherwise be eligible, due solely to any health status-related factor *(R.C. 3901.21(T)(1)(a))*.	Streamlines terminology to an "individual or employer-provided health benefit plan" and expands the prohibition to include plans for which an employer, not just an individual, would be eligible *(R.C. 3901.21(T)(1)(a))*.
Excluding or causing exclusion of an individual from coverage under an existing employer-provided policy, contract, or plan of health benefits due solely to any health status-related factor *(R.C. 3901.21(T)(1)(b))*.	Streamlines terminology to an "employer-provided health benefit plan" *(R.C. 3901.21(T)(1)(b))*.
No provision.	Prohibits steering an individual from coverage under an existing employer-provided health benefit plan to coverage under an individual

[1] 45 Code of Federal Regulations 146.123.

[2] R.C. 5747.87 and 5747.98.

[3] Section 3.

Current Law	H.B. 133
	health benefit plan due solely to any health status-related factor *(R.C. 3901.21(T)(1)(c))*.
No provision.	Prohibits offering employers or individuals financial or other benefits as incentives to not enroll, or terminate enrollment, in an employer-provided health benefit plan, including by offering individuals an alternative to an employer-provided health benefit plan, due solely to any health status-related factor *(R.C. 3901.21(T)(1)(d))*.

The bill specifies that the prohibitions described in the table above do not prohibiting either of the following:

- Providing information to an employer about an individual coverage health reimbursement arrangement or related tax credits available under the bill;
- Establishing, or advising an employer in the establishment of, an individual coverage health reimbursement arrangement.[4]

Penalties

The bill specifies insurers that engage in the unfair and deceptive practices related to employer-provided health benefit plans, described in the table above, are subject to a penalty of up to $25,000 plus administrative expenses incurred by the Ohio Department of Insurance (ODI) in the related investigation and administrative action. Under continuing law, unchanged by the bill, for all unfair and deceptive practices, if ODI finds that any person has engaged in a prohibited practice, ODI is required to issue a cease-and-desist order in relation to the violation. In addition, ODI may impose any or all of the following administrative remedies upon the person:

- Suspension or revocation of the person's insurance license;
- An order that an insurance company or agency not employ or permit the person responsible to serve as a director, consultant, or in any other capacity for such time as the superintendent determines would serve the public interest;
- An order that the person responsible return any payments received by the person as a result of the violation. [5]

Small employer plans

The bill also amends the definitions in another unfair and deceptive practice prohibition. Current law prohibits, with respect to health benefit plans issued to small employers, negligently

[4] R.C. 3901.21(T)(2).

[5] R.C. 3901.22(D)(4).

or willfully placing coverage for adverse risks with a certain carrier. It defines "**small employer**," in connection with a group health benefit plan and with respect to a calendar year and a plan year, an employer who employed an average of at least two but no more than 50 eligible employees on business days and who employs at least two employees on the first day of the plan year. Current law defines "**health benefit plan**" as any hospital or medical expense policy or certificate or any health plan provided by a carrier, that is delivered, issued for delivery, renewed, or used in this state on or after May 24, 1995. Current law defines "**carrier**" as any sickness and accident insurance company or health insuring corporation authorized to issue health benefit plans in this state or a multiple employer welfare arrangement.

The bill maintains this prohibition, but slightly changes the terminology, utilizing definitions found in the Insurance External Review Law. The term "**employer**" is used instead of "**small employer**" and left undefined. "**Health plan issuer**" is used instead of "**carrier**" and the term "**health benefit plan**" is left the same. "**Health plan issuer**" and "**health benefit plan**" are defined as follows:

- "**Health plan issuer**" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Superintendent of Insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. The term includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the Superintendent.

"**Health benefit plan**" means a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including benefit plans marketed in the individual or group market by all associations, whether bona fide or non-bona fide, including a limited benefit plan. The term excludes certain specified forms of coverage.[6]

HISTORY

Action	Date
Introduced	02-24-25
Reported, H. Ways & Means	06-03-25

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[6] R.C. 3901.21(U); R.C. 3922.01(L) and (P), not in the bill.