Ohio Revised Code

Section 1751.16 [Suspended eff. 1/1/2014 to 1/1/2026, per Section 3 of S.B. 9 of the 130th General Assembly, as amended] Option for conversion from group to individual contract.

Effective: October 16, 2009
Legislation: House Bill 1 - 128th General Assembly

(A) Except as provided in division (F) of this section, every group contract issued by a health insuring corporation shall provide an option for conversion to an individual contract issued on a direct-payment basis to any subscriber covered by the group contract who terminates employment or membership in the group, unless:

(1) Termination of the conversion option or contract is based upon nonpayment of premium after reasonable notice in writing has been given by the health insuring corporation to the subscriber.

(2) The subscriber is, or is eligible to be, covered for benefits at least comparable to the group contract under any of the following:

(a) Medicare;

(b) Any act of congress or law under this or any other state of the United States providing coverage at least comparable to the benefits under division (A)(2)(a) of this section;

(c) Any policy of insurance or health care plan providing coverage at least comparable to the benefits under division (A)(2)(a) of this section.

(B)(1) The direct-payment contract offered by the health insuring corporation pursuant to division (A) of this section shall provide the following:

(a) In the case of an individual who is not a federally eligible individual, benefits comparable to benefits in any of the individual contracts then being issued to individual subscribers by the health insuring corporation;

(b) In the case of a federally eligible individual, a basic and standard plan established under section 3924.10 of the Revised Code or plans substantially similar to the basic and standard plan in benefit design and scope of covered services. For purposes of division (B)(1)(b) of this section, the superintendent of insurance shall determine whether a plan is substantially similar to the basic or standard plan in benefit design and scope of covered services. The contractual periodic prepayments charged for such plans may not exceed the amounts specified below:

(i) For calendar years 2010 and 2011, an amount that is two times the base rate charged any other individual of a group to which the organization is currently accepting new business and for which similar copayments and deductibles are applied;

(ii) For calendar year 2012 and every calendar year thereafter, an amount that is one and one-half times the base rate charged any other individual of a group to which the health insuring corporation is currently accepting new business and for which similar copayments and deductibles are applied, unless the superintendent of insurance determines that the amendments by this act to sections 3923.58 and 3923.581 of the Revised Code, have resulted in the market-wide average medical loss ratio for coverage sold to individual insureds and nonemployer group insureds in this state, including open enrollment insureds, to increase by more than five and one quarter percentage points during calendar year 2010. If the superintendent makes that determination, the premium limit established by division (B)(1)(b)(i) of this section shall remain in effect.

(2) The direct payment contract offered pursuant to division (A) of this section may include a coordination of benefits provision as approved by the superintendent.

(3) For purposes of division (B) of this section:

(a) "Federally eligible individual" means an eligible individual as defined in 45 C.F.R. 148.103.

(b) "Base rate" means, as to any health benefit plan that is issued by a health insuring corporation, the lowest premium rate for new or existing business prescribed by the health insuring corporation for the same or similar coverage under a plan or arrangement covering any individual in a group with similar case characteristics.

(C) The option for conversion shall be available:

(1) Upon the death of the subscriber, to the surviving spouse with respect to such of the spouse and dependents as are then covered by the group contract;

(2) To a child solely with respect to the child upon the child's attaining the limiting age of coverage under the group contract while covered as a dependent under the contract;

(3) Upon the divorce, dissolution, or annulment of the marriage of the subscriber, to the divorced spouse, or, in the event of annulment, to the former spouse of the subscriber.

(D) No health insuring corporation shall use age or health status as the basis for refusing to renew a converted contract.

(E) Written notice of the conversion option provided by this section shall be given to the subscriber by the health insuring corporation by mail. The notice shall be sent to the subscriber's address in the records of the employer upon receipt of notice from the employer of the event giving rise to the conversion option. If the subscriber has not received notice of the conversion privilege at least fifteen days prior to the expiration of the thirty-day conversion period, then the subscriber shall have an additional period within which to exercise the privilege. This additional period shall expire fifteen days after the subscriber receives notice, but in no event shall the period extend beyond sixty days after the expiration of the thirty-day conversion period.

(F) This section does not apply to any group contract offering only supplemental health care services or specialty health care services.