Ohio Revised Code

Section 1751.18 Cancelling or failing to renew coverage.

Effective: September 29, 2015
Legislation: House Bill 64 - 131st General Assembly

(A)(1) No health insuring corporation shall cancel or fail to renew the coverage of a subscriber or enrollee because of any health status-related factor in relation to the subscriber or enrollee, the subscriber's or enrollee's requirements for health care services, or for any other reason designated under rules adopted by the superintendent of insurance.

(2) Unless otherwise required by state or federal law, no health insuring corporation, or health care facility or provider through which the health insuring corporation has made arrangements to provide health care services, shall discriminate against any individual with regard to enrollment, disenrollment, or the quality of health care services rendered, on the basis of the individual's race, color, sex, age, religion, military status as defined in section 4112.01 of the Revised Code, or status as a recipient of medicare or medicaid, or any health status-related factor in relation to the individual. However, a health insuring corporation shall not be required to accept a recipient of medicare or medical assistance, if an agreement has not been reached on appropriate payment mechanisms between the health insuring corporation and the governmental agency administering these programs. Further, except for open enrollment coverage under sections 3923.58 and 3923.581 of the Revised Code and except as provided in section 1751.65 of the Revised Code, a health insuring corporation may reject an applicant for nongroup enrollment on the basis of any health status-related factor in relation to the applicant.

(B) A health insuring corporation may cancel or decide not to renew the coverage of an enrollee if the enrollee has performed an act or practice that constitutes fraud or intentional misrepresentation of material fact under the terms of the coverage and if the cancellation or nonrenewal is not based, either directly or indirectly, on any health status-related factor in relation to the enrollee.

(C) An enrollee may appeal any action or decision of a health insuring corporation taken pursuant to section 2742(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-42, as amended. To appeal, the enrollee may submit a written complaint to the health insuring corporation pursuant to section 1751.19 of the

Revised Code. The enrollee may, within thirty days after receiving a written response from the health insuring corporation, appeal the health insuring corporation's action or decision to the superintendent.

(D) As used in this section, "health status-related factor" means any of the following:

(1) Health status;

(2) Medical condition, including both physical and mental illnesses;

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

(7) Evidence of insurability, including conditions arising out of acts of domestic violence;

(8) Disability.