Ohio Revised Code

Section 3923.58 [Suspended eff. 1/1/2014 to 1/1/2026, per Section 3 of S.B. 9 of the 130th General Assembly, as amended] Open enrollment coverage - insurers in the business of issuing individual policies of sickness and accident insurance.

Effective: March 23, 2015
Legislation: House Bill 201 - 130th General Assembly

(A) As used in sections 3923.58 and 3923.59 of the Revised Code:

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

(2) "Carrier," "health benefit plan," and "MEWA" have the same meanings as in section 3924.01 of the Revised Code.

(3) "Network plan" means a health benefit plan of a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier.

(4) "Ohio health care basic and standard plans" means those plans established under section 3924.10 of the Revised Code.

(5) "Pre-existing conditions provision" means a policy provision that excludes or limits coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage as to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received, or a pregnancy existing on the effective date of coverage.

(B) Beginning in January of each year, carriers in the business of issuing health benefit plans to individuals and nonemployer groups, except individual health benefit plans issued pursuant to

sections 1751.16 and 3923.122 of the Revised Code, shall accept applicants for open enrollment coverage, as set forth in this division, in the order in which they apply for coverage and subject to the limitation set forth in division (G) of this section. Carriers shall accept for coverage pursuant to this section individuals to whom both of the following conditions apply:

(1) The individual is not applying for coverage as an employee of an employer, as a member of an association, or as a member of any other group.

(2) The individual is not covered, and is not eligible for coverage, under any other private or public health benefits arrangement, including the medicare program established under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, or any other act of congress or law of this or any other state of the United States that provides benefits comparable to the benefits provided under this section, any medicare supplement policy, or any continuation of coverage policy under state or federal law.

(C) A carrier shall offer to any individual accepted under this section the Ohio health care basic and standard plans or health benefit plans that are substantially similar to the Ohio health care basic and standard plans in benefit plan design and scope of covered services.

A carrier may offer other health benefit plans in addition to, but not in lieu of, the plans required to be offered under this division. A basic health benefit plan shall provide, at a minimum, the coverage provided by the Ohio health care basic plan or any health benefit plan that is substantially similar to the Ohio health care basic plan in benefit plan design and scope of covered services. A standard health benefit plan shall provide, at a minimum, the coverage provided by the Ohio health care standard plan or any health benefit plan that is substantially similar to the Ohio health care standard plan in benefit plan design and scope of covered services.

For purposes of this division, the superintendent of insurance shall determine whether a health benefit plan is substantially similar to the Ohio health care basic and standard plans in benefit plan design and scope of covered services.

(D)(1) Health benefit plans issued under this section may establish pre-existing conditions provisions that exclude or limit coverage for a period of up to twelve months following the individual's effective

date of coverage and that may relate only to conditions during the six months immediately preceding the effective date of coverage. A health insuring corporation may apply a pre-existing condition provision for any basic health care service related to a transplant of a body organ if the transplant occurs within one year after the effective date of an enrollee's coverage under this section except with respect to a newly born child who meets the requirements for coverage under section 1751.61 of the Revised Code.

(2) In determining whether a pre-existing conditions provision applies to an insured or dependent, each policy shall credit the time the insured or dependent was covered under a previous policy, contract, or plan if the previous coverage was continuous to a date not more than sixty-three days prior to the effective date of the new coverage, exclusive of any applicable service waiting period under the policy.

(E) Premiums charged to individuals under this section may not exceed the amounts specified below:

(1) For calendar years 2010 and 2011, an amount that is two times the base rate for coverage offered to any other individual to which the carrier is currently accepting new business, and for which similar copayments and deductibles are applied;

(2) For calendar year 2012 and every year thereafter, an amount that is one and one-half times the base rate for coverage offered to any other individual to which the carrier 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 this section and section 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 (E)(1) of this section shall remain in effect. The superintendent's determination shall be supported by a signed letter from a member of the American academy of actuaries.

(F) In offering health benefit plans under this section, a carrier may require the purchase of health benefit plans that condition the reimbursement of health services upon the use of a specific network of providers.

(G)(1) A carrier shall not be required to accept new applicants under this section if the total number of the carrier's current insureds with open enrollment coverage issued under this section calculated as of the immediately preceding thirty-first day of December and excluding the carrier's medicare supplement policies and conversion or continuation of coverage policies under state or federal law and any policies described in division (L) of this section meets the following limits:

(a) For calendar years 2010 and 2011, four per cent of the carrier's total number of individual or nonemployer group insureds in this state;

(b) For calendar year 2012 and every year thereafter, eight per cent of the carrier's total number of insured individuals and nonemployer group insureds in this state, unless the superintendent of insurance determines that the amendments by this act to this section and section 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 enrollment limit established by division (G)(1)(a) of this section shall remain in effect. The superintendent's determination shall be supported by a signed letter from a member of the American academy of actuaries.

(2) An officer of the carrier shall certify to the department of insurance when it has met the enrollment limit set forth in division (G)(1) of this section. Upon providing such certification, the carrier shall be relieved of its open enrollment requirement under this section as long as the carrier continues to meet the open enrollment limit. If the total number of the carrier's current insureds with open enrollment coverage issued under this section falls below the enrollment limit, the carrier shall accept new applicants. A carrier may establish a waiting list if the carrier has met the open enrollment limit and shall notify the superintendent if the carrier has a waiting list in effect.

(H) A carrier shall not be required to accept under this section applicants who, at the time of enrollment, are confined to a health care facility because of chronic illness, permanent injury, or other infirmity that would cause economic impairment to the carrier if the applicants were accepted. A carrier shall not be required to make the effective date of benefits for individuals accepted under this section earlier than ninety days after the date of acceptance, except that when the individual had

prior coverage with a health benefit plan that was terminated by a carrier because the carrier exited the market and the individual was accepted for open enrollment under this section within sixty-three days of that termination, the effective date of benefits shall be the date of enrollment.

(I) The requirements of this section do not apply to any carrier that is currently in a state of supervision, insolvency, or liquidation. If a carrier demonstrates to the satisfaction of the superintendent that the requirements of this section would place the carrier in a state of supervision, insolvency, or liquidation, or would otherwise jeopardize the carrier's economic viability overall or in the individual market, the superintendent may waive or modify the requirements of division (B) or (G) of this section. The actions of the superintendent under this division shall be effective for a period of not more than one year. At the expiration of such time, a new showing of need for a waiver or modification by the carrier shall be made before a new waiver or modification is issued or imposed.

(J) No hospital, health care facility, or health care practitioner, and no person who employs any health care practitioner, shall balance bill any individual or dependent of an individual for any health care supplies or services provided to the individual or dependent who is insured under a policy issued under this section. The hospital, health care facility, or health care practitioner, or any person that employs the health care practitioner, shall accept payments made to it by the carrier under the terms of the policy or contract insuring or covering such individual as payment in full for such health care supplies or services.

As used in this division, "hospital" has the same meaning as in section 3727.01 of the Revised Code; "health care practitioner" has the same meaning as in section 4769.01 of the Revised Code; and "balance bill" means charging or collecting an amount in excess of the amount reimbursable or payable under the policy or health care service contract issued to an individual under this section for such health care supply or service. "Balance bill" does not include charging for or collecting copayments or deductibles required by the policy or contract.

(K) A carrier may pay an agent a commission in the amount of not more than five per cent of the premium charged for initial placement or for otherwise securing the issuance of a policy or contract issued to an individual under this section, and not more than four per cent of the premium charged for the renewal of such a policy or contract. The superintendent may adopt, in accordance with

Chapter 119. of the Revised Code, such rules as are necessary to enforce this division.

(L) This section does not apply to any policy that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, one-time-limited-duration policy that is less than twelve months, or other policy that offers only supplemental benefits.

(M) If a carrier offers a health benefit plan in the individual market through a network plan, the carrier may do both of the following:

(1) Limit the individuals that may apply for such coverage to those who live, work, or reside in the service area of the network plan;

(2) Within the service area of the network plan, deny the coverage to individuals if the carrier has demonstrated both of the following to the superintendent:

(a) The carrier will not have the capacity to deliver services adequately to any additional individuals because of the carrier's obligations to existing group contract holders and individuals.

(b) The carrier is applying division (M)(2) of this section uniformly to all individuals without regard to any health status-related factors of those individuals.

(N) A carrier that, pursuant to division (M)(2) of this section, denies coverage to an individual in the service area of a network plan, shall not offer coverage in the individual market within that service area for at least one hundred eighty days after the date the carrier denies the coverage.