Ohio Revised Code

Section 3923.581 [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 - carriers in the business of issuing health benefit plans to individuals or nonemployer groups.

Effective: October 16, 2009
Legislation: House Bill 1

(A) As used in this section:

(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," "MEWA," and "pre-existing conditions provision" have the same meanings as in section 3924.01 of the Revised Code.

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

(4) "Health status-related factor" means any of the following:

(a) Health status;

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

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

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

(h) Disability.

(5) "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.

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

(B) Beginning in January of each year, carriers in the business of issuing health benefit plans to individuals or nonemployer groups shall accept federally eligible individuals for open enrollment coverage, as provided in this section, in the order in which they apply for coverage and subject to the limitation set forth in division (J) of this section.

(C) No carrier shall do either of the following:

(1) Decline to offer such coverage to, or deny enrollment of, such individuals;

(2) Apply any pre-existing conditions provision to such coverage.

(D) A carrier shall offer to federally eligible individuals the Ohio health care basic and standard plans or plans substantially similar to the basic and standard plans in benefit design and scope of covered services. For purposes of this division, 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.

(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 calendar 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 3923.58 of the Revised Code, have resulted in a 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) 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 federally eligible 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 federally eligible 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 (F)(2) of this section uniformly to all federally eligible individuals without regard to any health status-related factor of those individuals.

(G) A carrier that, pursuant to division (F)(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 coverage is denied.

(H) A carrier may refuse to issue health benefit plans to federally eligible individuals if the carrier

has demonstrated both of the following to the superintendent:

(1) The carrier does not have the financial reserves necessary to underwrite additional coverage.

(2) The carrier is applying division (H) of this section uniformly to all federally eligible individuals in this state consistent with the applicable laws and rules of this state and without regard to any health status-related factor relating to those individuals.

(I) A carrier that, pursuant to division (H) of this section, refuses to issue health benefit plans to federally eligible individuals, shall not offer health benefit plans in the individual market in this state for at least one hundred eighty days after the date the coverage is denied or until the carrier has demonstrated to the superintendent that the carrier has sufficient financial reserves to underwrite additional coverage, whichever is later.

(J)(1) Except as provided in division (J)(2) of this section, 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 section 3923.58 of the Revised Code 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 3923.58 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 (J)(1)(a) 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 (J)(1) of this section. Upon providing such certification, the carrier shall be relieved of its open enrollment requirement under this section for 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. In the event that all the carriers subject to this section have individually met the enrollment limit set forth in division (J)(1) of this section in a calendar year, carriers shall again accept applicants for open enrollment coverage pursuant to this section, subject to an additional enrollment limit equal to one-half of the limitation set forth in division (J)(1) of this section.

(K) The superintendent may provide for the application of this section on a service-area-specific basis.

(L) The requirements of this section do not apply to any health benefit plan described in division (L) of section 3923.58 of the Revised Code.

(M) 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.