Ohio Revised Code

Section 3924.03 Health benefit plans covering small employers subject to conditions.

Effective: March 22, 1999
Legislation: House Bill 698 - 122nd General Assembly

Except as otherwise provided in section 2721 of the "Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-21, as amended, health benefit plans covering small employers are subject to the following conditions, as applicable:

(A)(1) Pre-existing conditions provisions shall not exclude or limit coverage for a period beyond twelve months, or eighteen months in the case of a late enrollee, following the individual's enrollment date and may only relate to a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six months immediately preceding the enrollment date.

Division (A)(1) of this section is subject to the exceptions set forth in section 2701(d) of the "Health Insurance Portability and Accountability Act of 1996."

(2) The period of any such pre-existing condition exclusion shall be reduced by the aggregate of the periods of creditable coverage, if any, applicable to the employee or dependent as of the enrollment date.

(3) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health benefit plan, if, after that period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage. Subsections (c)(2) to (4) and (e) of section 2701 of the "Health Insurance Portability and Accountability Act of 1996" apply with respect to crediting previous coverage.

(4) As used in division (A) of this section:

(a) "Creditable coverage" has the same meaning as in section 2701(c)(1) of the "Health Insurance Portability and Accountability Act of 1996."

(b) "Enrollment date" means, with respect to an individual covered under a group health benefit plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.

(B)(1) Except as provided in section 2712(b) to (e) of the "Health Insurance Portability and Accountability Act of 1996," if a carrier offers coverage in the small employer market in connection with a group health benefit plan, the carrier shall renew or continue in force such coverage at the option of the plan sponsor of the plan.

(2) A carrier may cancel or decide not to renew the coverage of any eligible employee or of a dependent of an eligible employee if the employee or dependent, as applicable, has performed an act or practice that constitutes fraud or made an 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 employee or dependent.

As used in division (B)(2) of this section, "health status-related factor" has the same meaning as in section 3924.031 of the Revised Code.

(C) A carrier shall not exclude any eligible employee or dependent, who would otherwise be covered under a health benefit plan, on the basis of any actual or expected health condition of the employee or dependent.

If, prior to November 24, 1995, a carrier excluded an eligible employee or dependent, other than a late enrollee, on the basis of an actual or expected health condition, the carrier shall, upon the initial renewal of the coverage on or after that date, extend coverage to the employee or dependent if all other eligibility requirements are met.

(D) No health benefit plan issued by a carrier shall limit or exclude, by use of a rider or amendment applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident, except for pre-existing conditions as permitted under division (A) of this section. If a health benefit plan that is delivered or issued for delivery prior to April 14, 1993, contains such limitations or exclusions, by use of a rider or amendment applicable to a specific individual, the plan shall

eliminate the use of such riders or amendments within eighteen months after April 14, 1993.

(E)(1) Except as provided in sections 3924.031 and 3924.032 of the Revised Code, and subject to such rules as may be adopted by the superintendent of insurance in accordance with Chapter 119. of the Revised Code, a carrier shall offer and make available every health benefit plan that it is actively marketing to every small employer that applies to the carrier for such coverage.

Division (E)(1) of this section does not apply to a health benefit plan that a carrier makes available in the small employer market only through one or more bona fide associations.

Division (E)(1) of this section shall not be construed to preclude a carrier from establishing employer contribution rules or group participation rules for the offering of coverage in connection with a group health benefit plan in the small employer market, as allowed under the law of this state. As used in division (E)(1) of this section, "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of employees and dependents and "group participation rule" means a requirement relating to the minimum number of employees or dependents that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(2) Each health benefit plan, at the time of initial group enrollment, shall make coverage available to all the eligible employees of a small employer without a service waiting period. The decision of whether to impose a service waiting period shall be made by the small employer. Such waiting periods shall not be greater than ninety days.

(3) Each health benefit plan shall provide for the special enrollment periods described in section 2701(f) of the "Health Insurance Portability and Accountability Act of 1996."

(4) At least once in every twelve-month period, a carrier shall provide to all late enrollees who are identified by the small employer, the option to enroll in the health benefit plan. The enrollment option shall be provided for a minimum period of thirty consecutive days. All delays of coverage imposed under the health benefit plan, including any pre-existing condition exclusion period, affiliation period, or service waiting period, shall begin on the date the carrier receives notice of the late enrollee's application or request for coverage, and shall run concurrently with each other.

(F) The benefit structure of any health benefit plan may, at the time of coverage renewal, be changed by the carrier to make it consistent with the benefit structure contained in health benefit plans being marketed to new small employer groups. If the health benefit plan is available in the small employer market other than only through one or more bona fide associations, the modification must be consistent with the law of this state and effective on a uniform basis among small employer group plans.

(G) A carrier may obtain any facts and information necessary to apply this section, or supply those facts and information to any other third-party payer, without the consent of the beneficiary. Each person claiming benefits under a health benefit plan shall provide any facts and information necessary to apply this section.

For purposes of this section, "bona fide association" means an association that has been actively in existence for at least five years; has been formed and maintained in good faith for purposes other than obtaining insurance; does not condition membership in the association on any health status-related factor, as defined in section 3924.031 of the Revised Code, relating to an individual, including an employee or dependent; makes health insurance coverage offered through the association available to all members regardless of any health status-related factor, as defined in section 3924.031 of the Revised Code, relating to such members or to individuals eligible for coverage through a member; does not make health insurance coverage offered through the association available other than in connection with a member of the association; and meets any other requirement imposed by the superintendent. To maintain its status as a "bona fide association," each association shall annually certify to the superintendent that it meets the requirements of this paragraph.