



**S.B. 136**  
125th General Assembly  
(As Introduced)

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**BILL SUMMARY**

- Establishes the Ohio Health Insurance Risk Pool.
- Repeals the annual periods of open enrollment that sickness and accident insurers, health insuring corporations, and MEWAs are required to hold.

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**CONTENT AND OPERATION**

**Repeals open enrollment program**

The Ohio Revised Code currently requires sickness and accident insurers, health insuring corporations, and multiple employer welfare arrangements (MEWA) in the business of selling individual health care policies, contracts, plans,

and agreements to hold an annual period of open enrollment, during which the health carriers are required to accept applicants for health care coverage (R.C. 1751.15, 3923.58, 3923.581, and 3923.59). Insurance premiums are restricted. Applicants for open enrollment policies, contracts, plans, and agreements are accepted in the order in which they apply for coverage, up to limits set by the open enrollment program. Reinsurers are required to reinsure the coverage that the carriers issue during the periods of open enrollment under the Open Enrollment Reinsurance Program (R.C. 3924.11(G)). A number of exceptions, limitations, requirements, prohibitions, and penalties apply to the open enrollment program.

The bill repeals both the open enrollment program and the Open Enrollment Reinsurance Program and creates the Ohio Health Insurance Risk Pool in its place to serve as a means of providing health care coverage to individuals who are unable to obtain affordable health care coverage in any other manner.

### **The Ohio Health Insurance Risk Pool**

#### **Creation of the Ohio Health Insurance Risk Pool; board members**

(secs. 3923.81(A), (E), and (G), 3923.82, and 3923.83)

The bill creates a body corporate and politic to be known as the Ohio Health Insurance Risk Pool ("Pool"), which is deemed to be both an instrumentality of the state and a public corporation.

The Pool is governed by nine board members. Seven of these members are appointed by the Superintendent of Insurance to staggered six-year terms. These board members must consist of:

(1) Two individuals affiliated with an *insurer* admitted and authorized to write *health insurance* in Ohio. One of these individuals must represent domestic insurers (*italicized terms* defined below);

(2) One member of the Ohio Association of Health Underwriters, who is licensed to sell insurance;

(3) One representative of the general public, who is not employed by or affiliated with an insurer, hospital, or health care provider except through the maintenance of personal insurance policies, contracts, or plans, and who reasonably can be expected to qualify for a benefit plan (Under the bill, "benefit plan" refers to the coverage offered by the Ohio Health Insurance Risk Pool to eligible individuals.);

(4) One individual representing health care providers, such as a physician or hospital administrator;

(5) Two representatives of the business community, one representing employers with 5,000 or more employees and one representing employers with less than 5,000 employees.

One of these seven individuals is designated by the Superintendent of Insurance to serve, at the Superintendent's pleasure, as chairperson of the Pool's board of directors.

The final two members of the board of directors are members of the Ohio General Assembly. One member is a Representative serving on the committee in the House of Representatives with jurisdiction over insurance issues, appointed by the chairman of the committee to a term matching the Representative's term of office. One member is a Senator serving on the committee in the Senate with jurisdiction over insurance issues, appointed by the chairman of the committee to a term matching the Senator's term of office.

If a vacancy occurs on the board, the Superintendent of Insurance or committee chair, as appropriate, is responsible for filling the vacancy in the same manner as the original appointment. The appointee is to serve for the duration of the departed member's unexpired term.

The bill requires the Department of Insurance to pay board members \$200 per board meeting, plus travel expenses, from the Department's general operating fund.

Under the bill, board members are not liable, and no cause of action may be brought against board members, for damages resulting from an act or omission of a board member that is taken in good faith in connection with the member's duties and responsibilities on the board.

As used in the bill, "health insurance" means "a sickness and accident insurance policy, health insuring corporation policy, contract, or agreement, or any other individual or group health care policy, plan, contract, or agreement that pays for or furnishes health care services." However, "health insurance" does not include "an individual or group policy, plan, contract, or agreement covering only accident, credit, dental, disability, long-term care, hospital indemnity, fixed indemnity, medicare supplement, specified disease, or vision care; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or a similar law; automobile medical-payment insurance; insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or an employer self-insured health benefit plan to the extent regulated by federal law."

The bill defines an "insurer" as any entity licensed or otherwise authorized to write health insurance in this state, any employer that funds and administers a self-insured employee health benefit plan subject to federal regulation under the Employee Retirement Income Security Act of 1974 ("ERISA"), and stop-loss and reinsurance carriers authorized to provide reinsurance or stop-loss coverage to insurers.

**Plan of operation**

(secs. 3923.81(I) and 3923.84)

The bill requires the Pool's initial board of directors to submit a plan of operation to the Superintendent of Insurance within 180 days after the appointment of the board's last member. The Pool's "plan of operation" consists of the Pool's articles, bylaws, and operating rules. The bill permits the Superintendent to adopt an interim plan of operation if the Pool's board fails to timely submit a plan. If an interim plan of operation is adopted, the plan continues in effect until the board submits and the Superintendent approves a new plan of operation meeting the bill's requirements.

A plan of operation must include provisions governing all of the following:

- (1) The operation of the Pool;
- (2) Selection of a third-party administrator using a competitive bidding process;
- (3) Creation of a fund, managed by the board, for administrative expenses;
- (4) Management and auditing of the Pool's assets and money;
- (5) Development and implementation of a program to publicize the existence of the Pool, the eligibility requirements for obtaining coverage under the Pool, and enrollment procedures;
- (6) Creation of a grievance committee to review complaints presented by applicants to the Pool and by Pool beneficiaries;
- (7) Such matters as are necessary and proper to the board's operation and the board's execution of its powers, duties, and obligations.

Following a hearing on the plan of operation, the bill requires the Superintendent of Insurance to approve the plan if the Superintendent determines that the plan will assure the fair, reasonable, and equitable administration of the

Pool. Reasonable notice of the hearing must be given to all parties in interest. The plan of operation is effective on the date it is approved by the Superintendent.

The board of directors is required to submit an amendment to the plan of operation for the Pool, to the Superintendent of Insurance, whenever the board believes an amendment is necessary to carry out the provisions of the Revised Code governing the Pool. An amendment does not take effect until approved by the Superintendent.

**Authority of the Pool; reports**

(secs. 3923.85(A), (B), and (D), 3923.89(D) to (G), and 3923.92)

The bill allows the Pool to exercise any authority that an insurer authorized to write health insurance in Ohio may exercise under the Revised Code. Without otherwise limiting the Pool's authority, the bill provides that the Pool may do all of the following in connection with its operation:

(1) Provide health benefit coverage and issue health insurance to eligible individuals. The Pool is required to offer at least one benefit plan option that is not subject to any provision of the Revised Code requiring the coverage of specific examinations, treatments, or services, or monetary benefits.

The bill limits the maximum lifetime benefits a beneficiary may receive from the Pool to one million dollars. However, the bill permits the Pool to offer plans with lower maximum lifetime benefits.

(2) Enter into contracts as necessary to its operation. The Pool may contract with other entities for administrative functions, or may contract with similar risk pools in other states with the approval of the Superintendent of Insurance for the joint performance of common administrative functions.

(3) Take civil action, including those actions necessary or proper to recover or collect assessments due to the Pool. The Pool may itself be sued.

(4) Institute any legal action necessary to avoid payment of improper claims, to recover amounts paid by the Pool as a mistake of fact or law, or to recover other amounts due to the Pool. Alternatively, any benefits due to a beneficiary may be reduced by or offset against any payments made to the beneficiary for expenses not covered by their benefit plan. Benefits otherwise payable to a beneficiary are reduced by amounts paid or payable through any other health insurance or health care plan, through workers' compensation coverage, motor vehicle insurance, or under any federal statute or program.

(5) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agent finder fees, claim reserve formulas, and perform any actuarial function appropriate to the operation of the Pool;

(6) Adopt policy forms, endorsements, riders, and application forms;

(7) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in operating the Pool;

(8) Employ and set the compensation of persons needed by the Pool to carry out the Pool's responsibilities and functions;

(9) Contract for stop-loss insurance for risks incurred by the Pool;

(10) Borrow money as necessary to implement the purposes of the Pool;

(11) Issue supplemental policies;

(12) Provide for and employ cost containment measures and requirements, including, but not limited to, pre-admission screening, second surgical opinion, and concurrent utilization case management, for the purpose of making the benefit plan more affordable;

(13) Design, utilize, contract, or otherwise arrange for delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations and health maintenance organizations;

(14) Provide for reinsurance on a facultative (acceptance of individual risks offered by a ceding insurer) or treaty basis (a contract providing for automatic reinsurance).

The Pool's board of directors is required to appoint a grievance committee. Under the bill, an applicant for coverage or an insured is permitted to file a complaint against the Pool with the grievance committee. The grievance committee is required to review the complaint and file a report with the Pool's board following the committee's review. The board is required to retain all written complaints and reports for a minimum of three years after receiving the complaint.

The board of directors is required to make an annual report to the Governor, the Speaker of the Ohio House of Representatives, the President of the Ohio Senate, and the Superintendent of Insurance, no later than the first day of June each year. The report must summarize the activities of the Pool during the preceding calendar year and provide information on the Pool's written and earned premiums, enrollment, administrative expenses, and incurred and paid losses.

### **Administration of the Pool**

(secs. 3923.86 and 3923.89(B))

The Pool's board of directors is required by the bill to select an insurer or a third-party administrator, licensed as such under Ohio's Insurance Law, Title 39 of the Revised Code, to administer the Pool. The board must select the administrator through the competitive bidding process provided for in the Pool's plan of operation. The board of directors is required to establish criteria for evaluating the applicants.

The bill requires the Pool's board of directors to consider all of the following factors when selecting the Pool's administrator: (1) the applicant's ability to manage health insurance, (2) the efficiency of the applicant's claims-paying process, (3) an estimate of the total charges for the applicant's administration of the Pool, (4) the applicant's ability to administer the Pool in a cost-efficient manner, and (5) the applicant's financial condition.

The third-party administrator selected by the board of directors is required to perform those functions relating to the Pool as delegated to it by the board. These functions may include: (1) paying claims, (2) billing, (3) making and distributing claim forms, (4) assisting beneficiaries with regard to the submission of claims, (5) reporting to the board with regard to the operation of the Pool, (6) determining, after the close of each calendar year, the Pool's net written and earned premiums, administrative expenses, and paid and incurred losses, and (7) reporting financial information to the board and the Superintendent of Insurance.

All of the following information must be provided to the beneficiaries of a benefit plan: (1) all applicable and required definitions, (2) a list of exclusions or limitations, (3) a description of covered services, and (4) the deductibles, coinsurance options, and copayment options that are required or permitted under the Pool.

### **Premium rates and risk factors**

(secs. 3923.87 and 3923.89(C))

The bill permits the Pool's board of directors to adjust the Pool's rates and rate schedules for all appropriate risk factors. Established actuarial and underwriting practices must be used to judge any risk factor considered. In setting a standard risk rate the Pool is required to consider the premium rates charged by insurers offering individual health care coverage. A standard risk rate must reflect the projected experience and expense of the coverage provided by the Pool.

The bill requires the initial rates set by the Pool to be at least 125%, but no more than 150%, of the rates established as standard individual rates. Subsequent rates must be set to fully provide for the expected cost of claims, but may not exceed 150% of the rates established as standard individual rates.

All rates must be submitted to the Superintendent of Insurance for the Superintendent's approval prior to use.

In order to preserve the financial integrity of the Pool, the bill permits the board of directors to adjust a benefit plan's deductibles, amounts of stop-loss coverage, and the time periods governing its preexisting condition restrictions. If the board makes such an adjustment, the board must report the adjustment to the Superintendent of Insurance within 30 days of the adjustment, in writing, along with the board's reasons for the adjustment.

**Eligibility for coverage; ineligible individuals**

(sec. 3923.81(B) to (D) and (J), 3923.85(C), 3923.88(A) to (E), and 3923.89(A))

**Eligibility for coverage**

Individuals are eligible for coverage under the bill for a benefit plan if the individual is a *resident* and provides evidence of any of the following:

(1) The individual applied to two or more insurers for health insurance, but was refused or rejected for coverage by those insurers. A rejection for stop-loss, excess loss, or reinsurance coverage does not constitute a rejection for health insurance coverage for this purpose.

(2) The individual only received offers of health insurance with conditional riders.

(3) The individual only received offers of health insurance at rates exceeding the Pool's rate.

(4) The individual has been diagnosed as having one of the medical conditions identified by the Pool's board of directors as automatically qualifying an afflicted individual for coverage. The bill requires the board to create a list of these medical conditions and allows the board to amend the list from time to time as appropriate.

(5) The individual is eligible for coverage under the federal "Health Insurance Portability and Accountability Act of 1996, ["HIPAA"]" 110 Stat. 1955, 42 U.S.C.A. 300gg, as amended, and has maintained health insurance for the previous 18 months, most recently through an employer-sponsored plan, with no

gap in coverage greater than 63 days, and has exhausted any available *COBRA continuation provision* or state continuation benefits. The Pool may not refuse coverage to an individual so eligible.

(6) The individual is eligible for the credit for health insurance costs under section 35 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 35, as amended.

As used in the bill, "COBRA continuation provision" has the same meaning as in section 733 of the federal "Employee Retirement Income Security Act of 1974," 29 U.S.C.A. 1001, et seq. "COBRA" means the "Consolidated Omnibus Budget Reconciliation Act of 1985," 99 P.L. 272. "Resident," as used in the bill, means any of the following: (1) an individual who has been legally domiciled in Ohio for a minimum of one year, (2) an individual who is legally domiciled in Ohio on the date of their application to the Pool and who is eligible for enrollment in the Pool as a result of HIPAA, or (3) an individual who is legally domiciled in Ohio on the date of application to the Pool and who is eligible for the credit for health reinsurance costs under section 35 of the "Internal Revenue Code of 1986," 26 U.S.C.A. 35, as amended.

The *dependents* of any individual eligible for coverage under the bill are also eligible for coverage under a benefit plan. If a child is the primary insured, resident *family members* are also eligible for coverage. As used in the bill, a "dependent" means any of the following: (1) a resident spouse or unmarried child under 19 years of age, (2) a child who is a full-time student under 25 years of age that is financially dependent upon the parent, (3) a child over 19 years of age for whom the parent is obligated to pay child support, (4) a child of any age who is disabled and dependent on the parent. A "family member" includes a parent, grandparent, brother, sister, or child of a dependent residing with the insured.

The Pool is also required to offer coverage that is consistent with individual major medical coverage to every individual who is not eligible for Medicare, operated under the "Social Security Act," 42 U.S.C.A. 301, as amended. With the approval of the Superintendent of Insurance, the Pool's board of directors is required to establish all of the following with regard to individuals eligible under this provision: (1) any required coverage, (2) a minimum of two health benefit products to be offered by the Pool, (3) applicable schedules of benefits, and (4) exclusions to coverage and other limitations on benefits.

Under the bill, eligible individuals may apply to a licensed insurance agent or to the Pool's administrator for coverage under a benefit plan. The Pool's board of directors must pay an agent a minimum of \$100 as a finder's fee for each individual application for coverage received, the amount to be set by the board.



### *Ineligible individuals*

Under the bill, an individual is *not eligible* for coverage under a benefit plan, if, at the time the individual applies for coverage, the individual is covered by health insurance.

An individual is *not eligible* for coverage under a benefit plan if the individual is or later becomes eligible for any other individual or group, private, state, federal, or military, health care benefits, including COBRA continuation benefits, except as follows:

(1) Continuation or conversion coverage may be maintained for the period of time an individual is satisfying any preexisting condition waiting period for coverage under a benefit plan;

(2) If the individual is eligible for the credit for health insurance costs under section 35 of the "Internal Revenue Code of 1986," 26 U.S.C.A. 35, as amended, and has three months of prior creditable coverage as described in section 110(e) of the "Internal Revenue Code of 1986," 26 U.S.C.A. 35, as amended, the requirement of exhaustion of any available COBRA continuation provision or state continuation benefit is waived;

(3) The coverage is employer group coverage, and the individual has been rejected or refused coverage by two or more insurers or has only received offers of health insurance with conditional riders;

(4) The coverage is individual coverage and the individual has been rejected or refused coverage by two or more insurers or has only received offers of health insurance with conditional riders or at rates exceeding the Pool's rates;

An individual is *not eligible* for coverage under a benefit plan if the individual:

(1) Terminated coverage in a benefit plan within the twelve months preceding the date that the application is made;

(2) Is confined in a county jail or imprisoned in a state prison;

(3) Has premiums that are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider;

(4) Previously had coverage in a benefit plan terminated for nonpayment of premiums or fraud.

### **Termination of coverage**

(sec. 3923.88(F) and (G))

The bill provides that coverage under a benefit plan ceases at any of the following times:

(1) On the date an individual is no longer a resident of Ohio, except for a child under 25 years of age who remains financially dependent upon a parent, a child for whom another is obligated to pay child support, or a child of any age who is disabled and dependent upon the parent, unless the individual's coverage is the result of being eligible under "HIPAA";

(2) On the date an individual requests coverage to end;

(3) On the death of the covered individual;

(4) On the date any provision of the Revised Code requires termination of coverage;

(5) Thirty-one days after the Pool sends an inquiry to the individual concerning the individual's eligibility, including an inquiry as to the individual's residence, to which the individual does not reply;

(6) Thirty-one days after the Pool premium becomes due, if the premium remains unpaid;

(7) Whenever the individual ceases to meet the bill's eligibility requirements.

A beneficiary may maintain coverage under a benefit plan, however, during the period the beneficiary satisfies a preexisting condition waiting period for health insurance that is intended to replace the benefit plan's coverage.

### **Benefits restricted for preexisting conditions**

(sec. 3923.90)

Under the bill, the coverage provided by a benefit plan excludes any charges and expenses incurred during the first twelve months following the effective date of coverage with regard to any condition for which medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage. This period of exclusion is reduced by the aggregate of the periods of creditable coverage that were in effect up to a maximum of 63 days before the application for coverage under a benefit plan.

The coverage of a preexisting condition may not be limited if the individual is eligible for enrollment in the Pool as a result of "HIPAA," if the individual has eighteen months of prior creditable coverage, the most recent of which is employer-sponsored, and has exhausted all available COBRA continuation provisions or state continuation benefits.

The coverage of a preexisting condition may not be limited if the individual is eligible for enrollment in the Pool as a result of their eligibility for the credit for health insurance costs under section 35 of the "Internal Revenue Code of 1986," 26 U.S.C.A. 35, as amended, if the individual had three months of prior creditable coverage as of the date the individual seeks to enroll in the Pool, not counting any period prior to a 63-day break in coverage.

### Assessments

(sec. 3923.91)

The board of directors of the Pool is required by the bill to assess insurers monthly for such amounts as the board finds necessary to fund the operation of the Pool. In setting the amount of the assessment, the board must consider the Pool's actual and expected losses, actuarially appropriate reserves for the Pool, and administrative expenses in excess of expected and collected premiums and federal loss reimbursements, if any, received by the Pool. An assessment is due on a date specified by the board, not less than 30 days after the board notifies an insurer of the amount of the assessment and the due date. An unpaid assessment accrues interest at 12% per annum on and after the due date.

Notwithstanding the above, the bill prohibits the Pool from assessing an insurer in an amount exceeding \$2 per month for each individual with a health insurance policy, contract, or agreement, certificate of group health insurance, or stop-loss or reinsurance contract, in force with the insurer. The Pool may not impose any additional assessment on the insurer, either directly or indirectly. The insurer is permitted to pass on the cost of the assessment to the insurer's policy, contract, or certificate holders. Each insurer that obtains excess or stop-loss insurance must include in its count of covered individuals all individuals whose coverage is insured by the company in whole or part. The Pool's board of directors is required to make reasonable efforts to ensure that each covered individual is counted only once with respect to any assessment imposed on an insurer. The board may use any reasonable method for estimating the number of covered individuals of an insurer if a specific number is unknown. The board may verify an insurer's assessment based on the annual statements and other reports required by the board. A reinsurer may exclude from its count of covered individuals those individuals who have been counted by their primary insurer or

by a primary reinsurer or a primary excess or stop-loss insurer for the purpose of determining that company's assessment.

If assessments and other receipts by the Pool, board, or administering party, exceed the Pool's actual losses and administrative expenses, the excess receipts are held at interest and must be used by the board to offset future losses or to reduce plan premiums. Future losses include reserves for claims incurred but not reported.

The bill requires the Superintendent of Insurance to adopt rules under the Administrative Procedure Act, providing the procedures, criteria, and forms needed to implement, collect, and deposit the assessments made by the board. The Superintendent may suspend or revoke, after notice and hearing, an insurer's license to engage in the business of insurance if the insurer fails to pay an assessment, or may levy a fine not to exceed 5% of the unpaid assessment per month.

### **Supervisory activities of the Superintendent of Insurance and Auditor of State**

(secs. 3923.93 and 3923.94)

The Auditor of State is required by the bill to audit and report on the affairs of the Pool at least once each year. The report must include the results of a financial audit and an economy and efficiency audit. The Auditor must ascertain the expenses incurred in the audit and certify the amount to the Pool's board of directors for reimbursement. The reimbursement is then deposited into the Ohio General Revenue Fund.

The Superintendent of Insurance is authorized under the bill to adopt rules, pursuant to the Administrative Procedure Act, to implement the creation and operation of the Ohio Health Insurance Risk Pool, including, as necessary, rules assigning additional powers and duties to the board of directors.

### **Applicability of bill to preexisting obligations**

Sections 3, 4, and 5 of the bill repeal Ohio's open enrollment program effective June 1, 2005, but the repeal does not effect existing obligations to those individuals with open enrollment coverage obtained prior to the repeal. The bill applies to health care policies, contracts, and agreements delivered, issued for delivery, or renewed on or after January 1, 2004. Assessments apply to all applicable insurance policies in force beginning January 1, 2004. Coverage under the Ohio Health Insurance Risk Pool must be made available no later than June 1,

2004, for individuals eligible for coverage under the "Trade Adjustment Assistance Act of 2002," and no later than June 1, 2005, for all other applicants.

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## **HISTORY**

ACTION	DATE	JOURNAL ENTRY
Introduced	10-14-03	p. 1088

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