

Ohio Association of Health Underwriters

Legislative Update

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ODI unveils draft Open Enrollment Rule

In preparation for the January 1, 2010 start date of Ohio's new open enrollment law, the Ohio Department of Insurance has prepared a draft rule which provides guidance to carriers as to what they must do to provide easy access to open enrollment information to consumers and agents. The initial draft had no reference to agents, so OAHU worked with ODI to make changes to the rule to reflect to the agent's role in representing consumers in the open enrollment process. Key provisions of the rule include:

- Requirements on carriers:
 - Toll free number available to public by 12/1/09
 - Open enrollment webpage by 1/1/10 that includes a table of premium rates so that a consumer can calculate the maximum premium that would be charged to a person of the same age, gender, geographic location and plan selection.
- Carrier shall inform applicant that is denied coverage of the availability of open enrollment coverage with that carrier.
- Applications must be available on-line and carrier must provide an on-line contact person who shall answer queries within 2 business days.
- Carrier must notify applicant, or agent of record, of acceptance or rejection of the application within five business days of receipt of a completed application.

- Carriers must include on webpage:
 - That open enrollment begins 1/1/10 and will remain open until carrier's statutory limit is reached;
 - Clear explanation of FEI and non-FEI, including eligibility requirements for each open enrollment product offered, the differences between the Basic and Standard Plans, and any other open enrollment offered.
 - Any pre-existing condition limitations.
 - Provide information regarding whether the carrier maintains a waiting list and the process of getting on the waiting list.

Below is the text of the draft rule. ODI will file the rule with the Joint Committee on Agency Rule Review in the near future.

OAC 3901-8-XX – Open enrollment

(A) Purpose

The purpose of this rule is to implement the open enrollment statute, Section 3923.58 and 3923.581 of the Revised Code, as recently amended on October 16, 2009, for open enrollment years starting January 1, 2010. This rule requires carriers to provide information to consumers, insurance agents and to the superintendent, pursuant to Section 3923.582 of the Revised Code. The open enrollment requirements in this rule apply to any carrier that is in the business of issuing health benefit plans to individuals and/or non-employer groups.

(B) Authority

This rule is promulgated pursuant to the authority stated in Sections 3901.041 and 3923.582 of the Revised Code.

(C) Advertisement of open enrollment coverage

Carriers subject to the requirement to provide open enrollment coverage under Section 3923.58 and 3923.581 of the Revised Code shall comply with the following steps by the dates specified.

1. Each carrier shall provide to the Superintendent by November 1, 2009, a toll free number that will be used to accept public inquiries on open enrollment coverage. The carrier shall make this number available to the public, beginning December 1, 2009.
2. The toll free number will be answered during the carrier's normal business hours.
3. Each carrier shall develop a webpage, by January 1, 2010, providing notice of the availability of the open enrollment coverage being offered pursuant to the terms of this rule. The open enrollment webpage must be easily accessible to visitors to the home page of the carrier's website.
4. The webpage shall include a table of premium rates to enable a consumer to calculate the maximum premium that would be charged to a person of the same age, gender, geographic location and plan selection.
5. The webpage shall be available at all times and kept as current as possible.
6. A carrier shall inform an applicant that has been denied other health coverage by that carrier of the availability of open enrollment coverage with that carrier.
7. Each carrier shall make coverage applications available on-line for consumers or insurance agents to fill out or print and mail to the company. Carriers shall also provide an on-line contact person who shall answer queries within 2 business days.

Carriers must notify applicants, or their agents of record, of the acceptance or rejection of their application within five business days of receipt of a completed application. Carriers may adjust the terms of coverage as necessary in the event subsequent receipt of relevant documents requires. If the carrier offers coverage subject to a waiting period under ORC 3923.581, the first day of the waiting period shall be the date of receipt of the completed application. No carrier may require enrollment to be made in person. Carriers may accept

applications for coverage on-line, by phone or by mail. A representative of the carrier may contact an agent or applicant who has submitted an application in order to explain the operations of the carrier and to answer any questions the agent or applicant may have. Every carrier shall make open enrollment applications and solicitation documents readily available to any potential agent or applicant who requests such material.

8. The following information shall be made available on the carrier's web page:
 - (a) Open enrollment will begin on January 1 of each year and will remain open until the carrier has reached its statutory limit;
 - (b) A clear explanation of Federally Eligible Individuals ("FEI") and non-FEI individuals including the eligibility requirements for each open enrollment product offered by the carrier; the differences between the Basic and Standard Plan and any other open enrollment coverage offered. A carrier may use Appendix A to this rule to satisfy this requirement;
 - (c) Under what circumstances an eligible applicant or the applicant's dependents may be subject to a preexisting condition limitation;
 - (d) The address and website where a person may obtain an application, if different from the open enrollment website;
 - (e) The telephone number that a customer may call and hours of operation and an e-mail address in order to request an application or to ask questions;
 - (f) The date the first payment will be due;
 - (g) A rate calculator or a page that would allow a consumer to calculate the actual or maximum premium that would be charged to a person of the same age, gender, geographic location and plan selection; if the rate provided is the maximum rate, the webpage shall explain in what circumstances the actual rate will vary;
 - (h) Information regarding the carrier's waiting list, if the carrier maintains one; the process of getting on the waiting list; and the process by which the carrier shall notify applicants of enrollment decisions.

9. Information regarding open enrollment must be easily accessible to callers of the toll free telephone number. Persons answering the toll free telephone number must be adequately trained and informed about the open enrollment process. In addition to the information required in #8 above, persons answering the toll free number must be able to answer customer questions and provide the actual rate, or the maximum rate, that will be applicable to the eligible applicant for all open enrollment products offered by the carrier.
10. No carrier may employ any scheme, plan, or device that restricts the ability of any person to enroll during open enrollment.
11. The carrier shall electronically certify on a form prescribed by the superintendent if and when it has met the enrollment limit. In addition, the carrier shall provide a status update to the superintendent with regard to any waiting list, if the carrier maintains a waiting list, on the 5th business day of the month for the previous month. The status update must also report when the carrier reopens enrollment in order to maintain its enrollment limit. A carrier that does not maintain a waiting list must explain to the superintendent how it will maintain its enrollment limit as current enrollees drop off.
12. The superintendent will provide on the Department of Insurance website a common access point for open enrollment information. The following information may be included:
 - (a) Carriers' toll free numbers;
 - (b) Links to carriers' open enrollment webpage;
 - (c) Whether a carrier's open enrollment program is open or closed;
 - (d) Other information as the superintendent deems appropriate.

(D) Reporting and data collection requirements for open enrollment

1. Carriers subject to the requirement to provide open enrollment coverage under Section 3923.58 and 3923.581 of the Revised Code shall provide data to the superintendent as requested.
2. Carriers are requested to file the data that is enumerated in Section 3923.022(C)(1)(a) through (c) and (e) of the Revised Code. It should be separately reported for the carrier's non-open enrollment policies and the open enrollment policies. This data should include:
 - (a) The amount of premiums earned by the carrier both before and after any costs related to the carrier's purchase of reinsurance coverage;

- (b) The total amount of claims for losses paid by the carrier both before and after any reimbursement from reinsurance coverage
 - (c) The amount of any losses incurred by the carrier but not reported by the carrier in the current or prior year; and
 - (e) The amount of costs incurred by the carrier for reinsurance coverage.
3. Carriers are to report this data electronically for calendar year 2009 and every year thereafter. The non-open enrollment policies include coverage sold to individual insureds or enrollees and non-employer group insureds or enrollees in this state. The open enrollment data should be reported separately for Federally Eligible Individual policies and non-Federally Eligible Individual policies. Federally Eligible Individual has the same meaning as in Section 3923.581 of the Revised Code.
 4. Carriers shall file this data electronically by April 1st of each year, starting with April 1, 2010.

ODI Issues Bulletin regarding Loss of Personal Information

Over the past several months OAHU has worked with other stakeholders and the Ohio Department of Insurance (ODI) concerning the situations in which insurers and agents should be required to notify ODI when a loss of personal information occurs. As a result of these discussions, ODI has issued a Bulletin that requires both insurers and agents to report the loss of a policyholder's personal information to ODI when the loss involves more than 250 residents of Ohio. Below is the Bulletin which becomes effective on November 2, 2009.

Bulletin 2009-12

Loss of Control of Policyholder Information

Effective Date: November 2, 2009

Policyholders and applicants are required to provide personal information ("Personal Information") to insurance companies. As such, this Personal Information is provided with a reasonable expectation that the insurance company will take all prudent and reasonable steps necessary to protect that information. In addition, this information is a valuable asset of the insurance company, and any loss of such information ("Loss of Control") is a serious matter that could involve considerable cost to the company. Therefore, there is an expectation that an insurance company which has suffered a theft or loss of monetary assets advise the Department. That expectation also applies to the theft or loss of policyholder's Personal Information.

Pursuant to O.R.C. Section 3901.07, all persons or entities holding a license or certificate of authority from the Superintendent of Insurance to conduct business within this state are required to report any Loss of Control of policyholder information within their possession to the Superintendent of Insurance

within fifteen calendar days of discovery of such Loss of Control. This reporting requirement shall apply in situations involving the loss of Personal Information of more than 250 residents of Ohio. Such report will be deemed a work paper and treated as required by O.R.C. Section 3901.48.

This reporting obligation extends to any Loss of Control by an agent appointed by such entity pursuant to O.R.C. Section 3905.20. The entity appointing such agent is responsible for educating that agent with respect to this obligation.

“Personal Information” means an individual’s name, consisting of the individual’s first name or first initial and last name, in combination with:

- a social security number, or
- a driver’s license number or state identification number, or
- a bank/credit/debit card or account number.

“Loss of Control” means the unauthorized access to, unauthorized acquisition of, or disappearance of any Personal Information, including with respect to computerized data the unauthorized access to and/or acquisition of that computerized data that compromises the security or confidentiality of Personal Information.

Mary Jo Hudson
Superintendent of Insurance

Newly Introduced Legislation

H.B. 310 (Garland & Driehaus) – Prostheses Coverage

Representatives Nancy Garland (D-New Albany) and Denise Driehaus (D-Cincinnati) introduced H.B. 310 on October 13, 2009 to require health insurers to provide coverage for prostheses benefits that are at least equal to the benefits provided under the Medicare program.

H.B. 300 (Dyer & Hottinger) – Insurance Agent Licensure

On October 6, 2009 Representatives Steve Dyer (D-Uniontown) and Jay Hottinger (R-Newark) introduced H.B. 300 to bring Ohio law into to compliance with national standards established by the National Association of Insurance Commissioners (NAIC) to provide uniformity in agent licensure and oversight. 46 other states have already adopted these standards. The bill was proposed after significant input from the Insurance Agent Education Advisory Council. Diane Oliver is OAHU’s representative on the Council. The bill is scheduled for its first hearing in the House Insurance Committee on October 14th.

H.J.R. 3 (Maag & Sears) – Health Care Constitutional Amendment

On August 26, 2009 Representatives Ron Maag (R-Lebanon) and Barbara Sears (R-Sylvania) introduced House Joint Resolution 3 to amend Ohio's Constitution to prohibit a law or rule from compelling a person, employer, or health care provider to participate in a health care system. The bill has been referred to the House Insurance Committee.

S.B. 159 (R. Miller) – Health Insurer Prohibition

Senator Ray Miller (D-Columbus) introduced S.B. 159 on August 6, 2009 to prohibit health insurers from denying payment for a service during or after the performance of the service if the insurer provided prior authorization for the service. The bill has been referred to the Senate Insurance, Commerce, & Labor Committee.

H.B. 256 (Gardner) – Small Business Health Care

On July 23, 2009 Representative Randy Gardner (R-Bowling Green) introduced H.B. 256 to create the Small Business Health Care Affordability Task Force to look at tax incentives for businesses, incentives for businesses to offer health wellness and disease prevention programs, what other states are doing in this area, and consider federal legislation regarding the provision of health insurance by small businesses and then report its findings and any recommendations to the Speaker and Minority Leader of the House, the president and Minority leader of the Senate and governor not later than six months following its initial organizational meeting. The Task Force is comprised of three House and three Senate members and up to five additional members who represent small business employers or employees or who are otherwise relevant to the duties of the Task Force. The bill has been referred to the House Insurance Committee.

S.B. 154 (Patton) – Pharmacy Benefit Manager Prohibition

On July 8, 2009 Senator Tom Patton (R-Strongsville) introduced S.B. 154 to prohibit a pharmacy benefit manager that has a relationship (ownership or under their control) with a retail pharmacy from using that relationship to the competitive disadvantage of other retail pharmacies, including allowing coverage of covered drugs dispensed by that retail pharmacy but not by other retail pharmacies. The bill has been referred to the Senate Insurance, Commerce & Labor Committee.

H.B. 198 (Lehner & Ujvagi) – Medical Home Demonstration Project

On June 2, 2009 Representatives Peggy Lehner (R-Kettering) and Peter Ujvagi (D-Toledo) introduced H.B. 198 to establish the Medical Home Model Demonstration Project and to provide for Choose Ohio First Scholarships to be awarded to medical students who agree to practice primary care in Ohio. The legislation contemplates the demonstration project being conducted in Montgomery and Lucas Counties. The bill has received two hearings in the House Healthcare Access & Affordability Committee.

H.B. 240 (Sears) – Medicaid Program

On June 23, 2009 Representative Barbara Sears (R-Sylvania) introduced H.B. 240 to require ODJFS to do the following things: (1) Issue a report on its efforts to minimize waste, fraud and abuse, (2) Create an alternative care management program, (3) create a disease management component of Medicaid and (4) impose a surety bond requirement on certain Medicaid providers. In addition, the bill requires local Medicaid agencies to report their costs associated with operating the Medicaid program. The bill has been referred to the House Health Committee.

S. B. 136 (R. Miler) - Telemedicine

On June 16, 2009 Senator Ray Miller (D-Columbus) introduced H.B. 136 to require health insurers and the Medicaid program to provide coverage for telemedicine services in the same manner that coverage is provided for face-to-face consultations. The bill has been referred to the Senate Insurance, Commerce & Labor Committee.

S.B. 137 (R. Miller) – Prompt Pay

Senator Ray Miller (D-Columbus) introduced S.B. 137 on June 16, 2009 to specify that Ohio’s prompt pay law applies to Medicaid Managed Care Plans. The bill has been referred to the Senate Health, Human Services & Aging Committee.

S.B. 138 (R. Miller) – Cancer Medications

On June 16, 2009 Senator Ray Miller introduced S.B. 138 to require health insurers that provide coverage for cancer chemotherapy treatment to provide coverage for certain prescribed, orally administered anti-cancer medications on a basis no less favorable than intravenously administered or injected cancer medications that are covered under the health insurance policy. The bill has been referred to the Senate Insurance, Commerce & Labor Committee.

S.B. 133 (Gillmor) H.B. 237 (Newcomb) – (Cancer Medications)

On June 10, 2009 and June 23, 2009 Senator Karen Gillmor (R-Tiffin) and Representative Deborah Newcomb (D-Conneaut) introduced S.B. 133 and H.B. 237, respectively, which would do the following:

- (1) Prohibit health insurance contracts that provide coverage for cancer chemotherapy treatment from providing coverage for a prescribed, orally administered cancer medication on a less favorable basis than coverage for intravenously administered or injected cancer medications.
- (2) Prohibit health insurance contracts that provide coverage for non-self-injectable medications, medications that must be compounded immediately prior to administration, or both, from doing either of the following:
 - a. Requiring an enrollee to take possession of such a medication from a pharmacy that is a retail seller, or
 - b. Giving an enrollee the option of having such a medication delivered directly to the enrollee by mail or any means of commercial shipment.

S.B. 133 has been referred to the Senate Insurance, Commerce & Labor Committee and H.B. 237 has been referred to the House Healthcare Access & Affordability Committee.

Active Pending Legislation

H.B. 122 & S.B. 98 (Boyd & T. Patton) – Physician Designations Protections

On April 4 and April 8, 2009, Representative Barbara Boyd (D-Cleveland Heights) and Senator Tom Patton (R-Strongsville), introduced H.B. 122 and S.B. 98, respectively, to place various requirements on health insurers that operate a system for physician designations including what must be considered in the evaluations, disclosure requirements, appeal rights and legal remedies against an insurer if a provider is adversely affected by a violation of the requirements. H.B. 122 is scheduled for a possible vote in the House Health Committee on October 12th and S.B. 98 has been referred to the Senate Insurance, Commerce & Labor Committee.

H.B. 8 (Celeste & Garland) – Autism Coverage

Representatives Ted Celeste (D-Grandview Heights) and Nancy Garland (D-New Albany) introduced H.B. 8 to prohibit health insurers from excluding coverage for specified services for individuals diagnosed with autism spectrum disorder. This legislation is one of the priority bills for the House Democrat Caucus. The bill passed out of the House Healthcare Access & Affordability Committee on March 31st. Provisions similar to H.B. 8 were included in the House-passed version of the budget bill but were removed in the Senate and were not included in the final version of the budget.

H.B. 81 (Boyd & Gardner) Diabetes Coverage Mandate

On March 18, 2009 Representatives Barbara Boyd (D-Cleveland Heights) and Randy Gardner (R-Bowling Green) introduced H.B. 81 to require health insurers to provide coverage for diabetes supplies, equipment, medications and education. The bill passed out of the House Health Committee on June 16, 2009.

H.B. 185 (DeGeeter & Book) – Material Amendments to Contracts

On May 19, 2009 Representatives Tim DeGeeter (D-Parma) and Todd Book (D-Portsmouth) introduced H.B. 185 to specify that a material amendment to a health care contract does not become part of the contract unless agreed upon by both parties. The bill passed out of the House Civil & Commercial Law Committee on June 30, 2009.

S.B. 89 (Morano) – Advanced Practice Nurses Prescriptive Authority

On April 1, 2009 Senator Sue Morano (D-Lorain) introduced S.B. 89 to authorize out-of-state advanced practice nurses with prescriptive authority to obtain prescriptive authority in Ohio without completing an externship if they meet certain criteria. The bill passed the Senate on July 13, 2009.

Cancer Related Legislation

H.B. 134, H.B. 135, & H.B. 136 (DeBose) – Mandatory Offering – Cancer Screenings

On April 16, 2009 Representative Michael DeBose (D-Cleveland) introduced three bills relating to various cancer screenings. All three bills would require that insurers offer to provide, as a supplemental health care service, benefits for the expenses of examinations and laboratory test for certain cancers. The offering must be to “any nonsymptomatic individual” and the examinations and tests offered must be in accordance with the most recently published American Cancer Society Guidelines. H.B. 134 relates to prostate, colorectal, ovarian and cervical cancer screenings; H.B. 135 relates to prostate cancer screenings; and H.B. 136, which also has Representative Lorraine Fende (D-Willowick) as a principal sponsor, relates to ovarian cancers screenings. All three bills have received sponsor testimony in the House Healthcare Access & Affordability Committee.

H.B. 51 (Miller) – Breast Cancer

Representative Eugene Miller (D-Cleveland) introduced H.B. 51 on February 26, 2009 to create the Triple Negative Breast Cancer Commission. The commission would promote the study of this cancer which is defined as “the subtype of breast cancer characterized by cells that lack receptors for the hormones estrogen and progesterone and the protein receptor known as the human epidermal growth factor receptor2, or HER2, and therefore cannot be treated with breast cancer drugs that target these receptors, including such drugs as tamoxifen and trastuzumab”. The bill has been referred to the House Health Committee.

H.B. 56 (Miller) – Colorectal Cancer Screenings

On March 3, 2009 Representative Eugene Miller (D-Cleveland) introduced H.B. 56 to require health insurers to provide benefits for colorectal exams and laboratory tests for cancer in accordance with the most recent published guidelines of the American Cancer Society. The bill received its second hearing in the House Insurance Committee on May 20th.

S.B. 64 – (Coughlin) - Colorectal Cancer Screenings

Senator Kevin Coughlin (R-Cuyahoga Falls) introduced S. B. 64 on March 4, 2009 to require health insurers to cover colorectal cancer screenings. The bill, which is the same as S.B. 278 which passed the Senate last session, specifies the specific colorectal cancer screenings which insurers must cover. The bill has been referred to the Senate Insurance, Commerce & Labor Committee.

Other Pending Legislation

H.B. 125 (Williams) – Establish Family Health Plus Component of Medicaid Program

On April 8, 2009 Representative Sandra Williams (D-Cleveland) introduced H.B. 125 to require the Director of Job and Family Services to seek a federal Medicaid waiver to establish the Family Health Plus component of the Medicaid program, and imposes an assessment on hospitals to help fund the program. The program establishes criteria to allow individuals 18 – 64 whose income or resources exceed the Medicaid program’s eligibility requirements to qualify for health care coverage under the Medicaid Family Plus component. The bill has been referred to the House Healthcare Access & Affordability Committee.

H.B. 146 (Hagan) – Authorize Counties to Participate in State Employee Plan

On April 22, 2009 Representative Bob Hagan (D-Youngstown) introduced H.B. 149 to authorize county officers and employees to participate in the state employee health insurance plan sponsored by the Ohio Department of Administrative Services. The bill has been referred to the House Insurance Committee.

H.B. 159 (Skindell & Hagan) – Establish Government-run Health Insurance System

Representatives Michael Skindell (D-Lakewood) Bob Hagan (D-Youngstown) jointly introduced H.B. 159 to establish a single-payer health care system for Ohio. The bill has received sponsor testimony in the House Healthcare Access & Affordability Committee.

S.B. 15 (D. Miller) – Enhanced Mental Health Parity

On February 10, 2009 Senator Dale Miller (D-Cleveland) introduced S.B. 15, the “enhanced mental health parity” legislation that mandates coverage for the diagnosis and treatment of all mental illnesses and substance abuse and drug addictions. It has been referred to the Senate Health, Human Services & Aging Committee.

S.B. 25 (Schaffer) – Deductibility of Medical Expenses

On February 10, 2009 Senator Tim Schaffer (R-Lancaster) introduced S.B. 25 to authorize the deduction of unreimbursed medical expenses to the extent the expenses exceed 1% of federal adjusted gross income. The current standard is unreimbursed expenses that exceed 7.5%. The bill received sponsor testimony in Senate Ways & Means & Economic Development Committee on February 18th.

S.B. 34 (D. Miller) – Group Health Insurance

Senator Dale Miller (D-Cleveland) introduced S.B. 34 on February 10, 2009 to require the Ohio Department of Administrative Services to create a health insurance program that allows municipalities, small employers and nonprofit corporations or associations to purchase for their employees the same policies provided to state employees. The bill has been referred to the Senate Insurance, Commerce & Labor Committee.

S.J.R. 2 (Coughlin) – Health Care Resolution

On February 24, 2009 Senator Kevin Coughlin (R-Cuyahoga Falls) introduced Senate Joint Resolution 2 to enact Section 43 of Article II of the Ohio Constitution to provide rights to people to enter into private contracts with health care providers for health care services and to purchase private health care coverage. The resolution has been referred to the Senate Insurance, Commerce & Labor Committee.