As Introduced

134th General Assembly
Regular Session
2021-2022

S. B. No. 139

Senator Lang
Cosponsor: Senator Romanchuk

A BILL

To amend sections 1739.02, 1739.05, 1739.12, 1739.13, and 3924.01 of the Revised Code to amend the law regulating multiple employer welfare arrangements.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 1739.02, 1739.05, 1739.12, 1739.13, and 3924.01 of the Revised Code be amended to read as follows:

Sec. 1739.02. (A) The following groups that have been organized and maintained in good faith ~~for a continuous period of five years or more for purposes~~, provided that the group has one substantial business purpose other than obtaining insurance, may establish, maintain, or operate a group self-insurance program under a multiple employer welfare arrangement that is chartered and created in this state under sections 1739.01 to 1739.22 of the Revised Code:

(1) A chamber of commerce;

(2) A trade association;

(3) An industry association;

(4) A professional association;

(5) A voluntary employee beneficiary association that is exempt from taxation by the internal revenue service under section 501(c)(9) of the Internal Revenue Code of 1986, as amended;

(6) A business league that is exempt from taxation by the internal revenue service under section 501(c)(6) of the Internal Revenue Code of 1986, as amended;

(7) An association of employers with a principal office located within the borders of this state or with a principal office within a metropolitan area that has boundaries in this state;

(8) Any other association that the superintendent of insurance may define by rule.

(B) Except as provided in section 9.833 and sections 1739.01 to 1739.22 of the Revised Code, no multiple employer welfare arrangement or other entity by which two or more employers jointly participate in a common employee welfare benefit plan shall operate a group self-insurance program in this state after four months after April 9, 1993.

(C) Sections 1739.01 to 1739.22 of the Revised Code do not apply to any entity that establishes, maintains, or operates a fully insured program.

(D) No person shall establish, operate, or maintain a multiple employer welfare arrangement providing benefits through a group self-insurance program in this state unless the multiple employer welfare arrangement has a valid certificate of

authority from the superintendent of insurance.

Sec. 1739.05. (A) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program may be established only if any of the following applies:

(1) The arrangement has and maintains a minimum enrollment of three hundred employees of two or more employers.

(2) The arrangement has and maintains a minimum enrollment of three hundred self-employed individuals.

(3) The arrangement has and maintains a minimum enrollment of three hundred employees or self-employed individuals in any combination of divisions (A)(1) and (2) of this section.

(B)(1) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program shall comply with all laws applicable to self-funded programs in this state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 3901.491, 3902.01 to 3902.14, 3923.041, 3923.24, 3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.602, 3923.63, 3923.80, 3923.84, 3923.85, 3923.851, 3923.86, 3923.87, 3923.89, 3923.90, 3924.031, 3924.032, and 3924.27 of the Revised Code.

(2) A self-insured multiple employer welfare arrangement shall be deemed a single large employer for the purposes of complying with division (B)(1) of this section, as applicable.

(C) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall solicit enrollments only through agents or solicitors licensed pursuant to Chapter 3905. of the Revised Code to sell

or solicit sickness and accident insurance.

(D) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall provide benefits only to individuals who are members, employees of members, or the dependents of members or employees, or are eligible for continuation of coverage under section 1751.53 or 3923.38 of the Revised Code or under Title X of the "Consolidated Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 U.S.C.A. 1161, as amended.

(E) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code is subject to, and shall comply with, sections 3903.81 to 3903.93 of the Revised Code in the same manner as other life or health insurers, as defined in section 3903.81 of the Revised Code.

Sec. 1739.12. (A) The excess loss funding program of a multiple employer welfare arrangement operating a group self-insurance program shall be filed with the superintendent of insurance.

(B) As a condition to the issuance and maintenance of a certificate of authority, a multiple employer welfare arrangement operating a group self-insurance program shall purchase individual stop-loss insurance from insurers authorized to transact business in this state ~~with a deductible retention of no more than five per cent of the arrangement's annual aggregate premium up to one million dollars and no more than two and one-half per cent of the arrangement's annual aggregate premium above that amount~~ with a retention level determined in accordance with sound actuarial principles and approved in rule by the superintendent. The arrangement also shall purchase, as a condition to the issuance and maintenance of a certificate of

authority, aggregate stop-loss insurance from insurers authorized to transact business in this state with a deductible retention of no more than one hundred twenty-five per cent of its projected claims for the succeeding fiscal year.

(C) Any excess or stop-loss insurance policy purchased by a multiple employer welfare arrangement shall provide that the superintendent must be notified by the arrangement of the cancellation of the policy for any reason, including the failure of the arrangement to pay any applicable premium.

(D) No excess or stop-loss insurance policy purchased by a multiple employer welfare arrangement shall ~~do any of the following~~ deny excess or stop-loss insurance coverage to an individual on the basis of actual or expected claims for ~~an~~ that individual or ~~an~~ the individual's given diagnosis~~:~~

~~(1) Assign a different attachment point for that individual;~~

~~(2) Assign a deductible to that individual that must be met before excess or stop-loss insurance applies;~~

~~(3) Deny excess or stop-loss insurance coverage to that individual~~.

Sec. 1739.13. (A)(1) A multiple employer welfare arrangement operating a group self-insurance program shall establish and maintain ~~a minimum surplus of not less than five hundred thousand dollars or such higher amounts of surplus as the superintendent of insurance may establish by rule~~ appropriate loss and loss expense reserves for the protection of the members and their employees, as determined in accordance with sound actuarial principles and 26 U.S.C. 419 and 419A.

(2) The superintendent may permit a multiple employer

welfare arrangement up to two years to accumulate the reserve requirement, and the superintendent may require such an arrangement to provide collateral until such time as the reserves are fully accumulated.

(B) Except as otherwise provided for in sections 1739.01 to 1739.21 of the Revised Code, the assets of a multiple employer welfare arrangement operating a group self-insurance program shall be invested only in securities or other investments permitted by the laws of this state for the investment of assets of domestic insurance companies other than life.

(C) A multiple employer welfare arrangement operating a group self-insurance program shall maintain assets in cash, receivables, or securities authorized by the laws of this state for the investment of assets of domestic insurance companies other than life in an amount that is equivalent to or higher than the unearned premiums and minimum surplus required under sections 1739.01 to 1739.22 of the Revised Code, the reserves for losses outstanding and unpaid, and any other liabilities of the arrangement.

Sec. 3924.01. As used in sections 3924.01 to 3924.14 of the Revised Code:

(A) "Actuarial certification" means a written statement prepared by a member of the American academy of actuaries, or by any other person acceptable to the superintendent of insurance, that states that, based upon the person's examination, a carrier offering health benefit plans to small employers is in compliance with sections 3924.01 to 3924.14 of the Revised Code. "Actuarial certification" shall include a review of the appropriate records of, and the actuarial assumptions and

methods used by, the carrier relative to establishing premium rates for the health benefit plans.

(B) "Adjusted average market premium price" means the average market premium price as determined by the board of directors of the Ohio health reinsurance program either on the basis of the arithmetic mean of all carriers' premium rates for an OHC plan sold to groups with similar case characteristics by all carriers selling OHC plans in the state, or on any other equitable basis determined by the board.

(C) "Base premium rate" means, as to any health benefit plan that is issued by a carrier and that covers at least two but no more than fifty employees of a small employer, the lowest premium rate for a new or existing business prescribed by the carrier for the same or similar coverage under a plan or arrangement covering any small employer with similar case characteristics.

(D) "Carrier" means any sickness and accident insurance company or health insuring corporation authorized to issue health benefit plans in this state or a MEWA. A sickness and accident insurance company that owns or operates a health insuring corporation, either as a separate corporation or as a line of business, shall be considered as a separate carrier from that health insuring corporation for purposes of sections 3924.01 to 3924.14 of the Revised Code.

(E) "Case characteristics" means, with respect to a small employer, the geographic area in which the employees work; the age and sex of the individual employees and their dependents; the appropriate industry classification as determined by the carrier; the number of employees and dependents; and such other objective criteria as may be established by the carrier. "Case

characteristics" does not include claims experience, health status, or duration of coverage from the date of issue.

(F) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefits plan covering the employee.

(G) "Eligible employee" means an employee who works a normal work week of thirty or more hours. "Eligible employee" does not include a temporary or substitute employee, or a seasonal employee who works only part of the calendar year on the basis of natural or suitable times or circumstances.

(H) "Health benefit plan" means any hospital or medical expense policy or certificate or any health plan provided by a carrier, that is delivered, issued for delivery, renewed, or used in this state on or after the date occurring six months after November 24, 1995. "Health benefit plan" does not include policies covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, or vision care; coverage under a one-time-limited-duration policy that is less than twelve months; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical-payment insurance; or 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.

(I) "Late enrollee" means an eligible employee or dependent who enrolls in a small employer's health benefit plan other than during the first period in which the employee or dependent is eligible to enroll under the plan or during a special enrollment period described in section 2701(f) of the

"Health Insurance Portability and Accountability Act of 1996," Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg, as amended.

(J) "MEWA" means any "multiple employer welfare arrangement" as defined in section 3 of the "Federal Employee Retirement Income Security Act of 1974," 88 Stat. 832, 29 U.S.C.A. 1001, as amended, except for any arrangement which is fully insured as defined in division (b)(6)(D) of section 514 of that act.

(K) "Midpoint rate" means, for small employers with similar case characteristics and plan designs and as determined by the applicable carrier for a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(L) "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 enrollment date as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the enrollment date. Genetic information shall not be treated as such a condition in the absence of a diagnosis of the condition related to such information.

For purposes of this division, "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.

(M) "Service waiting period" means the period of time

after employment begins before an employee is eligible to be covered for benefits under the terms of any applicable health benefit plan offered by the small employer.

(N)(1) "Small employer" means, in connection with a group health benefit plan and with respect to a calendar year and a plan year, an employer who employed an average of at least two but no more than fifty eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

(2) For purposes of division (N)(1) of this section, all persons treated as a single employer under 29 U.S.C. 1002(5) or subsection (b), (c), (m), or (o) of section 414 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, shall be considered one employer. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected the employer will employ on business days in the current calendar year. Any reference in division (N) of this section to an "employer" includes any predecessor of the employer. Except as otherwise specifically provided, provisions of sections 3924.01 to 3924.14 of the Revised Code that apply to a small employer that has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this division.

(O) "OHC plan" means an Ohio health care plan, which is the basic, standard, or carrier reimbursement plan for small employers and individuals established in accordance with section 3924.10 of the Revised Code.

Section 2. That existing sections 1739.02, 1739.05, 1739.12, 1739.13, and 3924.01 of the Revised Code are hereby repealed.