Ohio Legislative Service Commission

Bill Analysis

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Am. H.B. 511

130th General Assembly
(As Passed by the House)

Reps. Sears, Boose, Grossman, Henne, Romanchuk, Smith, Wachtmann, Young, Amstutz, Beck, Blessing, Burkley, Conditt, Green, Hackett, Hill, Scherer, Thompson, Batchelder

BILL SUMMARY

- Lowers to 26 (from 28) the age to which health insurance coverage must be extended, upon the request of the insured, under certain health policies or plans that provide coverage to an insured's unmarried dependent children.
- Increases to 30 (from 25) the minimum number of hours that an eligible employee works in a normal work week for the purposes of the law governing small employer health benefit plans.
- Specifies that a volunteer firefighter is not an employee for the purposes of the federal Patient Protection and Affordable Care Act.
- Increases the potential length of one-time, limited duration health insurance policies, from policies that are not longer than six months to policies that are less than 12 months.

CONTENT AND OPERATION

Insurance coverage for dependent children

The bill provides that, once an unmarried child has attained the limiting age for dependent children specified in a health insurance policy, contract, agreement, or benefit plan and upon the request of the insured, the health insurer must offer to cover the unmarried child until the child reaches age 26 if certain conditions are satisfied (see "**Limiting age**," below).[1] Current law requires that such coverage extend until the

[1] R.C. 1751.14, 3923.24, and 3923.241.

unmarried child reaches age 28; however, it does not require insurers to offer dependent coverage in general.

The insurers subject to these provisions of the bill are health insuring corporations, sickness and accident insurers, multiple employer welfare arrangements, and public employee benefit plans. The provisions do not apply to health insurance that is part of employee benefits offered by private employers that self-insure their benefit programs. These programs are generally precluded from state regulation by the federal Employee Retirement Income Security Act (ERISA) (see "**ERISA**," below).

As noted above, coverage must be extended to an unmarried dependent child upon the request of the insured and if certain conditions are met, including the following: (1) the child is the natural child, stepchild, or adopted child of the insured, (2) the child is an Ohio resident or a full-time student at an accredited public or private institution of higher education, (3) the child is not Medicaid or Medicare eligible, and (4) the child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage.

Application

These provisions of the bill apply to policies, contracts, agreements, and plans that are delivered, issued for delivery, or renewed in Ohio on or after January 1, 2015.[2]

Limiting age

Existing law allows a health insurance policy or plan offered by a sickness and accident insurer, a health insuring corporation, multiple employer welfare arrangement, or public employee benefit plan that offers coverage for unmarried dependent children to place a "limiting age" on such coverage. Under current law, the attainment of that age may not operate to terminate coverage if the child continues to be both: (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (2) primarily dependent on the policyholder for support or maintenance.

Mandated health benefits legislation

The bill's requirements regarding extended coverage for unmarried dependents could be considered mandated health benefits. Under current law, no mandated health benefits legislation enacted by the General Assembly may be applied to any policy, contract, plan, or other arrangement providing sickness and accident or other health benefits until the Superintendent of Insurance determines, pursuant to a hearing conducted in accordance with the Administrative Procedure Act, that the provision can

[2] Section 3.

be applied fully and equally in all respects to (1) employee benefit plans subject to regulation by the federal ERISA and (2) employee benefit plans established or modified by the state or its political subdivisions.[3]

The bill includes provisions that exempt its requirements regarding coverage for unmarried dependents from review by the Superintendent. Therefore, the coverage may be implemented without a hearing and determination that the coverage can be applied to employee benefit plans subject to ERISA.[4]

ERISA

ERISA is a comprehensive federal statute governing the administration of employee benefit plans. ERISA generally precludes state regulation of benefits offered by private employers that self-insure their benefit programs. Larger employers frequently choose to establish their own health insurance plans for their employees in lieu of purchasing coverage from a sickness and accident insurer or health insuring corporation.

Eligible employees under small employer benefit plans

The bill specifies, for the purposes of the law governing small employer benefit plans, that an eligible employee means an employee who works a normal work week of 30 or more hours. Current law provides that an eligible employee works a normal work week of 25 or more hours. A small employer, in connection with a group health benefit plan, is an employer who employed an average of at least two but no more than 50 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.[5] This change conforms Ohio law to provisions in the Patient Protection and Affordable Care Act (ACA) that relate to mandatory health insurance coverage.

Application

These provisions of the bill apply to policies, contracts, agreements, and plans that are delivered, issued for delivery, or renewed in Ohio on or after January 1, 2015.[6]

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[3] R.C. 3901.71, not in the bill.

[4] R.C. 1751.69(B) and 3923.85(B).

[5] R.C. 3924.01.

[6] Section 3.

Volunteer firefighters

With respect to a volunteer firefighter appointed by a municipal corporation or township, the bill provides that the firefighter is a bona fide volunteer and is not a municipal corporation or township employee for the purposes of the federal Patient Protection and Affordable Care Act.[7] The bill specifies that a firefighter is not an employee even if the firefighter or, in some instances, a family member of the firefighter, receives any benefits provided by the following:

(1) The Volunteer Fire Fighters' Dependents Fund;

(2) The Industrial Commission or Bureau of Workers' Compensation;

(3) An annuity program established by a township or municipal corporation for its volunteer firefighters;

(4) A standard liability and casualty insurance policy purchased by a township or municipal corporation for members of its fire department;

(5) The tuition waiver available to a person attending a state-funded college or university who is the child or spouse of a firefighter killed in the line of duty;

(6) A sickness and accident insurance policy that covers a volunteer fire department and its members;

(7) The law that prohibits an employer from terminating an employee who is a volunteer firefighter when that employee is absent from or late to work in order to respond to an emergency prior to the time the employee is to report to work.

One-time, limited-duration policies

The bill increases the potential length of one-time, limited-duration (OTLD) health insurance policies, from policies that are not longer than six months to policies that are less than 12 months.[8] OTLD policies are distinct from other health insurance policies in that certain requirements that apply to standard insurance policies do not apply to OTLD policies. The following is a list of the requirements that do not apply to OTLD policies:

- Uniform prescription drug information on standardized identification cards or other identifying electronic technology;

[7] R.C. 505.377, 737.082, and 737.222.

[8] See **COMMENT**.

- Limitations on administrative expenses retained in relation to health policies;
- Coverage of adult dependent children;
- Biologically based mental illness parity;
- Pre-existing conditions coverage;
- Coverage of emergency services;
- Required continuation of coverage;
- Requirements for the discontinuation of insurance products;
- Small employer health benefit plan law requirements.[9]

COMMENT

The operation of R.C. 3923.58 was suspended by S.B. 9 of the 130th General Assembly. This section required insurers to offer open enrollment to individuals that could not otherwise obtain insurance (perhaps because of a pre-existing condition). This section was suspended because the open enrollment program was largely subsumed by the federal Patient Protection and Affordable Care Act (PPACA). The bill's amendment of this section does not supersede that suspension.

Because OTLD policies do not have to meet certain requirements, such as the coverage of pre-existing conditions, they may not constitute qualified health plans with regard to the individual mandate enacted in the PPACA. As such, individuals covered by OTLD policies might be subject to the tax penalty associated with the mandate.

HISTORY

ACTION	DATE
Introduced	04-01-14
Reported, H. Health & Aging	05-14-14
Passed House (65-30)	05-28-14

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[9] R.C. 1739.061, 3923.24(E), 3923.241(D), 3923.281, 3923.57, 3923.58, 3923.601, 3923.83, and 3924.01(H).