DEPARTMENT OF INSURANCE

Licensing

- Eliminates the requirement that applications for a managing general agent (MGA) license or a public insurance adjuster certificate of authority be verified under oath.
- Aligns the deadline for completion of continuing education requirements for long-term care insurance agents with the agent's two-year license renewal period, as opposed to the two-year period beginning January 1.
- Makes selling, soliciting, or negotiating long-term care insurance before satisfying the continuing education requirement an unfair and deceptive practice in the business of insurance, in contrast to current law, under which failing to satisfy the continuing education requirement qualifies as such.

Pharmacy benefit managers (PBMs)

Reimbursement

- Requires pharmacy benefit managers (PBMs), other than the state PBM, to reimburse Ohio-incorporated pharmacies that dispense a drug product for the "actual acquisition cost," i.e., the amount paid to the drug wholesaler, plus a minimum dispensing fee determined by the Superintendent of Insurance.
- Prohibits a PBM from reimbursing an Ohio pharmacy less than the amount the PBM reimburses its affiliated pharmacies for providing the same drug product.
- Allows an Ohio pharmacy to decline to provide a drug product if the pharmacy would be reimbursed less than the required amount.

Violations

- Establishes a procedure by which an Ohio pharmacy may file a formal complaint alleging a violation of the bill's reimbursement requirements or requirements under continuing law concerning disclosure of maximum allowable cost pricing information.
- Requires the Superintendent, following notice and an opportunity for a hearing, to impose an administrative penalty on the PBM of $1,000 per day for each violation.

Retaliation

- Prohibits a PBM from retaliating against an Ohio pharmacy that reports an alleged violation of, or exercises a remedy under, the bill.

Health care provider payment requirements

- Requires a health plan issuer to offer all reasonably available methods of payment to a health care provider, including payment by check and electronic funds transfer.
- Prohibits a health plan issuer requiring payment by credit card.

- Requires a health plan issuer to offer at least one method of payment that does not require the health care provider to pay any associated fee.
- Requires health plan issuers to implement requests to change a payment method within 30 business days.
- Prohibits health plan issuers from charging a fee for implementing a change to a health care provider's payment method.

Reimbursement for certified registered nurse anesthetist services

- Prohibits a health benefit plan from varying the reimbursement rate for a covered service based on whether the service was provided by a certified registered nurse anesthetist or a physician.
- Specifies that the requirement does not prohibit a health benefit plan from establishing varying reimbursement rates based on quality or performance measures.

Licensing

(R.C. 3905.72, 3923.443, and 3951.03)

The bill eliminates the requirement that applications for a managing general agent (MGA) license or a public insurance adjuster certificate of authority be verified under oath of a notary public. An MGA is a specialized type of insurance agent that is vested with underwriting authority from an insurer. A public insurance adjuster is an insurance claimed adjuster employed by the policyholder for appraising and negotiating an insurance claim.

The bill also adjusts the deadlines by which long-term care insurance agents must complete continuing education requirements. Under current law, long-term care insurance agents must complete at least four hours of continuing education every two years beginning on the first day of January immediately following the issuance of the agent's license. Under the bill, the two-year period begins on the date an agent's license is issued.

Under current law, not completing the continuing education requirement by the deadline is an unfair and deceptive practice in the business of insurance. Under the bill, failing to satisfy the requirement is not a violation in and of itself, but rather selling, soliciting, or negotiating long-term care insurance before satisfying the continuing education requirement is the violation.

Pharmacy benefit managers

(R.C. 3959.111, 3959.121, and 3959.01)

Reimbursement

The bill sets a floor for the amount a pharmacy benefit manager (PBM) is required to reimburse a pharmacy, including an independent pharmacy, incorporated or organized in Ohio (an "Ohio pharmacy"). At minimum, a PBM must reimburse the Ohio pharmacy's actual acquisition cost for the drug product plus a minimum dispensing fee for the drug product

determined by the Superintendent of Insurance. Furthermore, the bill prohibits a PBM from reimbursing an Ohio pharmacy less than the amount the PBM reimburses its affiliated pharmacies for providing the same drug product. An Ohio pharmacy may decline to provide a drug product if the pharmacy would be reimbursed less than the amount required by the bill.

The bill defines "actual acquisition cost" as the amount that a drug wholesaler charges a pharmacy for the drug product, as evidenced by a billing invoice. A "drug wholesaler" is a wholesale drug distributor accredited by a nationally recognized nonprofit organization that represents the interests of state boards of pharmacy and to which the Ohio State Board of Pharmacy is a member.

The bill requires the Superintendent to determine a minimum dispensing fee for each drug product based on data collected by the Department of Medicaid in the Department's survey of the dispensing costs of terminal distributors. The Superintendent must publish the amount of the minimum dispensing fee and the dates to which it applies on a publicly accessible website maintained by the Department of Insurance. The first publication must occur within 90 days after the effective date of the provision. Thereafter, the Superintendent must update the minimum dispensing fees each time the Department of Medicaid publishes the results of its survey.

The bill specifies that the reimbursement requirements do not apply if they conflict with a pre-existing contract or agreement. However, if the contract or agreement is renewed or amended after the effective date of the provision, the PBM must ensure that the contract or agreement conforms to the bill's requirements. The bill does not prohibit a PBM from reimbursing a pharmacy more than the required amount.

Violations

The bill establishes a process by which an Ohio pharmacy may file a formal complaint against a PBM that the pharmacy believes to have violated the bill's reimbursement requirements or requirements under continuing law concerning disclosure of information used to determine maximum allowable cost pricing. The Superintendent must evaluate all such complaints based on the information included in the complaint and other information that may be available to the Superintendent.

If the Superintendent determines that a violation occurred, the Superintendent must issue a notice to the PBM with a clear explanation of the violation. Furthermore, after giving the PBM an opportunity for an adjudication hearing in accordance with the Administrative Procedure Act, the Superintendent must impose an administrative penalty of $1,000 for each violation. Each day that the violation continues after the PBM receives notice is considered a separate violation. All penalties collected from PBMs under the bill must be deposited to the Department of Insurance Operating Fund.

Retaliation

If an Ohio pharmacy reports an alleged violation of the reimbursement or disclosure requirements, or refuses to provide a drug product as described above, the bill prohibits any of the following "retaliatory" actions by the PBM:

- Terminating or refusing to renew a contract with the Ohio pharmacy without providing notice at least 90 days in advance;
- Increasing audits of the Ohio pharmacy without providing notice and a detailed description of the reason for the audits at least 90 days in advance;
- Failing to comply with prompt pay laws.

Health care provider payment requirements

(R.C. 3901.3815)

The bill requires health plan issuers to offer all reasonably available methods of payment to a health care provider, including payment by check and electronic funds transfer. Under continuing law, a "health care provider" is a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility, or health care practitioner. The bill defines "health plan issuer" to include any entity subject to Ohio insurance laws or the jurisdiction of the Superintendent of Insurance that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan. The term includes a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, a nonfederal, government health plan, or a third-party administrator (such as a Pharmacy Benefit Manager) and any vendor contracted by the foregoing. The term excludes plans regulated by the federal "Employee Retirement Income Security Act of 1974" (ERISA), which preempts most state insurance regulations.[90]

The bill prohibits health plan issuers from requiring health care providers to accept payment via credit card, with "credit card" being defined as a single-use or virtual payment card provided in an electronic, digital, facsimile, physical, or paper format. The bill requires health plan issuers to offer at least one method of payment that does not require the health care provider to pay an associated fee. If one of the available payment methods has an associated fee, health plan issuers are required, prior to initiating the first payment or upon changing the payment methods available, to do both of the following:

- Notify the health care provider that there may be fees associated with a particular payment method and disclose the amount of such fees;
- Provide the health care provider with clear instructions as to how to select each payment method either on the health plan issuer's website or through a means other than the contract offered to the health care provider.

If a health care provider requests a change in payment method, the health plan issuer must implement the change within 30 business days. The payment method selected by the health care provider remains in effect until the health care provider requests a different method. The bill prohibits a health plan issuer from charging a fee to change a payment method.

[90] 29 U.S.C. 1144.

Reimbursement for certified registered nurse anesthetist services

(R.C. 3902.631)

The bill prohibits a health benefit plan issued, amended, or renewed on or after the effective date of the provision from varying the reimbursement rate for a covered service based on whether the service was provided by a certified registered nurse anesthetist or a physician. The requirement applies only to covered services that a certified registered nurse anesthetist is authorized to provide. It does not prohibit an insurer from establishing varying reimbursement rates based on quality or performance measures.

Under continuing law, a "health benefit plan" is an agreement offered to provide or reimburse the costs of health care services. The term includes a limited benefit plan, except for a policy that covers only accident, dental, disability income, long-term care, hospital indemnity, supplemental coverage, specified disease, vision care, and other specified types of coverage. The term does not include a Medicare, Medicaid, or federal employee plan.[91]

[91] R.C. 3922.01, not in the bill.