# 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

- Prohibits a pharmacy benefit manager (PBM), other than the state 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 from charging a health care provider a fee for delivering payment through check or electronic funds transfer.
- Requires a health plan issuer to disclose fees charged by the health plan issuer or by an agent, affiliate, or third party contracted by the health plan issuer in connection with other methods of payment.

- Requires health plan issuers to allow providers to opt out of payment by credit card.
- Requires health plan issuers to implement requests to change a payment method within 31 business days.
- Prohibits health plan issuers from charging a fee for implementing a change to a health care provider's payment method.

## Ohio Assigned Risk Insurance Plan

- Requires insurance agents to take certain actions to confirm that a person seeking automobile insurance through the Ohio Assigned Risk Insurance Plan is unable to secure coverage through private insurers.

## Uninsured drivers

- Expands the persons who may report a driver or owner of a motor vehicle involved in an accident to the Bureau of Motor Vehicles for failure to maintain financial responsibility to include any person who suffers injury or property damage, as opposed to only persons who are also drivers of a vehicle involved in the accident.

## Reimbursement for out-of-network ambulance services

- Modifies one of the factors used to determine the minimum reimbursement rate that a health plan issuer must pay by default to an out-of-network ambulance for unanticipated emergency care, specifically by increasing the Medicare-based factor to 250% (from 100%) of the Medicare payment amount.

## 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 prohibits a pharmacy benefit manager (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 specifies that the reimbursement requirement does not apply if it conflicts 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 requirement. The bill does not prohibit a PBM from reimbursing an Ohio pharmacy more than the PBM reimburses its affiliated pharmacies.

## 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 requirement 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.[111]

The bill prohibits health plan issuers from charging a health care provider a fee for delivering payment through check or electronic funds transfer, either directly or indirectly through an agent, affiliate, or third party contracted by the health plan issuer in connection with the method of payment. Additionally, a health plan issuer that offers payment by credit card must provide a process by which a health care provider can opt out of that method of payment and select another method of payment.

If a health plan issuer or an agent, affiliate, or third party contracted by a health plan issuer in connection with one of the available payment methods, other than payment by check or electronic funds transfer, charges a fee, the bill requires the health plan issuer, prior to initiating the first payment or upon changing the payment methods available, to do both of the following:

- Notify the health care provider about potential fees associated with a particular payment method, disclose any charges by the health plan issuer, and advise the provider to contact their financial institution, credit card issuer, or payment processor about applicable 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 31 business days. The payment method selected by the health care provider remains in effect until the health care provider requests a different method or until the health plan issuer has not generated a payment to the provider for more than one year. The bill prohibits a health plan issuer from charging a fee to change a payment method.

[111] 29 U.S.C. 1144.

## Ohio Assigned Risk Insurance Plan

(R.C. 4509.70)

The bill requires insurance agents to meet certain due diligence requirements prior to submitting an application for automobile insurance to the Ohio Assigned Risk Insurance Plan (OARIP). The OARIP provides automobile insurance to licensed drivers that are unable to purchase automobile insurance through Ohio's voluntary market due to a variety of factors, such as driving history or first-time driver status.

Due diligence under the bill requires an insurance agent to contact at least five of the insurers the agents represents or, if the agent does not represent five insurers that generally provide automobile insurance, as many of such insurers as the agent represents. An insurance agent may assume that insurance coverage cannot be obtained after each insurer contacted declines coverage. An insurer is deemed to have declined coverage if the insurer fails to respond within ten days after the agent makes contact. Insurance agents are further prohibited from submitting an application to the OARIP if any other insurer eligible to do business in this state has in any way communicated a willingness to insure the applicant, even if the coverage provided by OARIP costs less than other insurers.

The OARIP may revoke the authority of any agent who fails to comply with these requirements to submit applications to the OARIP, with OARIP having sole authority over making final determinations as to whether an insurance agent has met the due diligence requirement.

## Uninsured drivers

(R.C. 4509.06)

The bill expands the persons who may report a driver or owner of a motor vehicle involved in an accident to the Bureau of Motor Vehicles (BMV) for failure to maintain financial responsibility. Under current law, the driver of any motor vehicle which is in any manner involved in a motor vehicle accident may, within six months after the accident, forward a written report of the accident to the BMV alleging that the driver or owner of any other vehicle involved in the accident was uninsured at the time of the accident. Under the bill, any person who is involved in such an accident, including as the driver of a motor vehicle, the owner of property, or any other person sustaining bodily injury or property damage as a result of the accident, may make such a report to the BMV.

## Reimbursement for out-of-network ambulance services

(R.C. 3902.51; Section 739.10)

In the case of ambulance services, the bill modifies the law that establishes the minimum reimbursement rate that a health plan issuer must pay for unanticipated out-of-network care for emergency services. One of the factors currently used to determine the minimum payment is the amount that would be paid by Medicare. Beginning with new, renewed, or modified health benefit plans, the bill increases the amount of the Medicare-based factor to 250% of the Medicare rate.

The bill does not change the remaining factors that must be taken into consideration when determining which factor creates the greatest payment. These factors are: (1) the amount negotiated with in-network providers and (2) the amount calculated by using the usual method for determining out-of-network payments. Further, the bill does not alter the authority of an ambulance to negotiate with a health plan issuer for an alternate reimbursement.