



Lisa Baumann

Final Analysis
Legislative Service Commission

Sub. S.B. 43

125th General Assembly
(As Passed by the General Assembly)

Sens. Spada, Robert Gardner, Blessing, Coughlin, Schuring, Jacobson, Fingerhut, DiDonato, Wachtmann, Harris, Schuler, Dann, Armbruster, Brady, Fedor, Hagan, Mallory, Roberts, Zurz

Reps. Barrett, Combs, DeBose, Beatty, S. Smith, Harwood, G. Smith, Hoops, Reidelbach, Buehrer, Carano, Clancy, Collier, Distel, Domenick, C. Evans, Flowers, Hagan, Hartnett, Hughes, Key, Kilbane, McGregor, Miller, Oelslager, Olman, Otterman, T. Patton, Price, Schmidt, Sferra, Slaby, J. Stewart, Taylor, Walcher, Wilson, Yates

Effective date: *

ACT SUMMARY

- Requires certain health insurers that issue or require the use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims to issue or require the use of a card or technology containing uniform information.
- Provides for those requirements to take effect one year after the act's effective date.
- Reduces from ten to two the number of employees life insurance must cover to be considered group life insurance.

* *The Legislative Service Commission had not received formal notification of the effective date at the time this analysis was prepared. Additionally, the analysis may not reflect action taken by the Governor.*

CONTENT AND OPERATION

Uniform prescription drug information

(R.C. 1739.061, 1751.111, 3923.601, and 3923.83)

The act requires specified health insurers¹ that issue or require the use of a standardized identification card or an electronic technology for the submission and routing of prescription drug claims to issue or require the use of a card or an electronic technology that contains uniform prescription drug information.² Under the act, one of the following requirements must be met:

(1) The card or technology must be in a format and contain information fields approved by the National Council for Prescription Drug Programs, or its successor organization, as specified in the Council's or successor organization's pharmacy identification card implementation guide in effect on the first day of October most immediately preceding the issuance or required use of the card or technology.

(2) If the health insurer requires the information for the submission and routing of a claim, the card or technology must contain any of the following information:

(a) The health insurer's name;

(b) The subscriber's³ or insured person's name, group number, and identification number;

(c) A telephone number to inquire about pharmacy-related issues;

(d) The issuer's international identification number labeled as "ANSI BIN" or "RxBIN";

(e) The processor's control number, labeled as "RxPCN";

¹ *The act's requirements also apply to certain persons under contract with a specified health insurer. (See "**Who must comply**" below.)*

² *The act does not specify what is meant by "electronic technology."*

³ *Existing law unchanged by the act defines a "subscriber" as a person who is responsible for making payments to a health insuring corporation for participation in a health care plan, or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health insuring corporation. (R.C. 1751.01(Z).)*

(f) The subscriber's or insured person's pharmacy benefits group number if different from the person's medical group number, labeled as "RxGrp."

If the standardized identification card or the electronic technology is also used for submission and routing of nonpharmacy claims, the designation "Rx" is required to be included as part of the labels the act identifies for the issuer's international identification number and the processor's control number if the issuer's international identification number or the processor's control number is different from medical and pharmacy claims.

If there is a change in the information contained in the standardized identification card or the electronic technology issued to a subscriber or insured person, the health insurer must issue a new card or electronic technology to the person. This requirement, however, does not require a health insurer to issue a new card or electronic technology to a subscriber or insured person more than once during a 12-month period.

The act specifies that its provisions are not to be construed as requiring insurers to produce more than one standardized identification card or one electronic technology for use by subscribers or insured persons accessing the health care benefits being provided.

Who must comply

(R.C. 1739.061(A)(1), 1751.111(A)(1), 3923.601(A)(1), and 3923.83(A)(1))

The act's requirements apply to sickness and accident insurers, health insuring corporations,⁴ multiple employer welfare arrangements (MEWAs),⁵ and public employee benefit plans that issue or require the use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims. The act's requirements also apply to persons contracted by these insurers to issue a standardized identification card or an electronic technology for submission and routing of prescription drug claims.

⁴ *Under existing law, a health insuring corporation is an entity, such as a health maintenance organization, that provides health care coverage through participating health care providers.*

⁵ *Existing law unchanged by the act defines a "multiple employer welfare arrangement" (MEWA) as any multiple employer welfare arrangement as defined in the federal Employee Retirement Income Security Act of 1974 (ERISA), except for any arrangement which is considered to be fully insured under ERISA.*

Exemptions

(R.C. 1739.061(A)(2), 1751.111(A)(2), 3923.601(A)(2), and 3923.83(A)(2))

The act's requirements do not apply to the following:

- (1) Medicaid;
- (2) Medicare Advantage;⁶
- (3) An individual or group policy of insurance, or program or arrangement, that covers only accident, credit, dental, disability income, long-term care, hospital indemnity, Medicare, Medicare supplement, Tricare,⁷ specified disease, or vision care;
- (4) One-time limited duration policies of six months or less;
- (5) Coverage issued as a supplement to liability insurance;
- (6) Insurance arising out of workers' compensation or similar law;
- (7) Automobile medical payment insurance;
- (8) Insurance under which benefits are payable regardless of fault that is required by statute to be contained in any liability insurance policy or equivalent self-insurance;
- (9) Coverage provided under an employer's self-insurance plan or by any of its administrators, to the extent that federal law supersedes, preempts, prohibits, or otherwise precludes the application of the act to the plan or its administrators.⁸

⁶ *Medicare Advantage, formerly known as Medicare+Choice, is the component of the Medicare Program that allows Medicare beneficiaries to receive their health benefits through private health insurers, primarily health maintenance organizations and other managed care arrangements (Henry J. Kaiser Family Foundation, "Medicare Advantage Fact Sheet," March 2004, available at www.kff.org/medicare/choice.cfm).*

⁷ *Tricare is the United States military health care program (www.tricare.osd.mil/beneficiary/).*

⁸ *In general, this means employee benefit plans subject to the Employee Retirement Income Security Act of 1974 (ERISA).*

Filing certificate with Superintendent of Insurance

(R.C. 1739.061(D), 1751.111(D), and 3923.601(D))

The act requires each sickness and accident insurer, health insuring corporation, and multiple employer welfare arrangement that is subject to the act to annually file a certificate with the Superintendent of Insurance certifying that it or any person it contracts with to issue a standardized identification card or electronic technology for submission and routing of prescription drug claims complies with the act's requirements concerning the cards and technology.

Effective date; application of provisions

(Sections 3 and 4)

The act's requirements concerning the standardized identification cards and electronic technology go into effect one year after the act's effective date. The act specifies that its requirements apply only with respect to the following:

(1) Health insuring corporation policies, contracts, and agreements delivered, issued for delivery, or renewed in Ohio on or after one year after the act's effective date;

(2) Sickness and accident insurance policies delivered, issued for delivery, renewed, or used in Ohio on or after one year after the act's effective date;

(3) Multiple employer welfare arrangements authorized to enter into a program or arrangement in Ohio on or after one year after the act's effective date;

(4) Public employee benefit plans established or modified by this state on or after one year after the act's effective date.

Definition of "group plan"

(R.C. 3917.01)

Under current law, "group life insurance" is that form of life insurance covering not less than ten employees with or without medical examination that is written under a policy issued to an employer, or to a trustee of a trust created by an employer, the premium on which is paid by the employer, the employer and employee jointly, or a trustee out of funds contributed by the employer or by the employer and employee jointly. The insurance must insure all of the employer's employees or all of any class of employees determined by sex, age, or conditions pertaining to employment.

The act reduces from ten to two the number of employees life insurance must cover to be considered group life insurance.

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	03-04-03	p. 165
Reported, S. Health, Human Services & Aging	04-06-04	p. 1710
Passed Senate (33-0)	04-21-04	pp. 1748-1749
Reported, H. Health	05-26-04	p. 2002
Passed House (97-2)	05-26-04	pp. 2010-2011
Senate Concurrence (31-0)	05-26-04	p. 2063

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