
DEPARTMENT OF INSURANCE

Multiple employer welfare arrangements

- Expands entities eligible to form a multiple employer welfare arrangement (MEWA) to include a chamber of commerce, a tax-exempt voluntary employee beneficiary association or business league, or any other association specified in rule by the Superintendent of Insurance.
- Extends from one year to five years the time frame a group must have been organized and maintained before registering as a MEWA.
- Increases the required minimum surplus for MEWAs from \$150,000 to \$500,000.
- Specifies that a MEWA is subject to the continuing law risk-based capital requirements for life or health insurers.
- Permits a MEWA to send notice of involuntary termination to a member by any manner permitted in the agreement, instead of only by certified mail.
- Prohibits a MEWA's stop-loss insurance policy from engaging in specified actions with respect to covered individuals.
- Prohibits a MEWA from enrolling a member in the MEWA's group self-insurance program until the MEWA has notified the member of the possibility of additional liability if the MEWA has insufficient funds.
- Requires MEWAs to annually file with the Superintendent of Insurance an actuarial certification.

Use of genetic information by insurers

- Prohibits health plan issuers from using genetic information in relation to providing health insurance coverage.

Surplus lines affidavit

- Replaces the surplus lines affidavit required for every insurance policy placed in the surplus lines market with a signed statement serving a similar purpose that does not need to be notarized.

Pharmacy benefit managers and maximum allowable cost

- Requires pharmacy benefit managers to be licensed as third-party administrators.



- Specifies requirements with regard to maximum allowable cost provisions in contracts instituted between pharmacies and pharmacy benefit managers

Multiple employer welfare arrangements

Eligibility requirements

(R.C. 1739.02; conforming changes in R.C. 1739.03 and 1739.20)

The bill makes changes to the eligibility requirements pertaining to groups forming a multiple employer welfare arrangement (MEWA). The bill expands the entities that are eligible to form a MEWA to include a chamber of commerce, a tax-exempt voluntary employee beneficiary association or business league, or any other association specified in rule by the Superintendent of Insurance. The bill also extends to five years the time period a group must have been organized and maintained before registering as a MEWA. Under current law, only a trade association, industry association, or professional association that has been maintained continuously for one year can form a MEWA.

Surplus requirement

(R.C. 1739.13; Section 812.10)

Current law requires a MEWA operating a group self-insurance program to maintain a minimum surplus level for the protection of the MEWA members and the members' employees. The bill increases the required minimum surplus from \$150,000 to \$500,000. These requirements take effect two years from the bill's effective date for MEWAs that have a valid certificate of authority on that date.

Risk-based capital requirements

(R.C. 1739.05(E) and 3903.81)

The bill subjects a MEWA to the continuing law risk-based capital requirements for life or health insurers, such as the duty to submit an annual report on risk-based capital levels and the duty to submit a risk-based capital plan after specified events.

Notice of involuntary termination

(R.C. 1739.07)

Continuing law permits a MEWA to involuntarily terminate a member's participation in the MEWA under specified circumstances. The bill permits a MEWA to



give a member written notice of an involuntary termination in any manner permitted in the agreement, instead of only by certified mail to the last address of record of the member as required under current law.

Stop-loss insurance policy prohibitions

(R.C. 1739.12)

Continuing law requires a MEWA operating a group self-insurance program to purchase individual stop-loss insurance from a licensed insurer authorized to do business in Ohio. "Stop-loss insurance" means an insurance policy under which a MEWA receives reimbursement for benefits it pays in excess of a preset deductible or limit.⁹⁹ The bill prohibits a stop-loss insurance policy purchased by a MEWA from doing any of the following based on actual or expected claims for an individual or an individual's diagnosis:

- Assign a different attachment point for that individual;
- Assign a deductible to that individual that must be met before stop-loss insurance applies;
- Deny stop-loss insurance coverage to that individual.

Notice regarding insufficient funds

(R.C. 1739.20)

Continuing law prohibits a MEWA from taking certain actions, such as refusing to pay proper claims arising under the group self-insurance coverage. The bill additionally prohibits enrolling a member in the MEWA's group self-insurance program before the MEWA has notified the member in writing of the possibility that the member may be required to make additional payments in the event the MEWA has insufficient funds. The MEWA must keep a copy of this notification in its program files to evidence compliance with this requirement.

Actuarial certification

(R.C. 1739.141)

The bill requires each MEWA to annually file with the Superintendent of Insurance an actuarial certification that includes a statement that the underwriting and rating methods of the carrier do all of the following:

⁹⁹ R.C. 1739.01(B), not in the bill.



- Comply with accepted actuarial practices;
- Are uniformly applied to arrangement members, employees of members, and the dependents of members or employees;
- Comply with the requirements for certificates and other forms used by a MEWA in connection with a group self-insurance program.

The certification must be filed by March 31 of each year.

Use of genetic information by insurers

(R.C. 1739.05, 1751.18, 1751.65, and 3923.66)

The bill prohibits health plan issuers from using genetic information in relation to providing health insurance coverage. Current law already prohibits health insuring corporations and sickness and accident insurers from using genetic information in relation to reviewing applications, determining insurability, or determining benefits. The bill expands this prohibition to apply to multiple employer welfare arrangements and public employee benefit plans. It also expands the prohibition to include the use of genetic information in setting health insurance premiums.

Surplus lines affidavit

(R.C. 3905.33)

The bill removes the current law requirement that, unless certain criteria are met, an insurance agent who procures or places insurance through a surplus lines broker must obtain an affidavit from the insured acknowledging that the policy will be placed with an insurer not licensed to do business in Ohio. Instead, the bill requires such an insurance agent to obtain a signed statement that does not need to be notarized from the insured acknowledging the same information.

Pharmacy benefit managers and maximum allowable cost

(R.C. 3959.01 and 3959.111)

Licensing as third-party administrators

The bill expands the definition of an "administrator," commonly referred to as a "third-party administrator," in the context of health insurance and services to include entities that administer prescription drug benefit claims, commonly referred to as "pharmacy benefit managers," thereby requiring pharmacy benefit managers to be licensed as third-party administrators. Current law stipulates that neither a health



insuring corporation nor a sickness and accident insurer is to be considered a third-party administrator with regard to the licensing requirement. The bill stipulates that, regardless of this exemption, if a health insuring corporation or sickness and accident insurer acts as a pharmacy benefit manager, then that health plan issuer must still comply with the contract requirements outlined below.

Contract requirements

The bill imposes requirements with regard to maximum allowable cost provisions in contracts instituted between pharmacies and pharmacy benefit managers (PBMs). To provide context, such provisions stipulate a maximum reimbursement to pharmacies for specific drugs, regardless of the cost to the pharmacy to procure the drug.

Under the contract required by the bill, a PBM must provide, within ten days of a request, to a pharmacy a list of the sources used to determine maximum allowable cost pricing. The list of maximum reimbursements is required to be kept up-to-date on a weekly basis. This including, removing items from the list as necessary. Any updates to the list must be readily accessible by the pharmacies.

The contract must stipulate that a drug cannot be placed on maximum allowable cost list unless it meets both of the following conditions:

- The drug is listed as "A" or "B" rated in the most recent version of the U.S. Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations (the "Orange Book"), or has an "NR" or "NA" rating or similar rating by nationally recognized reference.
- The drug is generally available for purchase by pharmacies in Ohio from a national or regional wholesaler and is not obsolete.

Appeals

The contract required by the bill must require the PBM to implement a process for pharmacies to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes all of the following:

- A 21-day limit on the right to appeal following the initial claim;
- A requirement that the appeal be investigated and resolved within 21-days after the appeal;
- A telephone number at which the pharmacy may contact the PBM to speak to a person responsible for processing appeals.



If an appeal is denied, a PBM must provide a reason for the appeal and the national drug code of a drug that may be purchased in Ohio by the pharmacy in this state or from a national or regional wholesaler at a price at or below the maximum reimbursement price. The appeals process must also include a requirement that a PBM make an adjustment to a date related to a claim not later than one day after the date related to a claim and not later than one day after the date of determination of the appeal. The adjustment is to be retroactive to the date the appeal was made and must apply to all situated pharmacies as determined by the PBM. This requirement does not prohibit a PBM from retroactively adjusting a claim for the appealing pharmacy or for any other similarly situated pharmacies.

Disclosures

The bill requires PBMs to make certain disclosures to health benefit plan sponsors for whom they administer claims. A PBM must disclose to a plan sponsor whether or not the PBM uses the same maximum allowable cost list when billing a plan sponsor as it does when reimbursing a pharmacy. If a PBM uses multiple maximum allowable cost lists, the PBM must disclose to a plan sponsor any differences between the amount paid to a pharmacy and the amount charged to a plan sponsor. These disclosures are to be made within ten days of a PBM and a plan sponsor signing a contract or within ten days of any update to a maximum allowable cost list or lists.

