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 former law, under which failing to satisfy the continuing education requirement qualifies as such.

Pharmacy benefit managers (VETOED)

Reimbursement

- Would have prohibited a pharmacy benefit manager (PBM), other than the state PBM, from reimbursing an Ohio pharmacy less than either the amount the PBM reimburses its affiliated pharmacies for providing the same drug product or the pharmacy's actual acquisition cost for the drug dispensed (VETOED).
- Would have allowed an Ohio pharmacy to decline to provide a drug product if the pharmacy would be reimbursed less than the required amount (VETOED).

Violations

- Would have permitted an Ohio pharmacy to file a formal complaint alleging a violation of the act's reimbursement requirements or requirements under continuing law concerning disclosure of maximum allowable cost pricing information (VETOED).
- Would have required 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 (VETOED).

Retaliation

- Would have prohibited a PBM from retaliating against an Ohio pharmacy that reported an alleged violation of, or exercised a remedy under, the act (VETOED).

Health care provider payment methods

- 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 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.

Reimbursement for certified registered nurse anesthetists

- 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.

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.

Private insurance outreach program

- Requires the Department of Insurance (ODI) to create and administer an outreach program to provide information, awareness, and assistance to Medicaid recipients to help them transition to private insurance.

Assisting end-stage renal disease patients

- Requires ODI to take certain actions regarding Medicare benefits for individuals with end-stage renal disease.
- Requires ODI to submit a report to the General Assembly by September 1, 2026, detailing its findings, including whether it is feasible to assist patients with end-stage renal disease in applying for Medicare.

Licensing

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

The act 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 act also adjusts the deadlines by which long-term care insurance agents must complete continuing education requirements. Under previous law, long-term care insurance agents must complete at least four hours of continuing education every two years beginning January 1 after the agent's license was issued. Under the act, the two-year period begins on the date an agent's license is issued.

Under previous law, not completing the continuing education by the deadline is an unfair and deceptive practice in the business of insurance. The act clarifies that 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 (VETOED)

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

Reimbursement

The Governor vetoed an item that would have imposed restrictions on how pharmacy benefit managers reimburse nonaffiliated pharmacies. The act would have prohibited a pharmacy benefit manager (PBM) from reimbursing an unaffiliated Ohio pharmacy less than either the amount the PBM reimburses its affiliated pharmacies for providing the same drug product or the unaffiliated pharmacy's actual acquisition cost for the drug dispensed. An unaffiliated Ohio pharmacy would have been authorized to decline to provide a drug product if the pharmacy would have been reimbursed less than the amount required by the act.

The act specified that the reimbursement requirement would not have applied if it conflicted with a pre-existing contract or agreement. However, if the contract or agreement would have been renewed or amended after the provision's effective date, the PBM would have been required to ensure that the contract or agreement conformed to the requirement. The act did not prohibit a PBM from reimbursing an unaffiliated Ohio pharmacy more than the PBM reimburses its affiliated pharmacies.

Violations

The act would have established a process by which an unaffiliated Ohio pharmacy could have filed a formal complaint against a PBM that the pharmacy believed to have violated the act's reimbursement requirement or requirements under continuing law concerning disclosure of information used to determine maximum allowable cost pricing. The Superintendent would have been required to evaluate all such complaints based on the information included in the complaint and other information available to the Superintendent.

If the Superintendent had determined that a violation occurred, the Superintendent would have been required to 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 would have had to impose an administrative penalty of $1,000 for each violation. Each day the violation continued after the PBM received notice would have been considered a separate violation.

Retaliation

If an Ohio pharmacy reported an alleged violation of the reimbursement or disclosure requirements, or refused to provide a drug product as described above, the following "retaliatory" actions by a PBM would have been prohibited:

- Terminating or refusing to renew a contract with the Ohio pharmacy without at least 90 days notice;
- 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 act 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 act 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.[84]

The act 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, defined by the act as a single-use or virtual payment card provided in an electronic, digital,

[84] 29 U.S.C. 1144.

facsimile, physical, or paper format, must provide a process by which a health care provider can opt out of that method 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 health plan issuer, prior to initiating the first payment or upon changing the payment methods available, must both:

- 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 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 provider remains in effect until the 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 act prohibits a health plan issuer from charging a fee to change a payment method.

Reimbursement for certified registered nurse anesthetists

(R.C. 3902.631)

The act prohibits a health benefit plan issued, amended, or renewed on or after September 30, 2025, 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.[85]

Ohio Assigned Risk Insurance Plan

(R.C. 4509.70)

The act 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). OARIP provides automobile insurance to licensed drivers who are unable to purchase

[85] R.C. 3922.01, not in the act.

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 act 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 it fails to respond within ten days after the agent makes contact. Insurance agents are further prohibited from submitting an application to OARIP if any other insurer eligible to do business in Ohio has in any way communicated a willingness to insure the applicant, even if the coverage provided by OARIP costs less than other insurers.

OARIP may revoke the authority of any agent who fails to comply with these requirements to submit applications to 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 act expands the list of 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 previous 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 act, 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.

Private insurance outreach program

(Section 739.20)

The act requires the Department of Insurance (ODI), during FY 2027, to create and administer an outreach program to provide information, awareness, and assistance to Medicaid recipients to help them transition from Medicaid to private insurance.

Assisting end-stage renal disease patients

(R.C. 3901.047)

The act requires ODI to do the following regarding individuals with end-stage renal disease:

- Evaluate Medicare application requirements and review state policies and procedures related to patients who are age 65 or younger and have end-stage renal disease;

- Review and identify whether there exist Medicare eligibility gaps for individuals with end-stage renal disease and take steps to address any identified gaps to improve patient access to Medicare benefits;
- Develop a process to assist patients with end-stage renal disease in applying for Medicare benefits.

ODI must submit a report to the General Assembly by September 1, 2026, detailing the review, including the feasibility of developing a process to help patients with end-stage renal disease apply for Medicare benefits. If ODI determines it is not feasible to do so, the report must state the results of those findings and the steps taken to reach that conclusion.