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 an actuarial certification.

Use of genetic information by insurers

- Prohibits public employee benefit plans and MEWAs from using genetic information in relation to reviewing applications, determining insurability, determining benefits, or the setting of premiums.

- Expands the prohibition against health insuring corporations and sickness and accident insurers using genetic information for specified purposes to include the setting of premiums.

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.

Continuing education for insurance agents

- Modifies the continuing education requirements for licensed insurance agents to specify that an agent must complete at least 24 hours of continuing education for each licensing period.

Innovative waiver regarding health insurance coverage

- Requires the Superintendent to apply for a federal waiver authorized by the Patient Protection and Affordable Care Act of 2010 for the purpose of establishing a system that provides access to affordable health insurance coverage for Ohio residents.

- Requires the Superintendent to include in the application a request for waivers of the federal employer and individual mandates established by the Patient Protection and Affordable Care Act.

Pharmacy benefit managers and maximum allowable cost

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

- Places requirements relating to maximum allowable cost on contracts between pharmacy benefit managers and plan sponsors.

- Prescribes disclosure requirements for health benefit plans offered through an exchange.

- Permits the Superintendent to assess a fine against a pharmacy benefit manager if the pharmacy benefit manager commits fraud or violates any of the act's requirements pertaining to pharmacy benefit managers.

Health insurer required provision of information

- Requires insurers offering health benefit plans through an Exchange to make available a list of the top 20% of services and an insured's expected contribution for each service.

- Specifies that an insurer that does not provide the required information is committing an unfair and deceptive practice in the business of insurance.

Multiple employer welfare arrangements

Eligibility

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

The act makes changes to the eligibility requirements pertaining to groups forming a multiple employer welfare arrangement (MEWA). The act 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 act also extends to five years the time period a group must have been organized and maintained before registering as a MEWA. Under former law, only a trade association, industry association, or professional association that was maintained continuously for one year could form a MEWA.

Surplus requirement

(R.C. 1739.13; Section 812.10)

Continuing 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 act increases the required minimum surplus from $150,000 to $500,000. These requirements take effect September 29, 2017, 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 act 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 act 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 former 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.[77] The act 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 act additionally prohibits a MEWA from 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 act 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:

- Comply with accepted actuarial practices;
- Are uniformly applied to arrangement members, employees of members, and the dependents of members or employees;

[77] R.C. 1739.01(B), not in the act.

- 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(B), 1751.18, 1751.65, and 3901.491)

The act prohibits health plan issuers from using genetic information in relation to providing health insurance coverage. Continuing law prohibits health insuring corporations and sickness and accident insurers from using genetic information in relation to reviewing applications, determining insurability, or determining benefits. The act expands this prohibition to apply to MEWAs 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 act removes the 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 act requires such an insurance agent to obtain a signed statement that does not need to be notarized from the insured acknowledging the same information.

Continuing education for insurance agents

(R.C. 3905.481)

The act modifies the continuing education requirements for licensed insurance agents to specify that an agent must complete at least 24 hours of continuing education *for* each licensing period. Former law required 24 hours of continuing education *in* each licensing period.

Innovative waiver regarding health insurance coverage

(R.C. 3901.052)

The act requires the Superintendent of Insurance to apply to the U.S. Secretary of Health and Human Services and the U.S. Secretary of the Treasury for an innovative waiver regarding health insurance coverage in Ohio as authorized by the Patient Protection and Affordable Care Act. The application is to provide for the establishment

of a system that provides access to affordable health insurance coverage for Ohio residents. The Superintendent must include in the application a request for waivers of the employer and individual mandates in the Patient Protection and Affordable Care Act. The employer mandate requires an employer with at least 50 full-time equivalent employees to offer qualifying health insurance coverage to at least a certain percentage of its full-time equivalent employees and their dependent children or pay a tax penalty.[78] The individual mandate is a requirement that an individual, unless exempt, obtain qualifying health coverage or pay a tax penalty.[79]

Pharmacy benefit managers and maximum allowable cost

(R.C. 3959.01, 3959.111, and 3959.12)

Licensure

Continuing law requires third-party administrators to obtain a license from the Department of Insurance. The act specifies that pharmacy benefit managers are a type of third-party administrator, and by extension, requires pharmacy benefit managers to be licensed as third-party administrators. A "pharmacy benefit manager" is an entity that contracts with pharmacies on behalf of a plan sponsor to provide pharmacy health benefit services or administration. "Plan sponsor" means an employer, an MEWA, public employee benefit plan, state agency, insurer, managed care organization, or other third-party payer that facilitates a health benefit plan that provides a drug benefit that is administered by a pharmacy benefit manager.

Maximum allowable cost

The act also sets requirements relating to maximum allowable cost on contracts between pharmacy benefit managers and pharmacies. "Maximum allowable cost" means a maximum drug product reimbursement for an individual drug or for a group of therapeutically and pharmaceutically equivalent multiple source drugs that are listed in the U.S. Food and Drug Administration's Orange Book (formally known as Approved Drug Products with Therapeutic Equivalence Evaluations).

Maximum allowable cost list

In order to place a prescription drug on any maximum allowable cost list (a list of drugs for which a pharmacy benefit manager imposes a maximum allowable cost), in the contract the pharmacy benefit manager must be required to ensure that all of the following conditions are met:

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[78] 26 U.S.C. 4980H.

[79] 26 U.S.C. 5000A.

- The drug is listed as "A" or "B" rated in the most recent version of the Orange Book, or has an "NR" or "NA" or similar rating by a nationally recognized reference.

- The drug is generally available for purchase by Ohio pharmacies from a national or regional wholesaler and is not obsolete.

The act requires a pharmacy benefit manager to maintain a procedure to eliminate drug products from the maximum allowable cost list in a timely manner.

Maximum allowable cost pricing

The act requires each contract between a pharmacy benefit manager and a pharmacy to include a provision granting the pharmacy the right to obtain, within ten days of any request, a current list of the sources the pharmacy benefit manager used to determine maximum allowable cost pricing. Additionally, the pharmacy benefit manager is required to update and implement its pricing information at least every seven days and provide a means by which pharmacies can promptly review pricing updates in a readily accessible format.

Appeal process

Each contract between a pharmacy benefit manager and a pharmacy must include an appeal, investigation, and dispute resolution process regarding maximum allowable cost pricing. The process must include 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 where the pharmacy may contact the pharmacy benefit manager to speak to a person responsible for processing appeals;

- A requirement that a pharmacy benefit manager provide a reason for any appeal denial and the national drug code of a drug that may be purchased in Ohio by the pharmacy at a price at or below the benchmark price determined by the pharmacy benefit manager;

- A requirement that a pharmacy benefit manager make an adjustment not later than one day after the date of determination of the appeal. The adjustment must be retroactive to the date the appeal was made and must apply to all similarly situated pharmacies. This requirement does not, however, prohibit a pharmacy benefit manager from retroactively

adjusting a claim for the appealing pharmacy or for another similarly situated pharmacy.

Disclosures

The act requires a pharmacy benefit manager to disclose to a plan sponsor whether or not the pharmacy benefit manager uses the same maximum allowable cost list when billing a plan sponsor as it does when reimbursing a pharmacy. If the pharmacy benefit manager uses multiple lists, the pharmacy benefit manager must disclose to the plan sponsor any difference between the amount paid to a pharmacy and the amount charged to the plan sponsor. The disclosures must be made within ten days of a pharmacy benefit manager and a plan sponsor signing a contract or within ten days of any applicable update to a maximum allowable cost list.

Health insurer compliance

The act specifies that a health insuring corporation or a sickness and accident insurer must comply with the act's maximum allowable cost provisions and is subject to the penalty imposed by the act (see "**Fining authority**," below) if the corporation or insurer is a pharmacy benefit manager.

Fining authority

The act permits the Superintendent to assess a fine against a third party administrator, including a pharmacy benefit manager, for (1) committing fraud or engaging in illegal activity in connection with administering pharmacy benefit management services or (2) violating any of the act's requirements pertaining to pharmacy benefit managers.

Health insurer required provision of information

(R.C. 3901.241)

The act requires an insurer offering a health benefit plan through a health benefit exchange established pursuant to the Patient Protection and Affordable Care Act, to make available for individuals seeking information on the plan a list of the top 20% of services utilized by individuals insured by the insurer. The list must include an enrollee's expected contribution for each service both when the enrollee has and has not met any associated deductibles. "Expected contribution" includes any copayments or cost sharing amounts that an enrollee is expected to pay under the plan.

The act specifies that an insurer that does not meet this requirement is guilty of an unfair and deceptive act or practice in the business of insurance, the penalties for

which include a cease and desist order, civil penalties up to $35,000, and suspension or revocation of the insurer's license.[80]

[80] R.C. 3901.19 to 3901.26, not in the act.