DEPARTMENT OF INSURANCE

Drug data disclosure

- Effective January 1, 2022, requires health plan issuers, including pharmacy benefit managers, to release specified cost-sharing and other information related to drugs covered under a health benefit plan.
- Specifies the format in which the information must be provided.

Hospital admissions and notification to health plan issuers

- Requires, when a patient covered by a health benefit plan is admitted to a hospital, the hospital to notify the health plan issuer of the admission within 48 hours.

Insurance agent pre-licensing education

- Authorizes the Superintendent of Insurance, when determining the criteria for pre-licensing education for insurance agents, to include classroom, online, and self-study options.

Joint venture title insurance companies

- Requires, for a title company that is a joint venture, the company's annual review to assess whether or not all members of the joint venture received revenue from the title company commensurate to their ownership interest in the title company.
- Requires, for title companies that are joint ventures, all members of the joint venture to be allowed or invited to join any successor joint ventures formed upon dissolution or termination of the original joint venture.

Long-term care insurance tax credit study

- Requires the Departments of Insurance and Medicaid to complete a joint study by July 1, 2022, analyzing whether offering tax credits or other incentives for the purchase of long-term care insurance would increase the number of Ohioans with such insurance.

Drug data disclosure

(R.C. 3902.50, 3902.60, 3902.70, and 3902.72)

Furnishing data

Effective January 1, 2022, the act requires a health plan issuer, including a pharmacy benefit manager, to furnish the following data for any and all drugs covered under a related health benefit plan upon request of a covered person, their health care provider, or the third-party representative:

- The covered person's eligibility information for any and all covered drugs;

- Cost-sharing information for any and all covered drugs, including a description of any variance in cost-sharing based on pharmacy, whether retail or mail order, or health care provider dispensing or administering the drugs;
- Any applicable utilization management requirements for any and all covered drugs, including prior authorization requirements, step therapy, quantity limits, and site-of-service restrictions.

The data must be furnished regardless of whether the request is made using the drug's unique billing code, such as a national drug code or health care common procedure coding system code, or a descriptive term, such as the brand or generic name of the drug. In addition, a health plan issuer, including a pharmacy benefit manager, may not deny or delay a request as a method of blocking the data from being shared based on how the drug was requested.

Under the act, a health plan issuer, including a pharmacy benefit manager, must ensure that the above data meets all of the following:

- It is current not later than one business day after any change is made;
- It is provided in real time;
- It is provided in the same format that the request is made by the covered person, their health care provider, or their third-party representative.

The act requires the format in which a health plan issuer, including a pharmacy benefit manager, replies to a request to use established industry content and transport standards published by either of the following:

- A standards developing organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, ASC X12, health level 7;
- A relevant federal or state governing body, including the Centers for Medicare and Medicaid Services or the Office of the National Coordinator for Health Information Technology.

Prohibitions

Under the act, a health plan issuer, including a pharmacy benefit manager, furnishing the required data may not do any of the following:

- Restrict, prohibit, or otherwise hinder, in any way, a health care provider from communicating or sharing any of the following:
  - Any of the required data;
  - Additional information on any lower-cost or clinically appropriate alternatives, whether or not they are covered under the covered person's health benefit plan;
  - Additional payment or cost-sharing information that may reduce the covered person's out-of-pocket costs, such as cash price or patient assistance and support programs whether sponsored by a manufacturer, foundation, or other entity.

- Except as may be required by law, interfere with, prevent, or materially discourage access to, exchange of, or use of the required data by doing any of the following:
  - Charging fees;
  - Not responding to a request at the time the request is made, if such a response is reasonably possible;
  - Implementing technology in nonstandard ways;
  - Instituting covered person consent requirements, processes, policies, procedures, or renewals that are likely to substantially increase the complexity or burden of accessing, exchanging, or using such data.
- Penalize a health care provider for disclosing such data to a covered person or for prescribing, administering, or ordering a clinically appropriate or lower-cost alternative.

Personal representatives

The act requires a health plan issuer, including a pharmacy benefit manager, to treat a personal representative of a covered person as the covered person for purposes of the above provisions. In addition, if a person has authority to act on behalf of a covered person in making decisions related to health care, a health plan issuer, including a pharmacy benefit manager, or its affiliates or entities acting on its behalf, must treat that person as a personal representative.

Definitions

"**Covered**" means the provision of benefits related to health care services to a covered person in accordance with a health benefit plan.

"**Covered person**" means a person covered under a health benefit plan.

"**Drug**" means the following:

- Any article recognized in the U.S. Pharmacopoeia and National Formulary, or any supplement to them, intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or animals;
- Any other article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or animals;
- Any article, other than food, intended to affect the structure or any function of the body of humans or animals;
- Any article intended for use as a component of any article specified above, but does not include devices or their components, parts, or accessories.

"**Health benefit plan**" means an agreement offered by a health plan issuer to provide or pay for the cost of health care services. "Health benefit plan" includes limited benefit plans, but does not include vision-only, dental-only, specified disease, disability, supplemental, or certain other specified types of limited plans. "Health benefit plan" does not include Medicare or Medicaid plans or any supplement to those plans.

"**Health care provider**" means a hospital, ambulatory care facility, long-term care facility, pharmacy, emergency facility, or health care practitioner (a physician, physician assistant, registered or licensed practical nurse, dentist, dental hygienist, optometrist, optician, pharmacist, psychologist, chiropractor, hearing aid dealer or fitter; speech-language pathologist, audiologist, specified type of therapist or counselor, dietitian, respiratory care professional, or EMT).

"**Health plan issuer**" means an entity subject to Ohio's insurance laws that contracts to provide, pay for, or reimburse any of the costs of health care services. The term includes a sickness and accident insurer, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, and a nonfederal, government health plan. The term also includes a third-party administrator, such as a pharmacy benefit manager, to the extent that the benefits the administrator is contracted to administer are subject to Ohio insurance laws or to the Superintendent's jurisdiction.

"**Pharmacy benefit manager**" means an entity that contracts with pharmacies on behalf of an employer, a multiple employer welfare arrangement, public employee benefit plan, state agency, insurer, managed care organization, or other third-party payer to provide pharmacy health benefit services or administration.

"**Prior authorization requirement**" means any practice implemented by a health plan issuer in which coverage of a health care service, device, or drug is dependent upon a covered person or a provider obtaining approval from the health plan issuer prior to the service, device, or drug being performed, received, or prescribed, as applicable. "Prior authorization requirement" includes prospective or utilization review procedures conducted prior to providing a health care service, device, or drug.

Hospital admissions and notification to health plan issuers

(R.C. 3727.80)

The act requires a hospital, when a patient is admitted to that hospital and informs the hospital that the patient is covered by a health benefit plan, to notify the health plan issuer of the admission within 48 hours. If the hospital is *not* informed that a patient is covered by a health benefit plan when the patient is admitted, then the hospital is required to notify the health plan issuer of the patient's admission within 48 hours of being informed. A hospital is considered to have been informed that a patient is covered under a health benefit plan when the patient provides the hospital the patient's health benefit plan identification card. The hospital must make the required notification either in writing or through a secure electronic transmission. If written notice is not possible, then the notice is to be made by telephone.

Insurance agent pre-licensing education

(R.C. 3905.04)

In order to qualify to sit for the insurance agent license exam, continuing law requires an insurance agent applicant to meet one of several specified education criteria, one of which is the completion of 20 hours of study in a program of insurance education approved and established by the Superintendent of Insurance. The act explicitly authorizes the

Superintendent, when determining the criteria for pre-licensing education for insurance agents, to include classroom, online, and self-study options.

Joint venture title insurance companies

(R.C. 3953.331 and 3953.36)

Under continuing law, every title insurance agent or agency that handles escrow, settlement, closing, or security deposit accounts must have an independent review made of its escrow, settlement, closing, and security deposit accounts.[77] The act specifies that for a title insurance company that is a joint venture,[78] the required annual review must assess whether or not all members of the joint venture received revenue during the year in question from the title company commensurate to their ownership interest in the company. In addition, the title insurance companies that are joint ventures must maintain sufficient records of their affairs, including their escrow operations, escrow trust accounts, and operating accounts so that the Superintendent of Insurance can adequately ensure that the title insurance company that is a joint venture and all members of the joint venture are in compliance with the requirements set forth in the act. The records must be kept for at least ten years following the transactions to which the records relate. The act requires the Superintendent to adopt rules setting forth the standards of the review required and the form in which this information is to be provided. The Superintendent may also prescribe by rule the specific records and documents to be kept.

For a title company that is a joint venture that is set to dissolve or terminate on a specified date, the act requires that all members of that joint venture must be allowed or invited to join any successor joint ventures formed upon dissolution or termination of the original joint venture.

Long-term care insurance tax credit study

(Section 757.30)

The act requires the Departments of Insurance and Medicaid to complete and submit to the Governor and General Assembly a joint study by July 1, 2022, analyzing whether offering tax credits or other incentives for the purchase of long-term care insurance would increase the number of Ohioans with such insurance. If so, the study must recommend incentive options and amounts that would encourage the purchase of such insurance.

The study must also analyze whether employers or other group plan providers should be able to purchase long-term care insurance policies for their employees or members and whether hybrid life insurance policies should be included in the departments' long-term care

[77] R.C. 3953.33, not in the act.

[78] A joint venture is a legal organization that takes the form of a short-term partnership in which the persons jointly undertake a transaction for mutual profit. Cornell Law School, Legal Information Institute, *Joint venture*, https://www.law.cornell.edu/wex/joint_venture.

partnership program. (That program allows individuals to purchase long-term care insurance policies while keeping assets that would otherwise disqualify the individuals from Medicaid.[79])

[79] R.C. 3923.41, not in the act.