As Reported by the Senate Financial Institutions, Insurance and Technology Committee

136th General Assembly

Regular Session **Sub. H. B. No. 229**

2025-2026

Representative Deeter

Cosponsors: Representatives Bird, John, Russo, Abdullahi, Baker, Brennan, Brent, Brewer, Brownlee, Click, Cockley, Daniels, Dovilla, Fischer, Glassburn, Grim, Hall, D., Hoops, Isaacsohn, Jarrells, Johnson, King, Lampton, Lawson-Rowe, Lett, Manning, Mathews, A., Mathews, T., McClain, Miller, J., Miller, M., Mohamed, Plummer, Ray, Ritter, Salvo, Santucci, Sigrist, Sims, Thomas, C., Thomas, D., Upchurch, White, A., White, E., Williams, Willis, Workman, Young

To amend sections 1751.92, 3905.24, 3923.87, 3959.01, 3959.111, 3959.12, and 3959.20; to amend, for the purpose of adopting new section numbers as indicated in parentheses, sections 3959.111 (3957.25), 3959.20 (3957.26), and 3959.22 (3957.27); and to enact sections 3957.01, 3957.02, 3957.03, 3957.04, 3957.05, 3957.06, 3957.07, 3957.08, 3957.09, 3957.10, 3957.11, 3957.12, 3957.13, 3957.14, 3957.15, 3957.16, and 3957.99 of the Revised Code to establish a stand-alone licensing process and new contractual requirements for pharmacy benefit managers.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 1751.92, 3905.24, 3923.87, 3959.01, 3959.111, 3959.12, and 3959.20 be amended; sections 3959.111 (3957.25), 3959.20 (3957.26), and 3959.22 (3957.27) be

amended for the purpose of adopting new section numbers as indicated in parentheses; and sections 3957.01, 3957.02, 3957.03, 3957.04, 3957.05, 3957.06, 3957.07, 3957.08, 3957.09, 3957.10, 3957.11, 3957.12, 3957.13, 3957.14, 3957.15, 3957.16, and 3957.99 of the Revised Code be enacted to read as follows:

Sec. 1751.92. Each health insuring corporation shall comply with the requirements of section ~~3959.20~~ 3957.26 of the Revised Code as they pertain to health plan issuers.

As used in this section, "health plan issuer" has the same meaning as in section 3922.01 of the Revised Code.

Sec. 3905.24. (A)(1) All records and other information obtained by the superintendent of insurance or the superintendent's deputies, examiners, assistants, or other employees, or agents relating to an investigation of an applicant for licensure under this chapter, or of an agent, solicitor, broker, or other person licensed or appointed under this chapter or Chapter 3951., 3957., or 3959. of the Revised Code, are confidential and are not public records as defined in section 149.43 of the Revised Code until the applicant, licensee, or appointee is provided notice and opportunity for hearing pursuant to Chapter 119. of the Revised Code with respect to such records or information. If no administrative action is initiated with respect to a particular matter about which the superintendent obtained records or other information as part of an investigation, all such records and information relating to that matter shall remain confidential for three years after the file on the matter is closed.

(2) Division (A)(1) of this section applies only to investigations that could result in administrative action under Title XVII or XXXIX or Chapter 119. of the Revised Code.

(B) The records and other information described in division (A) of this section shall remain confidential for all purposes except when it is appropriate for the superintendent and the superintendent's deputies, examiners, assistants, or other employees, or agents to take official action regarding the affairs of the applicant, licensee, or appointee or in connection with actual or potential criminal proceedings.

(C) Notwithstanding divisions (A) and (B) of this section, the superintendent may do either of the following:

(1) Share records and other information that are the subject of this section with the chief deputy rehabilitator, the chief deputy liquidator, other deputy rehabilitators and liquidators, and any other person employed by, or acting on behalf of, the superintendent pursuant to Chapter 3901. or 3903. of the Revised Code, with other local, state, federal, and international regulatory and law enforcement agencies, with local, state, and federal prosecutors, and with the national association of insurance commissioners and its affiliates and subsidiaries, provided that the recipient agrees to maintain the confidential status of the confidential record or other information and has authority to do so;

(2) Disclose records and other information that are the subject of this section in the furtherance of any regulatory or legal action brought by or on behalf of the superintendent or the state, resulting from the exercise of the superintendent's official duties.

(D) Notwithstanding divisions (A), (B), and (C) of this section, the superintendent may authorize the national association of insurance commissioners and its affiliates and subsidiaries by agreement to share confidential records and

other information received pursuant to division (C)(1) of this section with local, state, federal, and international regulatory and law enforcement agencies and with local, state, and federal prosecutors, provided that the recipient agrees to maintain the confidential status of the confidential record or other information and has authority to do so.

(E) Notwithstanding divisions (A), (B), and (C) of this section, the chief deputy rehabilitator, the chief deputy liquidator, and other deputy rehabilitators and liquidators may disclose records and other information that are the subject of this section in the furtherance of any regulatory or legal action brought by or on behalf of the superintendent, the rehabilitator, the liquidator, or the state resulting from the exercise of the superintendent's official duties in any capacity.

(F) Nothing in this section shall prohibit the superintendent from receiving records and other information in accordance with section 3901.045 of the Revised Code.

(G)(1) No waiver of any applicable privilege or claim of confidentiality in the records and other information that are the subject of this section shall occur as a result of sharing or receiving records or other information as authorized in divisions (C)(1), (D), and (F) of this section.

(2) The disclosure of records or other information in connection with a regulatory or legal action pursuant to divisions (C)(2) and (E) of this section does not prohibit an insurer or any other person from taking steps to limit the dissemination of the record or other information to persons not involved in or the subject of the regulatory or legal action on the basis of any recognized privilege arising under any other

section of the Revised Code or the common law.

(H) Employees or agents of the department of insurance shall not be required by any court in this state to testify in a civil action, if the testimony concerns any matter related to records or other information considered confidential under this section of which they have knowledge.

Sec. 3923.87. Each sickness and accident insurer or public employee benefit plan shall comply with the requirements of section ~~3959.20~~ 3957.26 of the Revised Code as they pertain to health plan issuers.

As used in this section, "health plan issuer" has the same meaning as in section 3922.01 of the Revised Code.

Sec. 3957.01. As used in this chapter:

(A) "Claims processing services" means administrative services performed in connection with processing and adjudicating claims relating to pharmacist services, including both of the following:

(1) Receiving payments for pharmacist services;

(2) Making payments to pharmacists or pharmacies for pharmacist services.

(B) "Contracted pharmacy" or "pharmacy" means a pharmacy, as defined in section 4729.01 of the Revised Code, located in this state and participating in either the network of a pharmacy benefit manager or in a health care or pharmacy benefit plan through a direct contract or through a contract with a pharmacy services administration organization, group purchasing organization, or another contracting agent.

(C) "Drug product reimbursement" means the amount paid by

a pharmacy benefit manager to a contracted pharmacy for the cost of the drug dispensed to a patient and does not include a dispensing or professional fee.

(D) "Fiscal year," "plan," "plan sponsor," and "self-insurance program" have the same meanings as in section 3959.01 of the Revised Code.

(E) "Health benefit plan" and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.

(F) "Insurance" has the same meaning as in section 3905.01 of the Revised Code.

(G) "Insurer" has the same meaning as in section 3901.32 of the Revised Code.

(H) "Licensee" means a person licensed as a pharmacy benefit manager under this chapter.

(I) "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 United States food and drug administration's approved drug products with therapeutic equivalence evaluations, commonly referred to as the orange book.

(J) "Maximum allowable cost list" means a list of the drugs for which a pharmacy benefit manager imposes a maximum allowable cost.

(K) "Other prescription drug or device services" means services other than claims processing services, provided directly or indirectly, whether in connection with or separate from claims processing services, including all of the following:

(1) Negotiating rebates, discounts, or other financial incentives and arrangements with drug companies;

(2) Disbursing or distributing rebates;

(3) Managing or participating in incentive programs or arrangements for pharmacist services;

(4) Negotiating or entering into contractual arrangements with pharmacists or pharmacies, or both;

(5) Developing formularies;

(6) Designing prescription benefit programs;

(7) Advertising or promoting services.

(L) "Pharmacist" means an individual licensed to engage in the practice of pharmacy, as defined in section 4729.01 of the Revised Code.

(M) "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 claims processing services, pharmacy benefit management services or administration, or other prescription drug or device services. "Pharmacy benefit manager" includes the state pharmacy benefit manager selected under section 5167.24 of the Revised Code.

(N) "Pharmacy benefit manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefit manager.

(O) "Pharmacy benefit management services" means services provided by a pharmacy benefit manager 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 claims processing services, administrative support or efficiencies, contracting, or other prescription drug or device services.

(P) "Pharmacy services administrative organization" means an organization that helps community pharmacies and pharmacy benefit managers or third-party payers achieve administrative efficiencies, including contracting and payment efficiencies.

(Q) "Rebate" means a discount or other price concession, or a payment attributable to the utilization of prescription drugs in this state, that is paid by a drug manufacturer directly to a pharmacy benefit manager after a claim has been processed and paid at a pharmacy.

(R) "Subject to this chapter" means, in the context of an agreement involving a pharmacy benefit manager, that the agreement is entered into, amended, or renewed on or after July 1, 2027.

(S) "Third-party payer" has the same meaning as in section 3901.38 of the Revised Code, except that the term does not include a pharmacy benefit manager subject to this chapter.

Sec. 3957.02. The superintendent of insurance shall establish by rule, adopted in accordance with Chapter 119. of the Revised Code, and administer a process for licensing pharmacy benefit managers in this state. The superintendent may adopt any other rules the superintendent deems necessary for the administration, implementation, and enforcement of this chapter.

When adopting rules pursuant to this section, the superintendent shall consider standards and procedures that have been found to be the best practices relative to the use and regulation of pharmacy benefit managers.

Sec. 3957.03. (A) On and after July 1, 2027, no person shall solicit a plan or plan sponsor that is domiciled in this state or has its principal headquarters or principal administrative office in this state to act as a pharmacy benefit manager for the plan or plan sponsor unless licensed under this chapter.

(B) No person shall provide pharmacy benefit management services pursuant to an agreement subject to this chapter unless licensed under this chapter.

(C) No person shall solicit a plan, act as a pharmacy benefit manager, or otherwise provide pharmacy benefit management services while the person's pharmacy benefit manager license is expired pursuant to division (C) of section 3957.08 of the Revised Code.

Sec. 3957.04. (A) A person that seeks to be licensed as a pharmacy benefit manager shall file an application with the superintendent of insurance in the form and manner prescribed by the superintendent. The application shall include all the information the superintendent considers necessary to process the application, including evidence satisfactory to the superintendent that the applicant meets the requirements specified in division (C) of this section.

(B) All applications for a pharmacy benefit manager license shall be accompanied by a nonrefundable filing fee of two thousand dollars per application. All fees collected under

this section and section 3957.08 of the Revised Code shall be paid into the state treasury to the credit of the department of insurance operating fund created under section 3901.021 of the Revised Code.

(C) To be eligible to receive a pharmacy benefit manager license, an applicant shall demonstrate to the superintendent that the applicant meets the requirements of this division.

(1) For an applicant seeking a pharmacy benefit manager license as an individual, the applicant shall meet all of the following requirements:

(a) The applicant must be at least eighteen years of age.

(b) The applicant must not have been previously convicted of a financially related felony.

(c) The applicant must not have committed any act that is grounds for the denial, suspension, or revocation of a license under this chapter.

(d) The applicant must consent to a criminal records check, and the results of the check must be determined to be satisfactory by the superintendent pursuant to section 9.79 of the Revised Code.

(e) The applicant must provide proof of United States citizenship or proof of legal authorization to work in the United States.

(f) The applicant must provide any additional information or documents required by the superintendent.

(2) For an applicant seeking a pharmacy benefit manager license as a business entity, the applicant shall meet all of the following requirements:

(a) The applicant must be domiciled or maintain its principal place of business in this state, as evidenced by a certificate of good standing issued by the secretary of state.

(b) The applicant must identify all officers, directors, partners, or members of the business entity and must identify any owners or members that hold five per cent or more ownership in the entity.

(c) The applicant must identify an officer, director, partner, or member responsible for the entity's compliance with this chapter.

(d) The applicant must not have been, and not have any officer, director, partner, or member that has been, previously convicted of a financially related felony.

(e) The applicant must not have committed, and not have any officer, director, partner, or member that has committed, any act that is grounds for the denial, suspension, or revocation of a license under this chapter.

(f) The applicant must provide any additional information or documents requested by the superintendent.

(3) An individual or business entity applicant may seek a nonresident pharmacy benefit manager license instead of a license under division (C)(1) or (2) of this section if the individual or entity holds a current, valid license in another state and meets all of the following requirements:

(a) The applicant must submit a complete application for a pharmacy benefit manager license to the superintendent in accordance with division (A) of this section.

(b) The applicant must not have committed any act that is

grounds for the denial, suspension, or revocation of a license under this chapter.

(c) If the applicant is a business entity, the applicant must provide a certificate of good standing for a foreign corporation issued by the secretary of state.

(d) If the applicant is a business entity, the applicant must identify all officers, directors, partners, or members of the business entity, and must identify any owners or members that hold five per cent or more ownership in the entity.

(e) The applicant must not have committed, and must not have any officer, director, partner, or member that has committed, any act that is grounds for the denial, suspension, or revocation of a license under this chapter.

(f) The applicant must be licensed in a state that issues nonresident pharmacy benefit manager licenses to residents of this state on the same basis as set forth in this section.

(g) The applicant must provide any additional information or documents requested by the superintendent.

(4) An individual or business entity applicant that does not meet the requirements of division (C)(3) of this section for a nonresident license must meet the requirements under division (C)(1) or (2) of this section.

Sec. 3957.05. The superintendent of insurance shall approve or deny an application for a license under this chapter within a reasonable time after receipt.

Sec. 3957.06. Within thirty days after denying an application for a license under this chapter, the superintendent of insurance shall notify the applicant of the denial and the

reasons for the denial. The superintendent shall include a statement in the notice advising that the applicant is entitled to a hearing, in accordance with Chapter 119. of the Revised Code, if the applicant requests such a hearing within thirty days after receipt of the notice.

Sec. 3957.07. Upon approving an application for a license under this chapter and receiving payment of the associated filing fee, the superintendent of insurance shall grant the applicant a license to operate as a pharmacy benefit manager in this state. The initial license is effective on the date the application is approved by the superintendent and expires annually on the thirtieth day of June. If the initial license application is approved in May or June, the license expires on the thirtieth day of June the following year. The superintendent shall renew an initial license in accordance with section 3957.08 of the Revised Code.

Sec. 3957.08. (A) The superintendent of insurance shall provide a renewal notice to each licensee not later than the first day of May each year.

(B) A licensee may renew its pharmacy benefit manager license by applying to the superintendent, in the form and manner prescribed by the superintendent, and paying a renewal fee of three thousand dollars before the date the license expires. A licensee shall not apply for a license renewal more than ninety days before the date the license expires.

(C) In the event that a licensee fails to apply for renewal and pay the renewal fee before the date the license expires, the license shall expire on the expiration date, and the former licensee is not authorized to operate as a pharmacy benefit manager in this state beginning on that date. A person

whose license is expired may apply to reinstate the license in the same manner as a license renewal under division (B) of this section, except that the filing fee is one and one-half times the renewal fee under division (B) of this section.

Sec. 3957.09. (A) Except as provided in division (G) of this section, no person shall act as a pharmacy benefit manager on or after July 1, 2027, without first entering into a written agreement with a plan sponsor.

(B) The pharmacy benefit manager shall retain the written agreement as part of the pharmacy benefit manager's official records for the duration of the agreement and for five years thereafter. Each agreement shall include, at a minimum, all of the following:

(1) The term of the agreement;

(2) An explanation of the services to be performed by the pharmacy benefit manager;

(3) The method and rate of compensation to be paid by the plan sponsor to the pharmacy benefit manager for services rendered;

(4) Provisions for the renewal and termination of the agreement.

(C) A pharmacy benefit manager shall maintain, for the duration of the agreement with the plan sponsor, customary and relevant books and records of all transactions and information relative to covered persons or beneficiaries. The pharmacy benefit manager shall maintain such customary and relevant books and records either electronically or in physical form at the pharmacy benefit manager's principal office or branch office and shall make those books and records available to the

superintendent or the superintendent's designee at any time upon request. Any protected health information received from the request shall be maintained in compliance with all applicable federal and state privacy laws, including the "Health Insurance Portability and Accountability Act of 1996," 42 U.S.C. 1320d, et seq. and the regulations adopted under that act.

(D) A pharmacy benefit manager shall account, annually or more frequently, to the plan sponsor for any pricing discounts, rebates of any kind, inflationary payments, credits, claw backs, fees, grants, charge backs, drug product reimbursements, or other benefits received by the pharmacy benefit manager. The pharmacy benefit manager shall give the plan sponsor access to all financial and utilization information used by the pharmacy benefit manager in relation to pharmacy benefit management services provided to the plan sponsor.

(E) A pharmacy benefit manager shall disclose, in writing, to the plan sponsor the terms and conditions of any contract or arrangement between the pharmacy benefit manager and any other party relating to pharmacy benefit management services provided by the pharmacy benefit manager to the plan sponsor, including pharmacy benefit management services provided to group purchasing organizations.

(F) A pharmacy benefit manager shall disclose, in writing, to the plan sponsor any activity, policy, practice, contract, or arrangement of the pharmacy benefit manager that directly or indirectly presents any conflict of interest concerning the pharmacy benefit manager's relationship with or obligation to the plan sponsor.

(G) Divisions (A) to (F) of this section apply to agreements subject to this chapter and pharmacy benefit

management services provided pursuant to those agreements. Nothing in those divisions applies to pharmacy benefit management services provided pursuant to an agreement that is not subject to this chapter.

(H) A pharmacy benefit manager licensed under this chapter shall, at all times, maintain any required insurance coverage or bond as provided for and mandated by the "Employee Retirement and Income Security Act of 1974," 29 U.S.C. 1001.

Sec. 3957.10. (A) Upon notice and hearing in accordance with Chapter 119. of the Revised Code, the superintendent of insurance may take any of the actions enumerated in division (C) of this section if the superintendent finds that a licensee has done any of the following:

(1) Violated any provision of this chapter, any rule adopted by the superintendent, or any consent agreement or order of the superintendent;

(2) Provided incorrect, misleading, incomplete, or materially false information in the licensure or renewal application;

(3) Obtained or attempted to obtain a license through misrepresentation or fraud;

(4) Misappropriated, converted, or improperly withheld insurance company premiums or contributions, excluding interest earnings received by the licensee that are disclosed in writing to the plan sponsor;

(5) In the transaction of business in this or another state, has been convicted of using fraudulent, coercive, or dishonest practices or has demonstrated incompetence, untrustworthiness, or financial irresponsibility;

(6) Failed to appear in response to a subpoena, examination, warrant, or other order lawfully issued by the superintendent;

(7) Is affiliated with, or is under the same general management or interlocking directorate or ownership of, another pharmacy benefit manager that transacts business in this state and that is not licensed under this chapter;

(8) Had a license or its equivalent denied, suspended, revoked, or not renewed in any other state, district, territory, or province;

(9) Has been, or has an owner that has been, convicted of a financially related felony;

(10) Has been, or has an owner that has been, convicted of or pleaded guilty to or no contest to a felony, regardless of whether a judgment of conviction has been entered by the court.

(B)(1) If the superintendent has information, in the department of insurance's files, from a complaint, or otherwise, that a person has engaged in or is about to engage in conduct described in division (A) of this section, or if the superintendent believes it to be in the best interest of the public, insurers, and plan sponsors, the superintendent may do either of the following:

(a) Investigate the person, as authorized under this section or in rules adopted by the superintendent;

(b) Issue subpoenas to any person for the purpose of compelling the attendance and testimony of witnesses or the production of books, accounts, papers, records, or documents.

(2) If the person fails to comply with an order or a

subpoena issued pursuant to division (B)(1) of this section, upon application of the superintendent, a judge of the court of common pleas of the county in which the individual resides or the entity is located, upon application of the superintendent, shall compel obedience by attachment proceedings for contempt, as in the case of disobedience with respect to the requirements of a subpoena issued from the court or a refusal to testify in the court.

(C) If the superintendent determines that a pharmacy benefit manager licensed under this chapter has engaged in any of the conduct described in division (A) of this section or if the superintendent believes it to be in the best interest of the public, insurers, and plan sponsors, the superintendent may take one or more of the following actions against the pharmacy benefit manager:

(1) Assess a civil penalty in an amount not to exceed fifteen thousand dollars per violation;

(2) Assess administrative costs to cover the expenses incurred by the department in the administrative action, including costs incurred in the investigation and hearing process. Any costs collected shall be paid into the state treasury to the credit of the department of insurance operating fund created in section 3901.021 of the Revised Code.

(3) Suspend the pharmacy benefit manager's license;

(4) Permanently revoke the pharmacy benefit manager's license;

(5) Refuse to issue a license under this chapter to an applicant;

(6) Refuse to renew a pharmacy benefit manager's license;

(7) Prohibit the pharmacy benefit manager licensee from engaging in the business of insurance, or if the licensee is an individual, being employed by a pharmacy benefit manager entity licensed under this chapter. The superintendent may, in the superintendent's discretion, determine the nature, conditions, and duration of these restrictions.

(8) Order corrective action in lieu of or in addition to the other penalties listed in this division. An order for corrective action may provide for the suspension of a civil penalty, license revocation, license suspension, or refusal to issue or renew a license, if the pharmacy benefit manager complies with the terms and conditions of the corrective action order.

(9) Accept a license surrender for cause by the pharmacy benefit manager. The surrender for cause shall be for at least five years and shall prohibit the pharmacy benefit manager from seeking any license authorized under Title XXXIX of the Revised Code during that time period. A surrender for cause is in lieu of a license revocation or suspension and may include a corrective action order described in division (C)(8) of this section.

(D) Upon receipt of notice of an order of suspension in accordance with sections 119.05 and 119.07 of the Revised Code, the pharmacy benefit manager shall promptly deliver its license to the superintendent, unless the order of suspension is appealed under section 119.12 of the Revised Code.

(E)(1) If a person engages in conduct that is a violation described in division (A) of this section and that has caused, is causing, or is about to cause substantial and material harm, or if the superintendent believes it to be in the best interest

of the public, insurers, and plan sponsors, the superintendent may issue an order requiring the person to cease and desist from engaging in the conduct.

(2) Immediately after issuing a cease and desist order under division (E)(1) of this section, the superintendent shall provide notice of the order to all persons known to be involved in the conduct. The notice may be served in accordance with section 119.05 of the Revised Code. Thereafter, the superintendent may publicize or otherwise notify all interested parties that the order has been issued. A notice issued under this division shall specify the particular act, omission, practice, or transaction that is the subject of the cease and desist order, and shall set a date, not more than fifteen days after the date of the order, for a hearing on the continuation or revocation of the order. Each person shall comply with the cease and desist order immediately upon receipt of the notice.

(3) The superintendent shall hold a hearing on the cease and desist order in accordance with Chapter 119. of the Revised Code, to the extent that chapter does not conflict with the procedures otherwise set forth in this section. Upon the application of a party and for good cause shown, the superintendent may continue the hearing. The superintendent shall issue a final order within fifteen days after objections are submitted for the hearing officer's report and recommendation either confirming or revoking the cease and desist order. The final order may be appealed, as provided under section 119.12 of the Revised Code.

(4) A cease and desist order issued under division (E)(1) of this section is cumulative and concurrent with the other remedies available under this section and does not prevent the

exercise of any other of those remedies.

(F) If the superintendent has reasonable cause to believe that a person has violated an order issued pursuant to this section, in whole or in part, the superintendent may request that the attorney general commence and prosecute an appropriate action or proceeding in the name of the state against the person. In an action brought pursuant to this division, the court may impose a civil penalty of not more than fifteen thousand dollars for each violation, injunctive relief, restitution, and any other appropriate relief.

Sec. 3957.11. (A) A pharmacy benefit manager shall notify the superintendent of insurance if the pharmacy benefit manager, or any owner of the pharmacy benefit manager, is subject to administrative action by a government entity having professional, occupational, or financial authority in this or another state while the pharmacy benefit manager holds a license under this chapter. The notice shall be provided not later than thirty days after the entry date of final disposition in the matter and shall include a copy of the order, consent order, or any other relevant documents related to the matter.

(B) A pharmacy benefit manager shall notify the superintendent of insurance if the pharmacy benefit manager, or any owner of the pharmacy benefit manager, is subject to a criminal prosecution in this or another state, other than a misdemeanor traffic offense, while the pharmacy benefit manager holds a license under this chapter. The notice shall be provided not later than thirty days after the person initially appears before a judge or magistrate and shall include a certified copy of the charging document. Not later than thirty days after final disposition of the criminal prosecution, the pharmacy benefit

manager shall provide to the superintendent a certified copy of the court's entry or order that reflects the final disposition of the prosecution and any other relevant document related to the prosecution.

Sec. 3957.12. (A) On and after July 1, 2027, no pharmacy benefit manager shall do any of the following:

(1) Use plan sponsor funds for any purpose not specifically set forth in writing by the pharmacy benefit manager;

(2) Fail to disclose in written solicitation materials and at least once annually to contracted plan sponsors any ownership relationship of five per cent or more between the pharmacy benefit manager and an insurer;

(3) Fail to remit insurance premiums within the policy period or within the time agreed to in writing between the insurer and the pharmacy benefit manager;

(4) Fail to disclose in writing the method of collecting and holding a plan sponsor's funds.

(B) This section does not apply to the extent that it conflicts with an agreement that is not subject to this chapter.

Sec. 3957.13. (A) On and after July 1, 2027, a pharmacy benefit manger shall do all of the following:

(1) Maintain relevant books and records that reflect all transactions administered by the pharmacy benefit manager pursuant to agreements that are subject to this chapter, specifically in regard to premiums or contributions received and deposited, and claims and authorized expenses paid.

(2) Prepare, journalize, and post the relevant books and

records described in division (A)(1) of this section in accordance with the terms and conditions of the service agreement between the pharmacy benefit manager and the insurer or plan sponsor and in accordance with the "Employee Retirement and Income Security Act of 1974," 29 U.S.C. 1001.

(3) Maintain the relevant books and records described in division (A)(1) of this section for the period during which the pharmacy benefit manager provides services for the applicable insurer or plan sponsor and for ten years thereafter.

(4) Maintain a cash receipts register of all premiums or contributions received, including, at minimum, the date such contributions are received and deposited.

(B) For purposes of the relevant books and records described in division (A)(1) of this section, a pharmacy benefit manager's description of a disbursement shall be in sufficient detail to identify the source document substantiating the purpose of the disbursement, and shall include all of the following:

(1) The check number;

(2) The date of disbursement;

(3) The person to whom the disbursement was made;

(4) The amount disbursed and, if the amount disbursed does not align with the amount billed or authorized, a written record as to the application for the disbursement;

(5) If the disbursement is for the earned pharmacy benefit manager fee or commission, a written record reflecting the identifying deposit from which the fee is matched.

(C) A pharmacy benefit manager shall support all journal

entries for receipts and disbursements with evidence that is referenced in the journal entry so that it may be traced for verification.

(D) A pharmacy benefit manager shall prepare and maintain monthly financial institution account reconciliations if requested by an insurer or plan sponsor as provided in any service agreement by and between the pharmacy benefit manager and the insurer or plan sponsor that is subject to this chapter.

(E) A pharmacy benefit manager shall prepare a report to be filed with the insurer or plan sponsor with which the pharmacy benefit manager has an agreement subject to this chapter within ninety days after the end of the fiscal year of the plan that, at minimum, discloses all of the following:

(1) The total premiums or contributions received from the plan sponsor, covered persons, or beneficiaries;

(2) The total administration fees withdrawn by the pharmacy benefit manager pursuant to the written service agreement;

(3) The total claim payments made during the reporting period.

(F) A pharmacy benefit manager shall pay return premiums or contributions to the insurer or plan sponsor with which the pharmacy benefit manager has an agreement subject to this chapter, or credit such return premiums or contributions to the account of the insurer or plan sponsor, within thirty days after receipt by the pharmacy benefit manager. If the pharmacy benefit manager credits the return premium or contribution to the insurer or plan sponsor, the pharmacy benefit manager shall show and apply the credit to the next billing statement sent to the

insurer or plan sponsor.

(G) On and after July 1, 2027, the superintendent of insurance may examine the relevant books and records described in division (A)(1) of this section of a pharmacy benefit manager as necessary to determine the following related to any contracts involving a pharmacy benefit manager and a plan sponsor of a health benefit plan or health plan issuer:

(1) The aggregate amount of rebates received by a pharmacy benefit manager;

(2) The aggregate amount of rebates distributed by a pharmacy benefit manager to an appropriate plan sponsor of a health benefit plan or health plan issuer;

(3) The aggregate amount of rebates passed on to a covered person under the health benefit plan at the point of sale that reduced the person's applicable deductible, copayment, coinsurance, or other cost-sharing amount;

(4) The individual and aggregate amount paid by a plan sponsor of a health benefit plan or health plan issuer to the pharmacy benefit manager for pharmacist services itemized by pharmacy, product, and goods and services, including other prescription drug or device services;

(5) The individual and aggregate amount a pharmacy benefit manager paid for pharmacist services itemized by pharmacy, product, and goods and services, including other prescription drug or device services.

(H) To carry out the duties of division (G) of this section, the superintendent may contract with a third party to examine the relevant books and records described in division (A)(1) of this section of a pharmacy benefit manager.

(I) A pharmacy benefit manager shall pay all expenses associated with the examination functions authorized or required by this section, including any expenses related to a contract with a third party to conduct that examination. The superintendent shall provide the pharmacy benefit manager with an itemized statement of the expenses incurred in the performance of those functions and, upon receipt of that statement, the pharmacy benefit manager shall remit the full amount of such expenses to the superintendent. The superintendent shall remit amounts received under this division to the treasurer of state pursuant to section 3901.021 of the Revised Code for deposit in the department of insurance operating fund.

(J) Upon written notification to a pharmacy benefit manager by the superintendent of insurance that the pharmacy benefit manager has violated any provision of this section, the pharmacy benefit manager shall correct the violation specified in the notice within sixty days.

Sec. 3957.14. (A) All information and data acquired by the superintendent of insurance or the department of insurance under this chapter is considered proprietary and confidential under section 3905.24 of the Revised Code and is not a public record under section 149.43 of the Revised Code.

(B) On and after July 1, 2027, no pharmacy benefit manager or representative of a pharmacy benefit manager shall cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading.

Sec. 3957.15. For purposes of licensure, this chapter does not apply to an employer's self-insurance program or fully

insured plan to the extent that federal law supersedes, preempts, prohibits, or otherwise precludes its application to such plan.

Sec. 3957.16. On receipt of a notice pursuant to section 3123.43 of the Revised Code, the superintendent of insurance shall comply with sections 3123.41 to 3123.50 of the Revised Code and any applicable rules adopted under section 3123.63 of the Revised Code with respect to a license issued pursuant to this chapter.

Sec. ~~3959.111~~ 3957.25. (A)(1)(a) In each contract between a pharmacy benefit manager and a pharmacy, the pharmacy shall be given the right to obtain from the pharmacy benefit manager, within ten days after any request, a current list of the sources used to determine maximum allowable cost pricing. In each contract between a pharmacy benefit manager and a pharmacy, the pharmacy benefit manager shall be obligated to update and implement the pricing information at least every seven days and provide a means by which contracted pharmacies may promptly review maximum allowable cost pricing updates in an electronic format that is readily available, accessible, and secure and that can be easily searched.

Subject to division (A)(1) of this section, a pharmacy benefit manager shall utilize the most up-to-date pricing data when calculating drug product reimbursements for all contracting pharmacies within one business day of any price update or modification.

(b) A pharmacy benefit manager shall maintain a written procedure to eliminate products from the list of drugs subject to maximum allowable cost pricing in a timely manner. The written procedure, and any updates, shall promptly be made

available to a pharmacy upon request.

(2) In each contract between a pharmacy benefit manager and a pharmacy, a pharmacy benefit manager shall be obligated to ensure that all of the following conditions are met prior to placing a prescription drug on a maximum allowable cost list:

(a) The drug is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, or has an "NR" or "NA" rating or similar rating by nationally recognized reference.

(b) The drug is generally available for purchase by pharmacies in this state from a national or regional wholesaler and is not obsolete.

(3) Each contract between a pharmacy benefit manager and a pharmacy shall include an electronic process to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes all of the following:

(a) A twenty-one-day limit on the right to appeal following the initial claim;

(b) A requirement that the appeal be investigated and resolved within twenty-one days after the appeal;

(c) A telephone number at which the pharmacy may contact the pharmacy benefit manager to speak to a person responsible for processing appeals;

(d) A requirement that a pharmacy benefit manager provide a reason for any appeal denial, including the national drug code and the identity of the national or regional wholesalers from whom the drug was generally available for purchase at or below

the benchmark price determined by the pharmacy benefit manager;

(e) A requirement that if the appeal is upheld or granted, then the pharmacy benefit manager shall adjust the drug product reimbursement to the pharmacy's upheld appeal price;

(f) 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 shall be retroactive to the date the appeal was made and shall apply to all situated pharmacies as determined by the pharmacy benefit manager. This requirement does not prohibit a pharmacy benefit manager from retroactively adjusting a claim for the appealing pharmacy or for any other similarly situated pharmacies.

(B)(1)(a) A pharmacy benefit manager shall disclose to the 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.

(b) If a pharmacy benefit manager uses multiple maximum allowable cost lists, the pharmacy benefit manager shall disclose in the aggregate to a plan sponsor any differences between the amount paid to a pharmacy and the amount charged to a plan sponsor.

(2) The disclosures required under division (B)(1) of this section shall be made within ten days of a pharmacy benefit manager and a plan sponsor signing a contract or on a quarterly basis.

(3)(a) Division (B) of this section does not apply to plans governed by the "Employee Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq. or medicare part D.

(b) As used in this division, "medicare part D" means the

voluntary prescription drug benefit program established under Part D of Title XVIII of the "Social Security Act," 42 U.S.C. 1395w-101, et seq.

(C) Notwithstanding division (B)(5) of section 3959.01 of the Revised Code, a health insuring corporation or a sickness and accident insurer shall comply with the requirements of this section and is subject to the penalties under section 3959.12 of the Revised Code if the corporation or insurer is a pharmacy benefit manager, as defined in section 3959.01 of the Revised Code.

(D) The superintendent may impose a monetary fine against a licensee if, upon investigation and after notice and opportunity for hearing in accordance with Chapter 119. of the Revised Code, the superintendent finds that the licensee has violated any provision of section 3957.26 of the Revised Code or any rule adopted by the superintendent pursuant to or to implement that section.

(E) The superintendent of insurance shall adopt rules as necessary to implement the requirements of this section.

Sec. ~~3959.20~~ 3957.26. (A) As used in this section and section 3957.27 of the Revised Code:

(1) "Administrator" has the same meaning as in section 3959.01 of the Revised Code.

(2) "Cost-sharing" means the cost to an individual insured under a health benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the plan.

~~(2) "Health benefit plan" and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.~~

(3) "Pharmacy audit" has the same meaning as in section 3901.81 of the Revised Code.

~~(4) "Pharmacy benefit manager" and "administrator" have the same meanings as in section 3959.01 of the Revised Code.~~

(B) No health plan issuer, pharmacy benefit manager, or any other administrator shall require cost-sharing in an amount, or direct a pharmacy to collect cost-sharing in an amount, greater than the lesser of either of the following from an individual purchasing a prescription drug:

(1) The amount an individual would pay for the drug if the drug were to be purchased without coverage under a health benefit plan;

(2) The net reimbursement paid to the pharmacy for the prescription drug by the health plan issuer, pharmacy benefit manager, or administrator.

(C)(1) No health plan issuer, pharmacy benefit manager, or administrator shall retroactively adjust a pharmacy claim for reimbursement for a prescription drug unless the adjustment is the result of either of the following:

(a) A pharmacy audit conducted in accordance with sections 3901.811 to 3901.814 of the Revised Code;

(b) A technical billing error.

(2) No health plan issuer, pharmacy benefit manager, or administrator shall charge a fee related to a claim unless the amount of the fee can be determined at the time of claim adjudication.

(D) The department of insurance shall create a web form that consumers can use to submit complaints relating to

violations of this section.

(E) Any pharmacy benefit manager license issued under this chapter may be suspended for a period not to exceed two years, revoked, or not renewed by the superintendent of insurance after notice to the licensee and hearing in accordance with Chapter 119. of the Revised Code, if upon investigation and proof the superintendent finds that the licensee has knowingly violated this section.

Sec. ~~3959.22~~ 3957.27. No health plan issuer, pharmacy benefit manager, or any other administrator shall prohibit a pharmacy from mailing or delivering drugs to patients as an ancillary service.

Sec. 3957.99. Whoever knowingly violates section 3957.03 of the Revised Code is guilty of a misdemeanor of the fourth degree.

Sec. 3959.01. As used in this chapter:

(A) "Administration fees" means any amount charged a covered person for services rendered. "Administration fees" includes commissions earned or paid by any person relative to services performed by an administrator.

(B) "Administrator" means any person who adjusts or settles claims on, residents of this state in connection with life, dental, health, prescription drugs, or disability insurance or self-insurance programs. "Administrator" includes a pharmacy benefit manager, except as described in division (B)(6) of this section. "Administrator" does not include any of the following:

(1) An insurance agent or solicitor licensed in this state whose activities are limited exclusively to the sale of

insurance and who does not provide any administrative services;

(2) Any person who administers or operates the workers' compensation program of a self-insuring employer under Chapter 4123. of the Revised Code;

(3) Any person who administers pension plans for the benefit of the person's own members or employees or administers pension plans for the benefit of the members or employees of any other person;

(4) Any person that administers an insured plan or a self-insured plan that provides life, dental, health, or disability benefits exclusively for the person's own members or employees;

(5) Any health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code or an insurance company that is authorized to write life or sickness and accident insurance in this state;

(6) On and after July 1, 2027, a pharmacy benefit manager licensed under Chapter 3957. of the Revised Code but only with respect to agreements that are entered into, amended, or renewed on or after that date.

(C) "Aggregate excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or trust for all benefits or claims paid during an agreement period on behalf of all covered persons under the plan or trust which exceed a stated deductible amount and subject to a stated maximum.

(D) "Contracted pharmacy" or "pharmacy" means a pharmacy located in this state participating in either the network of a pharmacy benefit manager or in a health care or pharmacy benefit plan through a direct contract or through a contract with a

pharmacy services administration organization, group purchasing organization, or another contracting agent.

(E) "Contributions" means any amount collected from a covered person to fund the self-insured portion of any plan in accordance with the plan's provisions, summary plan descriptions, and contracts of insurance.

(F) ~~"Drug product reimbursement" means the amount paid by a pharmacy benefit manager to a contracted pharmacy for the cost of the drug dispensed to a patient and does not include a dispensing or professional fee.~~

~~(G)~~ "Fiduciary" has the meaning set forth in section 1002(21)(A) of the "Employee Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C. 1001, as amended.

~~(H)~~ (G) "Fiscal year" means the twelve-month accounting period commencing on the date the plan is established and ending twelve months following that date, and each corresponding twelve-month accounting period thereafter as provided for in the summary plan description.

~~(I)~~ (H) "Insurer" means an entity authorized to do the business of insurance in this state or, for the purposes of this section, a health insuring corporation authorized to issue health care plans in this state.

~~(J)~~ (I) "Managed care organization" means an entity that provides medical management and cost containment services and includes a medicaid managed care organization, as defined in section 5167.01 of the Revised Code.

~~(K) "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 United States food and drug administration's approved drug products with therapeutic equivalence evaluations, commonly referred to as the orange book.~~

~~(L) "Maximum allowable cost list" means a list of the drugs for which a pharmacy benefit manager imposes a maximum allowable cost.~~

~~(M)~~ (J) "Multiple employer welfare arrangement" has the same meaning as in section 1739.01 of the Revised Code.

~~(N)~~ (K) "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. "Pharmacy benefit manager" includes the state pharmacy benefit manager selected under section 5167.24 of the Revised Code~~has the same meaning as in section 3957.01 of the Revised Code.

~~(O)~~ (L) "Plan" means any arrangement in written form for the payment of life, dental, health, or disability benefits to covered persons defined by the summary plan description and includes a drug benefit plan administered by a pharmacy benefit manager.

~~(P)~~ (M) "Plan sponsor" means the person who establishes the plan.

~~(Q)~~ (N) "Self-insurance program" means a program whereby an employer provides a plan of benefits for its employees without involving an intermediate insurance carrier to assume risk or pay claims. "Self-insurance program" includes but is not limited

to employer programs that pay claims up to a prearranged limit beyond which they purchase insurance coverage to protect against unpredictable or catastrophic losses.

~~(R)~~ (O) "Specific excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or trust for all benefits or claims paid during an agreement period on behalf of a covered person in excess of a stated deductible amount and subject to a stated maximum.

~~(S)~~ (P) "Summary plan description" means the written document adopted by the plan sponsor which outlines the plan of benefits, conditions, limitations, exclusions, and other pertinent details relative to the benefits provided to covered persons thereunder.

~~(T)~~ (Q) "Third-party payer" has the same meaning as in section 3901.38 of the Revised Code.

Sec. 3959.12. (A) Any license issued under sections 3959.01 to 3959.16 of the Revised Code may be suspended for a period not to exceed two years, revoked, or not renewed by the superintendent of insurance after notice to the licensee and hearing in accordance with Chapter 119. of the Revised Code. The superintendent may suspend, revoke, or refuse to renew a license if upon investigation and proof the superintendent finds that the licensee has done any of the following:

(1) Knowingly violated any provision of sections 3959.01 to 3959.16 ~~or 3959.20~~ of the Revised Code or any rule promulgated by the superintendent;

(2) Knowingly made a material misstatement in the application for the license;

(3) Obtained or attempted to obtain a license through

misrepresentation or fraud;

(4) Misappropriated or converted to the licensee's own use or improperly withheld insurance company premiums or contributions held in a fiduciary capacity, excluding, however, any interest earnings received by the administrator as disclosed in writing by the administrator to the plan sponsor;

(5) In the transaction of business under the license, used fraudulent, coercive, or dishonest practices;

(6) Failed to appear without reasonable cause or excuse in response to a subpoena, examination, warrant, or other order lawfully issued by the superintendent;

(7) Is affiliated with or under the same general management or interlocking directorate or ownership of another administrator that transacts business in this state and is not licensed under sections 3959.01 to 3959.16 of the Revised Code;

(8) Had a license suspended, revoked, or not renewed in any other state, district, territory, or province on grounds identical to those stated in sections 3959.01 to 3959.16 of the Revised Code;

(9) Been convicted of a financially related felony;

(10) Failed to report a felony conviction as required under section 3959.13 of the Revised Code.

(B) Upon receipt of notice of the order of suspension in accordance with sections 119.05 and 119.07 of the Revised Code, the licensee shall promptly deliver the license to the superintendent, unless the order of suspension is appealed under section 119.12 of the Revised Code.

(C) Any person whose license is revoked or whose

application is denied pursuant to sections 3959.01 to 3959.16 of the Revised Code is ineligible to apply for an administrators license for two years.

(D) The superintendent may impose a monetary fine against a licensee if, upon investigation and after notice and opportunity for hearing in accordance with Chapter 119. of the Revised Code, the superintendent finds that the licensee has ~~done either of the following:~~

~~(1) Committed~~ committed fraud or engaged in any illegal or dishonest activity in connection with the administration of pharmacy benefit management services~~;~~

~~(2) Violated any provision of section 3959.111 of the Revised Code or any rule adopted by the superintendent pursuant to or to implement that section~~.

Section 2. That existing sections 1751.92, 3905.24, 3923.87, 3959.01, 3959.111, 3959.12, 3959.20, and 3959.22 of the Revised Code are hereby repealed.