Ohio Revised Code

Section 3959.01 Third-party administrator definitions.

Effective: January 1, 2021
Legislation: House Bill 339 - 133rd General Assembly

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. "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.

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

(N) "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.

(O) "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) "Plan sponsor" means the person who establishes the plan.

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