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S.B. 284*
133rd General Assembly

Bill Analysis

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Version: As Reported by House Insurance

Primary Sponsors: Sens. Hottinger and Peterson

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SUMMARY

- Allows insurers in Ohio to claim reinsurance of risk as either an asset or a reduction in liability when the risk is reinsured by an insurer in a reciprocal jurisdiction and that meets certain criteria.
- Requires health insurers and Medicaid managed care organizations subject to the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 to comply with all applicable requirements of that act.
- Makes the telephone number of a party to a car accident a public record when the number is being sought by an insurer or insurance agent while investigating a claim.

DETAILED ANALYSIS

Reinsurance

Overview

The bill amends the law pertaining to accounting rules imposed on insurers when they reinsure risk. "Reinsurance" is when an insurer (the ceding insurer) purchases insurance from a separate insurer (the assuming insurer) to cover a portion or all of their potential liabilities. Under current law, insurers that reinsure risk with other insurers that meet certain standards may claim either reduced liabilities or increased assets when the ceding insurer's financial stability is assessed. Making such a claim is commonly referred to as "credit." The bill adds insurers in "reciprocal jurisdictions" to the possible list of eligible reinsurers and the criteria an assuming insurer in a reciprocal jurisdiction must meet to be an eligible reinsurer.

* This analysis was prepared before the report of the House Insurance Committee appeared in the House Journal. Note that the legislative history may be incomplete.

Reciprocal jurisdictions

Under the bill a reinsurer located in a reciprocal jurisdiction that wishes to be a reinsurer for purposes of the Credit for Reinsurance Law is eligible if certain criteria are met. The assuming insurer must meet all of the following requirements.[1]

The assuming insurer must have its head office, or be domiciled in, and be licensed in a reciprocal jurisdiction. A "reciprocal jurisdiction" is a jurisdiction that is one of the following:

- A non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the U.S. and the European Union, is a member state of the European Union;
- A U.S. jurisdiction that meets the requirements for accreditation under the National Association of Insurance Commissioners' (NAIC) financial standards and accreditation program;
- A qualified jurisdiction, as determined by the Superintendent, as described below under "**Qualified jurisdictions**," that is not otherwise described above and that meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified in rule.

"Covered agreement" means an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in Ohio or for allowing the ceding insurer to recognize credit for reinsurance.[2]

Surplus and capital requirements

The assuming insurer must have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be set forth in rule. If the assuming insurer is an association, it must have and maintain, on an ongoing basis, minimum capital and surplus equivalents, net of liabilities, calculated according to the methodology applicable in its domiciliary jurisdiction, and a central fund containing a balance in amounts determined by the Superintendent in rule.

The assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ratio, as applicable, that will be set forth in rule. If the assuming insurer is an association, it must have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and is also licensed.[3]

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[1] R.C. 3901.62(A)(6) and (E)(1) and 3901.64.

[2] R.C. 3901.62(E)(1)(a) and (E)(8).

[3] R.C. 3901.62(E)(1)(b) and (c).

Assurance

The assuming insurer must agree and provide adequate assurance to the Superintendent, in a form specified in rule, as follows:

- The assuming insurer must provide prompt written notice and explanation to the Superintendent if it falls below the minimum requirements described above under "**Surplus and capital requirements**" or if any regulatory action is taken against it for serious noncompliance with applicable law.
- The assuming insurer must consent in writing to the jurisdiction of the courts of Ohio and to the appointment of the Superintendent as agent for service of process. The Superintendent may require that consent for service of process be provided to the Superintendent and included in each reinsurance agreement. This requirement is not intended to be construed as limiting, or in any way altering, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws.
- The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained.
- Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award.
- The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement that involves Ohio's ceding insurers, and must agree to notify the ceding insurer and the Superintendent and to provide security in an amount equal to 100% of the assuming insurer's liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement. Such security must be in a form consistent with the Credit for Reinsurance Law and as specified by the Superintendent.[4]

Other requirements

The bill imposes additional requirements on insurers operating in reciprocal jurisdictions seeking to provide reinsurance in Ohio. First, the assuming insurer or its legal successor must provide, if requested by the Superintendent, on behalf of itself and any legal predecessors, certain documentation to the Superintendent, as specified in rule. Second, the assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements, pursuant

[4] R.C. 3901.62(E)(1)(d).

to criteria set forth in rule. Third, the assuming insurer's supervisory authority must confirm to the Superintendent on an annual basis, as of the preceding December 31, or on the annual date that the assuming insurer is statutorily required to report to the reciprocal jurisdiction, that the assuming insurer complies with the requirements described above under "**Surplus and capital requirements**." The bill specifies that it is not to be construed as prohibiting an assuming insurer from providing the Superintendent with information on a voluntary basis.[5]

Requirements for the Superintendent

Qualified jurisdictions

The Superintendent must timely create and publish a list of reciprocal jurisdictions. The Superintendent's list must include any reciprocal jurisdiction according to the definition of that term described above. The Superintendent must also consider any other reciprocal jurisdiction included on the list compiled by NAIC. The Superintendent may approve a jurisdiction that does not appear on NAIC's list of reciprocal jurisdictions in accordance with criteria established by the Superintendent.[6]

Removing jurisdictions from list

The Superintendent may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set forth in rules, except that the Superintendent must not remove from the list a reciprocal jurisdiction meeting the definition described above.

Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance ceded to an assuming insurer that has its home office or is domiciled in that jurisdiction must be allowed, if otherwise allowed pursuant to the Credit for Reinsurance Law.[7]

List of eligible assuming insurers

The Superintendent must timely create and publish a list of assuming insurers that have satisfied the conditions described above under "**Reciprocal jurisdictions**" and to which cessions must be granted credit in accordance with the Credit for Reinsurance Law.

The Superintendent may add an assuming insurer to this list if a jurisdiction accredited by NAIC has added such assuming insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the Superintendent described above under "**Assurance**" and complies with any additional requirements that the Superintendent may impose, except to the extent that they conflict with an applicable covered agreement.[8]

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[5] R.C. 3901.62(E)(1)(e), (f), (g), and (h).

[6] R.C. 3901.62(E)(2)(a).

[7] R.C. 3901.62(E)(2)(b).

[8] R.C. 3901.62(E)(3).

Revoking eligibility

If the Superintendent determines that an assuming insurer no longer meets one or more of the requirements described above under "**Reciprocal jurisdictions**," the Superintendent may revoke or suspend the eligibility of the assuming insurer for recognition under the Credit for Reinsurance Law.

While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with the Credit for Reinsurance Law.

If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the Superintendent and consistent with the provisions of the Credit for Reinsurance Law.[9]

Security

If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.[10]

Terms of reinsurance agreement

The bill specifies that its requirements are not to be construed as limiting, or in any way altering, the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by the Credit for Reinsurance Law or other applicable law, rule, or regulation.[11]

Application

Credit may be taken by insurers in reciprocal jurisdictions only for reinsurance agreements entered into, amended, or renewed on or after the bill's effective date, and only with respect to losses incurred and reserves reported on or after the later of the following:

- The date on which the assuming insurer has met all eligibility requirements listed above under "**Reciprocal jurisdictions**";
- The effective date of the new reinsurance agreement, amendment, or renewal.

[9] R.C. 3901.62(E)(4).

[10] R.C. 3901.62(E)(5).

[11] R.C. 3901.62(E)(6).

These application requirements do not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under the bill's amendments, as long as the reinsurance qualifies for credit under any other applicable provision of the Credit for Reinsurance Law.

The bill specifies that these application requirements are not to be construed as authorizing an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement, except as permitted by the terms of the agreement. And also that the bill is not to be interpreted as limiting, or in any way altering, the capacity of parties to any reinsurance agreement to renegotiate the agreement.[12]

Rules and regulations

The Superintendent may adopt rules and regulations to implement the bill's provisions.[13]

Mental health and substance use disorder parity

Background

Under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), certain health insurers that provide mental health and substance use disorder benefits must provide those benefits at parity to medical and surgical benefits, i.e., they must provide mental health and substance use disorder benefits on the same terms as medical and surgical benefits and cannot charge more for them or apply more restrictive requirements to them. The MHPAEA only requires parity *if* a plan covers mental health or substance use disorder benefits; it does not require plans to cover these benefits.[14]

MHPAEA application

As stated above, the MHPAEA does not require a health benefit plan to offer coverage for mental health and addiction services. It merely requires parity between standard medical benefits and mental health benefits *if* mental health benefits are offered under a plan. The following types of plans that offer mental health and addiction services coverage are *exempt* from the MHPAEA:

- Plans that cover 50 or fewer employees;
- Self-funded plans that cover more than 50 employees and the employer requests to opt out of MHPAEA requirements;

[12] R.C. 3901.62(E)(7).

[13] R.C. 3901.62(E).

[14] 29 United States Code (U.S.C.) 1185a.

- Large-group plans that incur at least 1% cost increase in a year since complying with MHPAEA.[15]

The only plans that *are* subject to MHPAEA are large group plans that do not incur significant costs and large self-funded plans that do not apply to opt out.

MHPAEA summary

In summary, the MHPAEA requires that, if a health benefit plan offers mental health and addiction services, then, for that plan, there must be parity between those benefits and the medical and surgical benefits offered by the plan in the following areas:

- Annual and lifetime dollar limits;
- Financial requirements;
- Quantitative treatment limitations;
- Nonquantitative treatment limitations.

Quantitative limitations are those benefits that have discreet numerical limits. For example, limiting the number of specialist visits covered under a plan would be a quantitative limitation. Nonquantitative limitations are those benefit limitations that do *not* have a discreet numerical limit. Examples of these would be things like a drug formulary, a determination of which provider types are allowed to be in-network, and step-therapy requirements.[16]

Overview

The bill requires all of the following to comply with the MHPAEA, provided they are subject to the MHPAEA:

- Every health plan issuer (an entity subject to Ohio Insurance Laws that contracts to reimburse health care costs under a health benefit plan, including a health insuring corporation, sickness and accident insurer, public employee benefit plan, self-funded multiple employer welfare arrangement, or third-party administrators such as a pharmacy benefit manager);
- Every health benefit plan (any contract offered by a health plan issuer to reimburse health care costs);
- Every Medicaid managed care organization.[17]

Continuing law requires each policy of group sickness and accident insurance providing hospital, surgical, or medical expense coverage for other than specific diseases or accidents only to provide outpatient, inpatient, and intermediate primary care benefits for alcoholism

[15] 29 U.S.C. 1185a(c).

[16] R.C. 3902.50(N) and 29 U.S.C. 1185a(a).

[17] R.C. 3902.36(B) and 5167.47(A) and R.C. 3922.01, not in the bill.

that are at least equal to $550 in any calendar year or 12-month period. These services must be performed by certain authorized professionals. When a person receives treatment for alcoholism from an approved or certified alcoholism treatment facility, the person remains entitled to these benefits only if one of the specified professionals certifies every three months that the person needs to continue utilizing the treatment. The bill does not alter these requirements.[18]

Enforcement

Insurance

The bill requires the Superintendent of Insurance to implement and enforce all applicable provisions of the MHPAEA and do all of the following:

- Proactively ensure compliance by health plan issuers;
- Evaluate all consumer and provider complaints regarding mental health and substance use disorder benefits for possible parity violations;
- Adopt rules as necessary to do both of the following:
  - Effectuate any provisions of the MHPAEA that relate to the business of insurance;
  - Enforce, monitor compliance with, and ensure continued compliance with the above parity requirements as they relate to insurance.[19]

Medicaid

The bill also requires the Medicaid Director to implement, enforce, and monitor compliance by Medicaid managed care organizations with all applicable requirements of the MHPAEA. Under the bill, the Medicaid Director is permitted to adopt rules as necessary to carry out the bill's parity requirements as they relate to the Medicaid program.[20]

Exemption from review by the Superintendent of Insurance

The bill's parity requirement might be considered a mandated health benefit. Under R.C. 3901.71, if the General Assembly enacts a provision for mandated health benefits, that provision cannot be applied to any health benefit plan until the Superintendent of Insurance determines that the provision can be applied fully and equally in all respects to employee benefit plans subject to regulation by the federal "Employee Retirement Income Security Act of 1974" (ERISA),[21] and to employee benefit plans established or modified by the state or any of

[18] R.C. 3923.29, not in the bill.

[19] R.C. 3902.36(C).

[20] R.C. 5167.47(B) and (C).

[21] 29 U.S.C. 1001, as amended.

its political subdivisions. ERISA appears to preempt any state regulation of such plans.[22] The bill contains provisions that exempt its requirements from this restriction.[23]

Public records

The Ohio Public Records Law generally requires every public office, when requested, to promptly prepare public records and make them available for inspection at all reasonable times during regular business hours. Some records, however, are not considered to be public records. Under current law, in the case of a motor vehicle accident involving a fatality, personal injury, or property damage in an amount greater than$1,000, the telephone numbers for a party to such an accident that are listed on any law enforcement record or report are not public records. The bill requires the public office to release these telephone numbers when requested by an insurer or insurance agent investigating an insurance claim resulting from a motor vehicle accident.[24]

"**Insurer**" generally means any person engaged in the business of insurance, guaranty, or membership, an inter-insurance exchange, a mutual or fraternal benefit society, or a health insuring corporation.[25]

"**Insurance agent**" means any person that, in order to sell, solicit, or negotiate insurance, is required to be licensed under the Ohio law.[26]

HISTORY

Action	Date
Introduced	02-18-20
Reported, S. Insurance & Financial Institutions	05-27-20
Passed Senate (32-0)	05-27-20
Reported, H. Insurance	---

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[22] 29 U.S.C. 1144.

[23] R.C. 3902.36(D).

[24] R.C. 149.43(A)(1)(mm) and R.C. 5502.11, not in the bill.

[25] R.C. 149.43(A)(18) and R.C. 3901.32, not in the bill.

[26] R.C. 149.43(A)(18) and R.C. 3905.01, not in the bill.