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Am. H. B. No. 135

Representatives Manchester, West

Cosponsors: Representatives Russo, Gross, Lepore-Hagan, Abrams, Baldrige, Bird, Blackshear, Boggs, Brent, Brown, Click, Creech, Crossman, Denson, Edwards, Galonski, Ghanbari, Ginter, Grendell, Hall, Hicks-Hudson, Hoops, Humphrey, Ingram, Jarrells, John, Johnson, Jones, Kelly, Kick, Koehler, Lanese, Leland, Lightbody, Lipps, Loychik, Manning, Miller, J., Miranda, O'Brien, Oelslager, Pavliga, Plummer, Riedel, Robinson, Roemer, Schmidt, Skindell, Smith, K., Smith, M., Sobecki, Stein, Sweeney, Sykes, Troy, White, Young, T., Speaker Cupp

A BILL

To amend section 1751.12 and to enact sections 1
3923.811 and 3959.21 of the Revised Code to 2
prohibit certain health insurance cost-sharing 3
practices. 4

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

Section 1. That section 1751.12 be amended and sections 5
3923.811 and 3959.21 of the Revised Code be enacted to read as 6
follows: 7

Sec. 1751.12. (A) (1) No contractual periodic prepayment 8
and no premium rate for nongroup and conversion policies for 9
health care services, or any amendment to them, may be used by 10
any health insuring corporation at any time until the 11
contractual periodic prepayment and premium rate, or amendment, 12
have been filed with the superintendent of insurance, and shall 13
not be effective until the expiration of sixty days after their 14

filing unless the superintendent sooner gives approval. The 15
filing shall be accompanied by an actuarial certification in the 16
form prescribed by the superintendent. The superintendent shall 17
disapprove the filing, if the superintendent determines within 18
the sixty-day period that the contractual periodic prepayment or 19
premium rate, or amendment, is not in accordance with sound 20
actuarial principles or is not reasonably related to the 21
applicable coverage and characteristics of the applicable class 22
of enrollees. The superintendent shall notify the health 23
insuring corporation of the disapproval, and it shall thereafter 24
be unlawful for the health insuring corporation to use the 25
contractual periodic prepayment or premium rate, or amendment. 26

(2) No contractual periodic prepayment for group policies 27
for health care services shall be used until the contractual 28
periodic prepayment has been filed with the superintendent. The 29
filing shall be accompanied by an actuarial certification in the 30
form prescribed by the superintendent. The superintendent may 31
reject a filing made under division (A) (2) of this section at 32
any time, with at least thirty days' written notice to a health 33
insuring corporation, if the contractual periodic prepayment is 34
not in accordance with sound actuarial principles or is not 35
reasonably related to the applicable coverage and 36
characteristics of the applicable class of enrollees. 37

(3) At any time, the superintendent, upon at least thirty 38
days' written notice to a health insuring corporation, may 39
withdraw the approval given under division (A) (1) of this 40
section, deemed or actual, of any contractual periodic 41
prepayment or premium rate, or amendment, based on information 42
that either of the following applies: 43

(a) The contractual periodic prepayment or premium rate, 44

or amendment, is not in accordance with sound actuarial principles. 45
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(b) The contractual periodic prepayment or premium rate, 47
or amendment, is not reasonably related to the applicable 48
coverage and characteristics of the applicable class of 49
enrollees. 50

(4) Any disapproval under division (A) (1) of this section, 51
any rejection of a filing made under division (A) (2) of this 52
section, or any withdrawal of approval under division (A) (3) of 53
this section, shall be effected by a written notice, which shall 54
state the specific basis for the disapproval, rejection, or 55
withdrawal and shall be issued in accordance with Chapter 119. 56
of the Revised Code. 57

(B) Notwithstanding division (A) of this section, a health 58
insuring corporation may use a contractual periodic prepayment 59
or premium rate for policies used for the coverage of 60
beneficiaries enrolled in medicare pursuant to a medicare risk 61
contract or medicare cost contract, or for policies used for the 62
coverage of beneficiaries enrolled in the federal employees 63
health benefits program pursuant to 5 U.S.C.A. 8905, or for 64
policies used for the coverage of medicaid recipients, or for 65
policies used for the coverage of beneficiaries under any other 66
federal health care program regulated by a federal regulatory 67
body, or for policies used for the coverage of beneficiaries 68
under any contract covering officers or employees of the state 69
that has been entered into by the department of administrative 70
services, if both of the following apply: 71

(1) The contractual periodic prepayment or premium rate 72
has been approved by the United States department of health and 73
human services, the United States office of personnel 74

management, the department of medicaid, or the department of 75
administrative services. 76

(2) The contractual periodic prepayment or premium rate is 77
filed with the superintendent prior to use and is accompanied by 78
documentation of approval from the United States department of 79
health and human services, the United States office of personnel 80
management, the department of medicaid, or the department of 81
administrative services. 82

(C) The administrative expense portion of all contractual 83
periodic prepayment or premium rate filings submitted to the 84
superintendent for review must reflect the actual cost of 85
administering the product. The superintendent may require that 86
the administrative expense portion of the filings be itemized 87
and supported. 88

(D) (1) Copayments, cost sharing, and deductibles must be 89
reasonable and must not be a barrier to the necessary 90
utilization of services by enrollees. 91

(2) A health insuring corporation, in order to ensure that 92
copayments, cost sharing, and deductibles are reasonable and not 93
a barrier to the necessary utilization of basic health care 94
services by enrollees shall impose copayment charges, cost 95
sharing, and deductible charges that annually do not exceed 96
forty per cent of the total annual cost to the health insuring 97
corporation of providing all covered health care services when 98
applied to a standard population expected to be covered under 99
the filed product in question. The total annual cost of 100
providing a health care service is the cost to the health 101
insuring corporation of providing the health care service to its 102
enrollees as reduced by any applicable provider discount. This 103
requirement shall be demonstrated by an actuary who is a member 104

of the American academy of actuaries and qualified to provide 105
such certifications as described in the United States 106
qualification standards promulgated by the American academy of 107
actuaries pursuant to the code of professional conduct. 108

(3) For purposes of division (D) of this section, all of 109
the following apply: 110

(a) Copayments imposed by health insuring corporations in 111
connection with a high deductible health plan that is linked to 112
a health savings account are reasonable and are not a barrier to 113
the necessary utilization of services by enrollees. 114

(b) Division (D) (2) of this section does not apply to a 115
high deductible health plan that is linked to a health savings 116
account. 117

(c) Catastrophic-only plans, as defined under the "Patient 118
Protection and Affordable Care Act," 124 Stat. 119, 42 U.S.C. 119
18022 and any related regulations, are not subject to the limits 120
prescribed in division (D) of this section, provided that such 121
plans meet all applicable minimum federal requirements. 122

(4) (a) When calculating an enrollee's contribution to any 123
applicable cost-sharing requirement for a prescription drug, a 124
health insuring corporation shall include any cost-sharing 125
amount paid by the enrollee and on behalf of the enrollee by 126
another person, group, or organization. 127

(b) The requirement prescribed under division (D) (4) (a) of 128
this section shall not apply with respect to cost-sharing for a 129
brand prescription drug for which there is a medically 130
appropriate generic equivalent, unless the prescriber determines 131
that the brand prescription drug is medically necessary. 132

(c) Divisions (D) (4) (a) and (D) (4) (b) of this section 133

shall not be construed as requiring a health insuring 134
corporation to provide coverage for a prescription drug that is 135
not included in the formulary or list of prescription drugs 136
covered under the pharmaceutical or medical benefit being 137
provided to an enrollee under the policy issued to the enrollee 138
by the health insuring corporation. 139

(d) A health insuring corporation shall not be deemed in 140
violation of division (D) (4) (a) or (D) (4) (b) of this section 141
solely for removing a prescription drug from the formulary or 142
list of prescription drugs covered under the pharmaceutical or 143
medical benefit being provided to an enrollee under a policy 144
issued to the enrollee by the health insuring corporation, if 145
such change to the health insuring corporation's formulary or 146
list of prescription drugs does not violate any other existing 147
state or federal laws or administrative rules. 148

(E) A health insuring corporation shall not impose 149
lifetime maximums on basic health care services. However, a 150
health insuring corporation may establish a benefit limit for 151
inpatient hospital services that are provided pursuant to a 152
policy, contract, certificate, or agreement for supplemental 153
health care services. 154

(F) The superintendent may adopt rules allowing different 155
copayment, cost sharing, and deductible amounts for plans with a 156
medical savings account, health reimbursement arrangement, 157
flexible spending account, or similar account; 158

(G) A health insuring corporation may impose higher 159
copayment, cost sharing, and deductible charges under health 160
plans if requested by the group contract, policy, certificate, 161
or agreement holder, or an individual seeking coverage under an 162
individual health plan. This shall not be construed as requiring 163

the health insuring corporation to create customized health plans for group contract holders or individuals. 164
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(H) As used in this section, ~~"health:~~ 166

(1) "Cost-sharing" has the same meaning as in section 1751.68 of the Revised Code. 167
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(2) "Generic equivalent" means a drug that is designated to be therapeutically equivalent, as indicated by the United States food and drug administration's publication titled approved drug products with therapeutic equivalence evaluations. 169
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(3) "Health savings account" and "high deductible health plan" have the same meanings as in the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 223, as amended. 173
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Sec. 3923.811. (A) As used in this section, "cost-sharing" has the same meaning as in section 3923.602 of the Revised Code. 176
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(B)(1) When calculating an insured's contribution to any applicable cost-sharing requirement for a prescription drug, a sickness and accident insurer shall include all amounts paid by the insured and on behalf of the insured by another person, group, or organization. 178
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(2) The requirement prescribed under division (B)(1) of this section shall not apply with respect to cost-sharing for a brand prescription drug for which there is a medically appropriate generic equivalent, unless the prescriber determines that the brand prescription drug is medically necessary. 183
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(C) Divisions (B)(1) and (B)(2) of this section shall not be construed as requiring a sickness and accident insurer to provide coverage for a prescription drug that is not included in the formulary or list of prescription drugs covered under the 188
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pharmaceutical or medical benefit being provided to an insured 192
person under the policy issued to the insured person by the 193
sickness and accident insurer. 194

(D) A sickness and accident insurer shall not be deemed in 195
violation of division (B) (1) or (B) (2) of this section solely 196
for removing a prescription drug from the formulary or list of 197
prescription drugs covered under the pharmaceutical or medical 198
benefit being provided to an insured person under a policy 199
issued to the insured person by the sickness and accident 200
insurer, if such change to the sickness and accident insurer's 201
formulary or list of prescription drugs does not violate any 202
other existing state or federal laws or administrative rules. 203

Sec. 3959.21. (A) Notwithstanding section 3959.01 of the 204
Revised Code, as used in this section, "pharmacy benefit 205
manager" means any person or entity that, pursuant to a contract 206
or other relationship with an insurer, managed care 207
organization, employer, or other third party, either directly or 208
through an intermediary, manages the prescription drug benefit 209
provided by the insurer, managed care organization, employer, or 210
third party, including any of the following: 211

(1) The processing and payment of claims for covered 212
prescription drugs; 213

(2) The performance of drug utilization review; 214

(3) The processing of drug prior authorization requests; 215

(4) The adjudication of appeals or grievances related to 216
the prescription drug benefit; 217

(5) Contracting with network pharmacies; 218

(6) Controlling the cost of covered prescription drugs; 219

(7) The performance of any other duty directly or 220
indirectly related to the processing or payment of claims for 221
covered prescription drugs. 222

(B) Subject to the insurance laws and rules of this state, 223
and subject to the jurisdiction of the superintendent of 224
insurance, a pharmacy benefit manager, in the performance of 225
contracted duties, shall comply with the terms of applicable 226
cost-sharing requirements regarding the prescribing, receipt, 227
administration, or coverage of a prescription drug detailed in 228
sections 1751.12 and 3923.811 of the Revised Code. 229

(C) This section shall not be construed as requiring a 230
pharmacy benefit manager, in the performance of contracted 231
duties and in accordance with sections 1751.12 and 3923.811 of 232
the Revised Code, to provide coverage for a prescription drug 233
that is not included in the formulary or list of prescription 234
drugs covered under the pharmaceutical or medical benefit being 235
provided to an enrollee or insured person. 236

(D) A pharmacy benefit manager shall not be deemed in 237
violation of this section, in the performance of contracted 238
duties and in accordance with sections 1751.12 and 3923.811 of 239
the Revised Code, solely for removing a prescription drug from 240
the formulary or list of prescription drugs covered under the 241
pharmaceutical or medical benefit being provided to an enrollee 242
or insured person, if such change to the formulary or list of 243
prescription drugs does not violate any other existing state or 244
federal laws or administrative rules. 245

Section 2. That existing section 1751.12 of the Revised 246
Code is hereby repealed. 247

Section 3. The amendments to section 1751.12 and the 248

enactment of sections 3923.811 and 3959.21 of the Revised Code 249
in this act apply to health benefit plans, as defined in section 250
3922.01 of the Revised Code, delivered, issued for delivery, 251
modified, or renewed on or after January 1, 2022. 252

Section 4. Section 1751.12 of the Revised Code is 253
presented in this act as a composite of the section as amended 254
by both H.B. 59 and H.B. 3 of the 130th General Assembly. The 255
General Assembly, applying the principle stated in division (B) 256
of section 1.52 of the Revised Code that amendments are to be 257
harmonized if reasonably capable of simultaneous operation, 258
finds that the composite is the resulting version of the section 259
in effect prior to the effective date of the section as 260
presented in this act. 261