As Reported by the House Public Health Policy Committee

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H. B. No. 177

Representative Manchester

Cosponsors: Representatives Liston, Abdullahi, Baker, Bird, Grim, Somani

A BILL

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

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

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

Sec. 1751.12. (A)(1) No contractual periodic prepayment and no premium rate for nongroup and conversion policies for health care services, or any amendment to them, may be used by any health insuring corporation at any time until the contractual periodic prepayment and premium rate, or amendment, have been filed with the superintendent of insurance, and shall not be effective until the expiration of sixty days after their filing unless the superintendent sooner gives approval. The filing shall be accompanied by an actuarial certification in the form prescribed by the superintendent. The superintendent shall disapprove the filing, if the superintendent determines within 8 9 10 11 12 13 14 15 16 17 18

the sixty-day period that the contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles or is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees. The superintendent shall notify the health insuring corporation of the disapproval, and it shall thereafter be unlawful for the health insuring corporation to use the contractual periodic prepayment or premium rate, or amendment. 19 20 21 22 23 24 25 26

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

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

(a) The contractual periodic prepayment or premium rate, or amendment, is not in accordance with sound actuarial principles. 44 45 46

(b) The contractual periodic prepayment or premium rate, or amendment, is not reasonably related to the applicable 47 48

coverage and characteristics of the applicable class of enrollees. 49 50

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

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

(1) The contractual periodic prepayment or premium rate has been approved by the United States department of health and human services, the United States office of personnel management, the department of medicaid, or the department of administrative services. 72 73 74 75 76

(2) The contractual periodic prepayment or premium rate is filed with the superintendent prior to use and is accompanied by 77 78

documentation of approval from the United States department of health and human services, the United States office of personnel management, the department of medicaid, or the department of administrative services. 79 80 81 82

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

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

(2) A health insuring corporation, in order to ensure that copayments, cost sharing, and deductibles are reasonable and not a barrier to the necessary utilization of basic health care services by enrollees shall impose copayment charges, cost sharing, and deductible charges that annually do not exceed forty per cent of the total annual cost to the health insuring corporation of providing all covered health care services when applied to a standard population expected to be covered under the filed product in question. The total annual cost of providing a health care service is the cost to the health insuring corporation of providing the health care service to its enrollees as reduced by any applicable provider discount. This requirement shall be demonstrated by an actuary who is a member of the American academy of actuaries and qualified to provide such certifications as described in the United States qualification standards promulgated by the American academy of actuaries pursuant to the code of professional conduct. 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108

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

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

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

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

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

(b) The requirement prescribed under division (D)(4)(a) of this section shall not apply with respect to cost-sharing paid on behalf of an enrollee by another person, group, or organization 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. 128 129 130 131 132 133 134

(c) Divisions (D)(4)(a) and (D)(4)(b) of this section shall not be construed as requiring a health insuring corporation to provide coverage for a prescription drug that is 135 136 137

not included in the formulary or list of prescription drugs covered under the pharmaceutical or medical benefit being provided to an enrollee under the policy issued to the enrollee by the health insuring corporation. 138 139 140 141

(d) A health insuring corporation shall not be deemed in violation of division (D)(4)(a) or (D)(4)(b) of this section solely for removing a prescription drug from the formulary or list of prescription drugs covered under the pharmaceutical or medical benefit being provided to an enrollee under a policy issued to the enrollee by the health insuring corporation, if such change to the health insuring corporation's formulary or list of prescription drugs does not violate any other existing state or federal laws or administrative rules. 142 143 144 145 146 147 148 149 150

(e)(i) If, under federal law, application of the requirement in division (D)(4)(a) of this section would result in health savings account ineligibility under 26 U.S.C. 223, then the requirement of division (D)(4)(a) of this section applies for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under 26 U.S.C. 223. 151 152 153 154 155 156 157 158

(ii) Division (D)(4)(e)(i) of this section does not apply with respect to items or services that are preventive care pursuant to division (c)(2)(C) of 26 U.S.C. 223, and the requirement of division (D)(4)(a) of this section applies to such items or services regardless of whether the minimum deductible under 26 U.S.C. 223 has been satisfied. 159 160 161 162 163 164

(E) A health insuring corporation shall not impose lifetime maximums on basic health care services. However, a health insuring corporation may establish a benefit limit for 165 166 167

inpatient hospital services that are provided pursuant to a 168
policy, contract, certificate, or agreement for supplemental 169
health care services. 170

(F) The superintendent may adopt rules allowing different 171
copayment, cost sharing, and deductible amounts for plans with a 172
medical savings account, health reimbursement arrangement, 173
flexible spending account, or similar account; 174

(G) A health insuring corporation may impose higher 175
copayment, cost sharing, and deductible charges under health 176
plans if requested by the group contract, policy, certificate, 177
or agreement holder, or an individual seeking coverage under an 178
individual health plan. This shall not be construed as requiring 179
the health insuring corporation to create customized health 180
plans for group contract holders or individuals. 181

(H) As used in this section~~, "health~~: 182

(1) "Cost-sharing" has the same meaning as in section 183
1751.68 of the Revised Code. 184

(2) "Generic equivalent" means a drug that is designated 185
to be therapeutically equivalent, as indicated by the United 186
States food and drug administration's publication titled 187
approved drug products with therapeutic equivalence evaluations. 188

(3) "Health benefit plan" has the same meaning as in 189
section 3922.01 of the Revised Code. 190

(4) "Health savings account" and "high deductible health 191
plan" have the same meanings as in the "Internal Revenue Code of 192
1986," 100 Stat. 2085, 26 U.S.C. 223, as amended. 193

Sec. 3923.811. (A) As used in this section: 194

(1) "Cost-sharing" has the same meaning as in section 195

3923.602 of the Revised Code. 196

(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. 197 198 199 200

(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 or on behalf of the insured by another person, group, or organization. 201 202 203 204 205

(2) The requirement prescribed under division (B)(1) of this section shall not apply with respect to cost-sharing paid on behalf of an enrollee by another person, group, or organization 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. 206 207 208 209 210 211 212

(3)(a) If, under federal law, application of the requirement of division (B)(1) of this section would result in health savings account ineligibility under 26 U.S.C. 223, then the requirement of division (B)(1) of this section applies for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under 26 U.S.C. 223. 213 214 215 216 217 218 219

(b) Division (B)(3)(a) of this section does not apply with respect to items or services that are preventive care pursuant to division (c)(2)(C) of 26 U.S.C. 223, and the requirement of division (B)(1) of this section applies to such items or services regardless of whether the minimum deductible under 26 220 221 222 223 224

U.S.C. 223 has been satisfied. 225

(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 pharmaceutical or medical benefit being provided to an insured person under the policy issued to the insured person by the sickness and accident insurer. 226 227 228 229 230 231 232

(D) A sickness and accident insurer shall not be deemed in violation of division (B)(1) or (B)(2) of this section solely for removing a prescription drug from the formulary or list of prescription drugs covered under the pharmaceutical or medical benefit being provided to an insured person under a policy issued to the insured person by the sickness and accident insurer, if such change to the sickness and accident insurer's formulary or list of prescription drugs does not violate any other existing state or federal laws or administrative rules. 233 234 235 236 237 238 239 240 241

Sec. 3959.21. (A) As used in this section: 242

(1) Notwithstanding section 3959.01 of the Revised Code, "pharmacy benefit manager" means any person or entity that, pursuant to a contract or other relationship with an insurer, managed care organization, employer, or other third party, either directly or through an intermediary, manages the prescription drug benefit provided by the insurer, managed care organization, employer, or third party, including any of the following: 243 244 245 246 247 248 249 250

(a) The processing and payment of claims for covered prescription drugs; 251 252

(b) The performance of drug utilization review; 253

(c) The processing of drug prior authorization requests; 254

(d) The adjudication of appeals or grievances related to the prescription drug benefit; 255 256

(e) Contracting with network pharmacies; 257

(f) Controlling the cost of covered prescription drugs; 258

(g) The performance of any other duty directly or indirectly related to the processing or payment of claims for covered prescription drugs. 259 260 261

(2) "Health benefit plan" has the same meaning as in section 3922.01 of the Revised Code. 262 263

(B)(1) Subject to the insurance laws and rules of this state, and subject to the jurisdiction of the superintendent of insurance, a pharmacy benefit manager, in the performance of contracted duties, shall comply with the terms of applicable cost-sharing requirements regarding the prescribing, receipt, administration, or coverage of a prescription drug detailed in sections 1751.12 and 3923.811 of the Revised Code. 264 265 266 267 268 269 270

(2)(a) If, under federal law, application of the requirement of division (B)(1) of this section would result in health savings account ineligibility under 26 U.S.C. 223, then the requirement of division (B)(1) of this section applies for health savings account-qualified high deductible health plans with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under 26 U.S.C. 223. 271 272 273 274 275 276 277

(b) Division (B)(2)(a) of this section does not apply with respect to items or services that are preventive care pursuant to division (c)(2)(C) of 26 U.S.C. 223, and the requirement of division (B)(1) of this section applies to such items or 278 279 280 281

services regardless of whether the minimum deductible under 26 U.S.C. 223 has been satisfied. 282 283

(C) This section shall not be construed as requiring a pharmacy benefit manager, in the performance of contracted duties and in accordance with sections 1751.12 and 3923.811 of the Revised Code, to provide coverage for a prescription drug that is not included in the formulary or list of prescription drugs covered under the pharmaceutical or medical benefit being provided to an enrollee or insured person. 284 285 286 287 288 289 290

(D) A pharmacy benefit manager shall not be deemed in violation of this section, in the performance of contracted duties and in accordance with sections 1751.12 and 3923.811 of the Revised Code, solely for removing a prescription drug from the formulary or list of prescription drugs covered under the pharmaceutical or medical benefit being provided to an enrollee or insured person, if such change to the formulary or list of prescription drugs does not violate any other existing state or federal laws or administrative rules. 291 292 293 294 295 296 297 298 299

Section 2. That existing section 1751.12 of the Revised Code is hereby repealed. 300 301

Section 3. The amendments to section 1751.12 and the enactment of sections 3923.811 and 3959.21 of the Revised Code in this act apply to health benefit plans, as defined in section 3922.01 of the Revised Code, delivered, issued for delivery, modified, or renewed on or after January 1, 2025. 302 303 304 305 306

Section 4. Section 1751.12 of the Revised Code is presented in this act as a composite of the section as amended by both H.B. 59 and H.B. 3 of the 130th General Assembly. The General Assembly, applying the principle stated in division (B) 307 308 309 310

of section 1.52 of the Revised Code that amendments are to be harmonized if reasonably capable of simultaneous operation, finds that the composite is the resulting version of the section in effect prior to the effective date of the section as presented in this act. 311 312 313 314 315