

**As Introduced**

**136th General Assembly**

**Regular Session**

**2025-2026**

**H. B. No. 937**

**Representatives Baker, Lorenz**

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To amend sections 1751.12 and 1751.32 and to enact 1  
sections 3923.811 and 3959.21 of the Revised 2  
Code to prohibit certain health insurance cost- 3  
sharing practices. 4

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

**Section 1.** That sections 1751.12 and 1751.32 be amended 5  
and sections 3923.811 and 3959.21 of the Revised Code be enacted 6  
to read as 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 45  
principles. 46

(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  
either of the following: 97

(a) The annual limitation on cost sharing incurred under a 98  
health plan under division (c) of 42 U.S.C. 18022; 99

(b) (i) Except as otherwise provided in division (D) (5) of 100  
this section, forty per cent of the total annual cost to the 101  
health insuring corporation of providing all covered health care 102  
services when applied to a standard population expected to be 103  
covered under the filed product in question. ~~The~~ 104

(ii) As used in division (D) (2) (b) of this section, "total 105  
annual cost of providing a health care service ~~is~~ means the 106  
cost to the health insuring corporation of providing the health 107  
care service to its enrollees as reduced by any applicable 108  
provider discount. ~~This requirement~~ 109

(iii) A health insuring corporation shall be demonstrated- 110  
by demonstrate compliance with division (D) (2) (b) of this 111  
section through an actuary who is a member of the American 112  
academy of actuaries and qualified to provide such 113  
certifications as described in the United States qualification 114  
standards promulgated by the American academy of actuaries 115  
pursuant to the code of professional conduct. 116

~~(3) For purposes of division (D) of this section, all of~~ 117  
~~the following apply:~~ 118

~~(a) No health insuring corporation shall directly or~~ 119  
~~indirectly set, alter, implement, or condition the terms of~~ 120  
~~coverage, including benefit design, based in full or in part on~~ 121  
~~the availability or amount of financial or product assistance~~ 122  
~~for a prescription drug.~~ 123

(4) Except as otherwise provided in division (D) (5) of 124  
this section, when calculating an enrollee's contribution to any 125  
applicable copayment charges, coinsurance, cost sharing, 126  
deductible, or other similar charges for a prescription drug, a 127  
health insuring corporation shall include all amounts paid by 128  
the enrollee and on behalf of the enrollee by another person, 129  
group, or organization. 130

(5) (a) Copayments imposed by health insuring corporations 131  
in connection with a high deductible health plan that is linked 132  
to a health savings account are reasonable and are not a barrier 133  
to the necessary utilization of services by enrollees for the 134  
purposes of division (D) (1) of this section. 135

(b) Division ~~(D) (2)~~ (D) (2) (b) of this section does not 136  
apply to a high deductible health plan that is linked to a 137  
health savings account. 138

(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.

(d) (i) Division (D) (4) (a) of this section does not apply to copayment charges, coinsurance, cost sharing, deductible, or similar charges 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.

(ii) As used in division (D) (5) (d) of this section, "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.

(e) (i) If a health insuring corporation's compliance with division (D) (2) (a) of this section would result in an enrollee losing eligibility for the federal income tax deduction, under 26 U.S.C. 223, for a health savings account linked to a high deductible plan, then that division applies only after the enrollee has met the minimum deductible required by federal law;

(ii) Division (D) (5) (e) (i) of this section does not apply with respect to items or services that are considered preventive care pursuant to division (c) (2) (C) of 26 U.S.C. 223, and the requirement of division (D) (2) (a) of this section applies to such items or services regardless of whether the minimum deductible under 26 U.S.C. 223 has been met.

(E) A health insuring corporation shall not impose 168  
lifetime maximums on basic health care services. However, a 169  
health insuring corporation may establish a benefit limit for 170  
inpatient hospital services that are provided pursuant to a 171  
policy, contract, certificate, or agreement for supplemental 172  
health care services. 173

(F) The superintendent may adopt rules allowing different 174  
copayment, cost sharing, and deductible amounts for plans with a 175  
medical savings account, health reimbursement arrangement, 176  
flexible spending account, or similar account; 177

(G) A health insuring corporation may impose higher 178  
copayment, cost sharing, and deductible charges under health 179  
plans if requested by the group contract, policy, certificate, 180  
or agreement holder, or an individual seeking coverage under an 181  
individual health plan. This shall not be construed as requiring 182  
the health insuring corporation to create customized health 183  
plans for group contract holders or individuals. 184

(H) As used in this section, "health savings account" and 185  
"high deductible health plan" have the same meanings as in the 186  
"Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 223, 187  
as amended. 188

**Sec. 1751.32.** Each health insuring corporation, annually, 189  
on or before the first day of March, shall file a report with 190  
the superintendent of insurance, covering the preceding calendar 191  
year. 192

The report shall be verified by an officer of the health 193  
insuring corporation, shall be in the form the superintendent 194  
prescribes, and shall include: 195

(A) A financial statement of the health insuring 196

corporation, including its balance sheet and receipts and	197
disbursements for the preceding year, which reflect, at a	198
minimum:	199
(1) All premium rate and other payments received for	200
health care services rendered;	201
(2) Expenditures with respect to all categories of	202
providers, facilities, insurance companies, and other persons	203
engaged to fulfill obligations of the health insuring	204
corporation arising out of its health care policies, contracts,	205
certificates, and agreements;	206
(3) Expenditures for capital improvements or additions	207
thereto, including, but not limited to, construction,	208
renovation, or purchase of facilities and equipment.	209
(B) A description of the enrollee population and	210
composition, group and nongroup;	211
(C) A summary of enrollee written complaints and their	212
disposition;	213
(D) A statement of the number of subscriber policies,	214
contracts, certificates, and agreements that have been	215
terminated by action of the health insuring corporation,	216
including the number of enrollees affected;	217
(E) A summary of the information compiled pursuant to	218
division (A) (5) of section 1751.04 of the Revised Code;	219
(F) A current report of the names and addresses of the	220
persons responsible for the conduct of the affairs of the health	221
insuring corporation as required by section 1751.03 of the	222
Revised Code. Additionally, the report shall include the amount	223
of wages, expense reimbursements, and other payments to these	224

persons for services to the health insuring corporation, and 225  
shall include a full disclosure of the financial interests 226  
related to the operations of the health insuring corporation 227  
acquired by these persons during the preceding year. 228

(G) An actuarial opinion in the form prescribed by the 229  
superintendent by rule; 230

(H) Certification as to whether the health insuring 231  
corporation has fully and completely complied with division (D)  
of section 1751.12 of the Revised Code during the preceding  
year. 232  
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(I) Any other information relating to the performance of 235  
the health insuring corporation that is necessary to enable the  
superintendent to carry out the superintendent's duties under  
this chapter. 236  
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**Sec. 3923.811.** (A) A sickness and accident insurer shall 239  
not impose copayment charges, coinsurance, cost sharing,  
deductible, or other similar charges that exceed the annual  
limitation on cost sharing incurred under a health plan under  
division (c) of 42 U.S.C. 18022. 240  
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(B) No sickness and accident insurer shall directly or 244  
indirectly set, alter, implement, or condition the terms of  
coverage, including benefit design, based in full or in part on  
the availability or amount of financial or product assistance  
for a prescription drug. 245  
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(C) Except as otherwise provided in division (D) of this 249  
section, when calculating an insured's contribution to any  
applicable copayment charges, coinsurance, cost sharing,  
deductible, or other similar charges for a prescription drug, a  
sickness and accident insurer shall include all amounts paid by 250  
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the insured and on behalf of the insured by another person, 254  
group, or organization. 255

(D) (1) Division (C) of this section shall not apply to 256  
copayment charges, coinsurance, cost sharing, deductible, or 257  
other similar charges paid on behalf of an insured by another 258  
person, group, or organization for a brand prescription drug for 259  
which there is a medically appropriate generic equivalent, as 260  
defined in section 1751.12 of the Revised Code, unless the 261  
prescriber determines that the brand prescription drug is 262  
medically necessary. 263

(2) If a sickness and accident insurer's compliance with 264  
division (C) of this section would result in an insured losing 265  
eligibility for the federal income tax deduction, under 26 266  
U.S.C. 223, for a health savings account linked to a high 267  
deductible plan, then that division applies only after the 268  
insured has met the minimum deductible required by federal law. 269

(3) Division (D) (2) of this section does not apply with 270  
respect to items or services that are considered preventive care 271  
pursuant to division (c) (2) (C) of 26 U.S.C. 223, and the 272  
requirement of division (C) of this section applies to such 273  
items or services regardless of whether the minimum deductible 274  
under 26 U.S.C. 223 has been met. 275

(E) On or before the first day of March each year, each 276  
sickness and accident insurer operating in this state shall 277  
certify to the superintendent of insurance whether the sickness 278  
and accident insurer fully and completely complied with the 279  
requirements of this section throughout the preceding calendar 280  
year. 281

Sec. 3959.21. (A) As used in this section: 282

<u>(1) Notwithstanding section 3959.01 of the Revised Code,</u>	283
<u>"pharmacy benefit manager" means any person or entity that,</u>	284
<u>pursuant to a contract or other relationship with an insurer,</u>	285
<u>managed care organization, employer, or other third party,</u>	286
<u>either directly or indirectly provides one or more pharmacy</u>	287
<u>benefit management services on behalf of a health benefit plan,</u>	288
<u>and any agent, contractor, intermediary, affiliate, subsidiary,</u>	289
<u>or related entity of such person that facilitates, provides,</u>	290
<u>directs, or oversees the provision of pharmacy benefit services.</u>	291
<u>(2) "Pharmacy benefit management service" includes all the</u>	292
<u>following:</u>	293
<u>(a) Negotiating the price of prescription drugs, including</u>	294
<u>negotiating and contracting for direct or indirect rebates,</u>	295
<u>discounts, or other price concessions;</u>	296
<u>(b) Processing and payment of claims for covered</u>	297
<u>prescription drugs;</u>	298
<u>(c) Managing or providing data related to a prescription</u>	299
<u>drug benefit;</u>	300
<u>(d) Processing of drug prior authorization requests;</u>	301
<u>(e) Adjudication of appeals or grievances related to the</u>	302
<u>prescription drug benefit;</u>	303
<u>(f) Contracting with network pharmacies;</u>	304
<u>(g) Controlling the cost of covered prescription drugs;</u>	305
<u>(h) Arranging alternative access to or funding of</u>	306
<u>prescription drugs;</u>	307
<u>(i) Performing any administrative, managerial, clinical,</u>	308
<u>pricing, financial, reimbursement, data administration or</u>	309

reporting, or billing services; 310

(j) Performing any other duty directly or indirectly 311  
related to the processing or payment of claims for covered 312  
prescription drugs. 313

(3) "Health benefit plan" has the same meaning as in 314  
section 3922.01 of the Revised Code. 315

(B) (1) Subject to the insurance laws and rules of this 316  
state, and subject to the jurisdiction of the superintendent of 317  
insurance, a pharmacy benefit manager, in the performance of 318  
contracted duties, shall comply with all applicable requirements 319  
and limitations concerning copayments, coinsurance, cost 320  
sharing, deductibles, or other similar charges detailed in 321  
sections 1751.12 and 3923.811 of the Revised Code. 322

(2) If a pharmacy benefit manager's compliance with 323  
division (B) (1) of this section would result in an enrollee or 324  
insured losing eligibility for the federal income tax deduction, 325  
under 26 U.S.C. 223, for a health savings account linked to a 326  
high deductible plan, then that division applies only after the 327  
enrollee or insured has met the minimum deductible required by 328  
federal law; 329

(3) Division (B) (2) of this section does not apply with 330  
respect to items or services that are considered preventive care 331  
pursuant to division (c) (2) (C) of 26 U.S.C. 223, and the 332  
requirement of division (B) (1) of this section applies to such 333  
items or services regardless of whether the minimum deductible 334  
under 26 U.S.C. 223 has been met. 335

(C) No pharmacy benefit manager shall seek, conspire, or 336  
contract with a health benefit plan to directly or indirectly 337  
set, alter, implement, or condition the terms of the health plan 338

coverage, including benefit design, based in part or entirely on 339  
information about the availability or amount of financial or 340  
product assistance available for a prescription drug. 341

(D) On or before the first day of March each year, each 342  
pharmacy benefit manager operating in this state shall certify 343  
to the superintendent of insurance whether the pharmacy benefit 344  
manager fully and completely complied with the requirements of 345  
this section throughout the preceding calendar year. 346

**Section 2.** That existing sections 1751.12 and 1751.32 of 347  
the Revised Code are hereby repealed. 348

**Section 3.** The amendment or enactment by this act of 349  
sections 1751.12, 1751.32, 3923.811, and 3959.21 of the Revised 350  
Code apply to health benefit plans, as defined in section 351  
3922.01 of the Revised Code, delivered, issued for delivery, 352  
modified, or renewed on or after January 1, 2027. 353

**Section 4.** Section 1751.12 of the Revised Code is 354  
presented in this act as a composite of the section as amended 355  
by both H.B. 59 and H.B. 3 of the 130th General Assembly. The 356  
General Assembly, applying the principle stated in division (B) 357  
of section 1.52 of the Revised Code that amendments are to be 358  
harmonized if reasonably capable of simultaneous operation, 359  
finds that the composite is the resulting version of the section 360  
in effect prior to the effective date of the section as 361  
presented in this act. 362