## As Introduced

## 136th General Assembly Regular Session 2025-2026

S. B. No. 207

5

## **Senators Manchester, Liston**

To amend sections 1751.12 and 1751.32 and to enact
sections 3923.811 and 3959.21 of the Revised

Code to prohibit certain health insurance costsharing 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

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 and no premium rate for nongroup and conversion policies for 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

- 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:
- (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.
- (2) The contractual periodic prepayment or premium rate is

  77
  filed with the superintendent prior to use and is accompanied by
  documentation of approval from the United States department of
  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
<pre>either of the following:</pre>	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

<u>(111) A health insuring corporation</u> shall <del>be demonstrated</del>	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 $\frac{(D)(2)}{(D)(2)(b)}$ 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	139
Protection and Affordable Care Act," 124 Stat. 119, 42 U.S.C.	140
18022 and any related regulations, are not subject to the limits	141
prescribed in division (D) of this section, provided that such	142
plans meet all applicable minimum federal requirements.	143
(d)(i) Division (D)(4)(a) of this section does not apply	144
to copayment charges, coinsurance, cost sharing, deductible, or	145
similar charges paid on behalf of an enrollee by another person,	146
group, or organization for a brand prescription drug for which	147
there is a medically appropriate generic equivalent, unless the	148
prescriber determines that the brand prescription drug is	149
medically necessary.	150
(ii) As used in division (D)(5)(d) of this section,	151
"generic equivalent" means a drug that is designated to be	152
therapeutically equivalent, as indicated by the United States	153
food and drug administration's publication titled approved drug	154
products with therapeutic equivalence evaluations.	155
(e)(i) If a health insuring corporation's compliance with	156
division (D)(2)(a) of this section would result in an enrollee	157
losing eligibility for the federal income tax deduction, under	158
26 U.S.C. 223, for a health savings account linked to a high	159
deductible plan, then that division applies only after the	160
enrollee has met the minimum deductible required by federal law;	161
(ii) Division (D)(5)(e)(i) of this section does not apply	162
with respect to items or services that are considered preventive	163
care pursuant to division (c)(2)(C) of 26 U.S.C. 223, and the	164
requirement of division (D)(2)(a) of this section applies to	165
such items or services regardless of whether the minimum	166
deductible under 26 U.S.C. 223 has been met.	167

(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
nearth 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
	220
(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)	232
of section 1751.12 of the Revised Code during the preceding	233
year.	234
(I) Any other information relating to the performance of	235
the health insuring corporation that is necessary to enable the	236
superintendent to carry out the superintendent's duties under	237
this chapter.	238
Sec. 3923.811. (A) A sickness and accident insurer shall	239
not impose copayment charges, coinsurance, cost sharing,	240
deductible, or other similar charges that exceed the annual	241
limitation on cost sharing incurred under a health plan under	242
division (c) of 42 U.S.C. 18022.	243
(B) No sickness and accident insurer shall directly or	244
indirectly set, alter, implement, or condition the terms of	245
coverage, including benefit design, based in full or in part on	246
the availability or amount of financial or product assistance	247
for a prescription drug.	248
(C) Except as otherwise provided in division (D) of this	249
section, when calculating an insured's contribution to any	250
applicable copayment charges, coinsurance, cost sharing,	251
deductible, or other similar charges for a prescription drug, a	252

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
<pre>medically necessary.</pre>	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

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