As Introduced

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S. B. No. 207

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 cost-sharing practices.

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 to read as follows:

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 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.

(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.

(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:

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

(b) The contractual periodic prepayment or premium rate, or amendment, is not reasonably related to the applicable coverage and characteristics of the applicable class of enrollees.

(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.

(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:

(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 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

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

(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.

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

(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 either of the following:

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

(b)(i) Except as otherwise provided in division (D)(5) of this section, 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~~

(ii) As used in division (D)(2)(b) of this section, "total annual cost of providing a health care service ~~is~~ " means 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~~

(iii) A health insuring corporation shall ~~be demonstrated by~~ demonstrate compliance with division (D)(2)(b) of this section through 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.

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

~~(a)~~ No health insuring corporation shall directly or 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.

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

(5)(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 for the purposes of division (D)(1) of this section.

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

(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 lifetime maximums on basic health care services. However, a health insuring corporation may establish a benefit limit for inpatient hospital services that are provided pursuant to a policy, contract, certificate, or agreement for supplemental health care services.

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

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

(H) As used in this section, "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.

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

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

(A) A financial statement of the health insuring

corporation, including its balance sheet and receipts and disbursements for the preceding year, which reflect, at a minimum:

(1) All premium rate and other payments received for health care services rendered;

(2) Expenditures with respect to all categories of providers, facilities, insurance companies, and other persons engaged to fulfill obligations of the health insuring corporation arising out of its health care policies, contracts, certificates, and agreements;

(3) Expenditures for capital improvements or additions thereto, including, but not limited to, construction, renovation, or purchase of facilities and equipment.

(B) A description of the enrollee population and composition, group and nongroup;

(C) A summary of enrollee written complaints and their disposition;

(D) A statement of the number of subscriber policies, contracts, certificates, and agreements that have been terminated by action of the health insuring corporation, including the number of enrollees affected;

(E) A summary of the information compiled pursuant to division (A)(5) of section 1751.04 of the Revised Code;

(F) A current report of the names and addresses of the persons responsible for the conduct of the affairs of the health insuring corporation as required by section 1751.03 of the Revised Code. Additionally, the report shall include the amount of wages, expense reimbursements, and other payments to these

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

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

(H) Certification as to whether the health insuring corporation has fully and completely complied with division (D) of section 1751.12 of the Revised Code during the preceding year.

(I) Any other information relating to the performance of the health insuring corporation that is necessary to enable the superintendent to carry out the superintendent's duties under this chapter.

Sec. 3923.811. (A) A sickness and accident insurer shall 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.

(B) No sickness and accident insurer shall directly or 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.

(C) Except as otherwise provided in division (D) of this 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

the insured and on behalf of the insured by another person, group, or organization.

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

(2) If a sickness and accident insurer's compliance with division (C) of this section would result in an insured 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 insured has met the minimum deductible required by federal law.

(3) Division (D)(2) 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 (C) 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) On or before the first day of March each year, each sickness and accident insurer operating in this state shall certify to the superintendent of insurance whether the sickness and accident insurer fully and completely complied with the requirements of this section throughout the preceding calendar year.

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

(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 indirectly provides one or more pharmacy benefit management services on behalf of a health benefit plan, and any agent, contractor, intermediary, affiliate, subsidiary, or related entity of such person that facilitates, provides, directs, or oversees the provision of pharmacy benefit services.

(2) "Pharmacy benefit management service" includes all the following:

(a) Negotiating the price of prescription drugs, including negotiating and contracting for direct or indirect rebates, discounts, or other price concessions;

(b) Processing and payment of claims for covered prescription drugs;

(c) Managing or providing data related to a prescription drug benefit;

(d) Processing of drug prior authorization requests;

(e) Adjudication of appeals or grievances related to the prescription drug benefit;

(f) Contracting with network pharmacies;

(g) Controlling the cost of covered prescription drugs;

(h) Arranging alternative access to or funding of prescription drugs;

(i) Performing any administrative, managerial, clinical, pricing, financial, reimbursement, data administration or

reporting, or billing services;

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

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

(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 all applicable requirements and limitations concerning copayments, coinsurance, cost sharing, deductibles, or other similar charges detailed in sections 1751.12 and 3923.811 of the Revised Code.

(2) If a pharmacy benefit manager's compliance with division (B)(1) of this section would result in an enrollee or insured 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 or insured has met the minimum deductible required by federal law;

(3) Division (B)(2) 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 (B)(1) of this section applies to such items or services regardless of whether the minimum deductible under 26 U.S.C. 223 has been met.

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

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

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

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

Section 3. The amendment or enactment by this act of sections 1751.12, 1751.32, 3923.811, and 3959.21 of the Revised Code 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, 2027.

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) 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.