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Representatives Manchester, West

Cosponsors: Representatives Russo, Gross, Lepore-Hagan, Abrams, Baldridge, 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 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 section 1751.12 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 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.

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

(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.

(b) Division (D)(2) 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.

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

(b) The requirement prescribed under division (D)(4)(a) 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.

(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 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.

(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.

(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~~:

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

(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.

(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.

Sec. 3923.811. (A) As used in this section, "cost-sharing" has the same meaning as in section 3923.602 of the Revised Code.

(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.

(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.

(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.

(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.

Sec. 3959.21. (A) Notwithstanding section 3959.01 of the Revised Code, as used in this section, "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:

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

(2) The performance of drug utilization review;

(3) The processing of drug prior authorization requests;

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

(5) Contracting with network pharmacies;

(6) Controlling the cost of covered prescription drugs;

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

(B) 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.

(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.

(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.

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

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, 2022.

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.