

As Reported by the House Public Health Policy Committee

135th General Assembly

Regular Session

2023-2024

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 1
3923.811 and 3959.21 of the Revised Code to 2
prohibit certain health insurance cost-sharing 3
practices. 4

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

Section 1. That section 1751.12 be amended and sections 5
3923.811 and 3959.21 of the Revised Code be enacted to read as 6
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 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 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
forty per cent of the total annual cost to the health insuring 97
corporation of providing all covered health care services when 98
applied to a standard population expected to be covered under 99
the filed product in question. The total annual cost of 100
providing a health care service is the cost to the health 101
insuring corporation of providing the health care service to its 102
enrollees as reduced by any applicable provider discount. This 103
requirement shall be demonstrated by an actuary who is a member 104
of the American academy of actuaries and qualified to provide 105
such certifications as described in the United States 106
qualification standards promulgated by the American academy of 107
actuaries pursuant to the code of professional conduct. 108

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

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

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

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

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

(b) The requirement prescribed under division (D) (4) (a) of 128
this section shall not apply with respect to cost-sharing paid 129
on behalf of an enrollee by another person, group, or 130
organization for a brand prescription drug for which there is a 131
medically appropriate generic equivalent, unless the prescriber 132
determines that the brand prescription drug is medically 133
necessary. 134

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

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

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

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

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

(E) A health insuring corporation shall not impose 165
lifetime maximums on basic health care services. However, a 166
health insuring corporation may establish a benefit limit for 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 197
to be therapeutically equivalent, as indicated by the United 198
States food and drug administration's publication titled 199
approved drug products with therapeutic equivalence evaluations. 200

(B) (1) When calculating an insured's contribution to any 201
applicable cost-sharing requirement for a prescription drug, a 202
sickness and accident insurer shall include all amounts paid by 203
the insured or on behalf of the insured by another person, 204
group, or organization. 205

(2) The requirement prescribed under division (B) (1) of 206
this section shall not apply with respect to cost-sharing paid 207
on behalf of an enrollee by another person, group, or 208
organization for a brand prescription drug for which there is a 209
medically appropriate generic equivalent, unless the prescriber 210
determines that the brand prescription drug is medically 211
necessary. 212

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

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

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

(C) Divisions (B) (1) and (B) (2) of this section shall not 226
be construed as requiring a sickness and accident insurer to 227
provide coverage for a prescription drug that is not included in 228
the formulary or list of prescription drugs covered under the 229
pharmaceutical or medical benefit being provided to an insured 230
person under the policy issued to the insured person by the 231
sickness and accident insurer. 232

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

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

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

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

(b) The performance of drug utilization review; 253

<u>(c) The processing of drug prior authorization requests;</u>	254
<u>(d) The adjudication of appeals or grievances related to the prescription drug benefit;</u>	255 256
<u>(e) Contracting with network pharmacies;</u>	257
<u>(f) Controlling the cost of covered prescription drugs;</u>	258
<u>(g) The performance of any other duty directly or indirectly related to the processing or payment of claims for covered prescription drugs.</u>	259 260 261
<u>(2) "Health benefit plan" has the same meaning as in section 3922.01 of the Revised Code.</u>	262 263
<u>(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.</u>	264 265 266 267 268 269 270
<u>(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.</u>	271 272 273 274 275 276 277
<u>(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</u>	278 279 280 281

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

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

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

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

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

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

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