

**As Passed by the House**

**134th General Assembly**

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**Am. H. B. No. 135**

**Representatives Manchester, West**

**Cosponsors: Representatives Russo, Gross, Lepore-Hagan, Abrams, Baldrige, 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 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 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 principles. 45  
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(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  
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 and 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 for a 129  
brand prescription drug for which there is a medically 130  
appropriate generic equivalent, unless the prescriber determines 131  
that the brand prescription drug is medically necessary. 132

(c) Divisions (D) (4) (a) and (D) (4) (b) of this section 133

shall not be construed as requiring a health insuring 134  
corporation to provide coverage for a prescription drug that is 135  
not included in the formulary or list of prescription drugs 136  
covered under the pharmaceutical or medical benefit being 137  
provided to an enrollee under the policy issued to the enrollee 138  
by the health insuring corporation. 139

(d) A health insuring corporation shall not be deemed in 140  
violation of division (D) (4) (a) or (D) (4) (b) of this section 141  
solely for removing a prescription drug from the formulary or 142  
list of prescription drugs covered under the pharmaceutical or 143  
medical benefit being provided to an enrollee under a policy 144  
issued to the enrollee by the health insuring corporation, if 145  
such change to the health insuring corporation's formulary or 146  
list of prescription drugs does not violate any other existing 147  
state or federal laws or administrative rules. 148

(E) A health insuring corporation shall not impose 149  
lifetime maximums on basic health care services. However, a 150  
health insuring corporation may establish a benefit limit for 151  
inpatient hospital services that are provided pursuant to a 152  
policy, contract, certificate, or agreement for supplemental 153  
health care services. 154

(F) The superintendent may adopt rules allowing different 155  
copayment, cost sharing, and deductible amounts for plans with a 156  
medical savings account, health reimbursement arrangement, 157  
flexible spending account, or similar account; 158

(G) A health insuring corporation may impose higher 159  
copayment, cost sharing, and deductible charges under health 160  
plans if requested by the group contract, policy, certificate, 161  
or agreement holder, or an individual seeking coverage under an 162  
individual health plan. This shall not be construed as requiring 163

the health insuring corporation to create customized health plans for group contract holders or individuals. 164  
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(H) As used in this section, ~~"health:~~ 166

(1) "Cost-sharing" has the same meaning as in section 1751.68 of the Revised Code. 167  
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(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. 169  
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(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. 173  
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**Sec. 3923.811.** (A) As used in this section, "cost-sharing" has the same meaning as in section 3923.602 of the Revised Code. 176  
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(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. 178  
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(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. 183  
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(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 188  
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pharmaceutical or medical benefit being provided to an insured 192  
person under the policy issued to the insured person by the 193  
sickness and accident insurer. 194

(D) A sickness and accident insurer shall not be deemed in 195  
violation of division (B) (1) or (B) (2) of this section solely 196  
for removing a prescription drug from the formulary or list of 197  
prescription drugs covered under the pharmaceutical or medical 198  
benefit being provided to an insured person under a policy 199  
issued to the insured person by the sickness and accident 200  
insurer, if such change to the sickness and accident insurer's 201  
formulary or list of prescription drugs does not violate any 202  
other existing state or federal laws or administrative rules. 203

**Sec. 3959.21.** (A) Notwithstanding section 3959.01 of the 204  
Revised Code, as used in this section, "pharmacy benefit 205  
manager" means any person or entity that, pursuant to a contract 206  
or other relationship with an insurer, managed care 207  
organization, employer, or other third party, either directly or 208  
through an intermediary, manages the prescription drug benefit 209  
provided by the insurer, managed care organization, employer, or 210  
third party, including any of the following: 211

(1) The processing and payment of claims for covered 212  
prescription drugs; 213

(2) The performance of drug utilization review; 214

(3) The processing of drug prior authorization requests; 215

(4) The adjudication of appeals or grievances related to 216  
the prescription drug benefit; 217

(5) Contracting with network pharmacies; 218

(6) Controlling the cost of covered prescription drugs; 219



(7) The performance of any other duty directly or 220  
indirectly related to the processing or payment of claims for 221  
covered prescription drugs. 222

(B) Subject to the insurance laws and rules of this state, 223  
and subject to the jurisdiction of the superintendent of 224  
insurance, a pharmacy benefit manager, in the performance of 225  
contracted duties, shall comply with the terms of applicable 226  
cost-sharing requirements regarding the prescribing, receipt, 227  
administration, or coverage of a prescription drug detailed in 228  
sections 1751.12 and 3923.811 of the Revised Code. 229

(C) This section shall not be construed as requiring a 230  
pharmacy benefit manager, in the performance of contracted 231  
duties and in accordance with sections 1751.12 and 3923.811 of 232  
the Revised Code, to provide coverage for a prescription drug 233  
that is not included in the formulary or list of prescription 234  
drugs covered under the pharmaceutical or medical benefit being 235  
provided to an enrollee or insured person. 236

(D) A pharmacy benefit manager shall not be deemed in 237  
violation of this section, in the performance of contracted 238  
duties and in accordance with sections 1751.12 and 3923.811 of 239  
the Revised Code, solely for removing a prescription drug from 240  
the formulary or list of prescription drugs covered under the 241  
pharmaceutical or medical benefit being provided to an enrollee 242  
or insured person, if such change to the formulary or list of 243  
prescription drugs does not violate any other existing state or 244  
federal laws or administrative rules. 245

**Section 2.** That existing section 1751.12 of the Revised 246  
Code is hereby repealed. 247

**Section 3.** The amendments to section 1751.12 and the 248

enactment of sections 3923.811 and 3959.21 of the Revised Code 249  
in this act apply to health benefit plans, as defined in section 250  
3922.01 of the Revised Code, delivered, issued for delivery, 251  
modified, or renewed on or after January 1, 2022. 252

**Section 4.** Section 1751.12 of the Revised Code is 253  
presented in this act as a composite of the section as amended 254  
by both H.B. 59 and H.B. 3 of the 130th General Assembly. The 255  
General Assembly, applying the principle stated in division (B) 256  
of section 1.52 of the Revised Code that amendments are to be 257  
harmonized if reasonably capable of simultaneous operation, 258  
finds that the composite is the resulting version of the section 259  
in effect prior to the effective date of the section as 260  
presented in this act. 261