As Reported by the House Health and Aging Committee

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Senators Oelslager, Tavares

Cosponsors: Senators Brown, Cafaro, Gardner, Hite, Kearney, Lehner, Schiavoni, Smith, Turner, LaRose, Manning, Skindell, Gentile, Burke, Eklund, Hughes, Jones, Obhof, Sawyer, Uecker
Representatives Wachtmann, Antonio, Barnes, Bishoff, Brown, Carney, Hagan, R., Hottinger, Johnson, Schuring

A B I L L

To amend sections 1739.05 and 5162.20 and to enact sections 1751.69, 3923.85, and 5164.09 of the Revised Code regarding insurance and Medicaid coverage for orally administered cancer medications.

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

Section 1. That sections 1739.05 and 5162.20 be amended and sections 1751.69, 3923.85, and 5164.09 of the Revised Code be enacted to read as follows:

Sec. 1739.05. (A) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program may be established only if any of the following applies:

(1) The arrangement has and maintains a minimum enrollment of three hundred employees of two or more employers.

(2) The arrangement has and maintains a minimum enrollment of three hundred self-employed individuals.

(3) The arrangement has and maintains a minimum enrollment of three hundred employees or self-employed individuals in any combination of divisions (A)(1) and (2) of this section.

(B) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program shall comply with all laws applicable to self-funded programs in this state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 3902.01 to 3902.14, 3923.24, 3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3923.80, 3923.85, 3924.031, 3924.032, and 3924.27 of the Revised Code.

(C) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall solicit enrollments only through agents or solicitors licensed pursuant to Chapter 3905. of the Revised Code to sell or solicit sickness and accident insurance.

(D) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall provide benefits only to individuals who are members, employees of members, or the dependents of members or employees, or are eligible for continuation of coverage under section 1751.53 or 3923.38 of the Revised Code or under Title X of the "Consolidated Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 U.S.C.A. 1161, as amended.

Sec. 1751.69. (A) As used in this section, "cost sharing" means the cost to an individual insured under an individual or group health insuring corporation policy, contract, or agreement according to any coverage limit, copayment, coinsurance,

deductible, or other out-of-pocket expense requirements imposed by the policy, contract, or agreement.

(B) Notwithstanding section 3901.71 of the Revised Code and subject to division (D) of this section, no individual or group health insuring corporation policy, contract, or agreement providing basic health care services or prescription drug services that is delivered, issued for delivery, or renewed in this state, if the policy, contract, or agreement provides coverage for cancer chemotherapy treatment, shall fail to comply with either of the following:

(1) The policy, contract, or agreement shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intraveneously administered or injected cancer medications.

(2) The policy, contract, or agreement shall not comply with division (B)(1) of this section by imposing an increase in cost sharing solely for orally administered, intravenously administered, or injected cancer medications.

(C) Notwithstanding any provision of this section to the contrary, an individual or group health insuring corporation policy, contract, or agreement shall be deemed to be in compliance with this section if the cost sharing imposed under such a policy, contract, or agreement for orally administered cancer treatments does not exceed one hundred dollars per prescription fill.

(D) The prohibitions in division (B) of this section do not preclude an individual or group health insuring corporation policy, contract, or agreement from requiring an enrollee to obtain prior authorization before orally administered cancer medication is dispensed to the enrollee.

(E) A health insuring corporation that offers coverage for basic health care services is not required to comply with division (B) of this section if all of the following apply:

(1) The health insuring corporation submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that compliance with division (B)(1) of this section for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(2) The health insuring corporation submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (E)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(3)(a) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (E)(1) and (2) of this section:

(i) Compliance with division (B)(1) of this section for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of basic health care services to increase more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(b) Any determination made by the superintendent under

division (E)(3) of this section is subject to Chapter 119. of the Revised Code.

Sec. 3923.85. (A) As used in this section, "cost sharing" means the cost to an individual insured under an individual or group policy of sickness and accident insurance or a public employee benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the policy or plan.

(B) Notwithstanding section 3901.71 of the Revised Code and subject to division (D) of this section, no individual or group policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state and no public employee benefit plan that is established or modified in this state shall fail to comply with either of the following:

(1) The policy or plan shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intraveneously administered or injected cancer medications.

(2) The policy or plan shall not comply with division (B)(1) of this section by imposing an increase in cost sharing solely for orally administered, intravenously administered, or injected cancer medications.

(C) Notwithstanding any provision of this section to the contrary, a policy or plan shall be deemed to be in compliance with this section if the cost sharing imposed under such a policy or plan for orally administered cancer treatments does not exceed one hundred dollars per prescription fill.

(D)(1) The prohibitions in division (B) of this section do not preclude an individual or group policy of sickness and

accident insurance or public employee benefit plan from requiring an insured or plan member to obtain prior authorization before orally administered cancer medication is dispensed to the insured or plan member.

(2) Division (B) of this section does not apply to the offer or renewal of any individual or group policy of sickness and accident insurance that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, disability income, or other policy that offers only supplemental benefits.

(E) An insurer that offers any sickness and accident insurance or any public employee benefit plan that offers coverage for basic health care services is not required to comply with division (B) of this section if all of the following apply:

(1) The insurer or plan submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that compliance with division (B)(1) of this section for a period of at least six months independently caused the insurer or plan's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(2) The insurer or plan submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (E)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the insurer or plan for the coverage of basic health care services.

(3)(a) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (E)(1) and (2) of this section:

(i) Compliance with division (B)(1) of this section for a period of at least six months independently caused the insurer or plan's costs for claims and administrative expenses for the coverage of basic health care services to increase more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the insurer or plan for the coverage of basic health care services.

(b) Any determination made by the superintendent under division (E)(3) of this section is subject to Chapter 119. of the Revised Code.

Sec. 5162.20. (A) The department of medicaid shall institute cost-sharing requirements for the medicaid program. The department shall not institute cost-sharing requirements in a manner that ~~disproportionately~~ does either of the following:

(1) Disproportionately impacts the ability of medicaid recipients with chronic illnesses to obtain medically necessary medicaid services;

(2) Violates section 5164.09 of the Revised Code.

(B)(1) No provider shall refuse to provide a service to a medicaid recipient who is unable to pay a required copayment for the service.

(2) Division (B)(1) of this section shall not be considered to do either of the following with regard to a medicaid recipient who is unable to pay a required copayment:

(a) Relieve the medicaid recipient from the obligation to pay a copayment;

(b) Prohibit the provider from attempting to collect an unpaid copayment.

(C) Except as provided in division (F) of this section, no provider shall waive a medicaid recipient's obligation to pay the provider a copayment.

(D) No provider or drug manufacturer, including the manufacturer's representative, employee, independent contractor, or agent, shall pay any copayment on behalf of a medicaid recipient.

(E) If it is the routine business practice of a provider to refuse service to any individual who owes an outstanding debt to the provider, the provider may consider an unpaid copayment imposed by the cost-sharing requirements as an outstanding debt and may refuse service to a medicaid recipient who owes the provider an outstanding debt. If the provider intends to refuse service to a medicaid recipient who owes the provider an outstanding debt, the provider shall notify the recipient of the provider's intent to refuse service.

(F) In the case of a provider that is a hospital, the cost-sharing program shall permit the hospital to take action to collect a copayment by providing, at the time services are rendered to a medicaid recipient, notice that a copayment may be owed. If the hospital provides the notice and chooses not to take any further action to pursue collection of the copayment, the prohibition against waiving copayments specified in division (C) of this section does not apply.

(G) The department of medicaid may collaborate with a state agency that is administering, pursuant to a contract entered into under section 5162.35 of the Revised Code, one or more components, or one or more aspects of a component, of the medicaid program as necessary for the state agency to apply the cost-sharing requirements to the components or aspects of a component that the state agency administers.

Sec. 5164.09. (A) Except as provided in division (C) of this section, the medicaid program shall cover prescribed, orally administered cancer medications on at least the same basis that it covers intraveneously administered or injected cancer medications. In implementing this section, the department of medicaid shall not institute cost-sharing requirements under section 5162.20 of the Revised Code for prescribed, orally administered cancer medications that are greater than any cost-sharing requirements instituted under that section for intraveneously administered or injected cancer medications.

(B) Division (A) of this section does not preclude the department from requiring a medicaid recipient to obtain prior authorization before a prescribed, orally administered cancer medication is dispensed to the recipient.

(C) This section shall not be implemented during a fiscal year if the medicaid director determines that this section's implementation would cause the costs of the medicaid program's coverage of prescribed drugs to increase by more than one per cent over such costs for the most recent previous fiscal year for which the amount of such costs is known.

Section 2. That existing sections 1739.05 and 5162.20 of the Revised Code are hereby repealed.

Section 3. Sections 5162.20 and 5164.09 of the Revised Code as amended or enacted by this act shall take effect January 1, 2015.

Section 4. This act shall be known as the "Robert L. Schuler Act" in honor of the late Robert L. Schuler who served in both the Ohio House of Representatives and the Ohio Senate.

Section 5. Sections 1739.05 and 1751.69 of the Revised Code,

as amended or enacted by this act, apply only to policies, contracts, and agreements that are delivered, issued for delivery, or renewed in this state on or after January 1, 2015. Section 3923.85 of the Revised Code, as enacted by this act, applies only to policies of sickness and accident insurance delivered, issued for delivery, or renewed in this state and public employee benefit plans that are established or modified in this state on or after January 1, 2015.