

**As Reported by the House Health and Aging Committee**

**130th General Assembly  
Regular Session  
2013-2014**

**Am. S. B. No. 99**

**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**

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**A B I L L**

To amend sections 1739.05 and 5162.20 and to enact 1  
sections 1751.69, 3923.85, and 5164.09 of the 2  
Revised Code regarding insurance and Medicaid 3  
coverage for orally administered cancer 4  
medications. 5

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

**Section 1.** That sections 1739.05 and 5162.20 be amended and 6  
sections 1751.69, 3923.85, and 5164.09 of the Revised Code be 7  
enacted to read as follows: 8

**Sec. 1739.05.** (A) A multiple employer welfare arrangement 9  
that is created pursuant to sections 1739.01 to 1739.22 of the 10  
Revised Code and that operates a group self-insurance program may 11  
be established only if any of the following applies: 12

(1) The arrangement has and maintains a minimum enrollment of 13  
three hundred employees of two or more employers. 14

(2) The arrangement has and maintains a minimum enrollment of 15  
three hundred self-employed individuals. 16

(3) The arrangement has and maintains a minimum enrollment of 17  
three hundred employees or self-employed individuals in any 18  
combination of divisions (A)(1) and (2) of this section. 19

(B) A multiple employer welfare arrangement that is created 20  
pursuant to sections 1739.01 to 1739.22 of the Revised Code and 21  
that operates a group self-insurance program shall comply with all 22  
laws applicable to self-funded programs in this state, including 23  
sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.381 24  
to 3901.3814, 3901.40, 3901.45, 3901.46, 3902.01 to 3902.14, 25  
3923.24, 3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 26  
3923.80, 3923.85, 3924.031, 3924.032, and 3924.27 of the Revised 27  
Code. 28

(C) A multiple employer welfare arrangement created pursuant 29  
to sections 1739.01 to 1739.22 of the Revised Code shall solicit 30  
enrollments only through agents or solicitors licensed pursuant to 31  
Chapter 3905. of the Revised Code to sell or solicit sickness and 32  
accident insurance. 33

(D) A multiple employer welfare arrangement created pursuant 34  
to sections 1739.01 to 1739.22 of the Revised Code shall provide 35  
benefits only to individuals who are members, employees of 36  
members, or the dependents of members or employees, or are 37  
eligible for continuation of coverage under section 1751.53 or 38  
3923.38 of the Revised Code or under Title X of the "Consolidated 39  
Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 40  
U.S.C.A. 1161, as amended. 41

Sec. 1751.69. (A) As used in this section, "cost sharing" 42  
means the cost to an individual insured under an individual or 43  
group health insuring corporation policy, contract, or agreement 44  
according to any coverage limit, copayment, coinsurance, 45

deductible, or other out-of-pocket expense requirements imposed by 46  
the policy, contract, or agreement. 47

(B) Notwithstanding section 3901.71 of the Revised Code and 48  
subject to division (D) of this section, no individual or group 49  
health insuring corporation policy, contract, or agreement 50  
providing basic health care services or prescription drug services 51  
that is delivered, issued for delivery, or renewed in this state, 52  
if the policy, contract, or agreement provides coverage for cancer 53  
chemotherapy treatment, shall fail to comply with either of the 54  
following: 55

(1) The policy, contract, or agreement shall not provide 56  
coverage or impose cost sharing for a prescribed, orally 57  
administered cancer medication on a less favorable basis than the 58  
coverage it provides or cost sharing it imposes for intravenously 59  
administered or injected cancer medications. 60

(2) The policy, contract, or agreement shall not comply with 61  
division (B)(1) of this section by imposing an increase in cost 62  
sharing solely for orally administered, intravenously 63  
administered, or injected cancer medications. 64

(C) Notwithstanding any provision of this section to the 65  
contrary, an individual or group health insuring corporation 66  
policy, contract, or agreement shall be deemed to be in compliance 67  
with this section if the cost sharing imposed under such a policy, 68  
contract, or agreement for orally administered cancer treatments 69  
does not exceed one hundred dollars per prescription fill. 70

(D) The prohibitions in division (B) of this section do not 71  
preclude an individual or group health insuring corporation 72  
policy, contract, or agreement from requiring an enrollee to 73  
obtain prior authorization before orally administered cancer 74  
medication is dispensed to the enrollee. 75

(E) A health insuring corporation that offers coverage for 76  
basic health care services is not required to comply with division 77  
(B) of this section if all of the following apply: 78

(1) The health insuring corporation submits documentation 79  
certified by an independent member of the American academy of 80  
actuaries to the superintendent of insurance showing that 81  
compliance with division (B)(1) of this section for a period of at 82  
least six months independently caused the health insuring 83  
corporation's costs for claims and administrative expenses for the 84  
coverage of basic health care services to increase by more than 85  
one per cent per year. 86

(2) The health insuring corporation submits a signed letter 87  
from an independent member of the American academy of actuaries to 88  
the superintendent of insurance opining that the increase in costs 89  
described in division (E)(1) of this section could reasonably 90  
justify an increase of more than one per cent in the annual 91  
premiums or rates charged by the health insuring corporation for 92  
the coverage of basic health care services. 93

(3)(a) The superintendent of insurance makes the following 94  
determinations from the documentation and opinion submitted 95  
pursuant to divisions (E)(1) and (2) of this section: 96

(i) Compliance with division (B)(1) of this section for a 97  
period of at least six months independently caused the health 98  
insuring corporation's costs for claims and administrative 99  
expenses for the coverage of basic health care services to 100  
increase more than one per cent per year. 101

(ii) The increase in costs reasonably justifies an increase 102  
of more than one per cent in the annual premiums or rates charged 103  
by the health insuring corporation for the coverage of basic 104  
health care services. 105

(b) Any determination made by the superintendent under 106

division (E)(3) of this section is subject to Chapter 119. of the 107  
Revised Code. 108

Sec. 3923.85. (A) As used in this section, "cost sharing" 109  
means the cost to an individual insured under an individual or 110  
group policy of sickness and accident insurance or a public 111  
employee benefit plan according to any coverage limit, copayment, 112  
coinsurance, deductible, or other out-of-pocket expense 113  
requirements imposed by the policy or plan. 114

(B) Notwithstanding section 3901.71 of the Revised Code and 115  
subject to division (D) of this section, no individual or group 116  
policy of sickness and accident insurance that is delivered, 117  
issued for delivery, or renewed in this state and no public 118  
employee benefit plan that is established or modified in this 119  
state shall fail to comply with either of the following: 120

(1) The policy or plan shall not provide coverage or impose 121  
cost sharing for a prescribed, orally administered cancer 122  
medication on a less favorable basis than the coverage it provides 123  
or cost sharing it imposes for intravenously administered or 124  
injected cancer medications. 125

(2) The policy or plan shall not comply with division (B)(1) 126  
of this section by imposing an increase in cost sharing solely for 127  
orally administered, intravenously administered, or injected 128  
cancer medications. 129

(C) Notwithstanding any provision of this section to the 130  
contrary, a policy or plan shall be deemed to be in compliance 131  
with this section if the cost sharing imposed under such a policy 132  
or plan for orally administered cancer treatments does not exceed 133  
one hundred dollars per prescription fill. 134

(D)(1) The prohibitions in division (B) of this section do 135  
not preclude an individual or group policy of sickness and 136

accident insurance or public employee benefit plan from requiring 137  
an insured or plan member to obtain prior authorization before 138  
orally administered cancer medication is dispensed to the insured 139  
or plan member. 140

(2) Division (B) of this section does not apply to the offer 141  
or renewal of any individual or group policy of sickness and 142  
accident insurance that provides coverage for specific diseases or 143  
accidents only, or to any hospital indemnity, medicare supplement, 144  
disability income, or other policy that offers only supplemental 145  
benefits. 146

(E) An insurer that offers any sickness and accident 147  
insurance or any public employee benefit plan that offers coverage 148  
for basic health care services is not required to comply with 149  
division (B) of this section if all of the following apply: 150

(1) The insurer or plan submits documentation certified by an 151  
independent member of the American academy of actuaries to the 152  
superintendent of insurance showing that compliance with division 153  
(B)(1) of this section for a period of at least six months 154  
independently caused the insurer or plan's costs for claims and 155  
administrative expenses for the coverage of basic health care 156  
services to increase by more than one per cent per year. 157

(2) The insurer or plan submits a signed letter from an 158  
independent member of the American academy of actuaries to the 159  
superintendent of insurance opining that the increase in costs 160  
described in division (E)(1) of this section could reasonably 161  
justify an increase of more than one per cent in the annual 162  
premiums or rates charged by the insurer or plan for the coverage 163  
of basic health care services. 164

(3)(a) The superintendent of insurance makes the following 165  
determinations from the documentation and opinion submitted 166  
pursuant to divisions (E)(1) and (2) of this section: 167

(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. 168  
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(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. 173  
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(b) Any determination made by the superintendent under division (E)(3) of this section is subject to Chapter 119. of the Revised Code. 177  
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**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: 180  
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(1) Disproportionately impacts the ability of medicaid recipients with chronic illnesses to obtain medically necessary medicaid services; 184  
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(2) Violates section 5164.09 of the Revised Code. 187

(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. 188  
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(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: 191  
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(a) Relieve the medicaid recipient from the obligation to pay a copayment; 194  
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(b) Prohibit the provider from attempting to collect an unpaid copayment. 196  
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(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 229  
section, the medicaid program shall cover prescribed, orally 230  
administered cancer medications on at least the same basis that it 231  
covers intravenously administered or injected cancer medications. 232  
In implementing this section, the department of medicaid shall not 233  
institute cost-sharing requirements under section 5162.20 of the 234  
Revised Code for prescribed, orally administered cancer 235  
medications that are greater than any cost-sharing requirements 236  
instituted under that section for intravenously administered or 237  
injected cancer medications. 238

(B) Division (A) of this section does not preclude the 239  
department from requiring a medicaid recipient to obtain prior 240  
authorization before a prescribed, orally administered cancer 241  
medication is dispensed to the recipient. 242

(C) This section shall not be implemented during a fiscal 243  
year if the medicaid director determines that this section's 244  
implementation would cause the costs of the medicaid program's 245  
coverage of prescribed drugs to increase by more than one per cent 246  
over such costs for the most recent previous fiscal year for which 247  
the amount of such costs is known. 248

**Section 2.** That existing sections 1739.05 and 5162.20 of the 249  
Revised Code are hereby repealed. 250

**Section 3.** Sections 5162.20 and 5164.09 of the Revised Code 251  
as amended or enacted by this act shall take effect January 1, 252  
2015. 253

**Section 4.** This act shall be known as the "Robert L. Schuler 254  
Act" in honor of the late Robert L. Schuler who served in both the 255  
Ohio House of Representatives and the Ohio Senate. 256

**Section 5.** Sections 1739.05 and 1751.69 of the Revised Code, 257

as amended or enacted by this act, apply only to policies, 258  
contracts, and agreements that are delivered, issued for delivery, 259  
or renewed in this state on or after January 1, 2015. Section 260  
3923.85 of the Revised Code, as enacted by this act, applies only 261  
to policies of sickness and accident insurance delivered, issued 262  
for delivery, or renewed in this state and public employee benefit 263  
plans that are established or modified in this state on or after 264  
January 1, 2015. 265