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Bill Analysis

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SUMMARY

- Requires health insuring corporations, sickness and accident insurers, and pharmacy benefit managers ("health plan issuers") to apply all amounts paid by or on behalf of covered individuals toward cost-sharing requirements for prescription drugs.
- Allows health plan issuers to exclude amounts paid on behalf of an enrollee by another person for a brand name prescription drug when a generic version exists and the brand name is not medically necessary.
- Prohibits health benefit plans from imposing any cost-sharing requirement that is greater than those imposed under federal law for high-deductible health plans. For 2025, those cost sharing maximums are $9,200 for self-only coverage and $18,400 for all other coverage.
- Prohibits health plan issuers from directly or indirectly setting, altering, implementing, or conditioning the terms of coverage, including benefit design, based in full or in part on the availability or amount of financial or product assistance for a prescription drug.
- Requires health plan issuers to certify compliance with the bill's requirements to the Superintendent of Insurance no later than the first day of March of each year.
- Applies to health benefit plans delivered, issued for delivery, modified, or renewed on or after January 1, 2027.

DETAILED ANALYSIS

Overview

The bill imposes requirements on how certain health plan issuers apply amounts paid by or on behalf of a covered individual towards a cost-sharing requirement. Generally speaking, a cost-sharing requirement is any cost to a covered individual for health services according to any

coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirement imposed by a health benefit plan.[1] The bill applies to health insuring corporations, sickness and accident insurers, and pharmacy benefit managers, referred to as "health plan issuers" in this analysis for convenience.[2]

Under the bill, a "pharmacy benefit manager" is 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:

- Negotiating the price of prescription drugs, including negotiating and contracting for direct or indirect rebates, discounts, or other price concessions;
- Processing and payment of claims for covered prescription drugs;
- Managing or providing data related to a prescription drug benefit;
- Processing of drug prior authorization requests;
- Adjudication of appeals or grievances related to a prescription drug benefit;
- Contracting with network pharmacies;
- Controlling the cost of covered prescription drugs;
- Arranging alternative access to or funding of prescription drugs;
- Performing any administrative, managerial, clinical, pricing, financial, reimbursement, data administration, reporting, or billing services;
- The performance of any other duty directly or indirectly related to the processing or payment of claims for covered prescription drugs.[3]

Cost-sharing requirements

Under the bill, a health plan issuer must include all amounts paid by a covered individual or by another person, group, or organization on behalf of the covered individual, when calculating the covered individual's contribution toward a cost-sharing requirement. For example, if a covered individual receives a coupon for a drug which stipulates that the drug manufacturer will pay the copayment for the drug, then, under the bill, such a payment would have to be counted toward any cost-sharing requirement the covered individual's health benefit plan might impose.[4]

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[1] See R.C. 1751.68 and 3923.602, not in the bill.

[2] R.C. 1751.12, 3923.811, and 3959.21.

[3] R.C. 3959.21(A)(1) and (2).

[4] R.C. 1751.12(D)(4), 3923.811(C), and 3959.21(B)(1).

The bill exempts any payment made on behalf of an enrollee by another person, group, or organization for a brand name drug when a generic equivalent exists, unless the prescriber determines the brand name drug to be medically necessary. The bill defines "generic equivalent" as a drug that is designated to be therapeutically equivalent, as indicated by the U.S. Food and Drug Administration's publication titled "Approved Drug Products with Therapeutic Equivalence Evaluations."[5]

If the bill's cost-sharing requirement would result in an enrollee losing eligibility for the federal income tax deduction for contributions to a health savings account (HSA), then those requirements apply only after the enrollee has satisfied the minimum deductible required by federal law.[6] Federal law allows individuals enrolled in a qualified high-deductible health plan to make pre-tax contributions to an HSA to pay for medical expenses. However, the HSA deduction is available only if the high-deductible health plan has an annual deductible of at least $1,000 for self-only coverage or $2,000 for family coverage.[7] The bill's exception for certain qualified high deductible health plans ensures that no enrollee loses an HSA deduction as a result of the bill's change to cost-sharing requirements.

Note that the federal law does not require high-deductible health plans to maintain a deductible for preventative care. As such, the bill's cost-sharing requirements apply to qualifying preventative care items and services regardless of whether the enrollee has satisfied the plan's minimum deductible.[8]

Additional requirements

The bill imposes a few additional requirements related to cost-sharing. First, the bill specifies that a health benefit plan is prohibited from imposing any cost-sharing requirement that is greater than those imposed under federal law for high-deductible health plans.[9] For 2025, those cost-sharing maximums are $9,200 for self-only coverage and $18,400 for all other coverage.[10] Note that the bill maintains the current law requirement that specifies that health benefit plans issued by health insuring corporations are not to impose total cost-sharing requirements in excess of 40% of the total annual cost to the health insuring corporation for providing all covered health care services when applied to a standard population expected to be

[5] R.C. 1751.12(D)(5)(d), 3923.811(D)(1), and 3959.21(B)(1). There appears to be a cross-reference error in division R.C. 1751.12(D)(5)(d)(i) of R.C. 1751.12. The reference to "Division (D)(4)(a)" should just be "Division (D)(4)."

[6] R.C. 1751.12(D)(5)(e)(i), 3923.811(D)(2), and 3959.21(B)(2).

[7] 26 United States Code (U.S.C.) 223, not in the bill.

[8] R.C. 1751.12(D)(5)(e)(ii), 3923.811(D)(3), and 3959.21(B)(3); 26 U.S.C. 223, not in the bill.

[9] R.C. 1751.12(D)(2)(a), 3923.811(A), and 3959(B)(1); 42 U.S.C. 18022, not in the bill.

[10] Centers for Medicare and Medicaid Services, *Maximum Annual Limitation on Cost Sharing*, cms.gov, (accessed September 25, 2025).

covered under the filed product in question.[11] The bill does not specify whether the greater or lesser of these two limitations is to be followed should they be in conflict.

Second, the bill prohibits health plan issuers from directly or indirectly setting, altering, implementing, or conditioning the terms of coverage, including benefit design, based in full or in part on the availability or amount of financial or product assistance for a prescription drug. With respect to pharmacy benefit managers, they are prohibited from seeking, conspiring, or contracting with a health benefit plan to circumvent the prescription drug financial or product assistance prohibition.[12]

Reporting requirements

The bill requires health plan issuers to certify their compliance with the bill's requirements pertaining to cost-sharing. For health insuring corporations, this certification must be added to the report already required under current law. All health plan issuers must provide this certification no later than the first day of March of each year.[13]

Interpretation and applicability

The bill applies to health benefit plans delivered, issued for delivery, modified, or renewed on or after January 1, 2027.[14]

HISTORY

Action	Date
Introduced	05-28-25

ANSB0207IN-136/ar

[11] R.C. 1751.12(D)(2)(b).

[12] R.C. 1751.12(D)(3), 3923.811(B), and 3959.21(C).

[13] R.C. 1751.32(H), 3923.811(E), and 3959.21(D).

[14] Section 3.