OHIO LEGISLATIVE SERVICE COMMISSION

www.lsc.ohio.gov

Office of Research and Drafting

Legislative Budget Office

S.B. 14
133rd General Assembly

Bill Analysis

Version: As Introduced

Primary Sponsor: Sen. Maharath

Nick Thomas, Research Associate

Summary

- Prohibits health plan issuers from requiring cost sharing for a drug that would be greater than the drug's cash price.
- Enables pharmacists to discuss cost sharing requirements for covered drugs.
- Prohibits health plan issuers from imposing a fee or other penalty on pharmacists for complying with the bill's requirements.
- Prohibits the Department of Medicaid from imposing a fee or other penalty on terminal distributors of dangerous drugs for complying with the bill's requirements

Detailed Analysis

Health plan issuers

The bill prohibits health plan issuers from imposing certain requirements related to cost-sharing and covered drugs. The bill applies to all of the following health plan issuers:

- Licensed third-party administrators, including pharmacy benefit managers;
- Health insuring corporations;
- Sickness and accident insurers;
- Public employee benefit plans;
- Multiple employer welfare arrangements;
- The Department of Medicaid.

Under the bill, a health plan issuer is prohibited from requiring a cost-sharing amount for a drug that is greater than the amount an individual would pay for the drug without being covered under the health benefit plan. In other words, a health plan issuer cannot require a covered individual to pay more than the cash price for a covered drug. Furthermore, a health plan issuer cannot require a pharmacy to collect such an amount.

If a covered individual chooses to pay the cash price for the drug, then a health plan issuer cannot exclude this amount from the covered individual's annual out-of-pocket maximum.

Note, however, that an out-of-pocket maximum is not the same as a deductible or other cost-sharing requirements. So, for example, such a payment could still be excluded from counting towards a covered individual's deductible. To provide an illustrative example, consider a health benefit plan with the following characteristics:

- A deductible of $1,000;
- An out-of-pocket maximum of $2,000;
- For standard drugs, a co-payment of $30;
- For all other drugs and services, a covered individual pays 100% until the deductible has been met.

On the first day of coverage, the covered individual is prescribed a standard drug. The drug's cash price is $20, but the covered individual's co-payment for the drug is $30. Under the bill, the health benefit plan can charge the covered individual no more than $20. When the covered individual pays the $20, this amount must be counted toward the $2,000 out-of-pocket maximum, but is *not* required to be counted toward the individual's deductible. So, the amount that the covered individual has spent toward the individual's deductible is still $0. But the amount that the covered individual has spent toward the individual's out-of-pocket maximum is now $20. When the covered individual reaches the deductible limit, the total amount that the individual has spent toward the out-of-pocket maximum will be $1,020.

The bill prohibits related "gag orders" on pharmacists. Under the bill, a health plan issuer cannot prohibit a pharmacist or other terminal distributor of a dangerous drug from discussing the cost-sharing requirements of a particular drug with a covered individual. In other words, the bill allows pharmacists to tell a covered individual when purchasing a drug without insurance would be cheaper than purchasing the drug with insurance.

Finally, under the bill, a health plan issuer cannot impose a penalty or fee on a pharmacy for complying with the bill's requirements. The Department of Medicaid additionally is prohibited from imposing a penalty or fee on a terminal distributor of a dangerous drug or an employee of a terminal distributor for complying with the bill's requirements. [1]

Violations

The bill specifies that the license of a third party administrator may be revoked, not renewed, or suspended for up to two years for knowingly violating the bill's requirements. The bill does not impose a specific penalty for other health plan issuers that violate the bill's requirements. However, continuing law, unchanged by the bill specifies that a person found to

[1] R.C. 1739.05, 1751.92, 3923.87, 3959.20, 4729.48, and 5162.201.

have violated any law relating to insurance is subject to a fine of not more than $25,000, imprisonment of not more than six months, or both.[2]

Application

The bill's requirements apply to contracts for pharmacy services and to health benefit plans entered into or amended on or after the bill's effective date.[3]

Definitions

The bill defines the following terms:

"Administrator" (also called a third-party administrator) means, generally, any person who adjusts or settles claims in connection with a variety of insurance programs. "Administrator" includes a pharmacy benefit manager.

"Cost-sharing" means the cost to a covered person under a health benefit plan according to any coverage limit, co-payment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the plan.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health plan issuer to cover the cost of health care services. "Health benefit plan" does not include certain specified limited benefit plans.

"Health plan issuer" means any entity subject to Ohio insurance laws and rules, or subject to the jurisdiction of the Superintendent of Insurance, that covers any of the costs of health care services. The term includes a sickness and accident insurer, a fraternal benefit society, a self-funded multiple employer welfare arrangement, and a nonfederal government health plan. "Health plan issuer" also includes a third-party administrator.

"Pharmacy" includes an Ohio-licensed pharmacist, as well as a pharmacy or any employee of a pharmacy or pharmacist.

"Pharmacy benefit manager" means an entity that contracts with pharmacies on behalf of an employer, state agency, insurer, or other third-party payer to provide pharmacy health benefit services or administration.

"Terminal distributor of dangerous drugs" means both of the following:

- A person who is engaged in the sale of dangerous drugs at retail;
- Any person (other than a manufacturer, repackager, outsourcing facility, third-party logistics provider, wholesale distributor, or pharmacist) who has possession, custody, or control of dangerous drugs for any purpose other than for that person's own use and consumption.

The term includes pharmacies, hospitals, and nursing homes.[4]

---

[2] R.C. 3959.12(A)(1); R.C. 3901.99(B), not in the bill.

[3] Section 3.

[4] R.C. 3959.20 and 5162.201; R.C. 3922.01, 3959.01, and 4729.01, not in the bill

History

Action	Date
Introduced	02-12-19

S0014-I-133/ts