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H.B. 135
134th General Assembly

Bill Analysis

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Version: As Passed by the House

Primary Sponsors: Reps. Manchester and West

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SUMMARY

- Requires health insuring corporations and sickness and accident insurers to apply amounts paid by or on behalf of covered individuals toward cost-sharing requirements.
- Exempts situations where a generic version of a brand name drug exists, but the prescribing physician prescribes the brand name drug without it being medically necessary.
- Specifies that the bill is not to be construed as requiring a health benefit plan to cover a drug that is not already covered.
- Specifies that withdrawing coverage of a drug is not a violation of the bill's requirements if doing so does not violate any other existing state or federal laws or administrative rules.

DETAILED ANALYSIS

The bill imposes requirements on how health plan issuers apply amounts paid by or on behalf of a covered individual towards a cost sharing requirement. Under current law, unchanged by the bill, "cost-sharing requirement" refers to 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 and sickness and accident insurers.[2]

Under the bill, health insuring corporations and sickness and accident insurers must include all amounts paid by a covered individual or by another person, group, or organization

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

[2] R.C. 1751.12 and 3923.811.

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 manufacturer of the drug 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.

The bill exempts any payment made 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."[3]

Lastly, the bill requires a pharmacy benefit manager, in the performance of its contracted duties, to comply with the terms of applicable cost-sharing requirements regarding the prescribing, receipt, administration, or coverage of a prescription drug detailed in the bill. 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:

- The processing and payment of claims for covered prescription drugs;
- The performance of drug utilization review;
- The processing of drug prior authorization requests;
- The adjudication of appeals or grievances related to the prescription drug benefit;
- Contracting with network pharmacies;
- Controlling the cost of covered prescription drugs;
- The performance of any other duty directly or indirectly related to the processing or payment of claims for covered prescription drugs.[4]

The bill includes several provisions guiding the interpretation of its requirements. First, the bill specifies that it is not to be construed as requiring a health plan issuer to provide coverage for a prescription drug that is not already covered under the plan. Second, a health plan issuer is not to be considered in violation of the bill's requirements solely for withdrawing coverage of a drug, if the removal of coverage does not violate any other existing state or federal laws or administrative rules.[5]

[3] R.C. 1751.12(D) and (H)(2) and 3923.811.

[4] R.C. 3959.21.

[5] R.C. 1751.12(D)(4)(c) and (d), 3923.811(C) and (D), and 3959.21(C) and (D).

The bill applies to health benefit plans delivered, issued for delivery, modified, or renewed on or after January 1, 2022.[6]

HISTORY

Action	Date
Introduced	02-18-21
Reported, H. Health	03-16-21
Re-reported, H. Rules and Reference	03-29-22
Passed House (89-0)	03-30-22

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[6] Section 3.