www.lsc.ohio.gov

OHIO LEGISLATIVE SERVICE COMMISSION

Office of Research and Drafting

Legislative Budget Office

Substitute Bill Comparative Synopsis

Sub. H.B. 192

136th General Assembly

House Insurance

Abby Gerty, Research Analyst

This table summarizes how the latest substitute version of the bill differs from the immediately preceding version. It addresses only the topics on which the two versions differ substantively. It does not list topics on which the two bills are substantively the same.

Previous Version (As Introduced)	Latest Version (I_136_0065-2)
Report contents	
Requires each pharmacy benefit manager (PBM) to submit a quarterly report to the Superintendent of Insurance and to contracted insurers and plan sponsors of all drug claims processed by the PBM in the preceding quarter *(R.C. 3959.151)*.	Requires the report of drug claims to include all the following: ▪ The date of service; ▪ The pharmacy number as provided by the National Council for Prescription Drug programs; ▪ The processor identification number; ▪ The processor control number; ▪ The group identification number; ▪ The national drug code number; ▪ The amount of product dispensed; ▪ The supply and number of days the prescription is intended to last; ▪ The Dispense as Writing (DAW) code; ▪ The provider payment attributed to the dispensing fee;

Previous Version (As Introduced)	Latest Version (I_136_0065-2)
	▪ The dispensing fee; ▪ The cost share paid by the covered person to the provider; ▪ The total payment made to the provider for the drug dispensed; ▪ The total reimbursement paid by the health benefit plan to the third-party administrator for the drug dispensed; ▪ The basis for the reimbursement to the third-party administrator; ▪ The usual and customary rate for the drug dispensed; ▪ Whether the drug dispensed is a generic; ▪ Whether the drug dispensed is a specialty drug *(R.C. 3959.151(B)(3)(b)*.
Contract requirements	
No provision.	Prohibits a "health plan issuer," including a PBM or other third-party administrator, from entering into, amending or renewing a contract with a pharmacy or pharmacist unless the contract does both of the following: ▪ Outlines the terms and conditions for the provision of pharmacy or pharmacist services; ▪ Prohibits a health plan issuer from retroactively denying, reducing reimbursement for, or seeking any refunds or recoupments for a claim for pharmacy or pharmacist services after receiving payment as part of the adjudication of the claim unless the claim was submitted fraudulently, or the pharmacy received an actual overpayment *(R.C. 3902.77)*.

Previous Version (As Introduced)	Latest Version (I_136_0065-2)
Prohibited acts	
No provision.	Prohibits a health plan issuer, including a PBM or other third-party administrator, from doing any of the following: ▪ Prohibiting, or imposing a penalty on, a pharmacy or pharmacist services for (1) selling a lower cost alternative if a lower cost alternative is available, or (2) providing information regarding lower cost alternatives; ▪ Discriminating against a pharmacy or pharmacist that is (1) located within the geographic coverage area of the health benefit plan, and (2) willing to agree to or accept terms and conditions for participation in the plan's network; ▪ Imposing limits, including quantity or refill frequency limits, on a covered person's access to medication from a pharmacy that are more restrictive than those existing for a pharmacy affiliate; ▪ Requiring a covered person to receive pharmacy or pharmacist services from a pharmacy affiliate by (1) requiring a covered person to obtain a specialty drug from a pharmacy affiliate, or (2) imposing cost-sharing requirements for the use of an unaffiliated pharmacy or pharmacist that are greater than such a requirement for the use of an affiliated pharmacy; ▪ Requiring a pharmacy or pharmacist to enter into an additional contract with an affiliate as a condition of contracting with the health plan issuer; ▪ Requiring a pharmacy or pharmacist, as a condition of a contract, to agree to payment rates for any affiliate of the health plan issuer that is not a party to the contract;

Previous Version (As Introduced)	Latest Version (I_136_0065-2)
	▪ Requiring a covered person, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail order pharmacy *(R.C. 3902.78)).*

SUHB0192-136/sb