Ohio Legislative Service Commission

Bill Analysis

Nick Thomas

S.B. 135

131st General Assembly
(As Introduced)

Sens. Cafaro and Jones, Brown, Thomas, Tavares, Lehner, LaRose

BILL SUMMARY

- Prohibits health plan issuers from imposing cost sharing of more than $150 for a one-month supply of a specialty drug.
- Prohibits health plan issuers from placing all drugs in a given class on a specialty tier.

CONTENT AND OPERATION

Overview

The bill prohibits health plan issuers from imposing cost sharing for specialty drugs of more than $150 for a one-month supply. The bill does not apply to health benefit plans that do not provide prescription drug coverage.[1] Furthermore, the bill prohibits health plan issuers from placing all drugs in a given class on a specialty tier.[2] The bill applies to health benefit plans issued by health insuring corporations, sickness and accident insurers, multiple employer welfare arrangements, and public employee benefit plans. It also only applies to prescription drug coverage issued or renewed on or after January 1, 2016.[3]

"Specialty drug" is defined under the bill as any drug that meets all of the following:

---

[1] R.C. 1739.05, 1751.691(B)(1), and 3923.851(B)(1).

[2] R.C. 1739.05, 1751.691(D), and 3923.851(D).

[3] Section 3.

- The drug is prescribed for an individual with a complex or chronic medical condition or a rare medical condition;
- The drug costs $600 or more for up to a 30-day supply;
- The drug is not typically stocked at retail pharmacies.

The drug must also have at least one of the following characteristics:

- It requires a difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug;
- It requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug.

"Specialty drug tier" means a tier of a preferred drug formulary that imposes cost-sharing requirements for specialty drugs that are higher than for nonspecialty drugs.[4]

Nonpreferred drugs

The bill specifies that if a specific specialty drug is not listed on a health benefit plan's preferred-drug formulary, then a covered individual may request that the drug in question be covered and subject to cost-sharing requirements as if it were listed on the formulary. Under the bill, the denial of such a request is to be treated as an adverse benefit determination, meaning that the denial can be appealed and, if the appeal is unsuccessful, sent for external review.[5]

Miscellaneous

The bill specifies that its contents are not to be construed as requiring a health plan issuer from doing any of the following:

- Providing coverage for any additional drugs not otherwise required by law;
- Implementing specific utilization management techniques, such as prior authorization or step therapy;

[4] R.C. 1751.691(A)(4) and (5) and 3923.851(A)(4). See **COMMENT**.

[5] R.C. 1739.05, 1751.691(B)(2), and 3923.851(B)(2).

- Stopping the use of any cost-sharing requirements, policies, or procedures that are not otherwise prohibited under the bill or any other section of law, including those strategies used to incentivize the use of preventative services, disease management, and low-cost treatment options;

- Requiring that specialty drugs be obtained through a designated pharmacy or other source of such drugs.[6]

The bill specifies that its contents are not to be construed as requiring a pharmacist to substitute a drug without the consent of the prescribing physician.[7]

Exemption from review by the Superintendent of Insurance

The restrictions imposed by this bill might be considered mandated health benefits. Under section 3901.71 of the Revised Code, no mandated health benefits legislation enacted by the General Assembly may be applied to any health benefit plan until the Superintendent of Insurance determines, pursuant to a hearing conducted in accordance with the Administrative Procedure Act, that the provision can be applied fully and equally in all respects to (1) employee benefit plans subject to regulation by the federal Employee Retirement Income Security Act of 1974 (ERISA) and (2) employee benefit plans established or modified by the state or any political subdivision of the state, or by any agency or instrumentality of the state or any political subdivision of the state. The bill includes a provision that exempts its requirements from this restriction.[8]

Section 3901.71 of the Revised Code defines "mandated health benefits" as required coverage, or required offering of coverage, for the expenses of specified services, treatments, or diseases under a health benefit plan.

Definitions

As used in the bill:

"Cost sharing" means the cost to an individual insured under a health benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the plan.

---

[6] R.C. 1739.05, 1751.691(C) and (E), and 3923.851(C) and (E).

[7] R.C. 1739.05, 1751.691(F), and 3923.851(F).

[8] R.C. 1751.691(B) and 3923.851(B).

"Preferred drug formulary" means any list that groups drugs covered by health benefit plan that groups the drugs into tiers and for which a cost-sharing requirement is established for each tier.

"Rare disease or condition" means a disease or condition that meets either of the following:

- The disease or condition affects less than 200,000 persons in the U.S.;
- The disease or condition affects more than 200,000 persons in the U.S., but it is expected that the cost to make and developed the drug cannot be recouped through domestic sales of the drug.[9]

Comment

Note that the term "specialty drug tier" is not defined under R.C. 3923.851. This appears to be a drafting error.

HISTORY

ACTION	DATE
Introduced	03-25-15

S0135-I-131.docx/emr

[9] R.C. 1739.05, 1751.691(A), and 3925.851(A) and, by reference, R.C. 1751.69 and 21 U.S.C. 360bb, not in the bill.