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OHIO LEGISLATIVE SERVICE COMMISSION

Office of Research and Drafting

Legislative Budget Office

H.B. 336
134th General Assembly

Fiscal Note & Local Impact Statement

Click here for H.B. 336's Bill Analysis

Version: As Introduced

Primary Sponsors: Reps. Lipps and West

Local Impact Statement Procedure Required: Yes

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Highlights

- The bill's provisions limit certain cost control practices, making it likely the bill would increase costs to the state employee health benefit plans. The state's costs to provide health benefits to employees and their dependents are paid from the Health Benefit Fund (Fund 8080). Fund 8080 receives funding in part through state agency contributions toward their employees' health benefits, transferred from the GRF and other state funds.
- Similarly, the bill is likely to increase costs to counties, municipalities, townships, and school districts statewide of providing health benefits to employees and their dependents. LBO staff could not determine the magnitude of the fiscal impact due to lack of information on the number of local government employers that will be affected.
- The bill may minimally increase the Department of Insurance's administrative costs for regulating health insurers, pharmacy benefit managers (PBMs), and certain third-party administrators (TPAs). Any increase in the Department's administrative costs would be paid from the Department of Insurance Operating Fund (Fund 5540).
- The bill's provisions are likely to increase costs to some degree for the Ohio Department of Medicaid (ODM), due to the rules and prohibitions put in place for Medicaid managed care organizations and their pharmacy benefit managers.

Detailed Analysis

Health insurers and pharmacies

The bill prohibits a health insurer that offers, issues, or administers a health benefit plan that covers pharmacy services, including prescription drug coverage, from (1) requiring a covered

person to fill a prescription at or obtain services from an affiliated pharmacy,[1] (2) restricting a covered person's ability to select a pharmacy if the selected pharmacy is in the health plan issuer's pharmacy provider network, (3) imposing a cost-sharing requirement on the covered person that differs depending on which in-network pharmacy the covered person uses, (4) imposing any other condition on a covered person or pharmacy that restricts a covered person's ability to use an in-network pharmacy of the covered person's choosing, (5) preventing a pharmacy from participating in the health plan issuer's network if the pharmacy agrees to the reasonable and relevant terms and conditions of the issuer's pharmacy provider contract and provides pharmacy services in accordance with all applicable state and federal laws, (6) requiring a pharmacy, as a condition of participation in the health plan issuer's network, to meet accreditation standards or certification requirements that are inconsistent with or in addition to those of the State Board of Pharmacy, (7) transferring or sharing records relating to prescription information containing patient identifiable or prescriber identifiable data to an affiliated pharmacy for any commercial purpose, and (8) knowingly making a misrepresentation to a covered person, pharmacist, pharmacy, or dispensing physician.[2]

These prohibitions do not apply to either of the following: (1) a health benefit plan offered by a health insuring corporation (HIC) under which a majority of covered services are provided by physicians employed by the health plan issuer or by a single contracted medical group, or (2) pharmacy services provided to an individual receiving inpatient or emergency services at a health care facility that provides medical services on an inpatient or resident basis.

Incentive payment and adjustment systems

The bill imposes several requirements on a health plan issuer's use of an incentive payment and adjustment system to determine pharmacy reimbursement payments for prescription drugs. Among them is a prohibition against such a system favoring the health plan issuer's affiliated pharmacies or discriminating against nonaffiliated pharmacies. A complete list of the requirements may be found in the LSC bill analysis.

Notice of lower cost alternatives

The bill specifies that each contract between a health plan issuer and a pharmacy must include a system by which the pharmacy can inform a covered person when a drug is available at a lower cost if purchased outside of the health benefit plan.

Time limits to obtain certain cancer drugs

The bill requires a health plan issuer to ensure that a covered person can obtain a covered orally administered prescription drug used to treat cancer within 72 hours following submission

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[1] The bill defines an "affiliated pharmacy" as a pharmacy in which a health plan issuer, either directly or indirectly through one or more intermediaries, has an investment or ownership interest or with which it shares common ownership.

[2] The bill specifies that the prohibition against transferring or sharing records relating to prescription information must not be construed to prohibit the exchange of prescription information between a health plan issuer and an affiliated pharmacy for purposes of pharmacy reimbursement, formulary compliance, pharmacy care, or utilization review.

of a clean claim[3] or prior authorization request to the health plan issuer, apart from the prior authorization time limits established under existing law. If the issuer is unable to do so by requiring the covered person to use a pharmacy in the issuer's pharmacy provider network or a dispensing physician in the issuer's physician provider network, the issuer must cover the drug if purchased from an out-of-network pharmacy or physician to the same extent as it would if the drug were dispensed by an in-network provider.

Within 24 hours of submission of a clean claim or prior authorization request for the drug to a health plan issuer, the issuer must confirm receipt of the claim and notify the prescribing provider in writing, including certain required information. If it is likely that the drug will not be available to a covered person within 72 hours of the initial submission, the health plan issuer is required to notify the covered person that he or she can use another pharmacy or dispensing physician to obtain the drug, including one that is not part of the health plan issuer's provider network.

Medicaid managed care organizations

The bill specifies that all of the above requirements apply to Medicaid managed care organizations, and additionally, as applicable, to their pharmacy benefit managers. In July 2022, Medicaid managed care organizations will begin using a single pharmacy benefit manager (PBM) selected by the Ohio Department of Medicaid (ODM). The same rules and prohibitions will continue to apply for this single PBM.

Civil action

The bill allows any covered person or pharmacy affected by a violation of provisions above by a health plan issuer or one or more of its intermediaries to bring a civil action against the health plan issuer or the intermediary for compensatory damages and injunctive or other equitable relief.

The bill applies to all health benefit plans under section 3922.01 of the Revised Code, including a nonfederal government health plan such as the state employee health benefit plan. The bill also applies to a Medicaid managed care organization and any Medicaid managed care plan's intermediaries, including their PBM.

Mail-order drugs

The bill prohibits any pharmacy from mailing a dangerous drug to a patient when the patient's prescriber has indicated that the patient needs an in-person consultation at the time the original or refill prescription is dispensed, provided, however, that a patient may voluntarily waive in writing the in-person consultation and elect to receive the dangerous drug via mail order.

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[3] A "clean claim" means a claim that can be processed without obtaining additional information from the prescribing provider or a third party, is not for a recipient who receives financial assistance for the drug, and is not for a prescribed drug that is associated with a national drug shortage that has been reported to the U.S. Food and Drug Administration.

Pharmacy audits

The bill expands the requirements related to an auditing entity. Under existing law, an auditing entity, which is any person or government entity that performs a pharmacy audit, including a payer, a PBM, or a licensed third-party administrator (TPA), is subject to certain requirements when the auditing entity is performing a pharmacy audit in Ohio. The following are new requirements: (1) an auditing entity must not penalize a pharmacy based solely on the fact that all materials requested by the auditing entity are not available during an onsite audit, (2) a pharmacy must have the opportunity to provide supplemental materials to the entity after the completion of an onsite audit, and (3) an audit must be limited to the lesser of the following: (a) 250 prescriptions, or (b) the number of prescriptions dispensed by a pharmacy in the 24-month period prior to the audit.

The bill specifies that an auditing entity (1) must not be compensated based on the level or amounts of recoupments, and (2) must not be required to pay any disputed recoupments resulting from an audit until after the final disposition of the audit, including the conclusion of any relevant appeals or dispute processes. The bill allows a pharmacy to seek injunctive relief against a payer or its contracted pharmacy benefit manager for a violation of this bill by an auditing entity.

Fiscal effect

The bill may minimally increase the Department of Insurance's administrative costs for regulating health insurers, PBMs, and TPAs that are subject to Ohio insurance laws. Any increase in the Department's administrative costs would be paid from the Department of Insurance Operating Fund (Fund 5540).

The bill's prohibitions and requirements are likely to increase costs to the state employee health benefit plans. Certain insurance industry practices, such as setting up provider networks, are employed to reduce plan costs, and the bill imposes restrictions on their use, such as the requirement to cover certain cancer drugs issued by out-of-network pharmacies if needed to meet the bill's 72-hour time limit. Currently, the state offers a self-insured health benefits plan in which the state pays all benefit costs directly while contracting with private insurers to administer the benefits. The state's costs to provide health benefits to employees and their dependents are paid from the Health Benefit Fund (Fund 8080). Fund 8080 receives funding through state employee payroll deductions and state agency contributions toward their employees' health benefits, which come out of the GRF and various other state funds. In addition, the bill is likely to increase costs to counties, municipalities, townships, and school districts statewide of providing health benefits to employees and their dependents. However, LBO staff could not determine the magnitude of the fiscal impact due to lack of information on the number of local government employers that will be affected by the bill's provisions. Any local governments whose plans already comply with the bill's prohibitions and requirements would not experience such an increase in costs.

The bill's provisions related to pharmacy audits are likely to have fiscal effects via the level or amounts of recoupments that would be paid from pharmacies in state and county hospitals or recouped from state and local government employee health benefit plans. LBO staff could not determine the magnitude of the fiscal impact due to lack of information on the number of such

audits and recoupments associated with such audits that would be paid from pharmacies in state and county hospitals or recouped from government employee health benefit plans.

Medicaid

As Medicaid managed care organizations and their PBMs are subject to the same prohibitions and requirements as other health plan issuers, the bill will likely increase some costs for ODM to comply with these provisions. The magnitude of these costs will depend on the extent to which provisions are not already adhered to by ODM, Medicaid managed care organizations, and their PBMs. Medicaid managed care organizations are paid via a capitated rate system, which means that any costs caused by the bill would be reflected in higher capitated rates paid by ODM, which would include many facets of managed care pricing in addition to the effects of this bill.

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