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Bill Analysis

Version: As Introduced

Primary Sponsor: Rep. Ingram

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SUMMARY

- Prohibits a health insurer and pharmacy benefit manager from engaging in certain activities related to pharmacy services and prescription drug coverage, including directing patients to affiliated pharmacies.
- Specifies that a violation of the bill is considered an unfair and deceptive act or practice in the business of insurance.

DETAILED ANALYSIS

Prohibited pharmacy-related activities

The bill prohibits a health plan issuer, which includes a health insurer or pharmacy benefit manager, that administers or covers pharmacy services, including prescription drugs, from doing any of the following:[1]

- Ordering or directing a covered person to fill a prescription or obtain services from an affiliated pharmacy;
- Restricting a covered person's ability to select a pharmacy if it is in the health plan issuer's provider network;
- Imposing a cost-sharing requirement on the covered person that differs depending on which in-network pharmacy the covered person uses;
- Imposing on a covered person or pharmacy any other condition that restricts a covered person's ability to use a pharmacy of their choice in the provider network;

[1] R.C. 3902.73(B).

- Knowingly making a misrepresentation to a covered person, pharmacy, or dispensing physician;
- Transferring to or sharing with an affiliated pharmacy for any commercial purpose records relating to prescription information that contain patient or prescriber identifiable data.

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

Pharmacy participation in health plan issuer networks

The bill prohibits a health plan issuer from preventing a pharmacy's participation in its provider network if the pharmacy meets both of the following criteria: (1) it willingly agrees to the terms and conditions of the health plan issuer's provider contract, and (2) it provides pharmacy services in accordance with all applicable law.[3]

The bill also forbids a health plan issuer from requiring, as a condition of participation in the issuer's network, a pharmacy to meet accreditation standards or certification requirements inconsistent with, or in addition to, those of the State Board of Pharmacy.[4]

Exceptions

The bill specifies that its prohibitions do not apply to either of the following:[5]

- A health benefit plan offered by a health insuring corporation under which a majority of covered services are provided by physicians employed by the health plan issuer or a single contracted medical group;
- 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.

Unfair and deceptive acts

A health plan issuer that violates the bill's provisions is considered to have engaged in an unfair and deceptive act or practice in the business of insurance.[6]

Note on ERISA

ERISA is a comprehensive federal statute governing the administration of employee benefit plans. ERISA generally precludes state regulation of benefits offered by private employers

[2] R.C. 3902.73(B)(7).

[3] R.C. 3902.73(B)(5).

[4] R.C. 3902.73(B)(6).

[5] R.C. 3902.73(C).

[6] R.C. 3902.73(D).

that self-insure their benefit programs. Larger employers frequently choose to establish their own health insurance plans for their employees in lieu of purchasing coverage from a health plan issuer.

Definitions

"**Affiliated pharmacy**" means 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.[7]

"**Health plan issuer**" means an entity subject to either the insurance laws and rules of Ohio or the jurisdiction of the superintendent of insurance and contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. This definition also includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.[8]

HISTORY

Action	Date
Introduced	05-17-22

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[7] R.C. 3902.73(A).

[8] R.C. 3922.01(P), not in the bill.