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S.B. 160*
136th General Assembly

Bill Analysis

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Version: As Reported by Senate Financial Institutions, Insurance and Technology

Primary Sponsors: Sens. Liston and Johnson

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SUMMARY

- Prohibits health insurers from taking certain actions with respect to a covered drug during a health benefit plan year, including increasing cost-sharing, removing the drug from the plan's formulary, or otherwise limiting or reducing coverage of the drug.
- Exempts from the bill's provisions a drug for which the wholesale acquisition cost increases by more than 5% plus the rate of inflation during the plan year, as compared to the average wholesale acquisition cost for the previous plan year.
- Enumerates actions that are permissible regarding drugs for which a generically equivalent drug or interchangeable biological product is available.

DETAILED ANALYSIS

Prohibition on medication switching

The bill prohibits a health plan issuer – during a health benefit plan year – from taking any of the following actions regarding a drug:

- Increasing a covered person's cost-sharing for the drug;
- Moving the drug to a greater cost-share tier of the plan's drug formulary;
- Removing the drug from its formulary, except in enumerated circumstances (see "**Removing drugs from formularies**" below);

* This analysis was prepared before the report of the Senate Financial Institutions, Insurance and Technology Committee appeared in the Senate Journal. Note that the legislative history may be incomplete.

- Limiting or reducing coverage of the drug for a covered person in any other way, including subjecting it to a new prior authorization requirement during a plan year if the drug was not previously subjected to a prior authorization requirement during the plan year.[1]

This prohibition applies to health benefit plans that are issued, delivered, issued for delivery, modified, or renewed on or after January 1, 2028.[2]

Removing drugs from formularies

While the bill generally prohibits a health plan issuer from removing a drug from its formulary, a drug may be removed from a formulary when any of the following occur:

- The U.S. Food and Drug Administration (FDA) has issued a statement calling into the question the clinical safety of the drug;
- The drug manufacturer has notified the FDA, as required by federal law, that its manufacture has been interrupted or permanently discontinued;
- The drug manufacturer has removed the drug from sale in the United States.[3]

Unfair and deceptive act or practice

Should a health plan issuer take such an action, the bill designates it as an unfair and deceptive act or practice in the business of insurance, which may result in the Superintendent of Insurance imposing certain penalties on the health plan issuer.[4]

Exception based on increase in drug price

The bill creates an exception to the prohibition on medication switching during a plan year if the wholesale acquisition cost for a prescription drug increases by more than 5% plus the rate of inflation, as compared to the average wholesale acquisition cost for the previous plan year. For purposes of this provision, the rate of inflation is the percentage increase or decrease in the consumer price index over a one-year period, as determined by the U.S. Bureau of Labor Statistics.[5]

If a health plan issuer seeks to take one of the prohibited actions for a drug that has a qualifying price increase during a plan year, the issuer must maintain supporting documentation that justifies the action for three years after the price increase. The health plan issuer must provide the documentation to the Department of Insurance upon request.[6]

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[1] R.C. 3902.65(B).

[2] Section 2.

[3] R.C. 3902.65(B)(3).

[4] R.C. 3902.65(F). *See also* R.C. 3901.20 to 3901.25, not in the bill.

[5] R.C. 3902.65(A)(3) and (E); R.C. 107.032, not in the bill.

[6] R.C. 3902.65(E).

Application to other insurance practices regarding covered drugs

The bill specifies that it does not prevent any of the following from occurring:

- A health plan issuer adding a drug to the plan's formulary;
- A health plan issuer removing a drug from its formulary if the drug's manufacturer no longer sells the drug in the United States;
- A health care provider prescribing another covered drug that the provider considers medically appropriate;
- A pharmacist substituting another epinephrine autoinjector for a prescribed autoinjector.[7]

The bill also provides that in the case of a prescribed drug for which a generically equivalent drug or interchangeable biological product is available, it does not prevent any of the following from occurring:

- A pharmacist substituting a generically equivalent drug or interchangeable biological product for the prescribed drug in accordance with continuing pharmacy law;
- A health plan issuer requiring the use of the generically equivalent drug or interchangeable biological product;
- A covered person using the generically equivalent drug or interchangeable biological product.[8]

Mandated health benefits

The bill specifies that its prohibitions are not subject to an existing law that could prevent the prohibitions from being applied until a review by the Superintendent of Insurance has been conducted with respect to mandated health benefits. Under current law, legislation mandating health benefits cannot be applied to any health benefits arrangement after the legislation is enacted unless the Superintendent holds a public hearing and determines that it can be applied fully and equally in all respects to (1) employee benefits plans that are subject to ERISA and (2) employee benefit plans established or modified by the state or its political subdivisions.[9]

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[7] R.C. 3902.65(D).

[8] R.C. 3902.65(C).

[9] R.C. 3902.50(F). R.C. 3901.71, not in the bill, and 29 United States Code (U.S.C.) 1001 *et seq.* ERISA is a comprehensive federal statute governing the administration of employee benefit plans. ERISA generally precludes state regulation of benefits offered by private employers 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 sickness and accident insurer or health insuring corporation.

Definitions

"**Generically equivalent drug**" means a drug (1) that contains identical amounts of the identical active ingredients, but not necessarily containing the same inactive ingredients, (2) that meets the identical compendial or other applicable standards for specified qualities as the prescribed brand name drug, and (3) for which the manufacturer or distributor holds, if applicable, either an approved new drug application or an approved abbreviated new drug application unless other approval by law or from the FDA is required. A drug is not a generically equivalent drug if the FDA has listed it as having proven bioequivalence problems.

"**Interchangeable biological product**" means a biological product that has been determined by the FDA to meet the certain specified standards for interchangeability or a biological product that was determined by the FDA to be therapeutically equivalent.[10]

"**Biological product**" means a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein, or analogous product, or any trivalent organic arsenic compound, applicable to the prevention, treatment, or cure of a disease or condition of human beings.[11]

"**Wholesale acquisition cost**" means the manufacturer's list price for a drug to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.[12]

HISTORY

Action	Date
Introduced	04-01-25
Reported, S. Financial Institutions, Insurance and Technology	--

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[10] R.C. 3902.65(A); R.C. 3715.01, not in the bill.

[11] R.C. 3715.01 and 42 United States Code (U.S.C.) 262(i)(1).

[12] R.C. 3902.65(A); 42 U.S.C. 1395w-3a.