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**INSCD8 Pharmacy benefit managers, pharmacists, and cost-sharing for drug purchases**

**R.C. 1739.05, 1751.92, 3923.87, 3959.12, 3959.20, 4729.47 and Section 757.23**

No provision.

Prohibits health plan issuers, pharmacy benefit managers (PBMs), or any other administrators from requiring cost-sharing in an amount greater than the lesser of either of the following: (1) the amount an individual would pay for the drug if the drug were to be purchased without coverage under a health benefit plan, or (2) the net reimbursement paid to the pharmacy for the prescription drug by the health plan issuer, PBM, or other administrator.

No provision.

Prohibits health plan issuers, PBMs, and other administrators from retroactively adjusting a pharmacy claim for reimbursement of a prescription drug unless the adjustment is the result of either (1) a pharmacy audit, or (2) a technical billing error.

No provision.

Prohibits health plan issuers, PBMs, or other administrators from charging a fee related to a claim unless the amount of the fee can be determined at the time of claim adjudication.

No provision.

Requires a pharmacist, pharmacy intern, or terminal distributor of dangerous drugs who has information indicating that the cost-sharing amount required by the patient's health benefit plan exceeds the permitted amount to provide such information to the patient and ensure that the patient is not charged the higher amount.

No provision.

Allows the Superintendent of Insurance to suspend for up to two years, revoke, or not renew any license issued to a PBM, or other administrator, if the PBM or administrator violates the

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price disclosure requirements. Requires the Department of Insurance to create a web form that consumers can use to submit complaints associated with violations of the requirements.

**Fiscal effect: May increase administrative costs for the Department of Insurance and the State Board of Pharmacy. Any such costs for the Department of Insurance may be offset in part by penalties collected by the Department, and would be paid from the Department of Insurance Operating Fund (Fund 5540). Any penalties collected by the Department will also be deposited into Fund 5540. Any increase in the Board's administrative costs will be paid from the Board's appropriation item 887609, Operating Expenses (Fund 4K90); all penalties collected by the Board will be deposited into Fund 4K90. The cost-sharing requirement may have the indirect fiscal effect of leading some health benefit plans to raise premiums to cover additional prescription costs, thereby increasing costs to local governments that provide health benefits to employees and their dependents.**

INSCD6

Direct primary care agreements

No provision.

R.C. 3901.95

Provides that direct primary care agreements that meet certain criteria are not considered insurance.

**Fiscal effect: None.**

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INSCD4

Telemedicine services

R.C. 3902.30

Requires all health benefit plans to provide coverage for telemedicine services on the same basis and to the same extent as in-person services. Prohibits such plans from excluding telemedicine services from coverage solely because they are telemedicine services. Prohibits such plans from (1) imposing a lifetime benefit maximum in relation to telemedicine services other than a maximum imposed on all plan benefits and (2) requiring cost-sharing for telemedicine services in an amount greater than that for comparable in-person services. Specifies that the requirement and prohibitions apply to all health benefit plans issued, offered, or renewed on or after January 1,

**Fiscal effect: The prohibition against excluding coverage for telemedicine services has the potential to increase costs for the state and local governments to provide health benefits to employees and their dependents. Currently, telemedicine service is not included in the state's health benefit plan, thus, it may minimally increase costs to the state to provide health benefits to employees and their dependents. To the extent that telemedicine services are already included in a local government's health benefit plan, there should be no impact on their costs of providing health benefits to employees and their dependents.**

No provision.

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**INSCD5            Minimum prices for health services**

No provision.

**R.C.            3902.31**

voids any provision in a contract between a third-party payer and a medical provider that 1) establishes minimum charges for health services or 2) prohibits the medical provider from advertising the provider's rates for a service. Defines third-party payers to include an insurer, a health insuring corporation, a labor organization, an employer, certain intermediary organizations, a third party administrator (such as a pharmacy benefit manager), a health delivery network, and any person that is obligated pursuant to a benefits contract to reimburse for covered health care services.

**Fiscal effect: No direct fiscal effect.**

**INSCD7            Reimbursement for out-of-network emergency care**

No provision.

**R.C.            3902.50, 3902.51, and Section 739.10**

Requires an insurer to reimburse an out-of-network provider for emergency services when those services are performed at an in-network facility. Prohibits an insurer from requiring cost-sharing from a covered person for such services at a higher rate than the in-network cost-sharing rate.

No provision.

Prohibits an out-of-network provider from balance billing a patient for nonemergency services when those services are performed at an in-network facility unless certain conditions are met.

No provision.

Requires the Superintendent of Insurance to establish alternate dispute resolution procedures to address disputes between a provider and an insurer.

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**Fiscal effect: The reimbursement requirement and the cost-sharing limitation may increase the costs for the state and local governments to provide health benefits to employees and their dependents. The requirement related to the alternative dispute resolution may minimally increase the Department of Insurance's administrative costs; any increase in such costs would be paid from Fund 5540.**

INSCD9

Health care price transparency

**R.C. 3962.01, 3962.011 through 3962.15, 5164.65, and Section 751.30**

No provision.

Adds to current health care price transparency requirements that apply to products, services, and procedures.

No provision.

Requires that certain health care providers and health plan issuers provide to patients or their representatives a cost estimate for nonemergency health care products, services, or procedures before each is provided. Enumerates certain information that must be included in a cost estimate. Specifies that the requirement applies to a health care provider that is a hospital or hospital system or is owned by a hospital or hospital system on the effective date of this bill. Specifies that on and after March 1, 2020, the requirement applies to all other health care providers.

No provision.

Requires the cost estimates to be provided within certain time limits and in accordance with all applicable laws pertaining to the privacy of patient-identifying information.

No provision.

Requires the Department of Insurance to create or procure a connector portal that health care providers may use to transmit information to health plan issuers for their use in generating cost estimates.

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No provision.

Grants qualified immunity from civil liability to a health care provider or health plan issuer that provides cost estimates in accordance with the bill's provisions.

No provision.

Authorizes the Superintendent of Insurance, the Department of Health, Department of Medicaid, or the relevant regulatory board to impose administrative remedies on a health plan issuer or health care provider who fails to comply with the bill's health care price transparency provisions.

No provision.

Specifies that a contract clause prohibiting a health care provider or health plan issuer from providing patients with quality or cost information is invalid and unenforceable.

No provision.

Authorizes any member of the General Assembly to intervene in litigation that challenges the bill's health care price transparency provisions or the existing law pertaining to price transparency.

No provision.

Specifies that it is the General Assembly's intent in enacting the bill's health care price transparency provisions to provide patients with the information they need to make informed choices regarding their health care, to maximize health care cost savings for all residents of Ohio, and to reduce the burden of health care expenditures on government entities, including Medicaid.

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Fiscal effect: The requirement that the Department of Insurance create or procure a connector portal would increase the Department's costs by an uncertain amount. Any increase in such costs would be paid from Fund 5540. Administrative costs for the departments of Insurance, Health, and Medicaid, and other regulatory boards may increase due to regulatory need to monitor compliance by health plan issuers and health care providers. Potential indirect reductions in costs to state and local public employee benefit plans and the Medicaid program due to potential increase in consumers shopping for lower prices for medical services; if there is any reduction in such costs, the magnitude of the reduction is very uncertain.

INSCD1

Market conduct examination

Section: 305.10

Permits the Superintendent of Insurance to assess the costs associated with a market conduct examination of an insurer doing business in this state against the insurer. Allows the Superintendent to enter into consent agreements to impose administrative assessments or fines for violations of insurance laws or rules. Requires all costs, assessments, or fines collected related to such violations to be deposited into the Department of Insurance Operating Fund (Fund 5540).

Fiscal effect: Potential revenue gain for Fund 5540.

Section: 305.10

Same as the Executive.

Fiscal effect: Same as the Executive.

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**INSCD2 Examinations of domestic fraternal benefit societies**

**Section: 305.10**

Allows the Director of Budget and Management, at the request of the Superintendent, to transfer cash from Fund 5540 to the Superintendent's Examination Fund (Fund 5550), only for expenses incurred in examining domestic fraternal benefit societies.

**Section: 305.10**

Same as the Executive.

**INSCD3 Transfer of funds for captive insurance company regulation**

**Section: 305.10**

Requires the Director of Budget and Management, in consultation with the Superintendent, to establish a schedule for repaying amounts previously transferred during fiscal years 2016 and 2017 from the Captive Insurance Regulation and Supervision Fund (Fund 5PT0) to Fund 5540, when funds from captive insurance company application fees, reimbursements from captive insurance companies for examinations, and other sources have accrued to Fund 5PT0 in such amounts as are deemed sufficient to sustain departmental operations related to captive insurers.

**Section: 305.10**

Same as the Executive.

**Fiscal effect: During FY 2016 and FY 2017, \$1.0 million was transferred from Fund 5540 to Fund 5PT0 to pay startup costs for regulating captive insurance companies before receipts related to such regulation were received and deposited into Fund 5PT0. The money had not been repaid to Fund 5540 as of March of this year. This provision would require repayment when the funds are sufficient for that purpose.**

**Fiscal effect: Same as the Executive.**

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DOHCD48

Facility fee prohibition

No provision.

R.C. 3702.21

Prohibits hospitals and other health care facilities, as well as physician offices, from charging a facility fee that is in addition to any fee for professional services.

No provision.

Exempts trauma centers from this prohibition.

**Fiscal effect: This provision will decrease revenues for public hospitals and other public facilities. There could be a decrease in expenditures for public health programs that reimburse for services provided in these facilities.**

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**MCDCD55 Health care price transparency**

No provision.

**R.C. 5164.65, 3962.01-3962.15, 751.30**

Requires ODM to comply with the health care price transparency law (See INSCD9).

**MCDCD20 Medicaid prompt payment requirements waiver**

**R.C. 5167.25 (repealed), with conforming changes: 3901.3814**

Repeals the requirement that the Medicaid Director apply for a waiver from the federal Medicaid prompt payment requirements that would instead require health insuring corporations to submit claims in accordance with requirements established by the Department of Insurance.

**Fiscal effect: None.**

**R.C. 5167.25 (repealed), with conforming changes: 3901.3814**

Same as the Executive.

**Fiscal effect: Same as the Executive.**

**MCDCD23 Updating references**

**R.C. 5168.03, 3901.381, 5168.05-5168.08**

Replaces references to the former U.S. Health Care Financing Administration with references to the U.S. Centers for Medicare and Medicaid Services.

**Fiscal effect: None.**

**R.C. 5168.03, 3901.381, 5168.05-5168.08**

Same as the Executive.

**Fiscal effect: Same as the Executive.**

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**MCDCD1            Temporary authority regarding employees**

**Section:    333.20**

Extends through July 1, 2021, the authority of ODM to establish, change, and abolish positions and to assign, reassign, classify, reclassify, transfer, reduce, promote, or demote employees who are not subject to state law governing public employee's collective bargaining.

Permits a portion of various ODM appropriation items to be used to pay for costs associated with the administration of the Medicaid Program, including the personnel actions listed above.

**Fiscal effect: None.**

**Section:    333.20**

Same as the Executive.

Same as the Executive.

**Fiscal effect: Same as the Executive.**

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DPSCD51

Non-opioid directives

R.C. 4765.60, 4765.601, 4765.602, 4765.603, 4765.604, 4765.604, 4765.605, 4765.606, 4765.607, 4765.608, 4765.609

(1) No provision.

(1) Requires the State Board of Emergency Medical, Fire, and Transportation Services, within one year of the provision's effective date, to develop and make available free of charge a non-opioid directive form for use by a patient who does not want to be provided an opioid analgesic.

(2) No provision.

(2) Provides that a patient's decision to sign a non-opioid directive form is voluntary and does not become effective until it is signed and placed in the patient's medical record.

(3) No provision.

(3) Requires an individual who places a signed non-opioid directive form in a patient's medical record, or that individual's delegate, to notify the State Board of Pharmacy that the patient has signed a non-opioid directive form and where the form is maintained.

(4) No provision.

(4) Requires a non-opioid directive form be distributed to each individual who has completed treatment with a community addiction services provider at the time of discharge from such treatment, and each individual who served a prison term for a drug offense.

(5) No provision.

(5) Provides that the patient may revoke a non-opioid directive form at any time.

(6) No provision.

(6) Provides immunity, generally, from criminal prosecution, civil liability, or professional disciplinary action to certain first responders, pharmacists or pharmacy interns, and prescribers when providing an opioid analgesic to a person with a non-

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(7) No provision.

opioid director form in certain specified situations.

(7) Prohibits the existence or nonexistence of a non-opioid directive from: (a) affecting the sale, procurement, issuance, or renewal of a life insurance policy or annuity, (b) modifying or invalidating the terms of a life insurance policy or annuity that is in effect on this provision's effective date, and (c) impairing or invalidating a life insurance policy or annuity or any health benefit plan.

**Fiscal effect: Uncertain.**