



www.lsc.ohio.gov

# OHIO LEGISLATIVE SERVICE COMMISSION

Office of Research  
and Drafting

Legislative Budget  
Office

H.B. 469  
133<sup>rd</sup> General Assembly

## Bill Analysis

**Version:** As Introduced

**Primary Sponsors:** Reps. Manchester and West

Nick Thomas, Research Analyst

### SUMMARY

- Requires health insuring corporations and sickness and accident insurers to apply amounts paid by or on behalf of covered individuals toward cost-sharing requirements.
- Exempts situations where a generic version of a brand name drug exists, but the prescribing physician prescribes the brand name drug without it being medically necessary.

### DETAILED ANALYSIS

The bill imposes requirements on how health plan issuers apply amounts paid by or on behalf of a covered individual towards a cost sharing requirement. Under current law, unchanged by the bill, “cost-sharing requirement” refers to any cost to a covered individual for health services according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirement imposed by a health benefit plan.<sup>1</sup> The bill applies to health insuring corporations and sickness and accident insurers.<sup>2</sup>

The bill requires these health plan issuers to include all amounts paid by a covered individual or on a covered individual’s behalf when calculating the covered individual’s contribution toward a cost-sharing requirement. For example, if a covered individual receives a coupon for a drug which stipulates that the manufacturer of the drug will pay the copayment for the drug, then, under the bill, such a payment would have to be counted toward any cost-sharing requirement the covered individual’s health benefit plan might impose.

---

<sup>1</sup> R.C. 1751.68 and 3923.602, not in the bill.

<sup>2</sup> R.C. 1751.12 and 3923.811.

The bill stipulates that its requirements only apply insofar as they are allowed under federal law. Also, the bill exempts any payment made for a brand name drug when a generic version of that drug exists, but the covered individual's physician prescribes the brand name drug, but does not consider the brand name drug to be medically necessary.

The bill specifies that if any of its requirements are deemed invalid or incapable of being enforced against a health plan issuer due to conflict with federal law, then such requirement is to remain in effect against all health benefit plans in such situations where no such conflict exists.<sup>3</sup>

The above provisions apply to health benefit plans delivered, issued for delivery, modified, or renewed 90 or more days after the bill's effective date.<sup>4</sup>

---



---

## HISTORY

Action	Date
Introduced	01-14-20

---

H0469-I-133/ar

---

<sup>3</sup> R.C. 1751.12(D)(4) and 3923.811(B).

<sup>4</sup> Section 3.