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H.B. 682
136th General Assembly

Bill Analysis

Version: As Introduced

Primary Sponsors: Reps. Craig and Manning

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SUMMARY

- Prohibits certain insurance practices regarding the administration of physician-administered drugs in a physician's office or an independent hospital, for patients with chronic, complex, rare, or life-threatening medical conditions.
- Applies the prohibitions to health benefit plans that are issued, amended, or renewed on or after January 1, 2027.

DETAILED ANALYSIS

Prohibit practices related to physician-administered drugs

The bill imposes certain prohibitions on health benefit plans that are related to pharmacy selection, coverage limitations, and billing regarding physician-administered drugs. A "physician-administered drug" means a drug, other than a vaccine, that:[1]

- Cannot reasonably be self-administered by the patient to whom the drug is prescribed or by an individual assisting the patient with self-administration; and
- Is typically administered by a physician or other health care provider, including when acting under a physician's delegation and supervision.

Specifically, a health benefit plan that is issued, amended, or renewed on or after January 1, 2027, cannot do any of the following when a physician administers a drug on an outpatient basis in a specified location:[2]

[1] R.C. 3902.65(A)(6).

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

- Require the drugs to be dispensed only by certain pharmacies or only by pharmacies participating in the health plan issuer's network;
- If the drug is otherwise covered, limit or exclude coverage for the drug (1) based on the covered person's choice of pharmacy or (2) because the drug is not dispensed by a pharmacy that participates in the health plan issuer's network;
- Require an in-network physician or other health care provider to bill or be reimbursed for the delivery and administration of the drug under the plan's pharmacy benefit instead of the medical benefit without: (1) informed consent from the covered person and (2) a written attestation by the covered person's physician or other health care provider that a delay in the drug's administration will not place the covered person at an increased health risk;
- Require that a covered person pay an additional fee or impose increased cost-sharing requirements for the drugs (1) based on the covered person's choice of pharmacy or (2) because the drug was not dispensed by a pharmacy that participates in the health plan issuer's network.

These prohibitions apply only to covered outpatient drugs administered in a "specified location," meaning a physician's office or an independent hospital (a hospital or group of hospitals that files jointly one financial statement and that has an annual patient service revenue derived in Ohio of less than $2 billion based on the financial statement).[3]

Applicability

The bill applies the above prohibitions only to covered persons with a chronic, complex, rare, or life-threatening medical condition and whose physician or other health care provider determines any of the following: [4]

- A delay of care would make disease progression probable;
- The use of a pharmacy within the health plan issuer's network would make death or patient harm probable or potentially cause a barrier to the covered person's compliance with his or her plan of care;
- It is necessary to have the drug dispensed by a different pharmacy based on the timeliness of the delivery or on dosage requirements.

The bill also clarifies that it cannot be construed to: (1) authorize a person to administer a drug when it is otherwise prohibited under Ohio law and (2) modify drug administration requirements under Ohio law, including any requirements related to the delegation and supervision of drug administration.[5]

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

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

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

Mandated health benefit

The bill's prohibitions might be considered a mandated health benefit. Under R.C. 3901.71, if the General Assembly enacts a provision for mandated health benefits, that provision cannot be applied to any health benefit plan until the Superintendent of Insurance determines that the provision can be applied fully and equally in all respects to employee benefit plans subject to regulation by the federal "Employee Retirement Income Security Act of 1974" (ERISA),[6] and to employee benefit plans established or modified by the state or any of its political subdivisions. ERISA appears to preempt any state regulation of such plans.[7] The bill exempts its prohibitions from this restriction.[8]

Definitions

The bill defines the following other terms:[9]

- "**Administer**" means to directly apply a drug to the body of a patient by injection, inhalation, ingestion, or any other means.
- A "**pharmacy**" includes a pharmacy located in or affiliated with an independent hospital.
- "**Physician**" is a person licensed by the state to practice medicine or surgery or osteopathic medicine or surgery.
- "**Health care provider**" is an individual who is licensed, certified, or otherwise authorized to provide health care services in the state.

HISTORY

Action	Date
Introduced	02-04-26

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[6] 29 United States Code (U.S.C.) 1001, as amended.

[7] 29 U.S.C. 1144.

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

[9] R.C. 3902.65(A).