As Introduced

131st General Assembly
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S. B. No. 135

Senators Cafaro, Jones
Cosponsors: Senators Brown, Thomas, Tavares, Lehner, LaRose

A BILL

To amend section 1739.05 and to enact sections 1751.691 and 3923.851 of the Revised Code to limit the out-of-pocket cost to an individual covered by a health plan for drugs used to treat rare diseases. 1 2 3 4 5

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That section 1739.05 be amended and sections 1751.691 and 3923.851 of the Revised Code be enacted to read as follows: 6 7 8

Sec. 1739.05. (A) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program may be established only if any of the following applies: 9 10 11 12

(1) The arrangement has and maintains a minimum enrollment of three hundred employees of two or more employers. 13 14

(2) The arrangement has and maintains a minimum enrollment of three hundred self-employed individuals. 15 16

(3) The arrangement has and maintains a minimum enrollment 17

of three hundred employees or self-employed individuals in any combination of divisions (A)(1) and (2) of this section. 18 19

(B) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program shall comply with all laws applicable to self-funded programs in this state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 3902.01 to 3902.14, 3923.24, 3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3923.80, 3923.85, 3923.851, 3924.031, 3924.032, and 3924.27 of the Revised Code. 20 21 22 23 24 25 26 27 28

(C) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall solicit enrollments only through agents or solicitors licensed pursuant to Chapter 3905. of the Revised Code to sell or solicit sickness and accident insurance. 29 30 31 32 33

(D) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall provide benefits only to individuals who are members, employees of members, or the dependents of members or employees, or are eligible for continuation of coverage under section 1751.53 or 3923.38 of the Revised Code or under Title X of the "Consolidated Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 U.S.C.A. 1161, as amended. 34 35 36 37 38 39 40 41

Sec. 1751.691. (A) As used in this section: 42

(1) "Cost sharing" has the same meaning as in section 1751.69 of the Revised Code. 43 44

(2) "Preferred drug formulary" means any list that groups drugs covered by an individual or group health insuring 45 46

corporation policy, contract, or agreement into tiers and for which a cost-sharing requirement is established for each tier. 47 48

(3) "Rare disease or condition" has the same meaning as in 21 U.S.C. 360bb(a)(2). 49 50

(4) "Specialty drug" means a prescription drug that meets all of the following: 51 52

(a) The drug is prescribed for an individual with a complex or chronic medical condition or a rare medical condition; 53 54 55

(b) The drug costs six hundred dollars or more for up to a thirty-day supply; 56 57

(c) The drug is not typically stocked at retail pharmacies; 58 59

(d) The drug has at least one of the following characteristics: 60 61

(i) It requires a difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug; 62 63 64

(ii) It requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug. 65 66 67

(5) "Specialty drug tier" means a tier of a preferred drug formulary that imposes cost-sharing requirements for specialty drugs that are higher than for nonspecialty drugs. 68 69 70

(B) Notwithstanding section 3901.71 of the Revised Code, an individual or group health insuring corporation policy, contract, or agreement providing prescription drug services that 71 72 73

is delivered, issued for delivery, or renewed in this state shall comply with both of the following: 74 75

(1) The policy, contract, or agreement shall not impose cost sharing for specialty drugs of more than one hundred fifty dollars for a one-month supply. 76 77 78

(2)(a) The policy, contract, or agreement shall establish a process by which a covered individual may request that a specialty drug that is not listed on a preferred drug formulary may be covered and subject to cost-sharing requirements as if it were listed on the formulary. 79 80 81 82 83

(b) The denial of such a request shall be treated as an adverse benefit determination, subject to internal appeal and external review under Chapter 3922. of the Revised Code. 84 85 86

(C) Nothing in this section shall be interpreted as requiring a policy, contract, or agreement to do any of the following: 87 88 89

(1) Provide coverage for any additional drugs not otherwise required by law; 90 91

(2) Implement specific utilization management techniques, such as prior authorization or step therapy; 92 93

(3) Stop the use of any cost-sharing requirements, policies, or procedures that are not otherwise prohibited under this section or any other section of law, including those strategies used to incentivize the use of preventative services, disease management, and low-cost treatment options. 94 95 96 97 98

(D) A policy, contract, or agreement shall not place all drugs in a given class on a specialty tier. 99 100

(E) Nothing in this section shall be interpreted as 101

prohibiting a policy, contract, or agreement from requiring that specialty drugs be obtained through a designated pharmacy or other source of such drugs. 102 103 104

(F) Nothing in this section shall be interpreted as requiring a pharmacist to substitute a drug without the consent of the prescribing physician. 105 106 107

Sec. 3923.851. (A) As used in this section: 108

(1) "Cost sharing" has the same meaning as in section 1751.69 of the Revised Code. 109 110

(2) "Preferred drug formulary" means any list that groups drugs covered by an individual or group policy of sickness and accident insurance or a public employee benefit plan into tiers and for which a cost-sharing requirement is established for each tier. 111 112 113 114 115

(3) "Rare disease or condition" has the same meaning as in 21 U.S.C. 360bb(a)(2). 116 117

(4) "Specialty drug" means a prescription drug that meets all of the following: 118 119

(a) The drug is prescribed for an individual with a complex or chronic medical condition or a rare medical condition; 120 121 122

(b) The drug costs six hundred dollars or more for up to a thirty-day supply; 123 124

(c) Is not typically stocked at retail pharmacies; 125

(d) The drug has at least one of the following characteristics: 126 127

(i) It requires a difficult or unusual process of delivery 128

to the patient in the preparation, handling, storage, inventory, or distribution of the drug; 129 130

(ii) It requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug. 131 132 133

(B) Notwithstanding section 3901.71 of the Revised Code, an individual or group policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state and a public employee benefit plan that is established or modified in this state, that provides prescription drug services shall comply with both of the following: 134 135 136 137 138 139

(1) The policy or plan shall not impose cost sharing for specialty drugs of more than one hundred fifty dollars for a one-month supply. 140 141 142

(2)(a) The policy or plan shall establish a process by which a covered individual may request that a specialty drug that is not listed on a preferred drug formulary may be covered and subject to cost-sharing requirements as if it were listed on the formulary. 143 144 145 146 147

(b) The denial of such a request shall be treated as an adverse benefit determination, subject to internal appeal and external review under Chapter 3922. of the Revised Code. 148 149 150

(C) Nothing in this section shall be interpreted as requiring a policy or plan to do any of the following: 151 152

(1) Provide coverage for any additional drugs not otherwise required by law; 153 154

(2) Implement specific utilization management techniques, such as prior authorization or step therapy; 155 156

(3) Stop the use of any cost-sharing requirements, policies, or procedures that are not otherwise prohibited under this section or any other section of law, including those strategies used to incentivize the use of preventative services, disease management, and low-cost treatment options. 157 158 159 160 161

(D) A policy or plan shall not place all drugs in a given class on a specialty tier. 162 163

(E) Nothing in this section shall be interpreted as prohibiting a policy or plan from requiring that specialty drugs be obtained through a designated pharmacy or other source of such drugs. 164 165 166 167

(F) Nothing in this section shall be interpreted as requiring a pharmacist to substitute a drug without the consent of the prescribing physician. 168 169 170

Section 2. That existing section 1739.05 of the Revised Code is hereby repealed. 171 172

Section 3. Sections 1739.05 and 1751.691 of the Revised Code, as amended or enacted by this act, apply only to policies, contracts, agreements, and arrangements that are delivered, issued for delivery, or renewed in this state on or after January 1, 2016. Section 3923.851 of the Revised Code, as enacted by this act, applies only to policies of sickness and accident insurance delivered, issued for delivery, or renewed in this state, and public employee benefit plans that are established or modified in this state, on or after January 1, 2016. 173 174 175 176 177 178 179 180 181 182