As Introduced

134th General Assembly

Regular Session **H. B. No. 153**

2021-2022

Representatives Liston, Carruthers

Cosponsors: Representatives Miranda, Leland, Lipps, West, Russo, Weinstein, Crossman, Lightbody, Lepore-Hagan, Click, O'Brien, Seitz

A BILL

To amend sections 3902.50, 3902.60, and 3902.70 and to enact section 3902.62 of the Revised Code regarding prescription drugs and medication switching.

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

Section 1. That sections 3902.50, 3902.60, and 3902.70 be amended and section 3902.62 of the Revised Code be enacted to read as follows:

Sec. 3902.50. As used in sections 3902.50 to ~~3902.54~~ 3902.71 of the Revised Code:

(A) "Ambulance" has the same meaning as in section 4765.01 of the Revised Code.

(B) "Clinical laboratory services" has the same meaning as in section 4731.65 of the Revised Code.

(C) "Cost sharing" means the cost to a covered person under a health benefit plan according to any copayment, coinsurance, deductible, or other out-of-pocket expense

requirement.

(D) "Covered person," "health benefit plan," "health care services," and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.

(E) "Emergency facility" has the same meaning as in section 3701.74 of the Revised Code.

(F) "Emergency services" means all of the following as described in 42 U.S.C. 1395dd:

(1) Medical screening examinations undertaken to determine whether an emergency medical condition exists;

(2) Treatment necessary to stabilize an emergency medical condition;

(3) Appropriate transfers undertaken prior to an emergency medical condition being stabilized.

(G) "Prior authorization requirement" means any practice implemented by a health plan issuer in which coverage of a health care service, device, or drug is dependent upon a covered person or a provider obtaining approval from the health plan issuer prior to the service, device, or drug being performed, received, or prescribed, as applicable. "Prior authorization requirement" includes prospective or utilization review procedures conducted prior to providing a health care service, device, or drug.

(H) "Unanticipated out-of-network care" means health care services, including clinical laboratory services, that are covered under a health benefit plan and that are provided by an out-of-network provider when either of the following conditions applies:

(1) The covered person did not have the ability to request such services from an in-network provider.

(2) The services provided were emergency services.

Sec. 3902.60. As used in sections 3902.60 and 3902.61 of the Revised Code:

(A) "Associated conditions" means the symptoms or side effects of stage four advanced metastatic cancer, or the treatment thereof, which would, in the judgment of the health care practitioner in question, jeopardize the health of a covered individual if left untreated.

(B) ~~"Covered person," "health benefit plan," and "health plan issuer" have the same meanings~~ "Health care provider" has the same meaning as in section 3922.01 of the Revised Code.

(C) "Stage four advanced metastatic cancer" means a cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other areas or parts of the body.

Sec. 3902.62. (A) As used in this section, "interchangeable biological product" and "generically equivalent drug" have the same meanings as in section 3715.01 of the Revised Code.

(B) Notwithstanding section 3901.71 of the Revised Code, with regard to health benefit plans amended, issued, or renewed on or after the effective date of this section, a health plan issuer shall not do any of the following during a plan year:

(1) Increase a covered person's burden of cost-sharing with respect to a drug;

(2) Move a drug to a more restrictive tier of a health

benefit plan's formulary;

(3) Remove a drug from a health benefit plan's formulary unless one of the following occurred:

(a) The United States food and drug administration issued a statement about the drug calling into question the clinical safety of the drug.

(b) The drug manufacturer notified the United States food and drug administration of a permanent discontinuance or interruption of the manufacture of the drug as required by 21 U.S.C. 356c.

(c) The drug manufacturer has removed the drug from sale in the United States.

(4) Limit or reduce coverage of a drug with respect to a covered person in any other way, including subjecting it to a prior authorization requirement.

(C) This section shall not be construed to do any of the following:

(1) Prevent a health plan issuer from adding a drug to its formulary;

(2) Prevent a health plan issuer from removing a drug from its formulary if the drug manufacturer has removed the drug from sale in the United States;

(3) Prevent a health care provider from prescribing another drug covered by the health benefit plan that the provider considers medically appropriate for the covered person;

(4) In the case of a prescribed drug for which a generically equivalent drug or interchangeable biological

product is available, prevent any of the following:

(a) A pharmacist from substituting the generically equivalent drug or interchangeable biological product for the prescribed drug in accordance with section 4729.38 of the Revised Code;

(b) A health plan issuer from requiring a covered person to use the generically equivalent drug or interchangeable biological product instead of the prescribed drug, even when the equivalent or product becomes available during a plan year;

(c) A covered person from using the generically equivalent drug or interchangeable drug product instead of the prescribed drug, even when the equivalent or product becomes available during a plan year.

(5) Prevent a pharmacist from substituting for a prescribed epinephrine autoinjector another epinephrine autoinjector pursuant to section 4729.382 of the Revised Code.

(D) A violation of this section shall be considered an unfair and deceptive practice in the business of insurance for the purposes of section 3901.21 of the Revised Code.

Sec. 3902.70. As used in this section and section 3902.71 of the Revised Code:

(A) "340B covered entity" and "third-party administrator" have the same meanings as in section 5167.01 of the Revised Code.

(B) ~~"Health plan issuer" has the same meaning as in section 3922.01 of the Revised Code.~~

~~(C)~~ "Terminal distributor of dangerous drugs" has the same meaning as in section 4729.01 of the Revised Code.

Section 2. That existing sections 3902.50, 3902.60, and 3902.70 of the Revised Code are hereby repealed.