As Introduced

134th General Assembly
Regular Session
2021-2022

H. B. No. 655

Representative Ingram

A BILL

To amend section 3902.50 and to enact section 3902.73 of the Revised Code to prohibit health insurers and pharmacy benefit managers from steering patients to affiliated pharmacies.

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

Section 1. That section 3902.50 be amended and section 3902.73 of the Revised Code be enacted to read as follows:

Sec. 3902.50. As used in sections 3902.50 to ~~3902.72~~ 3902.73 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" or "coverage" means the provision of benefits related to health care services to a covered person in

accordance with a health benefit plan.

(E) "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.

(F) "Drug" has the same meaning as in section 4729.01 of the Revised Code.

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

(H) "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.

(I) "Health care practitioner" has the same meaning as in section 3701.74 of the Revised Code.

(J) "Pharmacy benefit manager" has the same meaning as in section 3959.01 of the Revised Code.

(K) "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.

(L) "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. 3902.73. (A) As used in this section, "affiliated pharmacy" means a pharmacy in which a health plan issuer, either directly or indirectly through one or more intermediaries, has an investment or ownership interest or with which it shares common ownership.

(B) A health plan issuer that offers, issues, or administers a health benefit plan that covers pharmacy services, including prescription drug coverage, shall not do any of the following:

(1) Order or direct a covered person to fill a prescription at or obtain services from an affiliated pharmacy;

(2) Restrict a covered person's ability to select a pharmacy if the selected pharmacy is in the health plan issuer's pharmacy provider network;

(3) Impose a cost-sharing requirement on the covered person that differs depending on which in-network pharmacy the covered person uses;

(4) Impose any other condition on a covered person or

pharmacy that restricts a covered person's ability to use an in-network pharmacy of the covered person's choosing;

(5) Prevent a pharmacy from participating in the health plan issuer's network if the pharmacy meets both of the following criteria:

(a) The pharmacy is willing to agree to the terms and conditions of the health plan issuer's pharmacy provider contract.

(b) The pharmacy provides pharmacy services in accordance with all applicable state and federal laws.

(6) Require a pharmacy, as a condition of participation in the health plan issuer's network, to meet accreditation standards or certification requirements that are inconsistent with or in addition to those of the state board of pharmacy;

(7) Transfer or share records relating to prescription information containing patient-identifiable or prescriber-identifiable data to or with an affiliated pharmacy for any commercial purpose. Division (B)(7) of this section shall not be construed to prohibit the exchange of prescription information between a health plan issuer and an affiliated pharmacy for the limited purposes of pharmacy reimbursement, formulary compliance, pharmacy care, or utilization review.

(8) Knowingly make a misrepresentation to a covered person, pharmacist, pharmacy, or dispensing physician.

(C) This section does not apply to either of the following:

(1) A health benefit plan offered by a health insuring corporation under which a majority of covered services are

provided by physicians employed by the health plan issuer or by a single contracted medical group;

(2) Pharmacy services provided to an individual receiving inpatient or emergency services at a health care facility that provides medical services on an inpatient or resident basis.

(D) Whoever violates this section is considered to have engaged in an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

Section 2. That existing section 3902.50 of the Revised Code is hereby repealed.