As Introduced

130th General Assembly
Regular Session
2013-2014

S. B. No. 364

Senator Cafaro

Cosponsor: Senator Turner

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 of three hundred employees or self-employed individuals in any 17 18

combination of divisions (A)(1) and (2) of this section.

(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.

(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.

(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.

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

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

(2) "Preferred drug formulary" means any list that groups drugs covered by an individual or group health insuring corporation policy, contract, or agreement into tiers and for which a cost-sharing requirement is established for each tier.

(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 a person who has been diagnosed with either of the following: 53 54

(i) A physical, behavioral, or developmental condition that may or may not have any known cure and that is progressive, debilitating, or fatal if left untreated or under-treated, including multiple sclerosis, hepatitis C, and rheumatoid arthritis; 55 56 57 58 59

(ii) A rare disease or condition. 60

(b) The drug is not stocked at a majority of retail pharmacies. 61 62

(c) The drug has at least one of the following characteristics: 63 64

(i) It is an oral, injectable, or infusible drug. 65

(ii) It has unique storage or shipment requirements, such as refrigeration. 66 67

(iii) Patients receiving the drug require education and support beyond traditional dispensing activities. 68 69

(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. 70 71 72

(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 is delivered, issued for delivery, or renewed in this state shall comply with both of the following: 73 74 75 76 77

(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. 78 79 80

(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. 81 82 83 84 85

(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. 86 87 88

(C) Nothing in this section shall be interpreted as requiring a policy, contract, or agreement to do any of the following: 89 90

(1) Provide coverage for any additional drugs not otherwise required by law; 91 92

(2) Implement specific utilization management techniques, such as prior authorization or step therapy; 93 94

(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. 95 96 97 98 99

(D) A policy, contract, or agreement shall not place all drugs in a given class on a specialty tier. 100 101

(E) Nothing in this section shall be interpreted as prohibiting a policy, contract, or agreement from requiring that specialty drugs be obtained through a designated pharmacy or other source of such drugs. 102 103 104 105

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

prescribing physician. 108

Sec. 3923.851. (A) As used in this section: 109

(1) "Cost sharing" has the same meaning as in section 1751.69 of the Revised Code. 110 111

(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. 112 113 114 115 116

(3) "Rare disease or condition" has the same meaning as in 21 U.S.C. 360bb(a)(2). 117 118

(4) "Specialty drug" means a prescription drug that meets all of the following: 119 120

(a) The drug is prescribed for a person who has been diagnosed with either of the following: 121 122

(i) A physical, behavioral, or developmental condition that may or may not have any known cure and that is progressive, debilitating, or fatal if left untreated or under-treated, including multiple sclerosis, hepatitis C, and rheumatoid arthritis; 123 124 125 126 127

(ii) A rare disease or condition. 128

(b) The drug is not stocked at a majority of retail pharmacies. 129 130

(c) The drug has at least one of the following characteristics: 131 132

(i) It is an oral, injectable, or infusible drug. 133

(ii) It has unique storage or shipment requirements, such as refrigeration. 134 135

(iii) Patients receiving the drug require education and support beyond traditional dispensing activities. 136 137

(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: 138 139 140 141 142 143

(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. 144 145 146

(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. 147 148 149 150

(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. 151 152 153

(C) Nothing in this section shall be interpreted as requiring a policy or plan to do any of the following: 154 155

(1) Provide coverage for any additional drugs not otherwise required by law; 156 157

(2) Implement specific utilization management techniques, such as prior authorization or step therapy; 158 159

(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. 160 161 162 163 164

(D) A policy or plan shall not place all drugs in a given 165

class on a specialty tier. 166

(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. 167 168 169 170

(F) Nothing in this section shall be interpreted as requiring a pharmacist to substitute a drug without the consent of the prescribing physician. 171 172 173

Section 2. That existing section 1739.05 of the Revised Code is hereby repealed. 174 175

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, 2015. 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, 2015. 176 177 178 179 180 181 182 183 184