Ohio Legislative Service Commission

Bill Analysis

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H.B. 453

128th General Assembly
(As Introduced)

Reps. Boyd, Hagan, Harris, Yuko, Domenick, Weddington, Letson, Slesnick, Patten, S. Williams, Stewart, Oelslager

BILL SUMMARY

- Prohibits health care insurers from making certain changes with respect to prescription drug coverage without providing written notice to the health care providers, pharmacies, pharmacists, and persons with health care coverage who will be affected by the changes.

CONTENT AND OPERATION

Notification of changes to prescription drug coverage

(R.C. 1751.661, 3923.602, and 3923.611)

The bill prohibits a health insuring corporation, sickness and accident insurer, and public employee benefit plan from doing any of the following without providing prior written notice to all network health care providers, network pharmacies, network pharmacists, and persons covered under any affected policy, contract, agreement, or plan:

- Removing a prescription drug from its formulary, which the bill defines as a list of drugs covered under the applicable policy, contract, agreement, or plan;
- Moving a covered prescription drug to a higher copay tier;
- Interchanging a prescription drug (see **COMMENT**);
- Adding utilization management requirements for a prescription drug.

If any of the changes listed above are made, the bill provides that the change becomes effective on the renewal date of the policy, contract, agreement, or plan under which a person receives health care coverage. This effective date must be specified in the written notice that the bill requires to be provided to all network health care providers, network pharmacies, network pharmacists, and persons with health care coverage who will be affected by the prescription drug changes.

Exemption from restriction on new mandated health benefits

(R.C. 1751.661(B), 3923.602(B), and 3923.661(B))

Current law restricts the application of statutes that establish mandated health benefits.[1] Under this restriction, a statutory provision for mandated health benefits enacted after January 14, 1993,[2] cannot be applied to a policy, contract, plan, or other arrangement providing sickness and accident or other health benefits until the Superintendent of Insurance determines, pursuant to a hearing conducted in accordance with the Administrative Procedure Act (R.C. Chapter 119.), that the provision can be applied fully and equally in all respects to (1) employee benefit plans subject to regulation by the federal Employee Retirement Income Security Act of 1974 (ERISA)[3] and (2) employee benefit plans established or modified by the state or any political subdivision of the state, or by any agency or instrumentality of the state or any political subdivision of the state.

The bill's prohibitions on making changes relative to prescription drug coverage without providing advance notice may be considered a mandated health benefit. The bill, however, exempts these prohibitions from the existing law restriction on establishing new mandated health benefits.

[1] A "mandated health benefit" is defined as any required coverage, or required offering of coverage, for the expenses of specified services, treatments, or diseases under any policy, contract, plan, or other arrangement providing sickness and accident or other health benefits to policyholders, subscribers, or members (R.C. 3901.71(A) (not in the bill)).

[2] January 14, 1993, is the effective date of Am. Sub. H.B. 478 of the 119th General Assembly. H.B. 478 contained comprehensive provisions pertaining to health benefits and health insurers.

[3] ERISA is a federal statute that governs the administration of employee benefit plans. It generally precludes direct state regulation of benefits offered by private employers, but it allows state regulation of the business of insurance. Therefore, ERISA preempts the state's ability to require private "self-insuring" employers to offer to cover certain services. When an employer self-insures, the employer assumes the risk of the costs associated with providing the health benefits, as opposed to purchasing insurance coverage from a third-party that assumes the risk of those costs.

COMMENT

Drug "interchange" is one of the actions that the bill prohibits health care insurers from taking without providing advance notice to affected persons. The bill defines this action as the substitution of one version of a prescribed drug for the drug originally prescribed.[4] The following are specified as examples of drug interchange substitutions:

(1) A generic version for a brand-name version;

(2) A brand-name version for a generic version;

(3) A generic version by one manufacturer for[5] a generic version by a different manufacturer;

(4) A different formulation of the same drug;

(5) A different drug in the same class.

The substitution of a generic drug for a drug prescribed by its brand-name is expressly authorized under current law governing the practice of pharmacy, unless the health professional prescribing the drug indicates on the prescription that the drug must be "dispensed as written" or "D.A.W." (R.C. 4729.38, not in the bill). The State Board of Pharmacy interprets brand-name substitutions for generic drugs as being included within a pharmacist's authority to make generic substitutions.

However, current law does not authorize a pharmacist to dispense a different drug in the same class. This action, which is permitted in some states, is sometimes referred to as "therapeutic substitution" or "therapeutic interchange." In Ohio, a pharmacist must receive a new prescription from the prescribing practitioner before a different drug may be dispensed.

HISTORY

ACTION	DATE
Introduced	02-22-10

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[4] R.C. 1751.661(C)(2), 3923.602(C)(2), and 3923.611(C)(2).

[5] An amendment is necessary to correct this provision in the bill by changing the word "or" to "for."