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H.B. 177
135th General Assembly

Bill Analysis

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Version: As Reported by House Public Health Policy

Primary Sponsor: Rep. Manchester

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SUMMARY

- Requires health insuring corporations and sickness and accident insurers to apply all amounts paid by or on behalf of covered individuals toward cost-sharing requirements for prescription drugs.
- Allows health insuring corporations and sickness and accident insurers to exclude amounts paid on behalf of an enrollee by another person for a brand name prescription drug where a generic version exists and the brand name is not medically necessary.
- Requires pharmacy benefit managers to comply with all cost-sharing requirements applicable to health insuring corporations and sickness and accident insurers, including the new requirements enacted by the bill.
- Specifies that the bill is not to be construed as requiring a health insuring corporation, sickness and accident insurer, or pharmacy benefit manager to cover a drug that is not already covered.
- Specifies that withdrawing coverage of a drug is not a violation of the bill's requirements if doing so does not violate any other existing state or federal laws or administrative rules.

DETAILED ANALYSIS

Cost-sharing requirements

The bill imposes requirements on how certain health plan issuers apply amounts paid by or on behalf of a covered individual towards a cost sharing requirement. Under current law, unchanged by the bill, "cost-sharing requirement" refers to any cost to a covered individual for health services according to any coverage limit, copayment, coinsurance, deductible, or other

out-of-pocket expense requirement imposed by a health benefit plan.[1] The bill applies to health insuring corporations, sickness and accident insurers, and pharmacy benefit managers.[2]

Under the bill, health insuring corporations, sickness and accident insurers, and pharmacy benefit managers must include all amounts paid by a covered individual or by another person, group, or organization on behalf of the covered individual, when calculating the covered individual's contribution toward a cost-sharing requirement. For example, if a covered individual receives a coupon for a drug which stipulates that the drug manufacturer will pay the copayment for the drug, then, under the bill, such a payment would have to be counted toward any cost-sharing requirement the covered individual's health benefit plan might impose.[3]

The bill exempts any payment made on behalf of an enrollee by another person, group, or organization for a brand name drug when a generic equivalent exists, unless the prescriber determines the brand name drug to be medically necessary.[4] The bill defines "generic equivalent" as a drug that is designated to be therapeutically equivalent, as indicated by the U.S. Food and Drug Administration's publication titled "Approved Drug Products with Therapeutic Equivalence Evaluations."[5]

If the bill's cost-sharing requirement would result in an enrollee losing eligibility for the federal income tax deduction for contributions to a health savings account (HSA), then those requirements apply only after the enrollee has satisfied the minimum deductible required by federal law. Federal law allows individuals enrolled in a qualified high deductible health plan to make pre-tax contributions to a HSA to pay for medical expenses. However, the HSA deduction is available only if the high deductible health plan has an annual deductible of at least $1,000 for self-only coverage, or $2,000 for family coverage.[6] The bill's exception for certain qualified high deductible health plans ensures that no enrollee loses an HSA deduction as a result of the bill's change to cost-sharing requirements.[7]

However, the federal law does not require high deductible health plans to maintain a deductible for preventative care. As such, the bill's cost-sharing requirements apply to qualifying preventative care items and services regardless of whether the enrollee has satisfied the plan's minimum deductible.[8]

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[1] R.C. 1751.68 and 3923.602, not in the bill.

[2] R.C. 1751.12, 3923.811, and 3959.21.

[3] R.C. 1751.12(D)(4)(a), 3923.811(B)(1), and 3959.21(B)(1).

[4] R.C. 1751.12(D)(4)(b) and (H)(2), 3923.811(B)(2), and 3959.21(B)(1).

[5] R.C. 1751.12(H)(2) and 3923.811(A)(2).

[6] 26 United States Code (U.S.C.) 223, not in the bill.

[7] R.C. 1751.12(D)(4)(e)(ii), 3923.811(B)(3)(b), and 3959.21(B)(2)(b).

[8] R.C. 1751.12(D)(4)(e)(ii), 3923.811(B)(3)(b), and 3959.21(B)(2)(b); 26 U.S.C. 223, not in the bill.

Pharmacy benefit managers

The bill also requires a pharmacy benefit manager, in the performance of its contracted duties, to comply with the terms of applicable cost-sharing requirements regarding the prescribing, receipt, administration, or coverage of a prescription drug detailed in the bill and under continuing law. Under the bill, a "pharmacy benefit manager" is any person or entity that, pursuant to a contract or other relationship with an insurer, managed care organization, employer, or other third party, either directly or through an intermediary, manages the prescription drug benefit provided by the insurer, managed care organization, employer, or third party, including any of the following:

- The processing and payment of claims for covered prescription drugs;
- The performance of drug utilization review;
- The processing of drug prior authorization requests;
- The adjudication of appeals or grievances related to the prescription drug benefit;
- Contracting with network pharmacies;
- Controlling the cost of covered prescription drugs;
- The performance of any other duty directly or indirectly related to the processing or payment of claims for covered prescription drugs.[9]

Interpretation and applicability

The bill includes several provisions guiding the interpretation of its requirements. First, the bill specifies that it is not to be construed as requiring a health insuring corporation, sickness and accident insurer, or pharmacy benefit manager to provide coverage for a prescription drug that is not already covered under the plan. Second, a health insuring corporation, sickness and accident insurer, or pharmacy benefit manager is not to be considered in violation of the bill's requirements solely for withdrawing coverage of a drug, if the removal of coverage does not violate any other existing state or federal laws or administrative rules.[10]

The bill applies to health benefit plans delivered, issued for delivery, modified, or renewed on or after January 1, 2025.[11]

[9] R.C. 3959.21.

[10] R.C. 1751.12(D)(4)(c) and (d), 3923.811(C) and (D), and 3959.21(C) and (D).

[11] Section 3.

HISTORY

Action	Date
Introduced	05-22-23
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