As Introduced

135th General Assembly
Regular Session **H. B. No. 156**
2023-2024

Representatives Manning, Oelslager

A BILL

To amend section 3902.50 and to enact section 3902.63 of the Revised Code to amend the law related to physician-administered drugs.

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

Section 1. That section 3902.50 be amended and section 3902.63 of the Revised Code be enacted to read as follows:

Sec. 3902.50. As used in sections 3902.50 to 3902.72 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) Except as provided in section 3902.63 of the Revised Code, "health benefit plan" has the same meaning as in section 3922.01 of the Revised Code.

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

~~(J)~~ (K) "Pharmacy" has the same meaning as in section 4729.01 of the Revised Code.

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

~~(K)~~ (M) "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)~~ (N) "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. 3902.63. (A) As used in this section:

(1) "Affiliated pharmacy" means a pharmacy that controls, is controlled by, or is under common control with a pharmacy benefit manager. Such control may be direct or indirect through one or more intermediaries.

(2) Notwithstanding section 3902.50 of the Revised Code, "health benefit plan" has the same meaning as in section 3922.01 of the Revised Code, but also includes any pharmacy or drug benefit plan managed or administered by a pharmacy benefits manager.

(3) "Physician-administered drug or medication" means an outpatient drug, other than a vaccine, that cannot reasonably be self-administered by the patient to whom the drug is prescribed, or by an individual assisting the patient with the self-administration, and that is typically administered by a health

care provider in a physician's office, hospital outpatient infusion center, or other outpatient clinical setting.

(B) A health benefit plan issued, amended, or renewed on or after the effective date of this section may offer, but shall not require or incentivize, physician-administered drugs or medications to be dispensed by a specific pharmacy or affiliated pharmacy if any of the following are true:

(1) The choice of drug, strength, or dose depends on the covered person's clinical presentation, including weight changes, lab results, or adverse event grading.

(2) The drug requires compounding.

(3) The covered person, or the covered person's legal representative, has not consented in writing to the offered dispensing arrangement for a specified course of treatment.

(C) A health benefit plan issued, amended, or renewed on or after the effective date of this section shall not do any of the following:

(1) Limit or exclude coverage for a physician-administered drug or medication when it is not dispensed by a pharmacy or affiliated pharmacy if the drug is otherwise covered under the health benefit plan;

(2) Cover the drug or medication at a different benefits tier or with cost-sharing requirements that impose greater expense for a covered person if it is dispensed or administered at the physician's office, hospital outpatient infusion center, or other outpatient clinical setting rather than a pharmacy.

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