As Reported by the House Health Committee

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Representatives Clites, Carruthers

Cosponsors: Representatives Crossman, Ginter, Lepore-Hagan, Lipps, Miranda, O'Brien, Russo, Weinstein, West, Liston

A BILL

To enact section 3902.50 of the Revised Code regarding prescription drugs and medication switching.

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

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

Sec. 3902.50. (A) As used in this section:

(1) "Cost-sharing" means the cost to a covered person under a health benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirement.

(2) "Covered person," "health benefit plan," "health care provider" or "provider," "health plan issuer," and "health care services" have the same meanings as in section 3922.01 of the Revised Code.

(3) "Interchangeable biological product" and "generically equivalent drug" have the same meanings as in section 3715.01 of

the Revised Code.

(4) "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 health care provider obtaining approval from the health plan issuer prior to the service, device, or drug being performed, received, or prescribed, as applicable. "Prior authorization" includes prospective or utilization review procedures conducted prior to providing a health care service, device, or drug.

(B) A health plan issuer shall not do any of the following during a plan year:

(1) Increase a covered person's burden of cost-sharing with respect to a drug;

(2) Move a drug to a more restrictive tier of a health benefit plan's formulary;

(3) Remove a drug from a health benefit plan's formulary unless one of the following occurred:

(a) The United States food and drug administration issued a statement about the drug calling into question the clinical safety of the drug.

(b) The drug manufacturer notified the United States food and drug administration of a permanent discontinuance or interruption of the manufacture of the drug as required by 21 U.S.C. 356c.

(c) The drug manufacturer has removed the drug from sale in the United States.

(4) Limit or reduce coverage of a drug with respect to a

covered person in any other way, including subjecting it to a prior authorization requirement.

(C) This section shall not be construed to do any of the following:

(1) Prevent a health plan issuer from adding a drug to its formulary;

(2) Prevent a health plan issuer from removing a drug from its formulary if the drug manufacturer has removed the drug from sale in the United States;

(3) Prevent a health care provider from prescribing another drug covered by the health benefit plan that the provider considers medically appropriate for the covered person;

(4) In the case of a prescribed drug for which a generically equivalent drug or interchangeable biological product is available, prevent any of the following:

(a) A pharmacist from substituting the generically equivalent drug or interchangeable biological product for the prescribed drug in accordance with section 4729.38 of the Revised Code;

(b) A health plan issuer from requiring a covered person to use the generically equivalent drug or interchangable biological product instead of the prescribed drug, even when the equivalent or product becomes available during a plan year;

(c) A covered person from using the generically equivalent drug or interchangeable drug product instead of the prescribed drug, even when the equivalent or product becomes available during a plan year.

(5) Prevent a pharmacist from substituting for a

prescribed epinephrine autoinjector another epinephrine autoinjector pursuant to section 4729.382 of the Revised Code.

(D) A violation of this section shall be considered an unfair and deceptive practice in the business of insurance for the purposes of section 3901.21 of the Revised Code.

(E) This section shall not be subject to section 3901.71 of the Revised Code.

Section 2. This act shall apply to health benefit plans, as defined in section 3922.01 of the Revised Code, delivered, issued for delivery, modified, or renewed on or after the effective date of this act.