

**As Introduced**

**131st General Assembly**

**Regular Session**

**2015-2016**

**S. B. No. 135**

**Senators Cafaro, Jones**

**Cosponsors: Senators Brown, Thomas, Tavares, Lehner, LaRose**

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**A BILL**

To amend section 1739.05 and to enact sections 1  
1751.691 and 3923.851 of the Revised Code to 2  
limit the out-of-pocket cost to an individual 3  
covered by a health plan for drugs used to treat 4  
rare diseases. 5

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

**Section 1.** That section 1739.05 be amended and sections 6  
1751.691 and 3923.851 of the Revised Code be enacted to read as 7  
follows: 8

**Sec. 1739.05.** (A) A multiple employer welfare arrangement 9  
that is created pursuant to sections 1739.01 to 1739.22 of the 10  
Revised Code and that operates a group self-insurance program 11  
may be established only if any of the following applies: 12

(1) The arrangement has and maintains a minimum enrollment 13  
of three hundred employees of two or more employers. 14

(2) The arrangement has and maintains a minimum enrollment 15  
of three hundred self-employed individuals. 16

(3) The arrangement has and maintains a minimum enrollment 17

of three hundred employees or self-employed individuals in any 18  
combination of divisions (A) (1) and (2) of this section. 19

(B) A multiple employer welfare arrangement that is 20  
created pursuant to sections 1739.01 to 1739.22 of the Revised 21  
Code and that operates a group self-insurance program shall 22  
comply with all laws applicable to self-funded programs in this 23  
state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 24  
3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 25  
3902.01 to 3902.14, 3923.24, 3923.282, 3923.30, 3923.301, 26  
3923.38, 3923.581, 3923.63, 3923.80, 3923.85, 3923.851, 27  
3924.031, 3924.032, and 3924.27 of the Revised Code. 28

(C) A multiple employer welfare arrangement created 29  
pursuant to sections 1739.01 to 1739.22 of the Revised Code 30  
shall solicit enrollments only through agents or solicitors 31  
licensed pursuant to Chapter 3905. of the Revised Code to sell 32  
or solicit sickness and accident insurance. 33

(D) A multiple employer welfare arrangement created 34  
pursuant to sections 1739.01 to 1739.22 of the Revised Code 35  
shall provide benefits only to individuals who are members, 36  
employees of members, or the dependents of members or employees, 37  
or are eligible for continuation of coverage under section 38  
1751.53 or 3923.38 of the Revised Code or under Title X of the 39  
"Consolidated Omnibus Budget Reconciliation Act of 1985," 100 40  
Stat. 227, 29 U.S.C.A. 1161, as amended. 41

**Sec. 1751.691.** (A) As used in this section: 42

(1) "Cost sharing" has the same meaning as in section 43  
1751.69 of the Revised Code. 44

(2) "Preferred drug formulary" means any list that groups 45  
drugs covered by an individual or group health insuring 46

corporation policy, contract, or agreement into tiers and for 47  
which a cost-sharing requirement is established for each tier. 48

(3) "Rare disease or condition" has the same meaning as in 49  
21 U.S.C. 360bb(a)(2). 50

(4) "Specialty drug" means a prescription drug that meets 51  
all of the following: 52

(a) The drug is prescribed for an individual with a 53  
complex or chronic medical condition or a rare medical 54  
condition; 55

(b) The drug costs six hundred dollars or more for up to a 56  
thirty-day supply; 57

(c) The drug is not typically stocked at retail 58  
pharmacies; 59

(d) The drug has at least one of the following 60  
characteristics: 61

(i) It requires a difficult or unusual process of delivery 62  
to the patient in the preparation, handling, storage, inventory, 63  
or distribution of the drug; 64

(ii) It requires enhanced patient education, management, 65  
or support, beyond those required for traditional dispensing, 66  
before or after administration of the drug. 67

(5) "Specialty drug tier" means a tier of a preferred drug 68  
formulary that imposes cost-sharing requirements for specialty 69  
drugs that are higher than for nonspecialty drugs. 70

(B) Notwithstanding section 3901.71 of the Revised Code, 71  
an individual or group health insuring corporation policy, 72  
contract, or agreement providing prescription drug services that 73

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

(1) The policy, contract, or agreement shall not impose 76  
cost sharing for specialty drugs of more than one hundred fifty 77  
dollars for a one-month supply. 78

(2)(a) The policy, contract, or agreement shall establish 79  
a process by which a covered individual may request that a 80  
specialty drug that is not listed on a preferred drug formulary 81  
may be covered and subject to cost-sharing requirements as if it 82  
were listed on the formulary. 83

(b) The denial of such a request shall be treated as an 84  
adverse benefit determination, subject to internal appeal and 85  
external review under Chapter 3922. of the Revised Code. 86

(C) Nothing in this section shall be interpreted as 87  
requiring a policy, contract, or agreement to do any of the 88  
following: 89

(1) Provide coverage for any additional drugs not 90  
otherwise required by law; 91

(2) Implement specific utilization management techniques, 92  
such as prior authorization or step therapy; 93

(3) Stop the use of any cost-sharing requirements, 94  
policies, or procedures that are not otherwise prohibited under 95  
this section or any other section of law, including those 96  
strategies used to incentivize the use of preventative services, 97  
disease management, and low-cost treatment options. 98

(D) A policy, contract, or agreement shall not place all 99  
drugs in a given class on a specialty tier. 100

(E) Nothing in this section shall be interpreted as 101

prohibiting a policy, contract, or agreement from requiring that 102  
specialty drugs be obtained through a designated pharmacy or 103  
other source of such drugs. 104

(F) Nothing in this section shall be interpreted as 105  
requiring a pharmacist to substitute a drug without the consent 106  
of the prescribing physician. 107

**Sec. 3923.851.** (A) As used in this section: 108

(1) "Cost sharing" has the same meaning as in section 109  
1751.69 of the Revised Code. 110

(2) "Preferred drug formulary" means any list that groups 111  
drugs covered by an individual or group policy of sickness and 112  
accident insurance or a public employee benefit plan into tiers 113  
and for which a cost-sharing requirement is established for each 114  
tier. 115

(3) "Rare disease or condition" has the same meaning as in 116  
21 U.S.C. 360bb(a)(2). 117

(4) "Specialty drug" means a prescription drug that meets 118  
all of the following: 119

(a) The drug is prescribed for an individual with a 120  
complex or chronic medical condition or a rare medical 121  
condition; 122

(b) The drug costs six hundred dollars or more for up to a 123  
thirty-day supply; 124

(c) Is not typically stocked at retail pharmacies; 125

(d) The drug has at least one of the following 126  
characteristics: 127

(i) It requires a difficult or unusual process of delivery 128

to the patient in the preparation, handling, storage, inventory, 129  
or distribution of the drug; 130

(ii) It requires enhanced patient education, management, 131  
or support, beyond those required for traditional dispensing, 132  
before or after administration of the drug. 133

(B) Notwithstanding section 3901.71 of the Revised Code, 134  
an individual or group policy of sickness and accident insurance 135  
that is delivered, issued for delivery, or renewed in this state 136  
and a public employee benefit plan that is established or 137  
modified in this state, that provides prescription drug services 138  
shall comply with both of the following: 139

(1) The policy or plan shall not impose cost sharing for 140  
specialty drugs of more than one hundred fifty dollars for a 141  
one-month supply. 142

(2) (a) The policy or plan shall establish a process by 143  
which a covered individual may request that a specialty drug 144  
that is not listed on a preferred drug formulary may be covered 145  
and subject to cost-sharing requirements as if it were listed on 146  
the formulary. 147

(b) The denial of such a request shall be treated as an 148  
adverse benefit determination, subject to internal appeal and 149  
external review under Chapter 3922. of the Revised Code. 150

(C) Nothing in this section shall be interpreted as 151  
requiring a policy or plan to do any of the following: 152

(1) Provide coverage for any additional drugs not 153  
otherwise required by law; 154

(2) Implement specific utilization management techniques, 155  
such as prior authorization or step therapy; 156

(3) Stop the use of any cost-sharing requirements, 157  
policies, or procedures that are not otherwise prohibited under 158  
this section or any other section of law, including those 159  
strategies used to incentivize the use of preventative services, 160  
disease management, and low-cost treatment options. 161

(D) A policy or plan shall not place all drugs in a given 162  
class on a specialty tier. 163

(E) Nothing in this section shall be interpreted as 164  
prohibiting a policy or plan from requiring that specialty drugs 165  
be obtained through a designated pharmacy or other source of 166  
such drugs. 167

(F) Nothing in this section shall be interpreted as 168  
requiring a pharmacist to substitute a drug without the consent 169  
of the prescribing physician. 170

**Section 2.** That existing section 1739.05 of the Revised 171  
Code is hereby repealed. 172

**Section 3.** Sections 1739.05 and 1751.691 of the Revised 173  
Code, as amended or enacted by this act, apply only to policies, 174  
contracts, agreements, and arrangements that are delivered, 175  
issued for delivery, or renewed in this state on or after 176  
January 1, 2016. Section 3923.851 of the Revised Code, as 177  
enacted by this act, applies only to policies of sickness and 178  
accident insurance delivered, issued for delivery, or renewed in 179  
this state, and public employee benefit plans that are 180  
established or modified in this state, on or after January 1, 181  
2016. 182