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Bill Analysis
Legislative Service Commission

H.B. 253
125th General Assembly
(As Introduced)

Reps. T. Patton, Setzer, Barrett, Miller

BILL SUMMARY

- Requires health insuring corporations and insurers that provide for prescription drug coverage by participating pharmacies also provide coverage for covered drugs dispensed by any nonparticipating pharmacy willing to meet the same terms and conditions as the participating pharmacies.

CONTENT AND OPERATION

Coverage for prescription drug services by nonparticipating pharmacies

(secs. 1753.22 and 3923.72)

The bill prohibits an individual or group health insuring corporation policy, contract, or agreement, or individual or group sickness and accident insurance policy, that provides coverage for prescription drug services by participating pharmacies from excluding coverage for any covered drug dispensed by a nonparticipating pharmacy willing to meet the terms and conditions of the health insuring corporation or insurer's pharmacy program or network of pharmacies providing the prescription drug services. Under the bill, nonparticipating pharmacies include pharmacies that dispense drugs through the mail.

A violation of the prohibition against excluding prescription drug coverage for drugs dispensed by a "willing" pharmacy is an unfair or deceptive act or practice in the business of insurance under Ohio's unfair and deceptive trade practices law.¹ That law authorizes the Superintendent of Insurance to take administrative or court action against a health insuring corporation or insurer that engages in those acts or practices.

¹ Revised Code §§ 3901.21 to 3901.26.

Exemption from H.B. 478 requirements

The benefits provided for in this bill may be considered a coverage mandate (see **COMMENT**). Existing law (Revised Code section 3901.71) provides that no mandated health benefits legislation enacted on or after January 14, 1993, can apply to any health benefits arrangement until the Superintendent of Insurance holds a public hearing and determines that the provision can be applied fully and equally in all respects to (1) employee benefit plans subject to the Employee Retirement Income Security Act of 1974 (ERISA)² and (2) employee benefit plans established or modified by the state or its political subdivisions. The bill includes provisions exempting its requirements from this restriction.

COMMENT

Actuarial review

The benefits required by the bill may be considered "mandated benefits."^{1b} Under current law unchanged by the bill, the chairperson of a standing committee of either house may, at any time, request that the Director of the Legislative Service Commission review any bill assigned to the chairperson's committee to determine whether the bill includes a mandated benefit. If the Director determines that the bill includes a mandated benefit, the presiding officer of the chamber considering the bill may request that the Director arrange for performance of an independent healthcare actuarial review of the benefit. Not later than 60 days after the presiding officer's request for a review, the Director must submit the findings of the actuarial review to the chairperson of the committee to which the bill is

² ERISA is a comprehensive federal statute governing the administration of employee benefit plans. ERISA generally precludes state regulation of benefits offered by private employers that self-insure their benefit programs. Larger employers frequently choose to establish their own health insurance plans for their employees in lieu of purchasing coverage from an insurer or health insuring corporation.

³ "Mandated benefit" means the following, considered in the context of a sickness and accident insurance policy or a health insuring corporation policy, contract, or agreement: (1) any required coverage for a specific medical or health-related service, treatment, medication, or practice, (2) any required coverage for the services of specific health care providers, (3) any requirement that an insurer or health insuring corporation offer coverage to specific individuals or groups, (4) any requirement that an insurer or health insuring corporation offer specific medical or health-related services, treatments, medications, or practices to existing insureds or enrollees, (5) any required expansion of, or addition to, existing coverage, and (6) any mandated reimbursement amount to specific health care providers (R.C. 103.144, not in the bill).

assigned and to the ranking minority member of that committee. (R.C. 103.144 to 103.146, not in the bill.)

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	07-29-03	p. 1021

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