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Bill Analysis
Legislative Service Commission

H.B. 291

127th General Assembly
(As Introduced)

Reps. Patton, Batchelder, Schindel, Koziura, Setzer

BILL SUMMARY

- Prohibits health insuring corporations and sickness and accident insurers that include coverage for prescription drug services provided by participating pharmacies from excluding coverage of drug services provided by a nonparticipating pharmacy that is willing to meet the terms and conditions of the prescription drug plan of the insurer or health insuring corporation.

CONTENT AND OPERATION

Coverage for prescription drugs

(secs. 1753.22 and 3923.72)

The bill applies to policies, contracts, and agreements of health insuring corporations and sickness and accident insurers that include coverage for prescription drug services provided by participating pharmacies. It prohibits those policies, contracts, and agreements from excluding coverage of covered drugs dispensed by any nonparticipating pharmacy, including a pharmacy that dispenses drugs through the mail, that is willing to meet the terms and conditions of the pharmacy program of the health insuring corporation or of the network of pharmacies providing prescription drug services under the policy, contract, or agreement.

A violation of the provisions of the bill is an unfair and deceptive practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code. Those sections specify additional unfair and deceptive practices and provide for administrative and legal remedies for violation through the Superintendent of Insurance and the Attorney General.

Exemption from H.B. 478 requirements

The benefits provided for in this bill may be considered a coverage mandate (see **COMMENT**). Am. Sub. H.B. 478 of the 119th General Assembly 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) and (2) employee benefit plans established or modified by the state or its political subdivisions.¹ (Section 3901.71, not in the bill.) The bill includes provisions exempting its requirements from this restriction.

COMMENT

Actuarial review

The benefits required by the bill may be considered "mandated benefits."² Pursuant to Sub. H.B. 405 of the 124th General Assembly, 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 house that is considering the bill may request the Director to arrange for the 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

¹ 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.

² "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).

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

HISTORY

ACTION	DATE
Introduced	07-26-07

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