OAHU Legislative/Regulatory Update

Prepared by John T. McGough

January 15, 2019

I. Ohio Department of Insurance Issues Guidance regarding Pharmacy Gag Clauses

On April 3, 2018 the Ohio Department of Insurance Issued Bulletin 2018-02 applicable to TPAs, PBMs and Health Insurers. Here is the link to the Bulletin:
http://www.insurance.ohio.gov/Legal/Bulletins/Documents/2018-02.pdf
The Bulletin states that under current Ohio law, that pharmacy benefit managers, third party administrators and health insurers are prohibited from barring any person from informing an individual about less expensive ways to purchase prescription drugs that may also be available under any insurance policy or benefit plan.

The prohibition also includes requiring cost-sharing in an amount or directing a pharmacy to collect cost-sharing in an amount, greater than the amount an individual would pay for the prescription drug if the drug were purchased without coverage under a health benefit plan.

The prohibitions were effective immediately.

II. SB 265 – as Passed into Ohio law

Pharmacist-provided services - Reimbursement for covered services

The bill explicitly authorizes a health plan issuer to pay or reimburse a pharmacist for providing health care services if the pharmacist is legally authorized to provide the service and if the patient in question's health benefit plan covers the service. The bill specifically authorizes payment for the following services that continuing law authorizes a pharmacist to perform:

- Managing drug therapy under a consult agreement with a physician;
- Administering immunizations;

- Administering the following injectable drugs:

    An opioid antagonist used for treatment of drug addiction in a long-acting form;

    An antipsychotic drug in a long-acting form;

    Hydroxyprogesterone caproate; o Medroxyprogesterone acetate; Cobalamin.

This authorization applies to health insuring corporations, sickness and accident insurers, public employee benefit plans, multiple employer welfare arrangements, and the Department of Medicaid.

These provisions apply to non-Medicaid health benefit plans that are delivered, issued for delivery, or renewed in Ohio on or after the bill's effective date. Pharmacist services The bill explicitly authorizes pharmacists to provide the following types of services:

- Preventative medical services and counseling on health matters provided at a multi-purpose senior center;
- Necessary care in a jail or state correctional institution;
- Services provided in an ambulatory surgical facility for which an ambulatory surgical facility fee may be charged;
- Hospice services as a part of a hospice care program;
- Pediatric respite services as a part of a pediatric respite care program.

Step therapy exemption

The bill imposes requirements with regard to requesting and receiving exemptions to step therapy protocols. A health plan issuer must provide a clear, accessible, and convenient process for a prescribing health care provider to request a step therapy exemption, and any exemption request that is denied may be appealed. Additionally, a Medicaid provider must be able to make a step therapy exemption request online. Any request for a step therapy exemption must be accompanied by supporting rationale and documentation. The bill authorizes a non-Medicaid health plan issuer to use its existing medical exceptions process to meet these requirements. The bill requires, pursuant to a step therapy request or appeal, a health plan issuer to grant a step therapy exemption if any of the following apply to the individual in question:

- The required prescription drug in question is contraindicated for that specific patient, pursuant to the drug's United States Food and Drug Administration (USFDA) prescribing information;

- The patient has tried the required prescription drug while under their current, or a previous, health benefit plan, or another USFDA approved AB-rated prescription drug, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

Disclosures

The bill requires health plan issuers to make disclosures regarding step therapy protocols. A health plan issuer is to make available to all health care providers a list of all drugs that the plan issuer subjects to a step therapy protocol. If a health plan issuer offers more than one plan, and the step therapy protocol varies according to plan, then the plan issuer is to provide a separate list for each plan.

Unfair and deceptive practice

The bill designates, for non-Medicaid health plan issuers, a series of violations of the bill's requirements as an unfair and deceptive practice in the business of insurance.

The bill's step therapy provisions apply to health benefit plans issued or renewed on and after January 1, 2020.

III. S.B. 227 – Require Health Insurers to provide claims information

S.B. 227 was OAHU's top legislative priority. The legislation required health insurers to provide health claims information to employer groups. S.B. 227 was introduced by Senator Matt Huffman (R-Lima) on November 2, 2017. The legislation as introduced required health insurers to provide claims data to all sizes of employer groups. On January 16, 2018 proponent testimony was presented before the Senate Insurance & Financial Institutions Committee. Proponents testifying included:

- OAHU – OAHU member Brian Thompson provided the testimony in support of the legislation.
- Ohio Insurance Agents Association (formerly PIA) – also testified in support of the legislation
- AXIA Consulting – Based in the Cincinnati area, this company of 70+ employees explained the importance of employers being able to receive claims data to make informed decisions when purchasing health insurance. OAHU member David Conners helped facilitate the company's testimony.
- Other proponents included: MedBen, GMS and IMA of Louisiana (who testified that a similar law in Louisiana is working well).

On January 30, 2018, the two opponents testifying in opposition to the legislation were the Ohio Association of Health Plans (health insurers) and the National Multiple Sclerosis Society.

On May 22, 2018, S.B. 227 passed unanimously out of the Senate Insurance & Financial Institutions Committee and on May 23rd passed unanimously out of the Ohio Senate.

- The bill then was referred to the House Insurance Committee and on June 27, 2018 the bill received sponsor testimony in the Committee.

- On November 14, 2018 – Proponent Testimony provided by:
  1. OAHU – Barb Gerken

2. AXIA Consulting
3. Ohio Insurance Agents Association
4. NFIB-Ohio

- On November 28, 2014, Ohio Association of Health Plans submits written testimony which supports amendment agreed to by OAHU and OAHP.
- December 5, 2018 – House Insurance Committee passes S.B. 227 unanimously.
- December 6, 2018 - S.B. 227 fails to receive a House floor vote on the last legislative day of session.

IV. **H.B. 450** - To impose review and other requirements on existing health insurance mandated benefits and to establish requirements for the creation of new mandated benefits.

Status of the legislation: H.B. 450 received three hearings in the House Government Accountability & Oversight Committee but never received a vote by the Committee. The Ohio State Medical Association opposed the legislation and proponents of the legislation included the Ohio Chamber of Commerce, NFIB-Ohio, the Ohio Manufacturers Association, the Ohio Association of Health Plans and the Ohio Council of Retail Merchants. Several years ago similar legislation was enacted into Ohio law. After several actuarial studies were completed, the law was repealed. The apparent reason for the repeal was that the actuarial studies were somewhat costly to perform and the cost of a specific mandate, on a per-member-per-month basis was not very significant.