Ohio Revised Code

Section 3923.85 Cancer medication; coverage for orally and intravenously administered treatments.

Effective: March 23, 2015
Legislation: House Bill 201 - 130th General Assembly

(A) As used in this section, "cost sharing" means the cost to an individual insured under an individual or group policy of sickness and accident insurance or a public employee benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the policy or plan.

(B) Notwithstanding section 3901.71 of the Revised Code and subject to division (D) of this section, no individual or group policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state and no public employee benefit plan that is established or modified in this state shall fail to comply with either of the following:

(1) The policy or plan shall not provide coverage or impose cost sharing for a prescribed, orally administered cancer medication on a less favorable basis than the coverage it provides or cost sharing it imposes for intraveneously administered or injected cancer medications.

(2) The policy or plan shall not comply with division (B)(1) of this section by imposing an increase in cost sharing solely for orally administered, intravenously administered, or injected cancer medications.

(C) Notwithstanding any provision of this section to the contrary, a policy or plan shall be deemed to be in compliance with this section if the cost sharing imposed under such a policy or plan for orally administered cancer treatments does not exceed one hundred dollars per prescription fill. The costsharing limit of one hundred dollars per prescription fill shall apply to a high deductible plan, as defined in 26 U.S.C. 223, or a catastrophic plan, as defined in 42 U.S.C. 18022, only after the deductible has been met.

(D)(1) The prohibitions in division (B) of this section do not preclude an individual or group policy of sickness and accident insurance or public employee benefit plan from requiring an insured or plan

member to obtain prior authorization before orally administered cancer medication is dispensed to the insured or plan member.

(2) Division (B) of this section does not apply to the offer or renewal of any individual or group policy of sickness and accident insurance that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, disability income, or other policy that offers only supplemental benefits.

(E) An insurer that offers any sickness and accident insurance or any public employee benefit plan that offers coverage for basic health care services is not required to comply with division (B) of this section if all of the following apply:

(1) The insurer or plan submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that compliance with division (B)(1) of this section for a period of at least six months independently caused the insurer or plan's costs for claims and administrative expenses for the coverage of basic health care services to increase by more than one per cent per year.

(2) The insurer or plan submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (E)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the insurer or plan for the coverage of basic health care services.

(3)(a) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (E)(1) and (2) of this section:

(i) Compliance with division (B)(1) of this section for a period of at least six months independently caused the insurer or plan's costs for claims and administrative expenses for the coverage of basic health care services to increase more than one per cent per year.

(ii) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the insurer or plan for the coverage of basic health care services.

(b) Any determination made by the superintendent under division (E)(3) of this section is subject to Chapter 119. of the Revised Code.