



www.lsc.ohio.gov

OHIO LEGISLATIVE SERVICE COMMISSION

Office of Research
and Drafting

Legislative Budget
Office

H.B. 396
133rd General Assembly

Bill Analysis

Version: As Introduced

Primary Sponsor: Rep. Galonski

Yosef Schiff, Attorney

SUMMARY

- Prohibits a pharmacy benefit manager (PBM) from engaging in spread pricing, retroactively denying a claim, reducing payment to a pharmacy, or paying a pharmacy less than a certain specified cost.
- Requires a PBM to file reports with the Superintendent of Insurance regarding rebates and payments.
- Explicitly includes certain items in the definition of “maximum allowable cost.”
- Requires a PBM that has a contract with a Medicaid managed care organization regarding pharmacy benefit services or administration to comply with the bill’s provisions as well as all laws governing PBMs.

DETAILED ANALYSIS

Prohibitions

The bill prohibits a pharmacy benefit manager (PBM), including any health insuring corporation or sickness and accident insurer acting as a PBM, from doing any of the following:

- Charging a plan sponsor a contracted price for a prescription drug, and that contracted price differs from the amount the PBM directly or indirectly pays the pharmacist or pharmacy for that drug or for pharmacist services related to that drug (spread pricing);
- Directly or indirectly retroactively denying a claim or aggregate of claims after the claim or aggregate of claims has been adjudicated, unless any of the following apply:
 - The original claim was submitted fraudulently.
 - The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the drug or services in question.
 - The pharmacist services were not properly rendered by the pharmacy or pharmacist.

- Reducing, directly or indirectly, payment to a pharmacy for pharmacist services to an effective rate of reimbursement, including by permitting an insurer or plan sponsor to make such a reduction. “Effective rate of reimbursement” includes generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction or payment.
- Paying or reimbursing a pharmacy or pharmacist at an amount less than the national average drug acquisition cost or, if the national average acquisition cost is unavailable, the wholesale acquisition cost, for the ingredient drug product component of drugs provided by the pharmacist or pharmacy.¹

A **PBM** is an entity that contracts with pharmacies on behalf of an employer, a multiple employer welfare arrangement, public employee benefit plan, state agency, insurer, managed care organization, or other third-party payer to provide pharmacy health benefit services or administration. The term includes a PBM under contract with a Medicaid managed care organization to provide pharmacy health benefit services or administration under Ohio’s Medicaid Care Management System.²

Reporting

Under the bill, a PBM must file a quarterly report with the Superintendent of Insurance for each plan sponsor for which the PBM provides services. The report must contain all of the following information:

- The aggregate amount of rebates received by the PBM;
- The aggregate amount of rebates distributed to the related plan sponsor;
- The aggregate amount of rebates passed on to the enrollees of each plan sponsor at the point of sale that reduced the enrollee’s applicable cost-sharing amount;
- The individual and aggregate amount paid by the plan sponsor to the PBM for pharmacist services itemized by pharmacy, by product, and by goods and services;
- The individual and aggregate amount the PBM paid for pharmacist services itemized by pharmacy, by product, and by goods and services.

Information contained in the report is considered confidential, is not a public record, and must not be released.³

“**Rebate**” means a discount or other price concession or payment, including incentives, disbursements, and reasonable estimates of a volume-based discount, that meets both of the following:

¹ R.C. 3959.01(U) and 3959.30.

² R.C. 3959.01(O).

³ R.C. 3959.31.

- It is based on utilization of a prescription drug.
- It is paid by a manufacturer or third party, directly or indirectly to a PBM, pharmacy services administrative organization, or a pharmacy after a claim has been processed and paid at a pharmacy.⁴

Maximum allowable cost

PBMs are currently subject to certain requirements relating to the use of maximum allowable costs. For example, a PBM must give a pharmacy the right to obtain from the PBM a list of the sources used to determine maximum allowable cost pricing.⁵ Under existing law, “maximum allowable cost” means a maximum drug product reimbursement for an individual drug or for a group of therapeutically and pharmaceutically equivalent multiple source drugs that are listed in the United States Food and Drug Administration’s Approved Drug Products with Therapeutic Equivalence Evaluations, commonly referred to as the “Orange Book.” The bill includes the following items as maximum allowable costs:

- Average acquisition cost, including national average drug acquisition cost;
- Average manufacturer price;
- Average wholesale price;
- Brand effective rate or generic effective rate;
- Discount indexing;
- Federal upper limits;
- Wholesale acquisition cost;
- Any other term that a PBM or an insurer may use to establish reimbursement rates to a pharmacist or pharmacy for pharmacist services.⁶

Medicaid

The bill requires a PBM under contract with a Medicaid managed care organization to provide pharmacy benefit services or administration under the Medicaid managed care system to comply with the bill’s provisions regarding PBMs as described above.⁷

In addition, the bill clarifies that all other existing laws applicable to PBMs also apply to PBMs that are under such contracts.⁸

⁴ R.C. 3959.01(R).

⁵ R.C. 3959.111, not in the bill.

⁶ R.C. 3959.01(K).

⁷ R.C. 5167.122.

⁸ R.C. 5167.122, 3959.01(M), and 3959.01(O).

COMMENT

H.B. 166 of the 133rd General Assembly requires the Medicaid Director to select a third-party administrator to serve as the single PBM for Ohio's Medicaid managed care system if prescribed drugs are included in the system.⁹ Medicaid managed care organizations are required to use the state PBM.¹⁰ An amendment could be drafted to require the state PBM, rather than a PBM under contract with a Medicaid managed care organization, to comply with the bill's PBM provisions. This would make the bill's terminology more consistent with current law.

HISTORY

| Action | Date |
|------------|----------|
| Introduced | 11-05-19 |

H0396-I-133/ks

⁹ R.C. 5167.24.

¹⁰ R.C. 5167.241.