As Introduced

133rd General Assembly
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H. B. No. 396

Representative Galonski
Cosponsor: Representative Sobecki

A BILL

To amend section 3959.01 and to enact sections 3959.30, 3959.31, 3959.32, and 5167.122 of the Revised Code to impose requirements on pharmacy benefit managers.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That section 3959.01 be amended and sections 3959.30, 3959.31, 3959.32, and 5167.122 of the Revised Code be enacted to read as follows:

Sec. 3959.01. ~~(A)~~ As used in this chapter:

(A) "Administration fees" means any amount charged a covered person for services rendered. "Administration fees" includes commissions earned or paid by any person relative to services performed by an administrator.

(B) "Administrator" means any person who adjusts or settles claims on, residents of this state in connection with life, dental, health, prescription drugs, or disability insurance or self-insurance programs. "Administrator" includes a pharmacy benefit manager. "Administrator" does not include any of the following:

(1) An insurance agent or solicitor licensed in this state whose activities are limited exclusively to the sale of insurance and who does not provide any administrative services;

(2) Any person who administers or operates the workers' compensation program of a self-insuring employer under Chapter 4123. of the Revised Code;

(3) Any person who administers pension plans for the benefit of the person's own members or employees or administers pension plans for the benefit of the members or employees of any other person;

(4) Any person that administers an insured plan or a self-insured plan that provides life, dental, health, or disability benefits exclusively for the person's own members or employees;

(5) Any health insuring corporation holding a certificate of authority under Chapter 1751. of the Revised Code or an insurance company that is authorized to write life or sickness and accident insurance in this state.

(C) "Aggregate excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or trust for all benefits or claims paid during an agreement period on behalf of all covered persons under the plan or trust which exceed a stated deductible amount and subject to a stated maximum.

(D) "Contracted pharmacy" or "pharmacy" means a pharmacy located in this state participating in either the network of a pharmacy benefit manager or in a health care or pharmacy benefit plan through a direct contract or through a contract with a pharmacy services administration organization, group purchasing organization, or another contracting agent.

(E) "Contributions" means any amount collected from a covered person to fund the self-insured portion of any plan in accordance with the plan's provisions, summary plan descriptions, and contracts of insurance.

(F) "Drug product reimbursement" means the amount paid by a pharmacy benefit manager to a contracted pharmacy for the cost of the drug dispensed to a patient and does not include a dispensing or professional fee.

(G) "Fiduciary" has the meaning set forth in section 1002(21)(A) of the "Employee Retirement Income Security Act of 1974," 88 Stat. 829, 29 U.S.C. 1001, as amended.

(H) "Fiscal year" means the twelve-month accounting period commencing on the date the plan is established and ending twelve months following that date, and each corresponding twelve-month accounting period thereafter as provided for in the summary plan description.

(I) "Insurer" means an entity authorized to do the business of insurance in this state or, for the purposes of this section, a health insuring corporation authorized to issue health care plans in this state.

(J) "Managed care organization" means an entity that provides medical management and cost containment services and includes a medicaid managed care organization~~, as defined in section 5167.01 of the Revised Code~~.

(K)(1) "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.

(2) "Maximum allowable cost" includes all of the following:

(a) Average acquisition cost, including national average drug acquisition cost;

(b) Average manufacturer price;

(c) Average wholesale price;

(d) Brand effective rate or generic effective rate;

(e) Discount indexing;

(f) Federal upper limits;

(g) Wholesale acquisition cost;

(h) Any other term that a pharmacy benefit manager or an insurer may use to establish reimbursement rates to a pharmacist or pharmacy for pharmacist services.

(L) "Maximum allowable cost list" means a list of the drugs for which a pharmacy benefit manager imposes a maximum allowable cost.

(M) "Medicaid managed care organization" has the same meaning as in section 5167.01 of the Revised Code.

(N) "Multiple employer welfare arrangement" has the same meaning as in section 1739.01 of the Revised Code.

~~(N)~~ (O) "Pharmacy benefit manager" means 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.

~~(O)~~ "Pharmacy benefit manager" includes a pharmacy benefit manager under contract with a medicaid managed care organization to provide pharmacy health benefit services or administration under the care management system established under section 5167.03 of the Revised Code.

(P) "Plan" means any arrangement in written form for the payment of life, dental, health, or disability benefits to covered persons defined by the summary plan description and includes a drug benefit plan administered by a pharmacy benefit manager.

~~(P)~~ (Q) "Plan sponsor" means the person who establishes the plan.

~~(Q)~~ (R)(1) "Rebate" means a discount or other price concession or payment that meets both of the following:

(a) It is based on utilization of a prescription drug.

(b) It is paid by a manufacturer or third party, directly or indirectly to a pharmacy benefit manager, pharmacy services administrative organization, or a pharmacy after a claim has been processed and paid at a pharmacy.

(2) "Rebate" includes incentives, disbursements, and reasonable estimates of a volume-based discount.

(S) "Self-insurance program" means a program whereby an employer provides a plan of benefits for its employees without involving an intermediate insurance carrier to assume risk or pay claims. "Self-insurance program" includes but is not limited to employer programs that pay claims up to a prearranged limit

beyond which they purchase insurance coverage to protect against unpredictable or catastrophic losses.

~~(R)~~ (T) "Specific excess insurance" means that type of coverage whereby the insurer agrees to reimburse the insured employer or trust for all benefits or claims paid during an agreement period on behalf of a covered person in excess of a stated deductible amount and subject to a stated maximum.

~~(S)~~ (U) "Spread pricing" means the model of prescription drug pricing by which a pharmacy benefit manager charges a plan sponsor a contracted price for a prescription drug, and that contracted price differs from the amount the pharmacy benefit manager directly or indirectly pays the pharmacist or pharmacy for that drug or for pharmacist services related to that drug.

(V) "Summary plan description" means the written document adopted by the plan sponsor which outlines the plan of benefits, conditions, limitations, exclusions, and other pertinent details relative to the benefits provided to covered persons thereunder.

~~(T)~~ (W) "Third-party payer" has the same meaning as in section 3901.38 of the Revised Code.

Sec. 3959.30. (A) A pharmacy benefit manager shall not do any of the following:

(1) Engage in spread pricing;

(2) Directly or indirectly retroactively deny a claim or aggregate of claims after the claim or aggregate of claims has been adjudicated, unless any of the following apply:

(a) The original claim was submitted fraudulently.

(b) The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the drug or

services in question.

(c) The pharmacist services were not properly rendered by the pharmacy or pharmacist.

(3) Reduce, directly or indirectly, payment to a pharmacy for pharmacist services to an effective rate of reimbursement, including permitting an insurer or plan sponsor to make such a reduction. As used in division (A)(3) of this section, "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.

(4) Pay or reimburse 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.

(B) Notwithstanding division (B)(5) of section 3959.01 of the Revised Code, a health insuring corporation or a sickness and accident insurer shall comply with the requirements of this section and is subject to the penalties under section 3959.12 of the Revised Code if the corporation or insurer is operating as a pharmacy benefit manager.

Sec. 3959.31. (A) A pharmacy benefit manager shall report to the superintendent of insurance all of the following information:

(1) The aggregate amount of rebates received by the pharmacy benefit manager;

(2) The aggregate amount of rebates distributed to the related plan sponsor;

(3) 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;

(4) The individual and aggregate amount paid by the plan sponsor to the pharmacy benefit manager for pharmacist services itemized by pharmacy, by product, and by goods and services;

(5) The individual and aggregate amount a pharmacy benefit manager paid for pharmacist services itemized by pharmacy, by product, and by goods and services.

(B) The information required under division (A) of this section shall be provided on a quarterly basis and for each plan sponsor for which the pharmacy benefit manager provides services.

(C) The information required under division (A) of this section shall be considered confidential information, shall not be released, and shall not be considered a public record under section 149.43 of the Revised Code.

Sec. 3959.32. The superintendent of insurance shall adopt rules as necessary to implement the requirements of sections 3959.30 to 3959.32 of the Revised Code.

Sec. 5167.122. A pharmacy benefit manager under contract with a medicaid managed care organization to provide pharmacy benefit services or administration under the care management system shall comply with sections 3959.30 and 3959.31 of the Revised Code.

Section 2. That existing section 3959.01 of the Revised Code is hereby repealed.