As Introduced

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S. B. No. 263

Senator Hackett

Cosponsors: Senators Maharath, Wilson, Craig, Thomas, Antonio, Kunze

A BILL

To amend sections 5164.751 and 5167.01 and to enact sections 3902.50, 3902.51, 4729.49, and 5167.123 of the Revised Code to prohibit a pharmacy benefit manager from taking certain actions with respect to reimbursements made to health care providers that participate in the federal 340B Drug Pricing Program.

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

Section 1. That sections 5164.751 and 5167.01 be amended and sections 3902.50, 3902.51, 4729.49, and 5167.123 of the Revised Code be enacted to read as follows:

Sec. 3902.50. As used in this section and section 3902.51 of the Revised Code:

(A) "340B covered entity" has the same meaning as in section 5167.01 of the Revised Code.

(B) "Health plan issuer" has the same meaning as in section 3922.01 of the Revised Code.

(C) "Terminal distributor of dangerous drugs" has the same

meaning as in section 4729.01 of the Revised Code.

Sec. 3902.51. (A) On and after the effective date of this section, a contract entered into between a health plan issuer, including a third-party administrator, and a 340B covered entity shall not contain any of the following provisions:

(1) A reimbursement rate for a prescription drug that is less than the national average drug acquisition cost rate for that drug as determined by the United States centers for medicare and medicaid services, measured at the time the drug is administered or dispensed, or, if no such rate is available at that time, a reimbursement rate that is less than the wholesale acquisition cost of the drug, as defined in 42 U.S.C. 1395w-3a(c)(6)(B);

(2) A dispensing fee reimbursement amount that is less than the reimbursement amount provided to a terminal distributor of dangerous drugs under section 5164.753 of the Revised Code;

(3) A fee that is not imposed on a health care provider that is not a 340B covered entity;

(4) A fee amount that exceeds the fee amount for a health care provider that is not a 340B covered entity.

(B) No health plan issuer or third-party administrator making payments pursuant to a health benefit plan shall discriminate against a 340B covered entity in a manner that prevents or interferes with an enrollee's choice to receive a prescription drug from a 340B covered entity or its contracted pharmacies.

(C) Any provision of a contract entered into between a health plan issuer and a 340B covered entity that is contrary to division (A) of this section is unenforceable and shall be

replaced with the dispensing fee or reimbursement rate that applies for health care providers that are not 340B covered entities.

Sec. 4729.49. (A) As used in this section, "340B covered entity" and "medicaid managed care organization" have the same meanings as in section 5167.01 of the Revised Code.

(B) A contract between a terminal distributor of dangerous drugs and a 340B covered entity shall require the terminal distributor to comply with division (C) of this section.

(C) When paying a 340B covered entity for a dangerous drug dispensed to a patient, a terminal distributor shall pay to the 340B covered entity the full reimbursement amount the terminal distributor receives from the patient and the patient's health insurer, including a third-party administrator or medicaid managed care organization, except that the terminal distributor may deduct from the full reimbursement amount a fee agreed on in writing by the terminal distributor and the 340B covered entity.

Sec. 5164.751. (A) As used in this section, "state maximum allowable cost" means the per unit amount the medicaid program pays a terminal distributor of dangerous drugs for a prescribed drug included in the state maximum allowable cost program established under division (B) of this section. "State maximum allowable cost" excludes dispensing fees and copayments, coinsurance, or other cost-sharing charges, if any.

(B) ~~The~~ Subject to section 5167.123 of the Revised Code, the medicaid director shall establish a state maximum allowable cost program for purposes of managing medicaid payments to terminal distributors of dangerous drugs for prescribed drugs identified by the director pursuant to this division. The

director shall do all of the following with respect to the program:

(1) Identify and create a list of prescribed drugs to be included in the program.

(2) Update the list of prescribed drugs described in division (B)(1) of this section on a weekly basis.

(3) Review the state maximum allowable cost for each prescribed drug included on the list described in division (B)(1) of this section on a weekly basis.

Sec. 5167.01. As used in this chapter:

(A) "340B covered entity" means an entity described in section 340B(a)(4) of the "Public Health Service Act," 42 U.S.C. 256b(a)(4) and includes any pharmacy under contract with the entity to dispense drugs on behalf of the entity.

(B) "Affiliated company" means an entity, including a third-party payer or specialty pharmacy, with common ownership, members of a board of directors, or managers, or that is a parent company, subsidiary company, jointly held company, or holding company with respect to the other entity.

~~(B)~~ (C) "Care management system" means the system established under section 5167.03 of the Revised Code.

~~(C)~~ (D) "Controlled substance" has the same meaning as in section 3719.01 of the Revised Code.

~~(D)~~ (E) "Dual eligible individual" has the same meaning as in section 5160.01 of the Revised Code.

~~(E)~~ (F) "Emergency services" has the same meaning as in the "Social Security Act," section 1932(b)(2), 42 U.S.C. 1396u-

2(b)(2).

~~(F)~~ (G) "Enrollee" means a medicaid recipient who participates in the care management system and enrolls in a medicaid MCO plan.

~~(G)~~ (H) "ICDS participant" has the same meaning as in section 5164.01 of the Revised Code.

~~(H)~~ (I) "Medicaid managed care organization" means a managed care organization under contract with the department of medicaid pursuant to section 5167.10 of the Revised Code.

~~(I)~~ (J) "Medicaid MCO plan" means a plan that a medicaid managed care organization, pursuant to its contract with the department of medicaid under section 5167.10 of the Revised Code, makes available to medicaid recipients participating in the care management system.

~~(J)~~ (K) "Medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.

~~(K)~~ (L) "Network provider" has the same meaning as in 42 C.F.R. 438.2.

~~(L)~~ (M) "Nursing facility services" has the same meaning as in section 5165.01 of the Revised Code.

~~(M)~~ (N) "Part B drug" means a drug or biological described in section 1842(o)(1)(C) of the "Social Security Act," 42 U.S.C. 1395u(o)(1)(C).

~~(N)~~ (O) "Pharmacy benefit manager" has the same meaning as in section 3959.01 of the Revised Code.

~~(O)~~ (P) "Practice of pharmacy" has the same meaning as in section 4729.01 of the Revised Code.

~~(P)~~ (Q) "Prescribed drug" has the same meaning as in section 5164.01 of the Revised Code.

~~(Q)~~ (R) "Prior authorization requirement" has the same meaning as in section 5160.34 of the Revised Code.

~~(R)~~ (S) "Provider" means any person or government entity that furnishes services to a medicaid recipient enrolled in a medicaid MCO plan, regardless of whether the person or entity has a provider agreement.

~~(S)~~ (T) "Provider agreement" has the same meaning as in section 5164.01 of the Revised Code.

~~(T)~~ (U) "State pharmacy benefit manager" means the pharmacy benefit manager selected by and under contract with the medicaid director under section 5167.24 of the Revised Code.

~~(U)~~ (V) "Third-party administrator" means any person who adjusts or settles claims on behalf of an insuring entity in connection with life, dental, health, prescription drugs, or disability insurance or self-insurance programs and includes a pharmacy benefit manager.

Sec. 5167.123. (A) No contract between a medicaid managed care organization, including a third-party administrator, and a 340B covered entity shall contain any of the following provisions:

(1) A payment rate for a prescribed drug that is less than the national average drug acquisition cost rate for that drug as determined by the United States centers for medicare and medicaid services, measured at the time the drug is administered or dispensed, or, if no such rate is available at that time, a reimbursement rate that is less than the wholesale acquisition cost of the drug, as defined in 42 U.S.C. 1395w-3a(c)(6)(B);

(2) A fee that is not imposed on a health care provider that is not a 340B covered entity;

(3) A fee amount that exceeds the amount for a health care provider that is not a 340B covered entity.

(B) The organization, or its contracted third-party administrators, shall not discriminate against a 340B covered entity in a manner that prevents or interferes with a medicaid recipient's choice to receive a prescription drug from a 340B covered entity or its contracted pharmacies.

(C) Any provision of a contract entered into between the organization and a 340B covered entity that is contrary to division (A) of this section is unenforceable and shall be replaced with the dispensing fee or payment rate that applies for health care providers that are not 340B covered entities.

Section 2. That existing sections 5164.751 and 5167.01 of the Revised Code are hereby repealed.