As Introduced

135th General Assembly
Regular Session **H. B. No. 505**
2023-2024

Representatives Barhorst, Stewart

A BILL

To amend sections 3902.50, 5164.753, and 5167.243 and to enact sections 3902.75, 3902.76, 3959.151, 3959.21, 5167.127, and 5167.128 of the Revised Code regarding insurer and Medicaid program accreditation requirements for pharmacies, to impose drug cost reporting and payment requirements on pharmacy benefit managers, and to name this act the Community Pharmacy Protection Act.

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

Section 1. That sections 3902.50, 5164.753, and 5167.243 be amended and sections 3902.75, 3902.76, 3959.151, 3959.21, 5167.127, and 5167.128 of the Revised Code be enacted to read as follows:

Sec. 3902.50. As used in sections 3902.50 to ~~3902.72~~ 3902.76 of the Revised Code:

(A) "Ambulance" has the same meaning as in section 4765.01 of the Revised Code.

(B) "Clinical laboratory services" has the same meaning as in section 4731.65 of the Revised Code.

(C) "Cost sharing" means the cost to a covered person under a health benefit plan according to any copayment, coinsurance, deductible, or other out-of-pocket expense requirement.

(D) "Covered" or "coverage" means the provision of benefits related to health care services to a covered person in accordance with a health benefit plan.

(E) "Covered person," "health benefit plan," "health care services," and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.

(F) "Drug" has the same meaning as in section 4729.01 of the Revised Code.

(G) "Emergency facility" has the same meaning as in section 3701.74 of the Revised Code.

(H) "Emergency services" means all of the following as described in 42 U.S.C. 1395dd:

(1) Medical screening examinations undertaken to determine whether an emergency medical condition exists;

(2) Treatment necessary to stabilize an emergency medical condition;

(3) Appropriate transfers undertaken prior to an emergency medical condition being stabilized.

(I) "Health care practitioner" has the same meaning as in section 3701.74 of the Revised Code.

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

(K) "Prior authorization requirement" means any practice

implemented by a health plan issuer in which coverage of a health care service, device, or drug is dependent upon a covered person or a provider obtaining approval from the health plan issuer prior to the service, device, or drug being performed, received, or prescribed, as applicable. "Prior authorization requirement" includes prospective or utilization review procedures conducted prior to providing a health care service, device, or drug.

(L) "Unanticipated out-of-network care" means health care services, including clinical laboratory services, that are covered under a health benefit plan and that are provided by an out-of-network provider when either of the following conditions applies:

(1) The covered person did not have the ability to request such services from an in-network provider.

(2) The services provided were emergency services.

Sec. 3902.75. (A) As used in sections 3902.75 and 3902.76 of the Revised Code:

(1) Notwithstanding section 3902.50 of the Revised Code, "health plan issuer" has the same meaning as in section 3922.01 of the Revised Code but also includes an auditing entity, as defined in section 3901.81 of the Revised Code.

(2) "Pharmacy" has the same meaning as in section 4729.01 of the Revised Code and also includes a dispensing physician.

(B) A health plan issuer that offers, issues, or administers a health benefit plan that covers pharmacy services, including prescription drug coverage, shall not require a pharmacy, as a condition of participation in the health plan issuer's network, to meet accreditation standards or

certification requirements that are inconsistent with or in addition to those of the state board of pharmacy.

Sec. 3902.76. Any covered person or pharmacy affected by a violation of section 3902.75 of the Revised Code by a health plan issuer or one or more of its intermediaries may bring a civil action against the health plan issuer or the intermediary for compensatory damages and injunctive or other equitable relief.

Sec. 3959.151. (A) As used in this section:

(1) "Actual acquisition cost" means the amount actually expended to procure a drug product after any manufacturer price concessions or rebates.

(2) "Machine-readable format" means a digital representation of information in a file that can be imported or read into a computer system for further processing. "Machine-readable format" includes.XML and.CSV formats.

(B)(1) On or before the fifteenth day of each month, each pharmacy benefit manager shall provide to the superintendent of insurance and to its contracted insurers and plan sponsors, including contracted public employee benefit plans and contracted employers offering a self-insurance program, an electronic report in a machine-readable format of all drug claims processed the previous month. The single state pharmacy benefit manager established under section 5167.24 of the Revised Code shall submit its electronic report in a machine-readable format to the department of medicaid.

(2) The electronic report provided to an insurer, a plan sponsor, or the medicaid program shall include an itemized list of the actual acquisition cost of each drug product from all

drug product claims processed by the pharmacy benefit manager in the previous month for that insurer, that plan sponsor, or the medicaid program. The electronic report provided to the superintendent of insurance shall include an itemized list of the actual acquisition cost of each drug product from all drug product claims processed by the pharmacy benefit manager in the previous month for all insurers and plan sponsors.

(3) The itemized list shall notate the following for each drug product:

(a) If the drug was procured pursuant to the pharmacy benefit manager, insurer, plan sponsor, or department of medicaid's drug formulary or list of covered drugs;

(b) If the drug was procured outside of the drug formulary or list of covered drugs;

(c) If the drug is a brand-name drug;

(d) If the drug is a generic drug;

(e) If the drug is a specialty drug, including biological products.

(C)(1) No agreement between a pharmacy benefit manager and an insurer or plan sponsor, including a service agreement under section 3959.15 of the Revised Code, that is entered into, amended, or renewed on or after the effective date of this section shall prohibit disclosure of any of the information included in the itemized list required by division (B) of this section.

(2) Notwithstanding division (B) of this section, a pharmacy benefit manager is not required to disclose information deemed proprietary or confidential by a service agreement

between the pharmacy benefit manager and an insurer or plan sponsor that is entered into in accordance with section 3959.15 of the Revised Code before the effective date of this section, and in effect on the date the information would otherwise be submitted as part of the itemized list required by division (B) of this section.

(D) The superintendent of insurance shall adopt rules in accordance with Chapter 119. of the Revised Code for the purposes of implementing and administering this section.

Sec. 3959.21. (A) Except as otherwise provided in divisions (C) and (D) of this section, a pharmacy benefit manager shall pay both of the following to a contracted pharmacy for a claim for a drug product dispensed on or after the ninety-first day following the effective date of this section:

(1) A drug product reimbursement not less than the contracted pharmacy's actual acquisition cost of the drug dispensed;

(2) A dispensing fee not less than the minimum dispensing fee in effect for the date the drug is dispensed, as determined by the superintendent of insurance under division (B) of this section.

(B)(1) Not later than ninety days after the effective date of this section, the superintendent of insurance shall calculate a minimum dispensing fee to be paid for each drug product dispensed, equal to the average acquisition cost in this state to dispense the drug product, based on data collected by the department of medicaid through the survey conducted pursuant to section 5164.752 of the Revised Code. The superintendent shall publish the amount of the minimum dispensing fee and the dates

to which it applies on a publicly accessible web site maintained by the department of insurance.

(2) The superintendent of insurance shall calculate and publish the minimum dispensing fee described under division (B)(1) of this section each time the department of medicaid publishes the survey conducted pursuant to section 5164.752 of the Revised Code.

(C) Division (A) of this section does not apply to the extent that it conflicts with a contract or agreement entered into before the effective date of this section except that, if such a contract or agreement is amended or renewed after the effective date of this section, the contract or agreement shall conform to the requirements of that division. Division (A) of this section does not prohibit a pharmacy benefit manager from paying drug product reimbursements or dispensing fees in excess of the amounts required by that division.

(D) This section does not apply to the state pharmacy benefit manager established pursuant to section 5167.12 of the Revised Code.

Sec. 5164.753. (A) In December of every even-numbered year, the medicaid director shall establish dispensing fees, effective the following July, for terminal distributors of dangerous drugs that are providers of drugs under the medicaid program. In establishing dispensing fees, the director shall take into consideration the results of the survey conducted under section 5164.752 of the Revised Code. The director may establish dispensing fees that vary by terminal distributor, taking into consideration the volume of drugs a terminal distributor dispenses under the medicaid program or any other criteria the director considers relevant.

(B)(1) Not later than ninety days after the effective date of this section, the medicaid director shall calculate the minimum dispensing fee to be paid for each drug product dispensed, equal to the average acquisition cost in this state to dispense the drug product, based on data collected by the department through the survey conducted pursuant to section 5164.752 of the Revised Code, and publish the dispensing fee amount on an internet web site maintained by the department of medicaid.

(2) The medicaid director shall calculate the minimum dispensing fee as described under division (B)(1) of this section each time the survey's response is published.

Sec. 5167.127. (A) As used in sections 5167.127 and 5167.128 of the Revised Code, "pharmacy" has the same meaning as in section 3902.75 of the Revised Code.

(B) A medicaid managed care organization, or a pharmacy benefit manager under contract with the medicaid director or a medicaid managed care organization to administer its prescribed drugs benefit, shall not require a pharmacy to meet accreditation standards or certification requirements that are inconsistent with or in addition to those of the state board of pharmacy as a condition of participating in the organization's network.

Sec. 5167.128. Any enrollee or pharmacy affected by a violation of section 5167.127 of the Revised Code by a medicaid managed care organization or one or more of the organization's intermediaries, including a pharmacy benefit manager, may bring a civil action against the organization or the intermediary for compensatory damages and injunctive or other equitable relief.

Sec. 5167.243. (A) The state pharmacy benefit manager shall provide to the medicaid director a written quarterly report containing the following information from the immediately preceding quarter:

(1) The prices that the state pharmacy benefit manager negotiated for prescribed drugs under the care management system. The price must include any rebates the state pharmacy benefit manager received from the drug manufacturer;

(2) The prices the state pharmacy benefit manager paid to pharmacies for prescribed drugs;

(3) Any rebate amounts the state pharmacy benefit manager passed on to individual pharmacies;

(4) The percentage of savings in drug prices that are passed on to participants in the care management system;

(5) The information described in division (C) of section 5167.24 of the Revised Code;

(6) Any other information required by the director.

(B) The state pharmacy benefit manager shall provide to the director the monthly report as required by section 3953.151 of the Revised Code.

(C) The director may ask the state pharmacy benefit manager to provide additional information as necessary and shall collect other clinical data from the state pharmacy benefit manager as the director sees fit.

~~(C)~~ (D) At the time of contract execution, renewal, or modification, the department shall modify the reporting requirements under its medicaid managed care organization contracts as necessary to meet the requirements of this section.

Section 2. That existing sections 3902.50, 5164.753, and 5167.243 of the Revised Code are hereby repealed.

Section 3. Sections 3902.75 and 3902.76 of the Revised Code, as enacted in this act, apply to health benefit plans, as defined in section 3922.01 of the Revised Code, delivered, issued for delivery, modified, or renewed on or after the effective date of those sections.

Section 4. Sections 3902.75 and 3902.76 of the Revised Code, as enacted in this act, apply to contracts between health plan issuers, as defined in section 3922.01 of the Revised Code, and pharmacies entered into, modified, or renewed on or after the effective date of those sections.

Section 5. This act shall be known as the Community Pharmacy Protection Act.