**Amendment No. AM_136_0839-1**

Sub. H. B. No. 192
I_136_0065-2

_____ moved to amend as follows:

In line 1 of the title, delete "section" and insert "sections"; after "3902.50" insert ", 3959.01, and 3959.111"

In line 2 of the title, after "3902.78" insert ", 3959.121"

In line 3 of the title, delete "limit insurer"

Delete lines 4 through 8 of the title

In line 9 of the title, delete "and to name this act" and insert "enact"

In line 11, delete "section" and insert "sections"; after "3902.50" insert ", 3959.01, and 3959.111"

In line 12, after "3902.78" insert ", 3959.121"

In line 16, after "(A)" insert ""Affiliated pharmacy" or "pharmacy affiliate" means a pharmacy, including a specialty pharmacy, that directly or indirectly, through one or more intermediaries, meets any of the following criteria:

(1) It owns or controls a health plan issuer, pharmacy


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benefit manager, or other administrator of pharmacy benefits.

(2) It is owned or controlled by a health plan issuer, pharmacy benefit manager, or other administrator of pharmacy benefits.

(3) It is under common ownership or common control with a health plan issuer, pharmacy benefit manager, or other administrator of pharmacy benefits.

(B)"

In line 18, strike through "(B)" and insert "(C)"

In line 20, strike through "(C)" and insert "(D)"

In line 24, strike through "(D)" and insert "(E)"

In line 27, strike through "(E)" and insert "(F)"

In line 30, strike through "(F)" and insert "(G)"

In line 32, strike through "(G)" and insert "(H)"

In line 34, strike through "(H)" and insert "(I)"

In line 42, strike through "(I)" and insert "(J)"

In line 44, strike through "(J)" and insert "(K)"

In line 46, strike through "(K)" and insert "(L)"

In line 55, strike through "(L)" and insert "(M) "Specialty drug" means a drug used to treat chronic and complex or rare medical conditions that requires special handling or administration, provider care coordination, or patient education that cannot be provided by a nonspecialty pharmacy or pharmacist.

(N)"

In line 177, after "pharmacy" insert ";

(H) Unreasonably designate a prescription drug as a specialty drug to prevent a covered person from accessing the prescription drug or limiting a covered person's access to the prescription drug to a pharmacy or pharmacist that is within the health plan issuer's network"

After line 177, insert:

"**Sec. 3959.01.** As used in this chapter:

(A) "Actual acquisition cost" means the amount that a drug wholesaler charges a pharmacy for a drug product as listed on the pharmacy's billing invoice.

(B) "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)~~ (C) "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)~~ (D) "Affiliated pharmacy" has the same meaning as in section 3902.50 of the Revised Code.

(E) "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)~~ (F) "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)~~ (G) "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)~~ (H) "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)~~ (I) "Drug wholesaler" means a wholesale drug distributor accredited by a nationally recognized nonprofit organization that represents the interests of state boards of pharmacy and to which the state board of pharmacy is a member.

(J) "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)~~ (K) "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)~~ (L) "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)~~ (M) "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)~~ (N) "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.

~~(L)~~ (O) "Maximum allowable cost list" means a list of the drugs for which a pharmacy benefit manager imposes a maximum allowable cost, either directly or by setting forth a method for how the maximum allowable cost is calculated.

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

~~(N)~~ (Q) "National drug code number" or "national drug code" means the number registered for a drug pursuant to the listing system established by the United States food and drug administration under the "Drug Listing Act of 1972," 21 U.S.C. 360.

(R) "Ohio pharmacy" means a pharmacy, including an independent pharmacy, that is located in this state and that is licensed by the board of pharmacy under Chapter 4729. of the Revised Code.

(S) "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. "Pharmacy benefit manager" includes the state pharmacy benefit manager selected under section 5167.24 of the Revised Code.

~~(O)~~ (T) "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)~~ (U) "Plan sponsor" means the person who establishes the plan.

~~(Q)~~ (V) "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)~~ (W) "Specialty drug" has the same meaning as in section 3902.50 of the Revised Code.

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

**Sec. 3959.111.** (A)(1)(a) In each contract between a pharmacy benefit manager and a pharmacy, the pharmacy shall be given the right to obtain from the pharmacy benefit manager, within ten days after any request, a current list of the sources used to determine maximum allowable cost pricing. In each contract between a pharmacy benefit manager and a pharmacy, the

pharmacy benefit manager shall be obligated to update and implement the pricing information at least every seven days and provide a means by which contracted pharmacies may promptly review maximum allowable cost pricing updates in an electronic format that is readily available, accessible, and secure and that can be easily searched.

Subject to division (A)(1) of this section, a pharmacy benefit manager shall utilize the most up-to-date pricing data when calculating drug product reimbursements for all contracting pharmacies within one business day of any price update or modification.

(b) A pharmacy benefit manager shall maintain a written procedure to eliminate products from the list of drugs subject to maximum allowable cost pricing in a timely manner. The written procedure, and any updates, shall promptly be made available to a pharmacy upon request.

(2) In each contract between a pharmacy benefit manager and a pharmacy, a pharmacy benefit manager shall be obligated to ensure that all of the following conditions are met prior to placing a prescription drug on a maximum allowable cost list:

(a) The drug is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, or has an "NR" or "NA" rating or similar rating by nationally recognized reference.

(b) The drug is generally available for purchase by pharmacies in this state from a national or regional wholesaler and is not obsolete.

(3) Each contract between a pharmacy benefit manager and a

pharmacy shall include an electronic process to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes all of the following:

(a) A twenty-one-day limit on the right to appeal following the initial claim;

(b) A requirement that the appeal be investigated and resolved within twenty-one days after the appeal;

(c) A telephone number at which the pharmacy may contact the pharmacy benefit manager to speak to a person responsible for processing appeals;

(d) A requirement that a pharmacy benefit manager provide a reason for any appeal denial, including the national drug code and the identity of the national or regional wholesalers from whom the drug was generally available for purchase at or below the benchmark price determined by the pharmacy benefit manager;

(e) A requirement that if the appeal is upheld or granted, then the pharmacy benefit manager shall adjust the drug product reimbursement to the pharmacy's upheld appeal price;

(f) A requirement that a pharmacy benefit manager make an adjustment not later than one day after the date of determination of the appeal. The adjustment shall be retroactive to the date the appeal was made and shall apply to all situated pharmacies as determined by the pharmacy benefit manager. This requirement does not prohibit a pharmacy benefit manager from retroactively adjusting a claim for the appealing pharmacy or for any other similarly situated pharmacies.

(B)(1)(a) A pharmacy benefit manager shall disclose to the plan sponsor whether or not the pharmacy benefit manager uses

the same maximum allowable cost list when billing a plan sponsor as it does when reimbursing a pharmacy.

(b) If a pharmacy benefit manager uses multiple maximum allowable cost lists, the pharmacy benefit manager shall disclose in the aggregate to a plan sponsor any differences between the amount paid to a pharmacy and the amount charged to a plan sponsor.

(2) The disclosures required under division (B)(1) of this section shall be made within ten days of a pharmacy benefit manager and a plan sponsor signing a contract or on a quarterly basis.

(3)(a) Division (B) of this section does not apply to plans governed by the "Employee Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq. or medicare part D.

(b) As used in this division, "medicare part D" means the voluntary prescription drug benefit program established under Part D of Title XVIII of the "Social Security Act," 42 U.S.C. 1395w-101, et seq.

(C) Except as otherwise provided in division (F) of this section, on and after ninety days after the effective date of this amendment, a pharmacy benefit manager shall reimburse an Ohio pharmacy for drug products dispensed an amount that is not less than either of the following:

(1) The amount that the pharmacy benefit manager reimburses an affiliated pharmacy for providing the same drug product;

(2) The sum of the following:

(a) A drug product reimbursement not less than the Ohio

pharmacy's actual acquisition cost for the drug dispensed;

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

(D) An Ohio pharmacy may decline to provide a drug product to an individual or pharmacy benefit manager if the Ohio pharmacy would be paid less than the amount required by division (C) of this section.

(E)(1) Not later than ninety days after the effective date of this amendment, the superintendent of insurance shall determine a minimum dispensing reimbursement to be paid for each drug product based on data collected by the department of medicaid through the survey conducted pursuant to section 5164.752 of the Revised Code.

(2) The superintendent shall publish the amount of the minimum dispensing reimbursement and the dates to which it applies on a publicly accessible web site maintained by the department of insurance.

(3) The superintendent shall update the minimum dispensing reimbursement each time the department of medicaid publishes the survey conducted pursuant to section 5164.752 of the Revised Code.

(F)(1) Division (C) 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 amendment except that, if such a contract or agreement is amended or renewed after the effective date of this amendment, the contract or agreement shall conform to the requirements of that division. Division (C)

of this section does not prohibit a pharmacy benefit manager from paying drug product reimbursements or dispensing reimbursements in excess of the amounts required by that division.

(2) Divisions (C) and (D) of this section do not apply with respect to any state pharmacy benefit manager established pursuant to division (F) of section 124.81 of the Revised Code.

(G) Notwithstanding division ~~(B)(5)~~(C)(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 a pharmacy benefit manager, as defined in section 3959.01 of the Revised Code.

~~(D)~~ (H) No pharmacy benefit manager shall retaliate against an Ohio pharmacy that reports an alleged violation of, or exercises a right or remedy under, this section by doing any of the following:

(1) Terminating or refusing to renew a contract with the Ohio pharmacy without providing notice to the Ohio pharmacy at least ninety days in advance;

(2) Subjecting the Ohio pharmacy to increased audits without providing notice to the Ohio pharmacy and a detailed description of the reason for the audit at least ninety days in advance;

(3) Failing to promptly pay the Ohio pharmacy in accordance with sections 3901.38 to 3901.3814 of the Revised Code.

(I) If an Ohio pharmacy believes that a pharmacy benefit manager has violated this section, in addition to any other remedies provided by law, the Ohio pharmacy may file a formal complaint and provide evidence related to the complaint to the superintendent of insurance.

(J) The superintendent of insurance shall adopt rules ~~as necessary to implement the requirements of this section~~in accordance with Chapter 119. of the Revised Code for the purposes of implementing and administering this section. Notwithstanding any provision of section 121.95 of the Revised Code to the contrary, a regulatory restriction contained in a rule adopted by the superintendent in accordance with this section is not subject to sections 121.95 to 121.953 of the Revised Code.

**Sec. 3959.121.** (A) The superintendent of insurance shall evaluate any complaint filed by an Ohio pharmacy pursuant to section 3959.111 of the Revised Code.

(B)(1) If the superintendent determines, based on a complaint filed by an Ohio pharmacy or other information available to the superintendent, that a pharmacy benefit manager has violated section 3959.111 of the Revised Code, the superintendent shall do both of the following:

(a) Issue a notice of violation to the pharmacy benefit manager that clearly explains the violation;

(b) Impose an administrative penalty on the pharmacy benefit manager of one thousand dollars for each violation.

(2) Each day that a violation continues after the pharmacy benefit manager receives notice of the violation under division (B)(1)(a) of this section is considered a separate violation for

the purposes of the administrative penalty under division (B)(1)(b) of this section.

(C) Before imposing an administrative penalty under this section, the superintendent shall afford the pharmacy benefit manager an opportunity for an adjudication hearing under Chapter 119. of the Revised Code. At the hearing, the pharmacy benefit manager may challenge the superintendent's determination that a violation occurred, the superintendent's imposition of an administrative penalty, or both. The pharmacy benefit manager may appeal the superintendent's determination and the imposition of the administrative penalty in accordance with section 119.12 of the Revised Code.

(D) An administrative penalty collected under this section shall be deposited into the state treasury to the credit of the department of insurance operating fund created by section 3901.021 of the Revised Code."

In line 279, delete "section" and insert "sections"; after "3902.50" insert ", 3959.01, and 3959.111"

In line 280, delete "is" and insert "are"

The motion was _____ agreed to.

**SYNOPSIS**

**Pharmacy benefit managers reimbursement**

**R.C. 3902.50, 3902.78, 3959.01, 3959.111, and 3959.121**

Requires pharmacy benefit managers (PBMs), other than the

state PBM, to reimburse Ohio-incorporated pharmacies that dispense a drug product for the "actual acquisition cost," i.e., the amount paid to the drug wholesaler, plus a minimum dispensing fee determined by the Superintendent of Insurance.

Prohibits a PBM from reimbursing an Ohio pharmacy less than the amount the PBM reimburses its affiliated pharmacies for providing the same drug product.

Allows an Ohio pharmacy to decline to provide a drug product if the pharmacy would be reimbursed less than the required amount under the bill.

Prohibits a PBM from retaliating against an Ohio pharmacy that reports an alleged violation of, or exercises a remedy under, the bill's provisions by doing any of the following:

- Terminating or refusing to renew a contract without providing notice at least 90 days in advance;

- Increasing audits of the pharmacy without providing notice and a detailed description of the reason for the audits at least 90 days in advance;

- Failing to comply with prompt pay laws.

Establishes a procedure by which an Ohio pharmacy may file a formal complaint alleging a violation and the Superintendent may impose an administrative penalty on the PBM of $1,000 per day for each violation.

Allows the Superintendent to adopt rules to implement and administer the bill's provisions and exempts those rules from requirements, under continuing law, related to reducing regulatory restrictions.

Prohibits a health plan issuer from unreasonably

designating a prescription drug as a specialty drug to prevent a covered person from accessing the prescription drug or limiting a covered person's access to the prescription drug to a pharmacy or pharmacist that is within the health plan issuer's network.

Makes the following definitions for purposes of the laws governing health plan issuers and various coverage requirements:

-"Affiliated pharmacy" means a pharmacy, including a specialty pharmacy, that directly or indirectly, through one or more intermediaries, meets any of the following criteria:

--It owns or controls a health plan issuer, pharmacy benefit manager, or other administrator of pharmacy benefits;

--It is owned or controlled by a health plan issuer, pharmacy benefit manager, or other administrator of pharmacy benefits;

--It is under common ownership or common control with a health plan issuer, pharmacy benefit manager, or other administrator of pharmacy benefits.

-"Specialty drug" means a drug used to treat chronic and complex or rare medical conditions that requires special handling or administration, provider care coordination, or patient education that cannot be provided by a nonspecialty pharmacy or pharmacist.

Makes the following definitions for purposes of the laws regulating third-party administrators:

-"Actual acquisition cost" means the amount that a drug wholesaler charges a pharmacy for a drug product as listed on the pharmacy's billing invoice.

-"Drug wholesaler" means a wholesale drug distributor

accredited by a nationally recognized nonprofit organization that represents the interests of the State Boards of Pharmacy and to which the State Board of Pharmacy is a member.

-"National drug code number" or "national drug code" means the number registered for a drug pursuant to the listing system established by the United States food and drug administration under the federal "Drug Listing Act of 1972."

-"Ohio pharmacy" means a pharmacy, including an independent pharmacy, that is located in Ohio and that is licensed by the Board of Pharmacy.