Amendment No. AM_136_1041-2

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

_____ moved to amend the amendment labeled AM0839-1 as follows:

In line 2 of the amendment, after the first comma, insert "3902.72,"

In line 9 of the amendment, after the first comma insert "3902.72,"

In line 21 of the amendment, delete ", pharmacy benefit manager,"

After line 39 of the amendment, insert:

"After line 62, insert:

"Sec. 3902.72. (A) As used in this section~~, "health~~ :

(1) "Authorized third-party application" means a software application, web site, or service that a covered person authorizes to access their prescription drug pricing information and related data under a health benefit plan on their behalf.

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

(3) "Real-time pricing information" means current pricing data for a prescription drug that accurately reflects all of the following with respect to a covered person:

(a) The covered person's health benefit plan;

(b) Cost-sharing amounts under the plan;

(c) Whether the drug is included on the plan's formulary;

(d) Any utilization review requirements under the plan such as prior authorization, quantity limits, step therapy requirements, or other restrictions;

(e) Pricing information for covered pharmacies including retail, mail order, and specialty pharmacies.

(4) "Price transparency tool" means a web site, application, portal, or application programming interface that provides prescription drug pricing information to covered persons or their authorized representatives.

(B) A health plan issuer, including a pharmacy benefit manager, shall, upon request of a covered person, the covered person's health care provider, or the third-party representative, furnish the following data for any and all drugs covered under a related health benefit plan:

(1) The covered person's eligibility information for any and all covered drugs;

(2) Cost-sharing information for any and all covered drugs, including a description of any variance in cost-sharing based on pharmacy, whether retail or mail order, or health care provider dispensing or administering the drugs;

(3) Any applicable utilization ~~management~~ review requirements for any and all covered drugs, including prior authorization requirements, step therapy, quantity limits, and site-of-service restrictions.

(C) A health plan issuer, including a pharmacy benefit manager, providing the data required under division (B) of this section shall ensure that the data meets all of the following:

(1) It is current not later than one business day after any change is made.

(2) It is provided in real time.

(3) It is provided in the same format that the request is made by the covered person, the covered person's health care provider, or the third-party representative.

(D) The format in which a health plan issuer, including a pharmacy benefit manager, replies to a request made under division (B) of this section shall use established industry content and transport standards published by either of the following:

(1) A standards developing organization accredited by the American national standards institute, including the national council for prescription drug programs, ASC X12, health level 7;

(2) A relevant federal or state governing body, including the centers for medicare and medicaid services or the office of the national coordinator for health information technology.

(E) A health plan issuer, including a pharmacy benefit manager, shall furnish the data required under division (B) of this section regardless of whether the request is made using the drug's unique billing code, such as a national drug code or health care common procedure coding system code, or a descriptive term, such as the brand or generic name of the drug.

(F) A health plan issuer, including a pharmacy benefit manager, shall not deny or delay a request as a method of blocking the data required under division (B) of this section from being shared based on how the drug was requested.

(G) A health plan issuer, including a pharmacy benefit

manager, furnishing the data required under division (B) of this section shall not do any of the following:

(1) Restrict, prohibit, or otherwise hinder, in any way, a health care provider from communicating or sharing any of the following:

(a) Any of the data required under division (B) of this section;

(b) Additional information on any lower-cost or clinically appropriate alternatives, whether or not they are covered under the covered person's health benefit plan;

(c) Additional payment or cost-sharing information that may reduce the covered person's out-of-pocket costs, such as cash price or patient assistance and support programs whether sponsored by a manufacturer, foundation, or other entity.

(2) Except as may be required by law, interfere with, prevent, or materially discourage access, exchange, or use of the data required under division (B) of this section, including any of the following:

(a) Charging fees;

(b) Not responding to a request at the time the request is made, if such a response is reasonably possible;

(c) Implementing technology in nonstandard ways;

(d) Instituting covered person consent requirements, processes, policies, procedures, or renewals that are likely to substantially increase the complexity or burden of accessing, exchanging, or using such data.

(3) Penalize a health care provider for disclosing such

data to a covered person or for prescribing, administering, or ordering a clinically appropriate or lower-cost alternative.

(H)(1) A health plan issuer, including a pharmacy benefit manager, shall treat a personal representative of a covered person as the covered person for purposes of this section.

(2) If under applicable law a person has authority to act on behalf of a covered person in making decisions related to health care, a health plan issuer, including a pharmacy benefit manager, or its affiliates or entities acting on its behalf, shall treat such person as a personal representative under this section.

~~(I) Divisions (A) to (H) of this section take effect January 1, 2022.~~ (I)(1) Each health plan issuer, including any pharmacy benefit manager, shall develop, maintain, and make available at no cost to covered persons a comprehensive price transparency tool that provides real-time pricing information for prescription drugs. The issuer or pharmacy benefit manager shall make the tool available through multiple access methods, including all of the following:

(a) A public web site accessible without login credentials, that provides general pricing information for prescription drugs;

(b) A secure member portal, accessible to covered persons that provides personalized, real-time pricing information based on the person's health benefit plan;

(c) A standards-based application programming interface that enables covered persons to authorize third-party applications to access their personalized drug pricing information.

(2) The application programming interface shall meet all of the following requirements:

(a) Use established industry content and transport standards specified in division (D) of this section;

(b) Be documented with publicly available technical specifications that enable third-party developers to integrate with the interface;

(c) Provide the same data elements, data quality, and data timeliness as the health plan issuer or pharmacy benefit manager's own price transparency tools;

(d) Be updated at least once daily to reflect current pricing information, formulary changes, and benefit updates;

(e) Be available at no cost to covered persons or to authorized third-party applications accessing data on behalf of a covered person.

(J)(1) A health plan issuer, including a pharmacy benefit manager, shall permit a covered person to authorize one or more third-party applications to access the covered person's prescription drug pricing information and related data through the application programming interface.

(2) A covered person may authorize an authorized third-party application to access the covered person's real-time drug pricing information through the application programming interface. After an authorization, the health plan issuer or pharmacy benefit manager shall permit an authorized third-party application to access the covered person's information by attesting that it has obtained proper authorization from the covered person. A health plan issuer or pharmacy benefit manager

shall not require the covered person to separately submit authorization documentation to the health plan issuer or pharmacy benefit manager before the authorized third-party application accesses the data on the covered person's behalf.

(3) An authorization under division (J)(2) of this section shall meet all of the following requirements:

(a) Be clear, conspicuous, and written in plain language that a reasonable person would understand;

(b) Clearly identify what data will be shared and accessed by the third-party application;

(c) Allow the covered person to revoke authorization at any time;

(d) Obtain affirmative consent from the covered person, which may be obtained electronically.

(4) When a third-party application requests access to a covered person's prescription drug pricing information through an application programming interface, the health plan issuer or pharmacy benefit manager shall do all of the following:

(a) Accept the third-party application's attestation that proper authorization has been obtained from the covered person;

(b) Authenticate the covered person's identity using reasonable security measures;

(c) Provide access to the requested data within one business day of proper authentication, and not require additional authorization, verification, or approval steps beyond authentication by the covered person.

(5) A health plan issuer or pharmacy benefit manager may

require a third-party application to maintain records demonstrating that proper authorization was obtained from the covered person and may audit such records for compliance purposes. The health plan issuer or pharmacy benefit manager shall not use audit or recordkeeping requirements as a basis to delay, deny, or restrict a third-party application's access to a covered person's data when proper authentication has been completed.

(6) A covered person may revoke authorization to a third-party application at any time by notifying either the third-party application or the health plan issuer or pharmacy benefit manager. Upon receiving notice of revocation, the health plan issuer or pharmacy benefit manager shall terminate the third-party application's access to that covered person's data within one business day.

(K) A health plan issuer, including a pharmacy benefit manager, shall not do any of the following:

(1) Discriminate against, penalize, or impose adverse consequences on any covered person who authorizes a third-party application to access their prescription drug pricing information, including:

(a) Limiting or reducing the covered person's benefits;

(b) Increasing the covered person's cost-sharing amounts;

(c) Restricting the covered person's access to pharmacies or prescription drugs;

(d) Denying or delaying prior authorization or other coverage determinations.

(2) Provide preferential treatment to its own price

transparency tools compared to authorized third-party applications, including any of the following:

(a) Providing more complete, accurate, or timely data through its own tools;

(b) Offering lower prices or better coverage through its own tools;

(c) Implementing technical measures that degrade the performance or functionality of authorized third-party applications;

(d) Marketing or steering covered persons away from authorized third-party applications.

(3) Impose fees, charges, or other financial requirements on any of the following:

(a) Covered persons for authorizing third-party applications;

(b) Covered persons for accessing their prescription drug pricing information through authorized third-party applications;

(c) Authorized third-party applications for accessing prescription drug pricing information on behalf of covered persons through the application programming interface.

(4) Require a covered person to utilize the health plan issuer or pharmacy benefit manager's own price transparency tool as a condition of any of the following:

(a) Receiving prescription drug benefits;

(b) Obtaining favorable pricing or cost-sharing amounts for prescription drugs;

(c) Accessing formulary medications or obtaining prior authorization approval.

(L)(1) All prescription drug pricing information provided pursuant to this section shall meet all of the following requirements:

(a) The information shall be accurate and reflect the actual cost-sharing amounts the covered person is responsible for at the point of sale of the drug.

(b) The information shall be current as of not later than one business day after any change to pricing, formulary status, or benefit design.

(c) The information shall be consistent across all access methods, including the health plan issuer or pharmacy benefit manager's web site, member portal, and application programming interface.

(d) The information shall be complete and include all data elements specified in divisions (A)(3) and (B) of this section.

(2) If a health plan issuer or pharmacy benefit manager becomes aware of an error or inaccuracy in pricing information provided under this section, the health plan issuer or pharmacy benefit manager shall correct the error within one business day and honor any pricing information previously provided to a covered person or authorized third-party application if the covered person filled the prescription in reasonable reliance on that information.

(M)(1) The superintendent shall enforce the requirements of this section and may adopt rules as necessary to implement the requirements of this section. The rules shall be adopted in

accordance with Chapter 119. of the Revised Code. The rules may establish additional technical standards, implementation timelines, and compliance requirements relating to the data sharing authorized by this section.

(2) A violation of any provision of this section is an unfair or deceptive act or practice in the business of insurance under section 3901.21 of the Revised Code and is subject to the penalties enumerated in section 3901.22 of the Revised Code."

In line 70, delete "and also includes a dispensing physician"

After line 70, insert:

"(3) "Prescriber" has the same meaning as in section 4729.01 of the Revised Code."

In line 74, after "pharmacy" insert "or personally furnishing prescriber"

In line 77, after "pharmacy" insert "or the applicable licensing body of a personally furnishing prescriber"

In line 79, after "pharmacy" insert "or personally furnishing prescriber"

In line 86, after "pharmacy" insert "or personally furnishing prescriber"

In line 118, after "pharmacist" insert "or personally furnishing prescriber"

In line 128, after "pharmacist" insert "or personally furnishing prescriber"

In line 135, after "pharmacist" insert "or personally furnishing prescriber"

In line 142, after "pharmacist" insert "or personally furnishing prescriber"; delete "either" and insert "any"

In line 146, after "alternatives" insert ";

(3) Partnering with a third party relating to prescription drug price transparency and patient access to drugs pursuant to a valid prescription;

(4) Directly or through a third party, offering services or products to increase transparency and prescription drug access for patients, including:

(a) Simplified payment processes, electronic payments, or payment plans;

(b) Adherence support services or communications;

(c) Information regarding patient out-of-pocket drug costs or alternative medication options;

(d) Utilizing electronic transactions that allow a pharmacist or pharmacy to provide patients with information about prescription drug costs and benefits;

(e) Utilizing electronic transactions that allow a pharmacist or pharmacy to provide a patient with prior authorization support for a prescription drug;

(f) Sharing patient claims data or other health care transaction data with the patient, the patient's health care provider and the provider's business associates, or any third party authorized by the patient, when the pharmacist or pharmacy processes the claim or other electronic transaction, or at any time thereafter;

(g) As permitted by state and federal law, providing prescription

drug copayment assistance or other out-of-pocket cost support to patients for prescription drugs"

In line 147, after "pharmacist" insert "or personally furnishing prescriber"

In line 156, after "pharmacy" insert "or personally furnishing prescriber"

In line 164, after "pharmacist" insert "or personally furnishing prescriber"

In line 168, after "pharmacist" insert "or personally furnishing prescriber"

In line 172, after "pharmacist" insert "or personally furnishing prescriber""

In line 78 of the amendment, delete everything after "~~(C)~~"

Delete line 79 of the amendment

In line 80 of the amendment, delete "(E)" and insert "(D)"

In line 86 of the amendment, delete "(F)" and insert "(E)"

In line 92 of the amendment, delete "(G)" and insert "(F)"

In line 96 of the amendment, delete "(H)" and insert "(G)"

In line 100 of the amendment, delete "(I)" and insert "(H)"

In line 104 of the amendment, delete "(J)" and insert "(I)"

In line 107 of the amendment, delete "(K)" and insert "(J)"

In line 112 of the amendment, delete "(L)" and insert "(K)"

In line 116 of the amendment, delete "(M)" and insert "(L)"

In line 120 of the amendment, delete "(N)" and insert "(M)"

In line 127 of the amendment, delete "(O)" and insert "(N)"

In line 131 of the amendment, delete "(P)" and insert "(O)"

In line 133 of the amendment, delete "(Q)" and insert "(P)"

In line 138 of the amendment, delete "(R)" and insert "(Q)"

In line 142 of the amendment, delete "(S)" and insert "(R)"

In line 150 of the amendment, delete "(T)" and insert "(S)"

In line 155 of the amendment, delete "(U)" and insert "(T)"

In line 157 of the amendment, delete "(V)" and insert "(U)"

In line 164 of the amendment, delete "(W)" and insert "(V)"

In line 166 of the amendment, delete "(X)" and insert "(W)"

In line 171 of the amendment, delete "(Y)" and insert "(X)"

In line 176 of the amendment, delete "(Z)" and insert "(Y)"

In line 263 of the amendment, delete "either of the following:"

Delete lines 264 through 266 of the amendment

In line 267 of the amendment, delete "(2) The" and insert "the"

In line 268 of the amendment, delete "(a)" and insert "(1)"

In line 270 of the amendment, delete "(b)" and insert "(2)"

In line 372 of the amendment, after the first comma insert "3902.72,"

The motion was _____ agreed to.

SYNOPSIS

Definition of pharmacy

R.C. 3902.75, 3902.76, 3902.77, and 3902.78

Regarding the bill's provisions relating to pharmacy accreditation standards and insurer actions relating to the provision of pharmacy services, modifies the definition of "pharmacy" to remove reference to dispensing physicians, to accord with existing law, and instead refers separately to dispensing physicians ("personally furnishing prescribers").

Adds language prohibiting an insurer or pharmacy benefit manager from prohibiting pharmacies or dispensing physicians from partnering with third parties relating to increasing prescription drug price transparency or patient access to drugs pursuant to a valid prescription.

Affiliated pharmacies

R.C. 3959.01 and 3959.111

Regarding amendment language requiring a PBM to reimburse a pharmacy for dispensed drugs in an amount no less than (1) the amount the PBM reimburses an affiliated pharmacy for the same drug or (2) the sum of the pharmacy's actual acquisition cost for the drug and a dispensing fee, removes item (1) above.

Disclosure of covered person drug pricing data

R.C. 3902.72

Requires a health plan issuer, including a pharmacy benefit manager, to provide real-time pricing information of a covered person's prescription drug price information pursuant to the person's health benefit plan to an authorized third-party

application (such as a software app or website).

Permits a covered person to authorize an authorized third-party application to access the person's prescription drug pricing information described above.

Prohibits a health plan issuer or pharmacy benefit manager from engaging in practices to penalize a covered person for authorizing an authorized third-party application to access the person's prescription drug pricing information.

Specifies that a violation is an unfair and deceptive act in the business of insurance.

Prescription drug transparency

R.C. 3902.78

Prohibits a health insurer, pharmacy benefit manager, or other third-party payer from prohibiting a pharmacist from directly, or through a third party, offering services or products or providing information regarding prescription drug pricing and access, including enumerated services, products, and information.