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Sub. H. B. No. 192

To amend section 3902.50 and to enact sections 3902.75, 3902.76, 3902.77, 3902.78, and 3959.151 of the Revised Code to limit insurer accreditation requirements for pharmacies, to implement drug cost reporting requirements for pharmacy benefit managers, to prohibit certain conduct and contractual arrangements by insurers related to the provision of pharmacist services, 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 section 3902.50 be amended and sections 3902.75, 3902.76, 3902.77, 3902.78, and 3959.151 of the Revised Code be enacted to read as follows:

Sec. 3902.50. As used in sections 3902.50 to ~~3902.72~~ 3902.78 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 to 3902.78 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.

(C) In addition to any other remedies provided by law, any covered person or pharmacy affected by a violation of this section may file a formal complaint with the superintendent of insurance.

Sec. 3902.76. (A) The superintendent of insurance shall evaluate any complaint filed under section 3902.75 of the Revised Code.

(B)(1) If the superintendent determines, based on a complaint by a covered person or pharmacy or other information available to the superintendent, that a health plan issuer or one or more of the health plan issuer's intermediaries has violated section 3902.75 of the Revised Code, the superintendent shall do both of the following:

(a) Issue a notice of violation to the health plan issuer or intermediary that clearly explains the violation;

(b) Impose an administrative penalty on the health plan issuer or intermediary of one thousand dollars for each violation.

(2) Each day that a violation of section 3902.75 of the Revised Code continues after the health plan issuer or intermediary receives notice of 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 health plan issuer

or intermediary an opportunity for an adjudication hearing under Chapter 119. of the Revised Code. At the hearing, the health plan issuer or intermediary may challenge the superintendent's determination that a violation occurred, the superintendent's imposition of an administrative penalty, or both. The health plan issuer or intermediary may appeal the superintendent's determination and imposition of an 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.

Sec. 3902.77. No health plan issuer, including a pharmacy benefit manager or other third party administrator, shall enter into, amend, or renew a contract with a pharmacy or pharmacist for the provision of pharmacy or pharmacist services under a health benefit plan, either directly or through a pharmacy services administrative organization or group purchasing organization, unless the contract does both of the following:

(A) Outlines the terms and conditions for the provision of pharmacy or pharmacist services;

(B) Prohibits the health plan issuer from retroactively denying, reducing reimbursement for, or seeking any refunds or recoupments for a claim for pharmacy or pharmacist services, in whole or in part, from the pharmacy or pharmacist after returning a paid claim response as part of the adjudication of the claim, including claims for the cost of a medication or dispensed product and claims for pharmacy or pharmacist services that are deemed ineligible for coverage, unless either of the following apply:

(1) The original claim was submitted fraudulently.

(2) The pharmacy or pharmacist received an actual overpayment.

Sec. 3902.78. No health plan issuer, including a pharmacy benefit manager or other third party administrator, with respect to the provision of pharmacy or pharmacist services under a health benefit plan, shall do any of the following:

(A) Prohibit, or impose a penalty on, a pharmacy or pharmacist for either of the following:

(1) Selling a lower cost alternative to a covered person if a lower cost alternative is available;

(2) Providing information to a covered person regarding lower cost alternatives.

(B) Discriminate against a pharmacy or pharmacist that is both of the following:

(1) Located within the geographic coverage area of the health benefit plan;

(2) Willing to agree to or accept terms and conditions established for participation in the health plan issuer's network.

(C) Impose limits, including quantity limits or refill frequency limits, on a covered person's access to medication from a pharmacy that are more restrictive than those existing for a pharmacy affiliate;

(D) Require a covered person to receive pharmacy or pharmacist services from a pharmacy affiliate, including by doing either of the following:

(1) Requiring a covered person to obtain a specialty drug from a pharmacy affiliate;

(2) Imposing cost-sharing requirements for a covered person who uses an unaffiliated pharmacy or pharmacist that are greater than the cost-sharing requirement imposed by the health benefit plan for a covered person who uses an affiliated pharmacy.

(E) Require a pharmacy or pharmacist to enter into an additional contract with an affiliate of the health benefit plan as a condition of entering into a contract with the health benefit plan;

(F) Require a pharmacy or pharmacist, as a condition of a contract, to agree to payment rates for any affiliate of the health plan issuer that is not a party to the contract;

(G) Require a covered person, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail order pharmacy.

Sec. 3959.151. (A) As used in this section, "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) Each pharmacy benefit manager shall quarterly provide to the superintendent of insurance and to the pharmacy benefit manager's contracted insurers and plan sponsors, including contracted public employee benefit plans and contracted employers offering a self-insurance program, an electronic report of all drug claims processed the previous quarter in a machine-readable format that is also readable in

plain language without the use of software.

(2) The electronic report provided to an insurer, a plan sponsor, or the medicaid program shall include an itemized list of the maximum allowable cost of each drug product from all drug product claims processed by the pharmacy benefit manager in the previous quarter 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 quarter for all insurers and plan sponsors.

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

(i) 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;

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

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

(iv) If the drug is a generic drug;

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

(b) The itemized list of drugs dispensed shall include all the following:

(i) The date of service;

(ii) The pharmacy number as provided by the national council for prescription drug programs;

(iii) The processor identification number;

(iv) The processor control number;

(v) The group identification number;

(vi) The national drug code number;

(vii) The amount of product dispensed;

(viii) The supply and number of days the prescription is intended to last;

(ix) The dispense as written code;

(x) The provider payment attributed to the dispensing fee;

(xi) The dispensing fee;

(xii) The cost share paid by the covered person to the provider;

(xiii) The total payment made to the provider for the drug dispensed;

(xiv) The total reimbursement paid by the health benefit plan to the third party administrator for the drug dispensed;

(xv) The basis for reimbursement to the third party administrator;

(xvi) The usual and customary rate for the drug dispensed;

(xvii) Whether the drug dispensed is a generic;

(xviii) Whether the drug dispensed is a specialty drug.

(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) No pharmacy benefit manager shall retaliate against a pharmacy in this state that reports an alleged violation of this section 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 pharmacy without providing notice to the pharmacy at least ninety days in advance;

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

(3) Failing to promptly pay a pharmacy in accordance with sections 3901.381 to 3901.3814 of the Revised Code.

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

(F) 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. 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.

Section 2. That existing section 3902.50 of the Revised Code is hereby repealed.

Section 3. Sections 3902.75 to 3902.78 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 to 3902.78 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.