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Bill Analysis

Version: As Introduced

Primary Sponsors: Reps. Barhorst and Fischer

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SUMMARY

- Prohibits health plan issuers from requiring a pharmacy, as a condition of participating in their pharmacy networks, to meet accreditation standards or certification requirements different from those required by the State Board of Pharmacy.
- Requires each pharmacy benefit manager (PBM) to submit to the Superintendent of Insurance and its contracted insurers and plan sponsors a quarterly electronic report of all drug claims processed by the PBM during the previous month.
- Specifies that the report must include an itemized list of the actual acquisition cost of each drug product from all drug claims processed by the PBM in the previous quarter, with specified information about the drug's acquisition.
- Prohibits any agreement between a PBM and an insurer from prohibiting the disclosure of the information required in the itemized list.
- Allows a pharmacy to report an alleged violation of the bill's provisions by a PBM to the Superintendent of Insurance.
- Prohibits a PBM from retaliating against a pharmacy that reports a violation of the bill's provisions.
- Designates the bill as the Community Pharmacy Protection Act.

DETAILED ANALYSIS

Pharmacy accreditation standards

The bill prohibits health plan issuers from requiring a pharmacy to meet accreditation standards or certification requirements that are inconsistent with, or in addition to, those required by the State Board of Pharmacy, as a condition of participating in the health plan issuer's

pharmacy network. The prohibition applies to health benefit plans that are delivered, issued for delivery, or renewed on or after the bill's effective date and to contracts between health plan issuers and pharmacies entered into, modified, or renewed on or after the bill's effective date. "Health plan issuer" is defined by continuing law to include a broad range of insurers such as health insuring corporations, multiple employer welfare arrangements, sickness and accident insurers, public employee benefit plans, and pharmacy benefit managers (PBMs). The bill defines "pharmacy" as a place where pharmacist care derived from the principles of biological, chemical, behavioral, social, pharmaceutical, and clinical sciences is conducted, including when such care is provided by a dispensing physician.[1]

The bill authorizes a pharmacy or covered person affected by a health plan issuer's application of unlawful accreditation requirements to file a formal complaint to the Superintendent of Insurance. The Superintendent must evaluate all such complaints. If the Superintendent determines that a violation occurred, the Superintendent must provide notice to the offending health plan issuer or intermediary and allow an opportunity for an adjudication hearing in accordance with the Administrative Procedure Act. Unless the health plan issuer or intermediary prevails in the hearing, the Superintendent must impose an administrative penalty of $1,000 for each violation. Each day that the violation continues after the health plan issuer or intermediary receives notice is considered a separate violation and is, therefore, subject to an additional $1,000 penalty. All penalties collected under the bill must be deposited to the Department of Insurance Operating Fund.[2]

Pharmacy benefit managers

The bill also contains provisions specific to PBMs, which are licensed entities that process prescription drug claims on behalf of insurers. First, the bill requires PBMs to submit electronic reports regarding drug claims. Second, the bill prohibits a PBM from retaliating against a pharmacy that reports an alleged violation of the reporting requirements.

Electronic report

The bill requires each PBM to quarterly submit to the Superintendent of Insurance and to its contracted insurers and plan sponsors, an electronic report in a machine-readable format of all drug claims processed by the PBM during the previous quarter. For purposes of this requirement, 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, including .XML and .CSV formats.[3]

[1] R.C. 3902.75(A) and (B); Sections 3 and 4.

[2] R.C. 3902.75(C) and 3902.76.

[3] R.C. 3959.151(A) and (B)(1).

Report contents

The report to an insurer or plan sponsor, or the Ohio Department of Medicaid (ODM) must include an itemized list of the maximum allowable cost of each drug product from all drug claims processed by the PBM in the previous quarter for that insurer, sponsor, or ODM. The report to the Superintendent must include the actual acquisition cost of each drug product from all drug product claims processed by the PBM in the previous quarter for all insurers and plan sponsors. The actual acquisition cost is the amount actually expended to procure the drug after manufacturer price concessions or rebates.[4]

The itemized list must notate the following for each drug product:

- If the drug was procured through the PBM, insurer, or ODM's drug formulary or list of covered drugs or outside of the formulary or list;
- If the drug is brand name or generic;
- If the drug is a specialty drug, including a biological product.[5]

Despite this reporting requirement, a PBM is not required to disclose information that is deemed proprietary or confidential by a service agreement between the PBM and an insurer, existing on the bill's effective date and in effect on the date the information would otherwise be submitted in the itemized list.[6]

Agreements

The bill prohibits any agreement between a PBM and an insurer entered into on or after the bill's effective date from prohibiting disclosure of the information required in the itemized list.[7]

Rulemaking authority

The Superintendent of Insurance must adopt rules, in accordance with the Administrative Procedure Act, to implement the above requirements.[8]

[4] R.C. 3959.151(B)(1) and (2).

[5] R.C. 3959.151(B)(3).

[6] R.C. 3959.151(C)(2).

[7] R.C. 3959.151(C)(1).

[8] R.C. 3959.151(F).

Violations

If a pharmacy believes that a PBM has violated the bill's provisions, in addition to any other remedies under the law, a pharmacy may file a formal complaint and provide related evidence to the Superintendent of Insurance.[9]

Retaliation

The bill prohibits a PBM from retaliating against an Ohio pharmacy that reports an alleged violation of the bill's provisions or exercises a right or remedy. Retaliation includes any of the following:

- Terminating or refusing to renew a contract with the pharmacy without providing at least a 90-day notice;
- Subjecting a pharmacy to increased audits without providing at least a 90-day notice and a detailed description of the reason for the audit;
- Failing to promptly pay a pharmacy.[10]

HISTORY

Action	Date
Introduced	03-24-25

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[9] R.C. 3959.151(E).

[10] R.C. 3959.151(D).