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Bill Analysis

Version: As Introduced

Primary Sponsors: Reps. Barhorst and Stewart

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SUMMARY

- Prohibits health plan issuers and the Ohio Department of Medicaid (ODM), 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 monthly electronic report of all drug claims processed by the PBM during the previous month.
- Requires the single state PBM under the Medicaid program to submit its monthly report to ODM.
- 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 month, 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.
- Requires insurers to pay pharmacies the actual acquisition cost plus a minimum dispensing fee for drug claims.
- Requires the Superintendent of Insurance for insurers, and ODM for the Medicaid program, to establish minimum dispensing fees to be paid to pharmacies for drug claims.
- Designates the bill as the Community Pharmacy Protection Act.

DETAILED ANALYSIS

Pharmacy accreditation standards

The bill prohibits certain actions by health plan issuers – 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) – and the Medicaid program relative to contracting with pharmacies. Under the bill, health plan issuers offering health benefit plans that provide prescription drug coverage and the Ohio Department of Medicaid (ODM) cannot require a pharmacy, as a condition of participating in the health plan issuer's or ODM's pharmacy network, to meet accreditation standards or certification requirements that are inconsistent with or in addition to those required for pharmacists by the State Board of Pharmacy. The bill establishes a civil cause of action, which may be brought by any covered person or pharmacy affected by a violation of the above prohibition against the health plan issuer, ODM, or an intermediary for compensatory damages and injunctive or other equitable relief.[1]

Application to insurance contracts

The above 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.[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 requires the establishment of minimum dispensing fee amounts to be paid to pharmacists by insurers and ODM.

Electronic report

The bill requires each PBM, on or before the 15th of each month, to 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 month. The single state PBM under the Medicaid program must submit its report to ODM, instead of the Superintendent. 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.

[1] R.C. 3902.75, 3902.76, 5167.127, and 5167.128.

[2] Sections 3 and 4.

Report contents

The report to an insurer, plan sponsor, or ODM 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 month for that insurer, sponsor, or ODM. The report to the Superintendent must include that information 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.[3]

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.[4]

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.[5]

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.[6]

Rulemaking authority

The Superintendent of Insurance must adopt rules, in accordance with the Administrative Procedure Act, to implement the above requirements.[7]

Minimum payment amount for drug claims

The bill also imposes requirements for minimum payment amounts made by PBMs to pharmacies for drug claims under insurance policies. This requirement does not apply to the state PBM under the Medicaid program. For drugs dispensed beginning 91 days after the bill's

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

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

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

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

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

effective date, the bill requires PBMs to pay contracted pharmacies both of the following for the dispensed drug:

- A reimbursement amount no less than the pharmacy's actual acquisition cost for the drug;
- A dispensing fee not less than the minimum dispensing fee established pursuant to the bill (see **"Minimum dispensing fee**" below).[8]

This minimum payment requirement does not apply to the extent it conflicts with a contract or agreement entered into before the bill's effective date. If the contract or agreement is amended or renewed after the effective date, however, it must conform to the above requirements.[9]

Minimum dispensing fee

Within 90 days of the bill's effective date, the Superintendent of Insurance must calculate a minimum dispensing fee to be paid by an insurer for each drug product dispensed by a pharmacist. The fee must be equal to the average acquisition cost in Ohio to dispense the drug product, based on data collected by ODM under current law (see "**Updating minimum dispensing fees**" below). The Superintendent must publish the amount of the minimum dispensing fee and the dates it applies on a publicly accessible website maintained by the Department of Insurance.[10] For drug claims under the Medicaid program, ODM must similarly calculate a minimum dispensing fee using the same data and publish the dispensing fee amount and dates it applies on a public website maintained by ODM.[11]

Updating minimum dispensing fees

The bill requires the Superintendent of Insurance and ODM to recalculate and publish their minimum dispensing fees each time ODM publishes its biennial drug cost survey.[12] Under current law, ODM must initiate a confidential survey of the cost of dispensing drugs incurred by pharmacies in Ohio, to be used as the basis for establishing dispensing fees for pharmacies under the Medicaid program. The survey must be initiated in July of every even-numbered year.[13]

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[8] R.C. 3959.21(A) and (D).

[9] R.C. 3959.21(C).

[10] R.C. 3959.21(B)(1).

[11] R.C. 5164.753(B)(1).

[12] R.C. 3959.21(B)(2) and 5164.753(B)(2).

[13] R.C. 5164.752, not in the bill.

HISTORY

Action	Date
Introduced	04-24-24

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