

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

In line 2 of the amendment, after the first comma, insert "3902.72," 1

In line 9 of the amendment, after the first comma insert "3902.72," 2

In line 21 of the amendment, delete ", pharmacy benefit manager," 3

After line 39 of the amendment, insert: 4

"After line 62, insert: 5

"Sec. 3902.72. (A) As used in this section, ~~"health:~~ 6

(1) "Authorized third-party application" means a software 7
application, web site, or service that a covered person 8
authorizes to access their prescription drug pricing information 9
and related data under a health benefit plan on their behalf. 10

(2) "Health care provider" has the same meaning as in 11
section 3701.74 of the Revised Code. 12

(3) "Real-time pricing information" means current pricing 13
data for a prescription drug that accurately reflects all of the 14
following with respect to a covered person: 15

(a) The covered person's health benefit plan; 16

(b) Cost-sharing amounts under the plan; 17



<u>(c) Whether the drug is included on the plan's formulary;</u>	18
<u>(d) Any utilization review requirements under the plan</u>	19
such as <u>prior authorization, quantity limits, step therapy</u>	20
<u>requirements, or other restrictions;</u>	21
<u>(e) Pricing information for covered pharmacies including</u>	22
<u>retail, mail order, and specialty pharmacies.</u>	23
<u>(4) "Price transparency tool" means a web site,</u>	24
<u>application, portal, or application programming interface that</u>	25
<u>provides prescription drug pricing information to covered</u>	26
<u>persons or their authorized representatives.</u>	27
(B) A health plan issuer, including a pharmacy benefit	28
manager, shall, upon request of a covered person, the covered	29
person's health care provider, or the third-party	30
representative, furnish the following data for any and all drugs	31
covered under a related health benefit plan:	32
(1) The covered person's eligibility information for any	33
and all covered drugs;	34
(2) Cost-sharing information for any and all covered	35
drugs, including a description of any variance in cost-sharing	36
based on pharmacy, whether retail or mail order, or health care	37
provider dispensing or administering the drugs;	38
(3) Any applicable utilization management - <u>review</u>	39
requirements for any and all covered drugs, including prior	40
authorization requirements, step therapy, quantity limits, and	41
site-of-service restrictions.	42
(C) A health plan issuer, including a pharmacy benefit	43
manager, providing the data required under division (B) of this	44
section shall ensure that the data meets all of the following:	45

(1) It is current not later than one business day after 46
any change is made. 47

(2) It is provided in real time. 48

(3) It is provided in the same format that the request is 49
made by the covered person, the covered person's health care 50
provider, or the third-party representative. 51

(D) The format in which a health plan issuer, including a 52
pharmacy benefit manager, replies to a request made under 53
division (B) of this section shall use established industry 54
content and transport standards published by either of the 55
following: 56

(1) A standards developing organization accredited by the 57
American national standards institute, including the national 58
council for prescription drug programs, ASC X12, health level 7; 59

(2) A relevant federal or state governing body, including 60
the centers for medicare and medicaid services or the office of 61
the national coordinator for health information technology. 62

(E) A health plan issuer, including a pharmacy benefit 63
manager, shall furnish the data required under division (B) of 64
this section regardless of whether the request is made using the 65
drug's unique billing code, such as a national drug code or 66
health care common procedure coding system code, or a 67
descriptive term, such as the brand or generic name of the drug. 68

(F) A health plan issuer, including a pharmacy benefit 69
manager, shall not deny or delay a request as a method of 70
blocking the data required under division (B) of this section 71
from being shared based on how the drug was requested. 72

(G) A health plan issuer, including a pharmacy benefit 73

manager, furnishing the data required under division (B) of this	74
section shall not do any of the following:	75
(1) Restrict, prohibit, or otherwise hinder, in any way, a	76
health care provider from communicating or sharing any of the	77
following:	78
(a) Any of the data required under division (B) of this	79
section;	80
(b) Additional information on any lower-cost or clinically	81
appropriate alternatives, whether or not they are covered under	82
the covered person's health benefit plan;	83
(c) Additional payment or cost-sharing information that	84
may reduce the covered person's out-of-pocket costs, such as	85
cash price or patient assistance and support programs whether	86
sponsored by a manufacturer, foundation, or other entity.	87
(2) Except as may be required by law, interfere with,	88
prevent, or materially discourage access, exchange, or use of	89
the data required under division (B) of this section, including	90
any of the following:	91
(a) Charging fees;	92
(b) Not responding to a request at the time the request is	93
made, if such a response is reasonably possible;	94
(c) Implementing technology in nonstandard ways;	95
(d) Instituting covered person consent requirements,	96
processes, policies, procedures, or renewals that are likely to	97
substantially increase the complexity or burden of accessing,	98
exchanging, or using such data.	99
(3) Penalize a health care provider for disclosing such	100

data to a covered person or for prescribing, administering, or 101
ordering a clinically appropriate or lower-cost alternative. 102

(H) (1) A health plan issuer, including a pharmacy benefit 103
manager, shall treat a personal representative of a covered 104
person as the covered person for purposes of this section. 105

(2) If under applicable law a person has authority to act 106
on behalf of a covered person in making decisions related to 107
health care, a health plan issuer, including a pharmacy benefit 108
manager, or its affiliates or entities acting on its behalf, 109
shall treat such person as a personal representative under this 110
section. 111

~~(I) Divisions (A) to (H) of this section take effect~~ 112
~~January 1, 2022.~~ (I) (1) Each health plan issuer, including any 113
pharmacy benefit manager, shall develop, maintain, and make 114
available at no cost to covered persons a comprehensive price 115
transparency tool that provides real-time pricing information 116
for prescription drugs. The issuer or pharmacy benefit manager 117
shall make the tool available through multiple access methods, 118
including all of the following: 119

(a) A public web site accessible without login 120
credentials, that provides general pricing information for 121
prescription drugs; 122

(b) A secure member portal, accessible to covered persons 123
that provides personalized, real-time pricing information based 124
on the person's health benefit plan; 125

(c) A standards-based application programming interface 126
that enables covered persons to authorize third-party 127
applications to access their personalized drug pricing 128
information. 129

<u>(2) The application programming interface shall meet all</u>	130
<u>of the following requirements:</u>	131
<u>(a) Use established industry content and transport</u>	132
<u>standards specified in division (D) of this section;</u>	133
<u>(b) Be documented with publicly available technical</u>	134
<u>specifications that enable third-party developers to integrate</u>	135
<u>with the interface;</u>	136
<u>(c) Provide the same data elements, data quality, and data</u>	137
<u>timeliness as the health plan issuer or pharmacy benefit</u>	138
<u>manager's own price transparency tools;</u>	139
<u>(d) Be updated at least once daily to reflect current</u>	140
<u>pricing information, formulary changes, and benefit updates;</u>	141
<u>(e) Be available at no cost to covered persons or to</u>	142
<u>authorized third-party applications accessing data on behalf of</u>	143
<u>a covered person.</u>	144
<u>(J) (1) A health plan issuer, including a pharmacy benefit</u>	145
<u>manager, shall permit a covered person to authorize one or more</u>	146
<u>third-party applications to access the covered person's</u>	147
<u>prescription drug pricing information and related data through</u>	148
<u>the application programming interface.</u>	149
<u>(2) A covered person may authorize an authorized third-</u>	150
<u>party application to access the covered person's real-time drug</u>	151
<u>pricing information through the application programming</u>	152
<u>interface. After an authorization, the health plan issuer or</u>	153
<u>pharmacy benefit manager shall permit an authorized third-party</u>	154
<u>application to access the covered person's information by</u>	155
<u>attesting that it has obtained proper authorization from the</u>	156
<u>covered person. A health plan issuer or pharmacy benefit manager</u>	157

shall not require the covered person to separately submit 158
authorization documentation to the health plan issuer or 159
pharmacy benefit manager before the authorized third-party 160
application accesses the data on the covered person's behalf. 161

(3) An authorization under division (J)(2) of this section 162
shall meet all of the following requirements: 163

(a) Be clear, conspicuous, and written in plain language 164
that a reasonable person would understand; 165

(b) Clearly identify what data will be shared and accessed 166
by the third-party application; 167

(c) Allow the covered person to revoke authorization at 168
any time; 169

(d) Obtain affirmative consent from the covered person, 170
which may be obtained electronically. 171

(4) When a third-party application requests access to a 172
covered person's prescription drug pricing information through 173
an application programming interface, the health plan issuer or 174
pharmacy benefit manager shall do all of the following: 175

(a) Accept the third-party application's attestation that 176
proper authorization has been obtained from the covered person; 177

(b) Authenticate the covered person's identity using 178
reasonable security measures; 179

(c) Provide access to the requested data within one 180
business day of proper authentication, and not require 181
additional authorization, verification, or approval steps beyond 182
authentication by the covered person. 183

(5) A health plan issuer or pharmacy benefit manager may 184

require a third-party application to maintain records 185
demonstrating that proper authorization was obtained from the 186
covered person and may audit such records for compliance 187
purposes. The health plan issuer or pharmacy benefit manager 188
shall not use audit or recordkeeping requirements as a basis to 189
delay, deny, or restrict a third-party application's access to a 190
covered person's data when proper authentication has been 191
completed. 192

(6) A covered person may revoke authorization to a third- 193
party application at any time by notifying either the third- 194
party application or the health plan issuer or pharmacy benefit 195
manager. Upon receiving notice of revocation, the health plan 196
issuer or pharmacy benefit manager shall terminate the third- 197
party application's access to that covered person's data within 198
one business day. 199

(K) A health plan issuer, including a pharmacy benefit 200
manager, shall not do any of the following: 201

(1) Discriminate against, penalize, or impose adverse 202
consequences on any covered person who authorizes a third-party 203
application to access their prescription drug pricing 204
information, including: 205

(a) Limiting or reducing the covered person's benefits; 206

(b) Increasing the covered person's cost-sharing amounts; 207

(c) Restricting the covered person's access to pharmacies 208
or prescription drugs; 209

(d) Denying or delaying prior authorization or other 210
coverage determinations. 211

(2) Provide preferential treatment to its own price 212

<u>transparency tools compared to authorized third-party</u>	213
<u>applications, including any of the following:</u>	214
<u>(a) Providing more complete, accurate, or timely data</u>	215
<u>through its own tools;</u>	216
<u>(b) Offering lower prices or better coverage through its</u>	217
<u>own tools;</u>	218
<u>(c) Implementing technical measures that degrade the</u>	219
<u>performance or functionality of authorized third-party</u>	220
<u>applications;</u>	221
<u>(d) Marketing or steering covered persons away from</u>	222
<u>authorized third-party applications.</u>	223
<u>(3) Impose fees, charges, or other financial requirements</u>	224
<u>on any of the following:</u>	225
<u>(a) Covered persons for authorizing third-party</u>	226
<u>applications;</u>	227
<u>(b) Covered persons for accessing their prescription drug</u>	228
<u>pricing information through authorized third-party applications;</u>	229
<u>(c) Authorized third-party applications for accessing</u>	230
<u>prescription drug pricing information on behalf of covered</u>	231
<u>persons through the application programming interface.</u>	232
<u>(4) Require a covered person to utilize the health plan</u>	233
<u>issuer or pharmacy benefit manager's own price transparency tool</u>	234
<u>as a condition of any of the following:</u>	235
<u>(a) Receiving prescription drug benefits;</u>	236
<u>(b) Obtaining favorable pricing or cost-sharing amounts</u>	237
<u>for prescription drugs;</u>	238

<u>(c) Accessing formulary medications or obtaining prior authorization approval.</u>	239
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<u>(L) (1) All prescription drug pricing information provided pursuant to this section shall meet all of the following requirements:</u>	241
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<u>(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.</u>	244
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<u>(b) The information shall be current as of not later than one business day after any change to pricing, formulary status, or benefit design.</u>	247
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<u>(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.</u>	250
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<u>(d) The information shall be complete and include all data elements specified in divisions (A) (3) and (B) of this section.</u>	254
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<u>(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.</u>	256
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<u>(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</u>	264
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accordance with Chapter 119. of the Revised Code. The rules may 267
establish additional technical standards, implementation 268
timelines, and compliance requirements relating to the data 269
sharing authorized by this section. 270

(2) A violation of any provision of this section is an 271
unfair or deceptive act or practice in the business of insurance 272
under section 3901.21 of the Revised Code and is subject to the 273
penalties enumerated in section 3901.22 of the Revised Code." 274

In line 70, delete "and also includes a dispensing physician" 275

After line 70, insert: 276

"(3) "Prescriber" has the same meaning as in section 4729.01 of the 277
Revised Code." 278

In line 74, after "pharmacy" insert "or personally furnishing
prescriber" 279
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In line 77, after "pharmacy" insert "or the applicable licensing
body of a personally furnishing prescriber" 281
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In line 79, after "pharmacy" insert "or personally furnishing
prescriber" 283
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In line 86, after "pharmacy" insert "or personally furnishing
prescriber" 285
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In line 118, after "pharmacist" insert "or personally furnishing
prescriber" 287
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In line 128, after "pharmacist" insert "or personally furnishing
prescriber" 289
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In line 135, after "pharmacist" insert "or personally furnishing
prescriber" 291
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In line 142, after " <u>pharmacist</u> " insert " <u>or personally furnishing prescriber</u> "; delete " <u>either</u> " and insert " <u>any</u> "	293 294
In line 146, after " <u>alternatives</u> " insert " <u>;</u> "	295
(3) <u>Partnering with a third party relating to prescription drug price transparency and patient access to drugs pursuant to a valid prescription</u>	296 297 298
In line 147, after " <u>pharmacist</u> " insert " <u>or personally furnishing prescriber</u> "	299 300
In line 156, after " <u>pharmacy</u> " insert " <u>or personally furnishing prescriber</u> "	301 302
In line 164, after " <u>pharmacist</u> " insert " <u>or personally furnishing prescriber</u> "	303 304
In line 168, after " <u>pharmacist</u> " insert " <u>or personally furnishing prescriber</u> "	305 306
In line 172, after " <u>pharmacist</u> " insert " <u>or personally furnishing prescriber</u> "	307 308
In line 78 of the amendment, delete everything after " (C) "	309
Delete line 79 of the amendment	310
In line 80 of the amendment, delete " <u>(E)</u> " and insert " <u>(D)</u> "	311
In line 86 of the amendment, delete " <u>(F)</u> " and insert " <u>(E)</u> "	312
In line 92 of the amendment, delete " <u>(G)</u> " and insert " <u>(F)</u> "	313
In line 96 of the amendment, delete " <u>(H)</u> " and insert " <u>(G)</u> "	314
In line 100 of the amendment, delete " <u>(I)</u> " and insert " <u>(H)</u> "	315
In line 104 of the amendment, delete " <u>(J)</u> " and insert " <u>(I)</u> "	316

In line 107 of the amendment, delete " <u>(K)</u> " and insert " <u>(J)</u> "	317
In line 112 of the amendment, delete " <u>(L)</u> " and insert " <u>(K)</u> "	318
In line 116 of the amendment, delete " <u>(M)</u> " and insert " <u>(L)</u> "	319
In line 120 of the amendment, delete " <u>(N)</u> " and insert "(M)"	320
In line 127 of the amendment, delete " <u>(O)</u> " and insert " <u>(N)</u> "	321
In line 131 of the amendment, delete " <u>(P)</u> " and insert " <u>(O)</u> "	322
In line 133 of the amendment, delete " <u>(Q)</u> " and insert " <u>(P)</u> "	323
In line 138 of the amendment, delete " <u>(R)</u> " and insert " <u>(Q)</u> "	324
In line 142 of the amendment, delete " <u>(S)</u> " and insert " <u>(R)</u> "	325
In line 150 of the amendment, delete " <u>(T)</u> " and insert " <u>(S)</u> "	326
In line 155 of the amendment, delete " <u>(U)</u> " and insert " <u>(T)</u> "	327
In line 157 of the amendment, delete " <u>(V)</u> " and insert " <u>(U)</u> "	328
In line 164 of the amendment, delete " <u>(W)</u> " and insert " <u>(V)</u> "	329
In line 166 of the amendment, delete " <u>(X)</u> " and insert " <u>(W)</u> "	330
In line 171 of the amendment, delete " <u>(Y)</u> " and insert " <u>(X)</u> "	331
In line 176 of the amendment, delete " <u>(Z)</u> " and insert " <u>(Y)</u> "	332
In line 263 of the amendment, delete " <u>either of the following:</u> "	333
Delete lines 264 through 266 of the amendment	334
In line 267 of the amendment, delete " <u>(2) The</u> " and insert " <u>the</u> "	335
In line 268 of the amendment, delete " <u>(a)</u> " and insert " <u>(1)</u> "	336
In line 270 of the amendment, delete " <u>(b)</u> " and insert " <u>(2)</u> "	337
In line 372 of the amendment, after the first comma insert	338

"3902.72," 339

The motion was _____ agreed to.

SYNOPSIS 340

Definition of pharmacy 341

R.C. 3902.75, 3902.76, 3902.77, and 3902.78 342

Regarding the bill's provisions relating to pharmacy 343
accreditation standards and insurer actions relating to the 344
provision of pharmacy services, modifies the definition of 345
"pharmacy" to remove reference to dispensing physicians, to 346
accord with existing law, and instead refers separately to 347
dispensing physicians ("personally furnishing prescribers"). 348

Adds language prohibiting an insurer or pharmacy benefit 349
manager from prohibiting pharmacies or dispensing physicians 350
from partnering with third parties relating to increasing 351
prescription drug price transparency or patient access to drugs 352
pursuant to a valid prescription. 353

Affiliated pharmacies 354

R.C. 3959.01 and 3959.111 355

Regarding amendment language requiring a PBM to reimburse 356
a pharmacy for dispensed drugs in an amount no less than (1) the 357
amount the PBM reimburses an affiliated pharmacy for the same 358
drug or (2) the sum of the pharmacy's actual acquisition cost 359
for the drug and a dispensing fee, removes item (1) above. 360

Disclosure of covered person drug pricing data 361

R.C. 3902.72	362
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).	363 364 365 366 367
Permits a covered person to authorize an authorized third-party application to access the person's prescription drug pricing information described above.	368 369 370
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.	371 372 373 374
Specifies that a violation is an unfair and deceptive act in the business of insurance.	375 376