

# STATE OF NEW YORK

5411--D

Cal. No. 594

2021-2022 Regular Sessions

## IN ASSEMBLY

February 16, 2021

Introduced by M. of A. McDONALD, THIELE, ENGLEBRIGHT, BURDICK, MONTESANO, SCHMITT, REILLY, LAWLER, McDONOUGH, LEMONDES, DICKENS, SILLITTI, CUSICK, SIMON, ANGELINO, SALKA, DURSO, JACKSON, GUNTHER, GOTTFRIED, STECK, HAWLEY, FORREST, CONRAD -- read once and referred to the Committee on Insurance -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- recommitted to the Committee on Insurance in accordance with Assembly Rule 3, sec. 2 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- reported from committee, advanced to a third reading, amended and ordered reprinted, retaining its place on the order of third reading -- again amended on third reading, ordered reprinted, retaining its place on the order of third reading

AN ACT to amend the insurance law, in relation to enacting the "patient Rx information and choice expansion act"

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

1 Section 1. This act shall be known and may be cited as the "patient Rx  
2 information and choice expansion act" or the "PRICE act".

3 § 2. The insurance law is amended by adding a new section 341-a to  
4 read as follows:

5 § 341-a. Patient prescription pricing transparency. 1. Definitions.  
6 As used in this section:

7 (a) The terms "covered individual", "health plan", and "pharmacy bene-  
8 fit manager" shall have the same meanings as defined by section two  
9 hundred eighty-a of the public health law. The superintendent is  
10 expressly authorized to interpret these terms as if the definitions were  
11 stated within this article.

12 (b) "Cost-sharing information" means the amount a covered individual  
13 is required to pay to receive a drug that is covered under the covered  
14 individual's health plan.

EXPLANATION--Matter in italics (underscored) is new; matter in brackets  
[-] is old law to be omitted.

LBD08942-13-2

1 (c) "Covered/coverage" means those health care services to which a  
2 covered individual is entitled under the terms of the health plan.

3 (d) "Interoperability element" means hardware, software, integrated  
4 technologies or related licenses, technical information, privileges,  
5 rights, intellectual property, upgrades, or services that may be neces-  
6 sary to provide the data required in the requested format and consistent  
7 with the required format.

8 (e) "Electronic health record" means a digital version of a patient's  
9 paper chart and medical history that makes information available  
10 instantly and securely to authorized users.

11 (f) "Electronic prescribing system" means a system that enables pres-  
12 cribers to enter prescription information into a computer prescription  
13 device and securely transmit the prescription to pharmacies using a  
14 special software program and connectivity to a transmission network.

15 (g) "Electronic prescription" means an electronic prescription as  
16 defined in section thirty-three hundred two of the public health law.

17 (h) "Prescriber" means a health care provider licensed to prescribe  
18 medication or medical devices in the state.

19 (i) "Real-time benefit tool" or "RTBT" means an electronic  
20 prescription decision support tool that: (i) is capable of integrating  
21 with prescribers' electronic prescribing and, if feasible, electronic  
22 health record systems; and (ii) complies with the technical standards  
23 adopted by an American National Standards Institute (ANSI) accredited  
24 standards development organization.

25 (j) "Authorized third-party" shall include a third-party legally  
26 authorized under state or federal law subject to a Health Insurance  
27 Portability and Accountability Act (HIPAA) business associate agreement.

28 2. No later than July first, two thousand twenty-three, each health  
29 plan operating in the state shall, upon request of the covered individ-  
30 ual, his or her health care provider, or an authorized third-party on  
31 their behalf, furnish the cost, benefit, and coverage data set forth as  
32 required to the covered individual, his or her health care provider, or  
33 the third-party of his or her choosing and shall ensure that such data  
34 is (i) current no later than one business day after any change is made;  
35 (ii) provided in real time; and (iii) in a format that is easily acces-  
36 sible to the covered individual, in the case of his or her health care  
37 provider, through an electronic health records system.

38 3. The format of the request shall use established industry content  
39 and transport standards published by:

40 (a) A standards developing organization accredited by the American  
41 National Standards Institute (ANSI), including, the National Council for  
42 Prescription Drug Programs (NCPDP), ASC X12, Health Level 7; or

43 (b) A relevant federal or state governing body, including the Center  
44 for Medicare & Medicaid Services or the Office of the National Coordina-  
45 tor for Health Information Technology; or

46 (c) Another format deemed acceptable to the department which provides  
47 the data prescribed in subdivision two of this section and in the same  
48 timeliness as required by this section.

49 4. A facsimile shall not be considered an acceptable electronic format  
50 pursuant to this section.

51 5. Upon such request, the following data shall be provided for any  
52 drug covered under the covered individual's health plan:

53 (a) patient-specific eligibility information;

54 (b) patient-specific prescription cost and benefit data, such as  
55 applicable formulary, benefit, coverage and cost-sharing data for the

prescribed drug and clinically-appropriate alternatives, when appropriate;

(c) patient-specific cost-sharing information that describes variance in cost-sharing based on the pharmacy dispensing the prescribed drug or its alternatives, and in relation to the patient's benefit (i.e., spend related to out-of-pocket maximum);

(d) information regarding lower cost clinically-appropriate treatment alternatives; and

(e) applicable utilization management requirements.

6. Any health plan or pharmacy benefit manager shall furnish the data as required whether the request is made using the drug's unique billing code, such as a National Drug Code or Healthcare Common Procedure Coding System code or descriptive term. A health plan or pharmacy benefit manager shall not deny or unreasonably delay a request as a method of blocking the data set forth as required from being shared based on how the drug was requested.

7. A health plan or pharmacy benefit manager shall not restrict, prohibit, or otherwise hinder the prescriber from communicating or sharing benefit and coverage information that reflects other choices, such as cash price, lower cost clinically-appropriate alternatives, whether or not they are covered under the covered individual's plan, patient assistance and support programs and the cost available at the patient's pharmacy of choice.

8. A health plan or pharmacy benefit manager shall not, except as may be required by law, interfere with, prevent, or materially discourage access, exchange, or use of the data as required, which may include charging fees, or not responding to a request for such data in a reasonable time frame; nor penalize a health care provider or professional for disclosing such information to a covered individual or legally prescribing, administering, or ordering a clinically appropriate or lower-cost alternative.

9. Nothing in this section shall be construed to limit access to the most up-to-date patient-specific eligibility or patient-specific prescription cost and benefit data by the health plan.

10. Nothing in this section shall interfere with patient choice and a health care professional's ability to convey the full range of prescription drug cost options to a patient. Health plans or pharmacy benefit managers shall not restrict a health care professional from communicating to the patient prescription cost options.

11. No RTBT shall require a patient to utilize specific plan preferred drugs or pharmacies.

§ 3. Severability. If any provision of this act, or any application of any provision of this act, is held to be invalid, or to violate or be inconsistent with any federal law or regulation, that shall not affect the validity or effectiveness of any other provision of this act, or of any other application of any provision of this act, which can be given effect without that provision or application; and to that end, the provisions and applications of this act are severable.

§ 4. This act shall take effect one hundred eighty days after it shall have become a law. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.