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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:

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

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

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

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

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

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

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

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

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

(f) "Electronic prescribing system" means a system that enables prescribers to enter prescription information into a computer prescription device and securely transmit the prescription to pharmacies using a special software program and connectivity to a transmission network.

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

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

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

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

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

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

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

(b) A relevant federal or state governing body, including the Center for Medicare & Medicaid Services or the Office of the National Coordinator for Health Information Technology; or

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

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

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

(a) patient-specific eligibility information;

(b) patient-specific prescription cost and benefit data, such as 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.