

STATE OF NEW YORK

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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 -- 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

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) "Health plan" means benefits provided by any entity delivering or
8 issuing for delivery a policy of accident and health insurance pursuant
9 to section three thousand two hundred sixteen, or a group or blanket
10 accident and health insurance policy pursuant to section three thousand
11 two hundred twenty-one, or providing benefits pursuant to section four
12 thousand three hundred three of this chapter.

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

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

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

3 (d) "Enrollee" means the covered individual, policyholder, subscriber,
4 the insured, or person who has authority under applicable law to act on
5 behalf of an enrollee in making decisions related to health care, a
6 health plan, or pharmacy benefit manager, or its affiliates or entities.

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

12 (f) "Pharmacy benefit manager (PBM)" ensure that this term includes
13 pharmacy benefit managers, affiliates, or other entities acting on their
14 behalf.

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

18 (h) "Electronic prescribing system" means a system that enables pres-
19 cribers to enter prescription information into a computer prescription
20 device and securely transmit the prescription to pharmacies using a
21 special software program and connectivity to a transmission network.

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

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

26 (k) "Real-time benefit tool" or "RTBT" means an electronic
27 prescription decision support tool that: (i) is capable of integrating
28 with prescribers' electronic prescribing and electronic health record
29 systems; and (ii) complies with the technical standards adopted by an
30 American National Standards Institute (ANSI) accredited standards devel-
31 opment organization.

32 2. No later than July first, two thousand twenty-three, each health
33 plan operating in the state shall, upon request of the enrollee, his or
34 her health care provider, or a third-party on their behalf, furnish the
35 cost, benefit, and coverage data set forth as required to the enrollee,
36 his or her health care provider, or the third-party of his or her choos-
37 ing and shall ensure that such data is (i) current no later than one
38 business day after any change is made; (ii) provided in real time; and
39 (iii) in the same format that the request is made by the enrollee or his
40 or her health care provider.

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

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

46 (b) A relevant federal or state governing body, including the Center
47 for Medicare & Medicaid Services or the Office of the National Coordina-
48 tor for Health Information Technology.

49 4. A facsimile, proprietary payor or patient portal, or other elec-
50 tronic form shall not be considered acceptable electronic formats pursu-
51 ant to this section.

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

54 (a) patient-specific eligibility information;

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

1 prescribed drug and clinically-appropriate alternatives, when appropri-
2 ate;

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

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

9 (e) applicable utilization management requirements.

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

16 7. A health plan, or entities acting on a health plan's behalf, shall
17 not restrict, prohibit, or otherwise hinder the prescriber from commu-
18 nicating or sharing benefit and coverage information that reflects other
19 choices, such as cash price, lower cost clinically-appropriate alterna-
20 tives, whether or not they are covered under the enrollee's plan,
21 patient assistance and support programs and the cost available at the
22 patient's pharmacy of choice.

23 8. A health plan, or entities acting on a health plan's behalf, shall
24 not, except as may be required by law, interfere with, prevent, or mate-
25 rially discourage access, exchange, or use of the data as required,
26 which may include charging fees, not responding to a request at the time
27 made where such a response is reasonably possible, implementing technol-
28 ogy in nonstandard ways or instituting enrollee consent requirements,
29 processes, policies, procedures, or renewals that are likely to substan-
30 tially increase the complexity or burden of accessing, exchanging, or
31 using such data; nor penalize a health care provider or professional for
32 disclosing such information to an enrollee or prescribing, administer-
33 ing, or ordering a clinically appropriate or lower-cost alternative.

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

37 10. Nothing in this section shall interfere with patient choice and a
38 health care professional's ability to convey the full range of
39 prescription drug cost options to a patient. Health plans, or entities
40 acting on their behalf, shall not restrict a health care professional
41 from communicating to the patient prescription cost options.

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

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

51 § 4. This act shall take effect July 1, 2023. Effective immediately,
52 the addition, amendment and/or repeal of any rule or regulation neces-
53 sary for the implementation of this act on its effective date are
54 authorized to be made and completed on or before such effective date.