STATE OF NEW YORK

4620

2021-2022 Regular Sessions

IN SENATE

February 8, 2021

Introduced by Sen. BRESLIN -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance

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

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

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

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

(e) "Interoperability element" means hardware, software, integrated technologies or related licenses, technical information, privileges, rights, intellectual property, upgrades, or services that may be neces-

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

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sary to provide the data required in the requested format and consistent with the required format.

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

(g) "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.

(h) "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.

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

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

(k) "Real-time benefit tool" or "RTBT" means an electronic prescription decision support tool that: (i) is capable of integrating with prescribers' electronic prescribing and electronic health record systems; and (ii) complies with the technical standards adopted by the National Council for Prescription Drug Programs (NCPDP).

2. No later than July first, two thousand twenty-three, each health plan operating in the state shall, upon request of the enrollee, his or her health care provider, or a third-party on their behalf, furnish the cost, benefit, and coverage data set forth as required to the enrollee, 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 the same format that the request is made by the enrollee or his or her health care provider.

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.

4. A facsimile, proprietary payor or patient portal, or other electronic form shall not be considered acceptable electronic formats pursuant to this section.

5. Upon such request, the following data shall be provided for any drug covered under the enrollee'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, such as prior authorization, step therapy, quantity limits, and site-of-service restrictions.

6. Any health plan or PBM 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, such as the brand or generic name of the drug. A health plan or PBM shall not deny or 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 entities acting on a health plan's behalf, 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 enrollee's plan, patient assistance and support programs and the cost available at the patient's pharmacy of choice.

8. A health plan, or entities acting on a health plan's behalf, 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, not responding to a request at the time made where such a response is reasonably possible, implementing technology in nonstandard ways or instituting enrollee consent requirements, processes, policies, procedures, or renewals that are likely to substantially increase the complexity or burden of accessing, exchanging, or using such data; nor penalize a health care provider or professional for disclosing such information to an enrollee or 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 entities acting on their behalf, shall not restrict a health care professional from communicating to the patient prescription cost options.

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

§ 3. This act shall take effect July 1, 2023. 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.