

# STATE OF NEW YORK

4620--B

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 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- recommitted to the Committee on Insurance in accordance with Senate Rule 6, sec. 8 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

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.

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

18 (d) "Enrollee" means the covered individual, policyholder, subscriber,  
19 the insured, or person who has authority under applicable law to act on

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

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1 behalf of an enrollee in making decisions related to health care, a  
2 health plan, or pharmacy benefit manager, or its affiliates or entities.

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

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

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

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

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

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

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

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

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

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

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

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

50 (a) patient-specific eligibility information;

51 (b) patient-specific prescription cost and benefit data, such as  
52 applicable formulary, benefit, coverage and cost-sharing data for the  
53 prescribed drug and clinically-appropriate alternatives, when appropri-  
54 ate;

55 (c) patient-specific cost-sharing information that describes variance  
56 in cost-sharing based on the pharmacy dispensing the prescribed drug or

1 its alternatives, and in relation to the patient's benefit (i.e., spend  
2 related to out-of-pocket maximum);

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

5 (e) applicable utilization management requirements.

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

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

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

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

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

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

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

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