

STATE OF NEW YORK

836

2023-2024 Regular Sessions

IN SENATE

January 6, 2023

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

AN ACT to amend the insurance law and the public health law, in relation to patient prescription pricing transparency; and to repeal certain provisions of the insurance law related thereto

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

1 Section 1. Subsection 341-a of the insurance law, as added by a chap-
2 ter of the laws of 2022 amending the insurance law relating to enacting
3 the "patient Rx information and choice expansion act", as proposed in
4 legislative bills numbers S. 4620-C and A. 5411-D, is REPEALED.

5 § 2. Section 3217-a of the insurance law is amended by adding a new
6 subsection (g) to read as follows:

7 (g) (1) As used in this subsection:

8 (A) "Pharmacy benefit manager" shall have the meanings set forth in
9 section two hundred eighty-a of the public health law.

10 (B) "Cost-sharing information" means the amount an insured is required
11 to pay to receive a drug that is covered under the insured's insurance
12 policy.

13 (C) "Covered/coverage" means those health care services to which an
14 insured is entitled under the terms of the insurance policy.

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

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

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1 (G) "Prescriber" means a health care provider licensed to prescribe
2 medication or medical devices in this state.

3 (H) "Real-time benefit tool" or "RTBT" means an electronic
4 prescription decision support tool that: (i) is capable of integrating
5 with prescribers' electronic prescribing system and, if feasible, elec-
6 tronic health record systems; and (ii) complies with the technical stan-
7 dards adopted by an American National Standards Institute (ANSI) accred-
8 ited standards development organization.

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

12 (2) The provisions of this section shall not apply to any health plan
13 that exclusively serves individuals enrolled pursuant to a federal or
14 state insurance affordability program, including the medical assistance
15 program under title eleven of article five of the social services law,
16 child health plus under section twenty-five hundred eleven of the public
17 health law, the basic health program under section three hundred sixty-
18 nine-gg of the social services law, or a plan providing services under
19 title XVIII of the federal social security act.

20 (3) An insurer subject to this article or pharmacy benefit manager
21 shall, upon request of the insured, the insured's health care provider,
22 or an authorized third party on the insured's behalf, made to the insur-
23 er or pharmacy benefit manager, furnish the cost, benefit, and coverage
24 data required by this subsection to the insured, the insured's health
25 care provider, or the authorized third party and shall ensure that such
26 data is: (A) current no later than one business day after any change to
27 the cost, benefit, or coverage data is made; (B) provided through an
28 RTBT when the request is made by the insured's health care provider; and
29 (C) in a format that is easily accessible to the requestor.

30 (4) When providing the data required by paragraph three of this
31 subsection, the insurer or pharmacy benefit manager shall use estab-
32 lished industry content and transport standards published by:

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

36 (B) a relevant federal or state governing body, including the Center
37 for Medicare & Medicaid Services or the Office of the National Coordina-
38 tor for Health Information Technology; or

39 (C) another format deemed acceptable to the department which provides
40 the data prescribed in paragraph three of this subsection and in the
41 same timeliness as required by this section.

42 (5) A facsimile shall not be considered an acceptable electronic
43 format pursuant to this subsection.

44 (6) Upon a request made pursuant to paragraph three of this
45 subsection, the insurer or pharmacy benefit manager shall provide the
46 following data for any drug covered under the insured's insurance poli-
47 cy:

48 (A) insured-specific eligibility information;

49 (B) insured-specific prescription cost and benefit data, such as
50 applicable formulary, benefit, coverage and cost-sharing data for the
51 prescribed drug and clinically-appropriate alternatives, when appropri-
52 ate;

53 (C) insured-specific cost-sharing information that describes variance
54 in cost-sharing based on the pharmacy dispensing the prescribed drug or
55 its alternatives, and in relation to the insured's benefit; and

56 (D) applicable utilization management requirements.

1 (7) Any insurer or pharmacy benefit manager shall furnish the data as
2 required whether the request is made using the drug's unique billing
3 code, such as a National Drug Code or Healthcare Common Procedure Coding
4 System code or descriptive term. An insurer or pharmacy benefit manager
5 shall not deny or unreasonably delay processing a request.

6 (8) An insurer and pharmacy benefit manager shall not, except as may
7 be required or authorized by law, interfere with, prevent, or materially
8 discourage access, exchange, or use of the data as required; nor shall
9 an insurer or pharmacy benefit manager penalize a health care provider
10 for disclosing such information to an insured or legally prescribing,
11 administering, or ordering a lower cost clinically appropriate alterna-
12 tive.

13 (9) Nothing in this subsection shall be construed to limit access to
14 the most up-to-date insured-specific eligibility or insured-specific
15 prescription cost and benefit data by the insurer or pharmacy benefit
16 manager.

17 (10) Nothing in this subsection shall interfere with insured choice
18 and a health care provider's ability to convey the full range of
19 prescription drug cost options to an insured. Insurers and pharmacy
20 benefit managers shall not restrict a health care provider from communi-
21 cating to the insured prescription cost options.

22 § 3. Section 4324 of the insurance law is amended by adding a new
23 subsection (g) to read as follows:

24 (g) (1) As used in this subsection:

25 (A) "Pharmacy benefit manager" shall have the meaning set forth in
26 section two hundred eighty-a of the public health law.

27 (B) "Cost-sharing information" means the amount a subscriber is
28 required to pay to receive a drug that is covered under the subscriber's
29 insurance contract.

30 (C) "Covered/coverage" means those health care services to which a
31 subscriber is entitled under the terms of the insurance contract.

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

35 (E) "Electronic prescribing system" means a system that enables pres-
36 cribers to enter prescription information into a computer prescription
37 device and securely transmit the prescription to pharmacies using a
38 special software program and connectivity to a transmission network.

39 (F) "Electronic prescription" shall have the meaning set forth in
40 section thirty-three hundred two of the public health law.

41 (G) "Prescriber" means a health care provider licensed to prescribe
42 medication or medical devices in this state.

43 (H) "Real-time benefit tool" or "RTBT" means an electronic
44 prescription decision support tool that: (i) is capable of integrating
45 with prescribers' electronic prescribing system and, if feasible, elec-
46 tronic health record systems; and (ii) complies with the technical stan-
47 dards adopted by an American National Standards Institute (ANSI) accred-
48 ited standards development organization.

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

52 (2) The provisions of this section shall not apply to any health plan
53 that exclusively serves individuals enrolled pursuant to a federal or
54 state insurance affordability program, including the medical assistance
55 program under title eleven of article five of the social services law,
56 child health plus under section twenty-five hundred eleven of the public

1 health law, the basic health program under section three hundred sixty-
2 nine-gg of the social services law, or a plan providing services under
3 title XVIII of the federal social security act.

4 (3) A health service, hospital service, or medical expense indemnity
5 corporation subject to this article or pharmacy benefit manager shall,
6 upon request of the subscriber, the subscriber's health care provider,
7 or an authorized third party on the subscriber's behalf, made to the
8 health service, hospital service, or medical expense indemnity corpo-
9 ration or pharmacy benefit manager, furnish the cost, benefit, and
10 coverage data required by this subsection to the subscriber, the
11 subscriber's health care provider, or the authorized third party and
12 shall ensure that such data is: (A) current no later than one business
13 day after any change to the cost, benefit, or coverage data is made; (B)
14 provided through a RTBT when the request is made by the subscriber's
15 health care provider; and (C) in a format that is easily accessible to
16 the requestor.

17 (4) When providing the data required by paragraph three of this
18 subsection, the health service, hospital service, or medical expense
19 indemnity corporation or pharmacy benefit manager shall use established
20 industry content and transport standards published by:

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

24 (B) a relevant federal or state governing body, including the Center
25 for Medicare & Medicaid Services or the Office of the National Coordina-
26 tor for Health Information Technology.

27 (C) another format deemed acceptable to the department which provides
28 the data prescribed in paragraph three of this subsection and in the
29 same timeliness as required by this section.

30 (5) A facsimile shall not be considered an acceptable electronic
31 format pursuant to this subsection.

32 (6) Upon a request made pursuant to paragraph three of this
33 subsection, the health service, hospital service, or medical expense
34 indemnity corporation or pharmacy benefit manager shall provide the
35 following data for any drug covered under the subscriber's insurance
36 contract:

37 (A) subscriber-specific eligibility information;

38 (B) subscriber-specific prescription cost and benefit data, such as
39 applicable formulary, benefit, coverage, and cost-sharing data for the
40 prescribed drug and clinically-appropriate alternatives, when appropri-
41 ate;

42 (C) subscriber-specific cost-sharing information that describes vari-
43 ance in cost-sharing based on the pharmacy dispensing the prescribed
44 drug or its alternatives, and in relation to the insured's benefit; and

45 (D) applicable utilization management requirements.

46 (7) A health service, hospital service, or medical expense indemnity
47 corporation or pharmacy benefit manager shall furnish the data as
48 required whether the request is made using the drug's unique billing
49 code, such as a National Drug Code or Healthcare Common Procedure Coding
50 System code or descriptive term. A health service, hospital service, or
51 medical expense indemnity corporation or pharmacy benefit manager shall
52 not deny or unreasonably delay processing a request.

53 (8) A health service, hospital service, or medical expense indemnity
54 corporation and pharmacy benefit manager shall not, except as may be
55 required or authorized by law, interfere with, prevent, or materially
56 discourage access, exchange, or use of the data as required; nor shall a

1 health service, hospital service, or medical expense indemnity corpo-
2 ration or pharmacy benefit manager penalize a health care provider for
3 disclosing such information to a subscriber or legally prescribing,
4 administering, or ordering a lower cost, clinically appropriate alterna-
5 tive.

6 (9) Nothing in this subsection shall be construed to limit access to
7 the most up-to-date subscriber-specific eligibility or subscriber-spe-
8 cific prescription cost and benefit data by the health service, hospital
9 service, or medical expense indemnity corporation or pharmacy benefit
10 manager.

11 (10) Nothing in this subsection shall interfere with subscriber choice
12 and a health care provider's ability to convey the full range of
13 prescription drug cost options to a subscriber. Health service, hospital
14 service, or medical expense indemnity corporations and pharmacy benefit
15 managers shall not restrict a health care provider from communicating to
16 the subscriber prescription cost options.

17 § 4. Section 4408 of the public health law is amended by adding a new
18 subdivision 8 to read as follows:

19 8. (a) As used in this subdivision:

20 (i) "Pharmacy benefit manager" shall have the meaning set forth in
21 section two hundred eighty-a of this chapter.

22 (ii) "Cost-sharing information" means the amount a subscriber is
23 required to pay to receive a drug that is covered under the subscriber's
24 insurance contract.

25 (iii) "Covered/coverage" means those health care services to which a
26 subscriber is entitled under the terms of the subscriber contract.

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

30 (v) "Electronic prescribing system" means a system that enables pres-
31 cribers to enter prescription information into a computer prescription
32 device and securely transmit the prescription to pharmacies using a
33 special software program and connectivity to a transmission network.

34 (vi) "Electronic prescription" shall have the meaning set forth in
35 section thirty-three hundred two of this chapter.

36 (vii) "Prescriber" means a health care provider licensed to prescribe
37 medication or medical devices in this state.

38 (viii) "Real-time benefit tool" or "RTBT" means an electronic
39 prescription decision support tool that: (1) is capable of integrating
40 with prescribers' electronic prescribing system and, if feasible, elec-
41 tronic health record systems; and (2) complies with the technical stand-
42 ards adopted by an American National Standards Institute (ANSI) accred-
43 ited standards development organization.

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

47 (b) The provisions of this section shall not apply to any health plan
48 that exclusively serves individuals enrolled pursuant to a federal or
49 state insurance affordability program, including the medical assistance
50 program under title eleven of article five of the social services law,
51 child health plus under section twenty-five hundred eleven of this chap-
52 ter, the basic health program under section three hundred sixty-nine-gg
53 of the social services law, or a plan providing services under title
54 XVIII of the federal social security act.

55 (c) A health maintenance organization or pharmacy benefit manager
56 shall, upon request of the subscriber, the subscriber's health care

1 provider, or an authorized third party on the subscriber's behalf, made
2 to the health maintenance organization or pharmacy benefit manager,
3 furnish the cost, benefit, and coverage data required by this subdivi-
4 sion to the subscriber, the subscriber's health care provider, or the
5 authorized third party and shall ensure that such data is: (i) current
6 no later than one business day after any change to the cost, benefit, or
7 coverage data is made; (ii) provided through a RTBT when the request is
8 made by the subscriber's health care provider; and (iii) in a format
9 that is easily accessible to the requestor.

10 (d) When providing the data required by paragraph (c) of this subdivi-
11 sion, the health maintenance organization or pharmacy benefit manager
12 shall use established industry content and transport standards published
13 by:

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

17 (ii) a relevant federal or state governing body, including the Center
18 for Medicare & Medicaid Services or the Office of the National Coordina-
19 tor for Health Information Technology.

20 (iii) another format deemed acceptable to the department which
21 provides the data prescribed in paragraph (c) of this subdivision and in
22 the same timeliness as required by this section.

23 (e) A facsimile shall not be considered an acceptable electronic
24 format pursuant to this subdivision.

25 (f) Upon a request made pursuant to paragraph (c) of this subdivision,
26 the health maintenance organization or pharmacy benefit manager shall
27 provide the following data for any drug covered under the subscriber's
28 subscriber contract:

29 (i) subscriber-specific eligibility information;

30 (ii) subscriber-specific prescription cost and benefit data, such as
31 applicable formulary, benefit, coverage, and cost-sharing data for the
32 prescribed drug and clinically-appropriate alternatives, when appropri-
33 ate;

34 (iii) subscriber-specific cost-sharing information that describes
35 variance in cost-sharing based on the pharmacy dispensing the prescribed
36 drug or its alternatives, and in relation to the insured's benefit; and

37 (iv) applicable utilization management requirements.

38 (g) A health maintenance organization or pharmacy benefit manager
39 shall furnish the data as required whether the request is made using the
40 drug's unique billing code, such as a National Drug Code or Healthcare
41 Common Procedure Coding System code or descriptive term. A health main-
42 tenance organization or pharmacy benefit manager shall not deny or
43 unreasonably delay processing a request.

44 (h) A health maintenance organization and pharmacy benefit manager
45 shall not, except as may be required or authorized by law, interfere
46 with, prevent, or materially discourage access, exchange, or use of the
47 data as required; nor shall a health maintenance organization or pharma-
48 cy benefit manager penalize a health care provider for disclosing such
49 information to a subscriber or legally prescribing, administering, or
50 ordering a lower cost, clinically appropriate alternative.

51 (i) Nothing in this subdivision shall be construed to limit access to
52 the most up-to-date subscriber-specific eligibility or subscriber-spe-
53 cific prescription cost and benefit data by the health maintenance
54 organization or pharmacy benefit manager.

55 (j) Nothing in this subdivision shall interfere with subscriber choice
56 and a health care provider's ability to convey the full range of

1 prescription drug cost options to a subscriber. Health maintenance
2 organizations and pharmacy benefit managers shall not restrict a health
3 care provider from communicating to the subscriber prescription cost
4 options.

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

12 § 6. This act shall take effect on the same date and in the same
13 manner as a chapter of the laws of 2022 amending the insurance law
14 relating to enacting the "patient Rx information and choice expansion
15 act", as proposed in legislative bills numbers S. 4620-C and A. 5411-D,
16 takes effect.