STATE OF NEW YORK

2200

2023-2024 Regular Sessions

IN ASSEMBLY

January 23, 2023

Introduced by M. of A. McDONALD -- read once and referred to the Committee on Insurance

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:

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"patient Rx information and choice expansion act", as proposed in legislative bills numbers S. 4620-C and A. 5411-D, is REPEALED.

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

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

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

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

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

(D) "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.

(E) "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.

(F) "Electronic prescription" means an electronic prescription as 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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(G) "Prescriber" means a health care provider licensed to prescribe medication or medical devices in this state.

(H) "Real-time benefit tool" or "RTBT" means an electronic prescription decision support tool that: (i) is capable of integrating with prescribers' electronic prescribing system 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.

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

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

(4) When providing the data required by paragraph three of this subsection, the insurer or pharmacy benefit manager 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 paragraph three of this subsection and in the same timeliness as required by this section.

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

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

(A) insured-specific eligibility information;

(B) insured-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) insured-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 insured's benefit; and

(D) applicable utilization management requirements.

(7) Any insurer 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. An insurer or pharmacy benefit manager shall not deny or unreasonably delay processing a request.

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

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

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

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

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

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

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

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

(D) "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.

(E) "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.

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

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

(H) "Real-time benefit tool" or "RTBT" means an electronic prescription decision support tool that: (i) is capable of integrating with prescribers' electronic prescribing system 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.

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

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

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

(4) When providing the data required by paragraph three of this subsection, the health service, hospital service, or medical expense indemnity corporation or pharmacy benefit manager 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.

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

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

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

(A) subscriber-specific eligibility information;

(B) subscriber-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) subscriber-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 insured's benefit; and

(D) applicable utilization management requirements.

(7) A health service, hospital service, or medical expense indemnity corporation 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 service, hospital service, or medical expense indemnity corporation or pharmacy benefit manager shall not deny or unreasonably delay processing a request.

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

health service, hospital service, or medical expense indemnity corporation or pharmacy benefit manager penalize a health care provider for disclosing such information to a subscriber or legally prescribing, administering, or ordering a lower cost, clinically appropriate alternative.

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

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

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

8. (a) As used in this subdivision:

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

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

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

(iv) "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.

(v) "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.

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

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

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

(ix) "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.

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

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

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

(d) When providing the data required by paragraph (c) of this subdivision, the health maintenance organization or pharmacy benefit manager shall use established industry content and transport standards published by:

(i) 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

(ii) 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.

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

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

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

(i) subscriber-specific eligibility information;

(ii) subscriber-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;

(iii) subscriber-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 insured's benefit; and

(iv) applicable utilization management requirements.

(g) A health maintenance organization 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 maintenance organization or pharmacy benefit manager shall not deny or unreasonably delay processing a request.

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

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

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

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

§ 5. 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.

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