

As Introduced

**135th General Assembly
Regular Session
2023-2024**

H. B. No. 505

Representatives Barhorst, Stewart

A BILL

To amend sections 3902.50, 5164.753, and 5167.243 1
and to enact sections 3902.75, 3902.76, 2
3959.151, 3959.21, 5167.127, and 5167.128 of the 3
Revised Code regarding insurer and Medicaid 4
program accreditation requirements for 5
pharmacies, to impose drug cost reporting and 6
payment requirements on pharmacy benefit 7
managers, and to name this act the Community 8
Pharmacy Protection Act. 9

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 3902.50, 5164.753, and 5167.243 10
be amended and sections 3902.75, 3902.76, 3959.151, 3959.21, 11
5167.127, and 5167.128 of the Revised Code be enacted to read as 12
follows: 13

Sec. 3902.50. As used in sections 3902.50 to ~~3902.72~~ 14
3902.76 of the Revised Code: 15

(A) "Ambulance" has the same meaning as in section 4765.01 16
of the Revised Code. 17

(B) "Clinical laboratory services" has the same meaning as 18
in section 4731.65 of the Revised Code. 19

(C) "Cost sharing" means the cost to a covered person 20
under a health benefit plan according to any copayment, 21
coinsurance, deductible, or other out-of-pocket expense 22
requirement. 23

(D) "Covered" or "coverage" means the provision of 24
benefits related to health care services to a covered person in 25
accordance with a health benefit plan. 26

(E) "Covered person," "health benefit plan," "health care 27
services," and "health plan issuer" have the same meanings as in 28
section 3922.01 of the Revised Code. 29

(F) "Drug" has the same meaning as in section 4729.01 of 30
the Revised Code. 31

(G) "Emergency facility" has the same meaning as in 32
section 3701.74 of the Revised Code. 33

(H) "Emergency services" means all of the following as 34
described in 42 U.S.C. 1395dd: 35

(1) Medical screening examinations undertaken to determine 36
whether an emergency medical condition exists; 37

(2) Treatment necessary to stabilize an emergency medical 38
condition; 39

(3) Appropriate transfers undertaken prior to an emergency 40
medical condition being stabilized. 41

(I) "Health care practitioner" has the same meaning as in 42
section 3701.74 of the Revised Code. 43

(J) "Pharmacy benefit manager" has the same meaning as in 44
section 3959.01 of the Revised Code. 45

(K) "Prior authorization requirement" means any practice 46

implemented by a health plan issuer in which coverage of a 47
health care service, device, or drug is dependent upon a covered 48
person or a provider obtaining approval from the health plan 49
issuer prior to the service, device, or drug being performed, 50
received, or prescribed, as applicable. "Prior authorization 51
requirement" includes prospective or utilization review 52
procedures conducted prior to providing a health care service, 53
device, or drug. 54

(L) "Unanticipated out-of-network care" means health care 55
services, including clinical laboratory services, that are 56
covered under a health benefit plan and that are provided by an 57
out-of-network provider when either of the following conditions 58
applies: 59

(1) The covered person did not have the ability to request 60
such services from an in-network provider. 61

(2) The services provided were emergency services. 62

Sec. 3902.75. (A) As used in sections 3902.75 and 3902.76 63
of the Revised Code: 64

(1) Notwithstanding section 3902.50 of the Revised Code, 65
"health plan issuer" has the same meaning as in section 3922.01 66
of the Revised Code but also includes an auditing entity, as 67
defined in section 3901.81 of the Revised Code. 68

(2) "Pharmacy" has the same meaning as in section 4729.01 69
of the Revised Code and also includes a dispensing physician. 70

(B) A health plan issuer that offers, issues, or 71
administers a health benefit plan that covers pharmacy services, 72
including prescription drug coverage, shall not require a 73
pharmacy, as a condition of participation in the health plan 74
issuer's network, to meet accreditation standards or 75

certification requirements that are inconsistent with or in 76
addition to those of the state board of pharmacy. 77

Sec. 3902.76. Any covered person or pharmacy affected by a 78
violation of section 3902.75 of the Revised Code by a health 79
plan issuer or one or more of its intermediaries may bring a 80
civil action against the health plan issuer or the intermediary 81
for compensatory damages and injunctive or other equitable 82
relief. 83

Sec. 3959.151. (A) As used in this section: 84

(1) "Actual acquisition cost" means the amount actually 85
expended to procure a drug product after any manufacturer price 86
concessions or rebates. 87

(2) "Machine-readable format" means a digital 88
representation of information in a file that can be imported or 89
read into a computer system for further processing. "Machine- 90
readable format" includes.XML and.CSV formats. 91

(B)(1) On or before the fifteenth day of each month, each 92
pharmacy benefit manager shall provide to the superintendent of 93
insurance and to its contracted insurers and plan sponsors, 94
including contracted public employee benefit plans and 95
contracted employers offering a self-insurance program, an 96
electronic report in a machine-readable format of all drug 97
claims processed the previous month. The single state pharmacy 98
benefit manager established under section 5167.24 of the Revised 99
Code shall submit its electronic report in a machine-readable 100
format to the department of medicaid. 101

(2) The electronic report provided to an insurer, a plan 102
sponsor, or the medicaid program shall include an itemized list 103
of the actual acquisition cost of each drug product from all 104

drug product claims processed by the pharmacy benefit manager in 105
the previous month for that insurer, that plan sponsor, or the 106
medicaid program. The electronic report provided to the 107
superintendent of insurance shall include an itemized list of 108
the actual acquisition cost of each drug product from all drug 109
product claims processed by the pharmacy benefit manager in the 110
previous month for all insurers and plan sponsors. 111

(3) The itemized list shall notate the following for each 112
drug product: 113

(a) If the drug was procured pursuant to the pharmacy 114
benefit manager, insurer, plan sponsor, or department of 115
medicaid's drug formulary or list of covered drugs; 116

(b) If the drug was procured outside of the drug formulary 117
or list of covered drugs; 118

(c) If the drug is a brand-name drug; 119

(d) If the drug is a generic drug; 120

(e) If the drug is a specialty drug, including biological 121
products. 122

(C) (1) No agreement between a pharmacy benefit manager and 123
an insurer or plan sponsor, including a service agreement under 124
section 3959.15 of the Revised Code, that is entered into, 125
amended, or renewed on or after the effective date of this 126
section shall prohibit disclosure of any of the information 127
included in the itemized list required by division (B) of this 128
section. 129

(2) Notwithstanding division (B) of this section, a 130
pharmacy benefit manager is not required to disclose information 131
deemed proprietary or confidential by a service agreement 132

between the pharmacy benefit manager and an insurer or plan 133
sponsor that is entered into in accordance with section 3959.15 134
of the Revised Code before the effective date of this section, 135
and in effect on the date the information would otherwise be 136
submitted as part of the itemized list required by division (B) 137
of this section. 138

(D) The superintendent of insurance shall adopt rules in 139
accordance with Chapter 119. of the Revised Code for the 140
purposes of implementing and administering this section. 141

Sec. 3959.21. (A) Except as otherwise provided in 142
divisions (C) and (D) of this section, a pharmacy benefit 143
manager shall pay both of the following to a contracted pharmacy 144
for a claim for a drug product dispensed on or after the ninety- 145
first day following the effective date of this section: 146

(1) A drug product reimbursement not less than the 147
contracted pharmacy's actual acquisition cost of the drug 148
dispensed; 149

(2) A dispensing fee not less than the minimum dispensing 150
fee in effect for the date the drug is dispensed, as determined 151
by the superintendent of insurance under division (B) of this 152
section. 153

(B) (1) Not later than ninety days after the effective date 154
of this section, the superintendent of insurance shall calculate 155
a minimum dispensing fee to be paid for each drug product 156
dispensed, equal to the average acquisition cost in this state 157
to dispense the drug product, based on data collected by the 158
department of medicaid through the survey conducted pursuant to 159
section 5164.752 of the Revised Code. The superintendent shall 160
publish the amount of the minimum dispensing fee and the dates 161

to which it applies on a publicly accessible web site maintained 162
by the department of insurance. 163

(2) The superintendent of insurance shall calculate and 164
publish the minimum dispensing fee described under division (B) 165
(1) of this section each time the department of medicaid 166
publishes the survey conducted pursuant to section 5164.752 of 167
the Revised Code. 168

(C) Division (A) of this section does not apply to the 169
extent that it conflicts with a contract or agreement entered 170
into before the effective date of this section except that, if 171
such a contract or agreement is amended or renewed after the 172
effective date of this section, the contract or agreement shall 173
conform to the requirements of that division. Division (A) of 174
this section does not prohibit a pharmacy benefit manager from 175
paying drug product reimbursements or dispensing fees in excess 176
of the amounts required by that division. 177

(D) This section does not apply to the state pharmacy 178
benefit manager established pursuant to section 5167.12 of the 179
Revised Code. 180

Sec. 5164.753. (A) In December of every even-numbered 181
year, the medicaid director shall establish dispensing fees, 182
effective the following July, for terminal distributors of 183
dangerous drugs that are providers of drugs under the medicaid 184
program. In establishing dispensing fees, the director shall 185
take into consideration the results of the survey conducted 186
under section 5164.752 of the Revised Code. The director may 187
establish dispensing fees that vary by terminal distributor, 188
taking into consideration the volume of drugs a terminal 189
distributor dispenses under the medicaid program or any other 190
criteria the director considers relevant. 191

(B) (1) Not later than ninety days after the effective date 192
of this section, the medicaid director shall calculate the 193
minimum dispensing fee to be paid for each drug product 194
dispensed, equal to the average acquisition cost in this state 195
to dispense the drug product, based on data collected by the 196
department through the survey conducted pursuant to section 197
5164.752 of the Revised Code, and publish the dispensing fee 198
amount on an internet web site maintained by the department of 199
medicaid. 200

(2) The medicaid director shall calculate the minimum 201
dispensing fee as described under division (B) (1) of this 202
section each time the survey's response is published. 203

Sec. 5167.127. (A) As used in sections 5167.127 and 204
5167.128 of the Revised Code, "pharmacy" has the same meaning as 205
in section 3902.75 of the Revised Code. 206

(B) A medicaid managed care organization, or a pharmacy 207
benefit manager under contract with the medicaid director or a 208
medicaid managed care organization to administer its prescribed 209
drugs benefit, shall not require a pharmacy to meet 210
accreditation standards or certification requirements that are 211
inconsistent with or in addition to those of the state board of 212
pharmacy as a condition of participating in the organization's 213
network. 214

Sec. 5167.128. Any enrollee or pharmacy affected by a 215
violation of section 5167.127 of the Revised Code by a medicaid 216
managed care organization or one or more of the organization's 217
intermediaries, including a pharmacy benefit manager, may bring 218
a civil action against the organization or the intermediary for 219
compensatory damages and injunctive or other equitable relief. 220

Sec. 5167.243. (A) The state pharmacy benefit manager	221
shall provide to the medicaid director a written quarterly	222
report containing the following information from the immediately	223
preceding quarter:	224
(1) The prices that the state pharmacy benefit manager	225
negotiated for prescribed drugs under the care management	226
system. The price must include any rebates the state pharmacy	227
benefit manager received from the drug manufacturer;	228
(2) The prices the state pharmacy benefit manager paid to	229
pharmacies for prescribed drugs;	230
(3) Any rebate amounts the state pharmacy benefit manager	231
passed on to individual pharmacies;	232
(4) The percentage of savings in drug prices that are	233
passed on to participants in the care management system;	234
(5) The information described in division (C) of section	235
5167.24 of the Revised Code;	236
(6) Any other information required by the director.	237
(B) <u>The state pharmacy benefit manager shall provide to</u>	238
<u>the director the monthly report as required by section 3953.151</u>	239
<u>of the Revised Code.</u>	240
(C) <u>The director may ask the state pharmacy benefit</u>	241
<u>manager to provide additional information as necessary and shall</u>	242
<u>collect other clinical data from the state pharmacy benefit</u>	243
<u>manager as the director sees fit.</u>	244
(C) -(D) <u>At the time of contract execution, renewal, or</u>	245
<u>modification, the department shall modify the reporting</u>	246
<u>requirements under its medicaid managed care organization</u>	247
<u>contracts as necessary to meet the requirements of this section.</u>	248

Section 2. That existing sections 3902.50, 5164.753, and 5167.243 of the Revised Code are hereby repealed.	249 250
Section 3. Sections 3902.75 and 3902.76 of the Revised Code, as enacted in this act, apply to health benefit plans, as defined in section 3922.01 of the Revised Code, delivered, issued for delivery, modified, or renewed on or after the effective date of those sections.	251 252 253 254 255
Section 4. Sections 3902.75 and 3902.76 of the Revised Code, as enacted in this act, apply to contracts between health plan issuers, as defined in section 3922.01 of the Revised Code, and pharmacies entered into, modified, or renewed on or after the effective date of those sections.	256 257 258 259 260
Section 5. This act shall be known as the Community Pharmacy Protection Act.	261 262