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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 882 Session of 2021

INTRODUCED BY GAYDOS, POLINCHOCK, HILL-EVANS, JAMES, SAYLOR, MOUL, ZIMMERMAN, HERSHEY, CIRESI, MILLARD AND THOMAS, MARCH 12, 2021

REFERRED TO COMMITTEE ON INSURANCE, MARCH 12, 2021

AN ACT

Amending the act of November 21, 2016 (P.L.1318, No.169), entitled "An act providing for pharmacy audit procedures, for registration of pharmacy benefits managers and auditing entities, for maximum allowable cost transparency and for prescription drugs reimbursed under the PACE and PACENET program; and making related repeals," in pharmacy benefit manager cost transparency requirements, providing for sharing of cost, benefit and coverage data required.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The act of November 21, 2016 (P.L.1318, No.169), known as the Pharmacy Audit Integrity and Transparency Act, is amended by adding a section to read:

Section 703.1. Sharing of cost, benefit and coverage data required.

(a) General rule.--A health insurer or PBM shall, upon request of a covered individual, the covered individual's health care practitioner or a third party on behalf of the covered individual or health care practitioner, furnish the cost, benefit and coverage data specified in subsection (d) to the

covered individual, the health care practitioner or the third party and shall ensure that such data is:

(1) Current no later than one business day after any change is made.

(2) Provided in real time.

(3) In the same format that the request is made by the covered individual, the health care practitioner or the third party.

(b) Format of request.--The request must be submitted with established industry content and transport standards published by:

(1) a standards developing organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, ASC X12, Health Level 7; or

(2) a relevant Federal or State governing body, including the Centers for Medicare and Medicaid Services or the Office of the National Coordinator for Health Information Technology.

(c) Electronic formats unacceptable.--A facsimile, proprietary payor or patient portal or other electronic form shall not be considered an acceptable electronic format under this section.

(d) Required data.--Upon request, the following data shall be provided for a drug covered under the covered individual's health policy:

(1) The covered individual's eligibility information for the drug.

(2) A list of clinically-appropriate alternatives to the drug covered under the covered individual's health plan.

(3) Cost-sharing information for the drug and alternatives, including a description of a variance in cost-sharing based on pharmacy, whether retail or mail order, or health care provider dispensing or administering the drug or alternative.

(4) The applicable utilization management requirements for the drug or alternatives, including prior authorization, step therapy, quantity limits and site-of-service restrictions.

(e) Duty to provide information.--A health insurer or PBM shall furnish the data specified in subsection (d), 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.

(f) Prohibited conduct.--

(1) A health insurer or PBM may not deny or delay a request as a method of blocking the data specified in subsection (d) from being shared based on how the drug was requested.

(2) A health insurer or PBM furnishing the data specified in subsection (d) may not:

(i) Restrict, prohibit or otherwise hinder a health care professional or health care provider from communicating or sharing the data specified in subsection (d) or additional information on a lower-cost or clinically appropriate alternative, whether or not covered under the covered individual's plan or additional payment or cost-sharing information that may reduce the patient's out-of-pocket costs, such as cash price or

patient assistance and support programs whether sponsored by a manufacturer, foundation or other entity.

(ii) Except as may be required by law, interfere with, prevent or materially discourage access to, exchange or use of the data specified in subsection (d), including charging fees, not responding to a request at the time made where a response is reasonably possible, implementing technology in nonstandard ways or instituting covered individual consent requirements, processes, policies, procedures or renewals that are likely to substantially increase the complexity or burden of accessing, exchanging or using the data.

(iii) Penalize a health care practitioner for disclosing the data specified in subsection (d) to a covered individual or prescribing, administering or ordering a clinically appropriate or lower-cost alternative.

(g) Personal representatives.--

(1) For the purposes of this section, a health insurer or PBM shall treat a personal representative as the covered individual.

(2) If, under applicable law, a person has authority to act on behalf of a covered individual in making decisions relating to health care, a health insurer or PBM or an affiliate or entity acting on its behalf, shall treat the person as a personal representative under this section.

Section 2. This act shall take effect in 60 days.