Ohio Revised Code

Section 3902.72 Health plan issuer disclosure of drug data.

Effective: January 1, 2022

Legislation: House Bill 110 - 134th General Assembly

(A) As used in this section, "health care provider" has the same meaning as in section 3701.74 of the Revised Code.

(B) A health plan issuer, including a pharmacy benefit manager, shall, upon request of a covered person, the covered person's health care provider, or the third-party representative, furnish the following data for any and all drugs covered under a related health benefit plan:

(1) The covered person's eligibility information for any and all covered drugs;

(2) Cost-sharing information for any and all covered drugs, including a description of any variance in cost-sharing based on pharmacy, whether retail or mail order, or health care provider dispensing or administering the drugs;

(3) Any applicable utilization management requirements for any and all covered drugs, including prior authorization requirements, step therapy, quantity limits, and site-of-service restrictions.

(C) A health plan issuer, including a pharmacy benefit manager, providing the data required under division (B) of this section shall ensure that the data meets all of the following:

(1) It is current not later than one business day after any change is made.

(2) It is provided in real time.

(3) It is provided in the same format that the request is made by the covered person, the covered person's health care provider, or the third-party representative.

(D) The format in which a health plan issuer, including a pharmacy benefit manager, replies to a request made under division (B) of this section shall use established industry content and transport

standards published by either of the following:

(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;

(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.

(E) A health plan issuer, including a pharmacy benefit manager, shall furnish the data required under division (B) of this section regardless of whether the request is made using the drug's unique billing code, such as a national drug code or health care common procedure coding system code, or a descriptive term, such as the brand or generic name of the drug.

(F) A health plan issuer, including a pharmacy benefit manager, shall not deny or delay a request as a method of blocking the data required under division (B) of this section from being shared based on how the drug was requested.

(G) A health plan issuer, including a pharmacy benefit manager, furnishing the data required under division (B) of this section shall not do any of the following:

(1) Restrict, prohibit, or otherwise hinder, in any way, a health care provider from communicating or sharing any of the following:

(a) Any of the data required under division (B) of this section;

(b) Additional information on any lower-cost or clinically appropriate alternatives, whether or not they are covered under the covered person's health benefit plan;

(c) Additional payment or cost-sharing information that may reduce the covered person's out-of-pocket costs, such as cash price or patient assistance and support programs whether sponsored by a manufacturer, foundation, or other entity.

(2) Except as may be required by law, interfere with, prevent, or materially discourage access,

exchange, or use of the data required under division (B) of this section, including any of the following:

(a) Charging fees;

(b) Not responding to a request at the time the request is made, if such a response is reasonably possible;

(c) Implementing technology in nonstandard ways;

(d) Instituting covered person consent requirements, processes, policies, procedures, or renewals that are likely to substantially increase the complexity or burden of accessing, exchanging, or using such data.

(3) Penalize a health care provider for disclosing such data to a covered person or for prescribing, administering, or ordering a clinically appropriate or lower-cost alternative.

(H)(1) A health plan issuer, including a pharmacy benefit manager, shall treat a personal representative of a covered person as the covered person for purposes of this section.

(2) If under applicable law a person has authority to act on behalf of a covered person in making decisions related to health care, a health plan issuer, including a pharmacy benefit manager, or its affiliates or entities acting on its behalf, shall treat such person as a personal representative under this section.

(I) Divisions (A) to (H) of this section take effect January 1, 2022.