Ohio Revised Code

Section 3959.111 Access to information regarding maximum allowable cost pricing.

Effective: April 6, 2017
Legislation: Senate Bill 319 - 131st General Assembly

(A)(1)(a) In each contract between a pharmacy benefit manager and a pharmacy, the pharmacy shall be given the right to obtain from the pharmacy benefit manager, within ten days after any request, a current list of the sources used to determine maximum allowable cost pricing. In each contract between a pharmacy benefit manager and a pharmacy, the pharmacy benefit manager shall be obligated to update and implement the pricing information at least every seven days and provide a means by which contracted pharmacies may promptly review maximum allowable cost pricing updates in an electronic format that is readily available, accessible, and secure and that can be easily searched.

Subject to division (A)(1) of this section, a pharmacy benefit manager shall utilize the most up-to-date pricing data when calculating drug product reimbursements for all contracting pharmacies within one business day of any price update or modification.

(b) A pharmacy benefit manager shall maintain a written procedure to eliminate products from the list of drugs subject to maximum allowable cost pricing in a timely manner. The written procedure, and any updates, shall promptly be made available to a pharmacy upon request.

(2) In each contract between a pharmacy benefit manager and a pharmacy, a pharmacy benefit manager shall be obligated to ensure that all of the following conditions are met prior to placing a prescription drug on a maximum allowable cost list:

(a) The drug is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, or has an "NR" or "NA" rating or similar rating by nationally recognized reference.

(b) The drug is generally available for purchase by pharmacies in this state from a national or regional wholesaler and is not obsolete.

(3) Each contract between a pharmacy benefit manager and a pharmacy shall include an electronic process to appeal, investigate, and resolve disputes regarding maximum allowable cost pricing that includes all of the following:

(a) A twenty-one-day limit on the right to appeal following the initial claim;

(b) A requirement that the appeal be investigated and resolved within twenty-one days after the appeal;

(c) A telephone number at which the pharmacy may contact the pharmacy benefit manager to speak to a person responsible for processing appeals;

(d) A requirement that a pharmacy benefit manager provide a reason for any appeal denial, including the national drug code and the identity of the national or regional wholesalers from whom the drug was generally available for purchase at or below the benchmark price determined by the pharmacy benefit manager;

(e) A requirement that if the appeal is upheld or granted, then the pharmacy benefit manager shall adjust the drug product reimbursement to the pharmacy's upheld appeal price;

(f) A requirement that a pharmacy benefit manager make an adjustment not later than one day after the date of determination of the appeal. The adjustment shall be retroactive to the date the appeal was made and shall apply to all situated pharmacies as determined by the pharmacy benefit manager. This requirement does not prohibit a pharmacy benefit manager from retroactively adjusting a claim for the appealing pharmacy or for any other similarly situated pharmacies.

(B)(1)(a) A pharmacy benefit manager shall disclose to the plan sponsor whether or not the pharmacy benefit manager uses the same maximum allowable cost list when billing a plan sponsor as it does when reimbursing a pharmacy.

(b) If a pharmacy benefit manager uses multiple maximum allowable cost lists, the pharmacy benefit manager shall disclose in the aggregate to a plan sponsor any differences between the amount paid

to a pharmacy and the amount charged to a plan sponsor.

(2) The disclosures required under division (B)(1) of this section shall be made within ten days of a pharmacy benefit manager and a plan sponsor signing a contract or on a quarterly basis.

(3)(a) Division (B) of this section does not apply to plans governed by the "Employee Retirement Income Security Act of 1974," 29 U.S.C. 1001, et seq. or medicare part D.

(b) As used in this division, "medicare part D" means the voluntary prescription drug benefit program established under Part D of Title XVIII of the "Social Security Act," 42 U.S.C. 1395w-101, et seq.

(C) Notwithstanding division (B)(5) of section 3959.01 of the Revised Code, a health insuring corporation or a sickness and accident insurer shall comply with the requirements of this section and is subject to the penalties under section 3959.12 of the Revised Code if the corporation or insurer is a pharmacy benefit manager, as defined in section 3959.01 of the Revised Code.

(D) The superintendent of insurance shall adopt rules as necessary to implement the requirements of this section.