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June 2019 Legislative Session Health Care Bills

OVERVIEW

The New York State Legislature voted on a bipartisan basis to pass several health care related bills at the end of the 2019 legislative session, which concluded last week. Significant legislation passed by the Senate and Assembly, which will now be sent to Governor Andrew Cuomo for consideration, include:

- A bill preventing mid-year drug formulary changes (A02969A/S02849-A)
- A bill regulating pharmacy benefit managers (PBMs) (A02836A/S06531)
- A bill extending protections from excessive out-of-network hospital emergency charges (A0804/S06544A)

A summary of each bill is provided below.

DRUG FORMULARY CHANGES

The Assembly (146-1) and Senate (56-6) both voted to pass a bill to prevent health plans from making changes to their prescription drug formularies during a contract year. This includes prohibiting a health plan from:

- Removing a prescription drug from a formulary;
- Moving a prescription drug into a higher benefit tier (for which a higher deductible, copay, or coinsurance applies); or
- Adding utilization management restrictions to a prescription drug on a formulary, unless such changes occur at the time of enrollment or issuance of coverage.

These prohibitions would apply beginning on the start date of the open enrollment period for a plan through the end of the plan year for that open enrollment period. The following exceptions apply:

- A health plan may introduce an AB-rated generic or biosimilar equivalent of a branded drug at a lower benefit tier and move the branded version to a higher benefit tier at the same time; and
- A health plan may remove a prescription drug from coverage due to a determination by the federal Food and Drug Administration (FDA) that it should be removed from the market. This includes new utilization management restrictions issued pursuant to FDA safety concerns.

The regulations would not supersede the terms of a collective bargaining agreement or the rights of labor unions to collectively bargain changes to formularies.

The bill would also require health plans to notify policyholders of if they intend to remove a prescription drug from a formulary or alter deductible, copayment, or coinsurance requirements in the upcoming plan year at least 30 days prior to the open enrollment period for the following plan year. This notice of changes must also be posted on the plan's online formulary and in any prescription drug finder system that the plan provides to the public.

PHARMACY BENEFIT MANAGERS

The Assembly (147-0) and the Senate (49-13) voted to pass a bill to regulate PBM practices to require additional transparency and provide various protections to patients, pharmacists, health plans, and providers.

Patient and Provider Protections

The bill would require that PBMs render services "for the best interests primarily of the covered individual, and the health plan or provider." The bill would require the insurance superintendent, in consultation with the health commissioner, to develop minimum standards for the issuance of a license for PBMs that would address the following:

- Elimination of conflicts of interests and deceptive practices;
- Anti-competitive practices;
- Unfair claims practices; and
- Protection of consumers.

Health care providers and covered individuals would be entitled to legal relief for any injury or loss caused by any violation of the PBM's duties, obligations, or requirements.

Pharmacy Protections

PBMs would be required to include in contracts a reasonable process for pharmacies to appeal, investigate, and resolve disputes regarding multi-source generic drug pricing within 30 days of initial claim submission. In particular:

- To deny such an appeal, a PBM must identify the national drug code of a therapeutically equivalent drug that is available for purchase by pharmacies in the State at a price equal to or less than the maximum allowable cost of the drug; and
- If an update to the maximum allowable cost is warranted, a PBM must adjust the cost of the drug for all similarly situated pharmacies in its network in the State.

The bill would also prohibit PBMs from engaging in the following with respect to contracts with pharmacies:

- Pharmacy "gag clauses", which penalize a pharmacist or pharmacy for disclosing various drug pricing information (e.g., information about cheaper equivalent drugs, or alternative methods of purchasing the drug such as paying in cash);
- Charging or collecting from an individual a copayment greater than the pharmacy's total submitted costs. If an individual pays a copayment, the pharmacy will retain the adjudicated costs, which the PBM will not recoup; and
- Requiring a pharmacy to meet any pharmacy accreditation standard or recertification requirements other than federal and state requirements for licensure as a pharmacy.

Payments

The bill would require all funds received by PBMs for services rendered to be deposited into a trust that may only be used or distributed pursuant to the PBM's contract with the health plan or provider, including any administrative fee or payment to compensate the PBM for its services. PBMs must ensure that any portion of income, payments, and financial benefits is passed through to the health plan or

provider in full. Spread pricing, which occurs when a PBM retains a portion of funds in addition to the amount paid to the pharmacy to fill the prescription, would be included in these requirements.

Information Transparency

The bill would require PBMs to provide the insurance superintendent, health plans, and providers information on the following:

- Pricing discounts;
- Rebates;
- Inflationary payments;
- Credits;
- Clawbacks;
- Fees;
- Grants;
- Chargebacks;
- Reimbursements; and
- Any other benefits received by the PBM.

Health plans and providers would have access to all financial and utilization information of the PBM for rendered services. PBMs would also be required to disclose the following to health plans and providers:

- The terms and conditions of any contract or arrangement with any third party related to services rendered, including dispensing fees paid to the pharmacies;
- Any activity, policy, practice, contract, or arrangement that directly or indirectly presents any conflict of interest with the PBM's relationship with or obligation to the health plan or provider.

If any of the above information is deemed proprietary or a trade secret by the PBM, such information would be kept confidential by the insurance superintendent, health plan, or provider.

Prescriptions

Under this bill, PBMs would be prohibited from substituting one prescription drug for another or altering the terms of a prescription when dispensing the prescription, except with the explicit approval of the prescriber or as required or permitted by law.

EXCESSIVE HOSPITAL EMERGENCY CHARGES

The Assembly (144-0) and Senate (62-0) voted to pass a bill regulating out-of-network costs for hospital emergency charges. Current New York State law protects patients from having to pay out-of-network costs for emergency departments (EDs) if they are taken to an ED at a hospital that is not in the network of their health plan. The health plan must cover the out-of-network emergency costs, while the patient remains responsible for in-network copayments, coinsurance, and deductibles.

Effective January 1, 2020, the bill would allow out-of-network hospitals to bill emergency services rendered to an individual directly to that individual's health plan, but the health plan would be permitted to take the out-of-network charges to an arbitrator, which is the current process for bills from out-of-network physicians. However, under this bill the health plan must provide an initial payment to the out-of-network hospital of at least 25 percent greater than the health plan's in-network payment would have been for the same claim, based on the health plan's most recent contract with the hospital. This payment

would not preclude either party from submitting the charges to the independent dispute resolution process or preclude the hospital from seeking additional payment from the health plan prior to a decision by the dispute resolution entity. The health plan would also be required to ensure that the individual who received services at the out-of-network hospital will not incur greater out-of-pocket costs for such services than the individual would have incurred at an in-network hospital.

These regulations would only apply if the health plan and hospital had previously entered into a participating provider agreement. If the prior contract between the hospital and health plan expired greater than 12 months prior to the payment of the disputed claim, the payment amount would be adjusted based on the medical consumer price index. The bill would also require that at least 60 days prior to the termination of a contract between a hospital and health plan, the parties must use a mutually-agreed-upon mediator to assist in resolving any outstanding contractual issues. However, the results of the mediation will not be binding on the parties.

These regulations would not apply to safety net hospitals, defined as hospitals for whom at least 60 percent of inpatient discharges annually consist of Medicaid enrollees, dual Medicare and Medicaid enrollees, or the uninsured.