GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2021

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HOUSE BILL 178
PROPOSED COMMITTEE SUBSTITUTE H178-PCS10483-BC-9

Short Title: Access to Prescription Drug Cost Information. (Public)

Sponsors:

Referred to:

March 1, 2021

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ACCESS TO ACCURATE PRESCRIPTION DRUG BENEFIT COST INFORMATION.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 58 of the General Statutes is amended by adding a new Article to read:

"Article 56B.

"Access to Prescription Drug Benefit Cost Information.

"**§ 58-56B-1. Definitions.**

The following definitions apply in this Article:

(1) Coverage. – The drug formulary information for a health benefit plan that includes the brand and generic prescription drugs that the payor will cover for a specific patient under the patient's health benefit plan.

(2) Dispenser. – Anyone licensed to dispense prescription drugs under the laws of this State.

(3) Health care services. – A health or medical care procedure or service rendered by a health care provider or prescriber that does at least one of the following:

a. Provides testing, diagnosis, or treatment of a human disease or dysfunction.

b. Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

(4) Intermediary. – Any entity, including real-time networks and translation services, that accepts an electronic transaction from another organization and electronically routes the transaction to a receiving entity or facilitates the routing of prescription drug benefit transactions.

(5) Patient-specific eligibility information. – Information on the status of the health benefit plan and the prescription benefit available under a health benefit plan provided to a specific patient by a payor, including any exclusions and limitations under the health benefit plan and the prescription drug benefit under the health benefit plan.

(6) Patient-specific prescription drug benefit and cost information. – The type of prescription drug coverage offered to a patient by the patient's payor and any out-of-pocket costs that may be incurred by the patient under the coverage, including the patient's copayment, coinsurance, and deductible.

(7) Payor. – Any of the following:

a. An insurer or nonprofit health service plan that provides hospital, medical, prescription drug, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State.
b. A health maintenance organization that provides hospital, medical, or surgical benefits or prescribes drugs to individuals or groups under contracts that are issued or delivered in the State.

(8) Pharmacy benefits manager. – As defined in G.S. 58-56A-1.
(9) Prescriber. – A licensed health care professional authorized by law to prescribe a prescription drug.
(10) Provider. – Any person or facility that is licensed or authorized in this State to provide health care services.
(11) Real time. – Exchange of patient eligibility, product coverage, and benefit financials for a choice product and pharmacy and identification of coverage restrictions and alternatives when they exist. This information is delivered immediately after product selection using electronic prescribing platforms or systems.
(12) Standard transaction. – Any electronic process that does all of the following:
a. Facilitates interoperability and data exchange of prescription drug benefit and investigation response information.
b. Is developed by an organization accredited by the American National Standards Institute.
(13) Switch. – Has the same meaning as the term "intermediary."
(14) Therapeutically equivalent alternative. – Any prescription drug that does all of the following:
a. Has the same clinical effect and safety profile to another prescription drug prescribed for a patient.
b. Is known to have nearly identical properties to another prescription drug prescribed for a patient.
c. Uses real-time prescription benefit standards developed by an organization accredited by the American National Standards Institute.

"**§ 58-56B-5. Findings of fact.**

The General Assembly of North Carolina makes the following findings:

(1) There is a need for clear and meaningful transparency that lowers out-of-pocket prescription drug costs for patients and drives clinically appropriate, data-driven shared decision making that ensures patients are informed and understand the full range of options to obtain their medically necessary medications.
(2) Patients need to understand the opportunity to derive full value of their health benefit plan formularies and understand coverage and payment considerations for drugs on those formularies, including lower-cost clinical and therapeutic alternatives.
(3) Patients need to understand the opportunity to benefit from competitive pricing of prescription drugs outside their health benefit plan's prescription drug formulary, whether in the form of a lower cash price, patient assistance, or foundation programs.

"**§ 58-56B-10. Access to prescription drug benefit and cost information.**

(a) Health benefit plans, pharmacy benefits managers, or any entities acting on behalf of a health benefit plan shall electronically provide to (i) any point of prescribing of a prescription drug, (ii) any point of dispensing of a prescription drug, or (iii) any patient-facing, real-time

benefit tool the minimum information described in G.S. 58-56B-15(c) to inform patient prescription price transparency and patients' access to their prescribed medications.

(b) Payors, providers, pharmacies, and other organizations involved in the process of prescribing, dispensing, paying for, and exchanging information relating to prescription drugs, including intermediaries, real-time networks, switches, and translation services shall take any actions necessary to facilitate the creation of, access to, and use of the technology described in subsection (a) of this section.

(c) Patient prescription price transparency technology shall not be prohibited from displaying patient financial and resource assistance when that information is available for the prescription drug selected by a provider.

"**§ 58-56B-15. Real-time requirements.**

(a) Requests for patient-specific drug benefit and cost information through the technology required under G.S. 58-56B-10 and any responses to those requests using that technology shall be sent and received in real time.

(b) The real-time exchange of patient-specific eligibility information, including any information related to a health benefit plan's coverage, benefits, formulary, and cost-sharing requirements, shall be facilitated using health care industry standards developed by an organization accredited by the American National Standards Institute.

(c) Electronic health records shall display, through real-time integration, the most up-to-date patient-specific eligibility information, including information on a health benefit plan's coverage, benefits, formulary, cost-sharing requirements, therapeutically equivalent alternatives, and prior authorization requirements.

(d) Electronic health record vendors, payors, providers, prescribers, pharmacies, and other organizations involved in the process of prescribing, dispensing, paying for, and exchanging information relating to prescription drugs shall partner with intermediaries to ensure the delivery of accurate patient-specific prescription price transparency information.

(e) Intermediaries shall be capable of supporting and using a standard transaction that meets the requirements of this section.

(f) Patient-specific information, as described in G.S. 58-56B-15(c), shall be provided in real time.

"**§ 58-56B-20. Benefit and cost information requirements.**

(a) Nothing in this Article shall interfere with patient choice and a health care professional's ability to convey the full range of prescription drug cost options to a patient. Health benefit plans, pharmacy benefit managers, or any entities acting on behalf of a health benefit plan shall not restrict a health care professional from communicating prescription cost options to a patient.

(b) A payor shall not prohibit the display of patient-specific prescription drug benefit and cost information at the point of prescribing that reflects options available for covering the cost of a prescription drug other than what may be available under the patient's health benefit plan, including cash-pay options, coverage through assistance or support programs, and cost coverage options at the patient's pharmacy of choice.

(c) A provider or prescriber shall communicate to a patient the most therapeutically appropriate treatment for the patient's diagnosis and, when appropriate, prescription drug cost information, including the cash price, therapeutically equivalent alternatives, and delivery options for a prescription drug.

(d) In order to protect a patient's privacy and right to choose the means of prescription drug cost coverage, if a patient chooses not to use the prescription drug benefit under the patient's health benefit plan to obtain a prescription drug, a provider does not have an obligation to convey that fact to the payor who provides the health benefit plan.

(e) A pharmacist filling a prescription for a specific biological product may substitute an interchangeable biological product only if (i) the prescriber has not indicated that the pharmacist

may not substitute an interchangeable biosimilar biological product for the prescribed biological product and (ii) the Food and Drug Administration has determined the biological product to be substituted is interchangeable with the prescribed biological product.

"**§ 58-56B-25. Construction.**

Nothing in this Article shall be construed to interfere with a patient's choice of prescription drug cost coverage or to interfere with patient choice and the ability of a health care professional to convey the full range of prescription drug cost options to a patient. Health benefit plans, pharmacy benefit managers, or any entities acting on behalf of a health benefit plan shall not restrict a health care professional from communicating prescription cost options to a patient."

SECTION 2. This act becomes effective January 1, 2023.