STATE OF OKLAHOMA

1st Session of the 57th Legislature (2019)

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 2632 By: Echols

COMMITTEE SUBSTITUTE

An Act relating to insurance; creating the Patient's Right to Pharmacy Choice Act; declaring purpose; defining terms; providing for compliance standards for retail pharmacy networks; providing for review of retail pharmacy network access; prohibiting certain actions; prohibiting certain restrictions; requiring health insurer to monitor compliance; requiring specific uses for certain compensation; requiring health insurer file annual report; directing a health insurer's pharmacy and therapeutics committee to establish a formulary; prohibiting conflicts of interest; providing conditions for persons to serve on pharmacy and therapeutics committee; prohibiting compensation; providing for publication of drug formulary; requiring regular updates; authorizing Insurance Commissioner investigative powers; establishing a Right to Patient Choice Advisory Committee; providing the Right to Patient Choice Advisory Committee with certain powers; providing for composition and appointment of the Right to Patient Choice Advisory Committee; providing term length; providing hearings be held in accordance with the Administrative Procedures Act; providing for confidentiality; providing exception; providing for codification; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6958 of Title 36, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Patient's Right to Pharmacy Choice Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6959 of Title 36, unless there is created a duplication in numbering, reads as follows:

The purpose of the Patient's Right to Pharmacy Choice Act is to establish minimum and uniform access to a provider and standards and prohibitions on restrictions of a patient's right to choose a pharmacy provider.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6960 of Title 36, unless there is created a duplication in numbering, reads as follows:

For purposes of the Patient's Right to Pharmacy Choice Act:

1. "Benefit plan" means any health benefit plan offered by a health insurance carrier, health maintenance organization, managed care entity, or any other entity that provides prescription drug benefits to covered individuals, including workers' compensation programs, state-administered health benefit plans and self-funded benefit programs;

2. "Mail-order pharmacy" means a pharmacy licensed by this state that primarily dispenses and delivers covered drugs via common carrier;

3. "Pharmacy benefits manager" or "PBM" means a person, business or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a PBM in a contractual or employment relationship in the performance of pharmacy benefits management for a managed-care company, nonprofit hospital, medical service organization, insurance company, third-party payor or a health program administered by a department of this state;

4. "Pharmacy and therapeutics committee" or "P&T committee" means a committee at a hospital or a health insurance plan that decides which drugs will appear on that entity's drug formulary;

5. "Retail pharmacy network" means retail pharmacy providers contracted with the entity providing or administering a benefit plan in which the pharmacy primarily fills and sells prescriptions via a retail, storefront location;

6. "Rural service area" means a five-digit ZIP code in which the population density is less than one thousand (1,000) individuals per square mile;

7. "Suburban service area" means a five-digit ZIP code in which the population density is between one thousand (1,000) and three thousand (3,000) individuals per square mile; and

8. "Urban service area" means a five-digit ZIP code in which the population density is greater than three thousand (3,000) individuals per square mile.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6961 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Retail pharmacy networks shall comply with the following access standards:

1. At least ninety percent (90%) of covered individuals in the benefit plan's urban service area live within two (2) miles of a retail pharmacy participating in the benefit plan's retail pharmacy network;

2. At least ninety percent (90%) of covered individuals in the benefit plan's urban service area live within five (5) miles of a retail pharmacy designated as a preferred participating pharmacy in the benefit plan's retail pharmacy network;

3. At least ninety percent (90%) of covered individuals in the benefit plan's suburban service area live within five (5) miles of a retail pharmacy participating in the benefit plan's retail pharmacy network;

4. At least ninety percent (90%) of covered individuals in the benefit plan's suburban service area live within seven (7) miles of a retail pharmacy designated as a preferred participating pharmacy in the benefit plan's retail pharmacy network;

5. At least seventy percent (70%) of covered individuals in the benefit plan's rural service area live within fifteen (15) miles of a retail pharmacy participating in the benefit plan's retail pharmacy network; and

6. At least seventy percent (70%) of covered individuals in the benefit plan's rural service area live within eighteen (18) miles of a retail pharmacy designated as a preferred participating pharmacy in the benefit plan's retail pharmacy network.

B. Mail-order pharmacies shall not be used to meet access standards for retail pharmacy networks.

C. Pharmacy benefits managers and benefit plans shall not require patients to use pharmacies that are directly or indirectly owned by the pharmacy benefits manager or benefit plan, including all regular prescriptions, refills or specialty drugs regardless of day supply.

D. Pharmacy benefits managers and benefit plans shall not in any manner on any material, including but not limited to mail and ID cards, include the name of any pharmacy, hospital or other providers unless it specifically lists all pharmacies, hospitals and providers participating in the preferred and nonpreferred pharmacy and health networks.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6962 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Insurance Department shall review and approve retail pharmacy network access for all benefit plans to ensure compliance with Section 4 of this act.

B. A pharmacy benefits manager (PBM), or PBM representative of a PBM, shall not:

1. Cause or knowingly permit the use of advertisement, promotion, solicitation, representation, proposal or offer that is untrue, deceptive or misleading;

2. Charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including without limitation a fee for:

a. the submission of a claim,

b. enrollment or participation in a retail pharmacy network, or

c. the development or management of claims processing services or claims payment services related to participation in a retail pharmacy network;

3. Reimburse a pharmacy or pharmacist in the state an amount less than the amount that the PBM reimburses a pharmacy owned by or under common ownership with a PBM for providing the same covered services. The reimbursement amount shall be calculated on a per-unit basis using the same generic product identifier or generic code number submitted by the PBM-owned or PBM-affiliated pharmacy;

4. Deny a pharmacy the opportunity to participate in any pharmacy network at standard or preferred participation status if

the pharmacy is willing to accept the terms and conditions that the PBM has established for other pharmacies as a condition of standard network participation or preferred network participation status;

5. Deny, limit or terminate a pharmacy's contract based on employment status of any employee who has an active license to dispense, despite probation status, with the State Board of Pharmacy;

6. Impose on a covered individual a monetary advantage or penalty, including a higher cost-sharing or additional fee which would affect a covered individual's choices of network pharmacy;

7. Retroactively deny or reduce reimbursement for a covered service claim after returning a paid claim response as part of the adjudication of the claim, unless:

a. the original claim was submitted fraudulently, or

b. the pharmacy service provided related to the subject claim violated the Oklahoma Pharmacy Act; or

8. Fail to make any payment due to a pharmacy or pharmacist for covered services properly rendered in the event a PBM terminates a pharmacy or pharmacist from a pharmacy benefits manager network.

C. The prohibitions under this section shall apply to contracts between pharmacy benefits managers and pharmacists or pharmacies for participation in retail pharmacy networks.

1. A pharmacy benefits manager's contract with a pharmacist or pharmacy shall not contain a provision prohibiting disclosure to

patients of billed or allowed amounts, reimbursement rates or out-of-pocket costs.

2. A pharmacy benefits manager contract with a participating pharmacist or pharmacy shall not prohibit, restrict or limit disclosure of information to the Insurance Commissioner, law enforcement or state and federal governmental officials investigating or examining a complaint or conducting a review of a pharmacy benefits manager's compliance with the requirements under the Patient's Right to Pharmacy Choice Act.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6963 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health insurer shall be responsible for monitoring all activities carried out by, or on behalf of, the health insurer under the Patient's Right to Pharmacy Choice Act, and for ensuring that all requirements of this act are met.

B. Whenever a health insurer contracts with another person to perform activities required under this act, the health insurer shall be responsible for monitoring the activities of that person with whom the health insurer contracts and for ensuring that the requirements of this act are met.

C. A health insurer owes a fiduciary duty to all covered persons with respect to the provision of prescription drug benefits.

D. A covered person shall be notified at the point of sale when the cash price for the purchase of a prescription drug is less than the covered person's copayment or coinsurance price for the purchase of the same prescription drug.

E. A health insurer or any entity hired or employed to manage a prescription drug plan or plans shall not restrict a covered person's choice of provider for prescription drugs and shall not require or incentivize using any discounts in cost-sharing to covered persons to receive prescription drugs from mail order pharmacies.

F. A health insurer, pharmacy or any entity hired or employed to manage a prescription drug plan shall adhere to all Oklahoma laws, statutes and rules when mailing, shipping and/or causing to be mailed or shipped prescription drugs into the State of Oklahoma.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6964 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. All compensation remitted by a pharmaceutical manufacturer, developer or labeler, directly or indirectly related to a health benefit plan or pharmacy benefit plan, shall be remitted to, and retained by, that health benefit plan or pharmacy benefit plan for the purposes described in subsection C of this section.

B. All compensation received by or on behalf of a health insurer from a pharmaceutical manufacturer, developer or labeler shall be used by the health insurer to:

1. Lower health benefit plan or pharmacy benefit plan premiums for covered persons;

2. Lower copayment and coinsurance amounts for covered persons; or

3. Expand pharmacy benefit plan coverage.

C. A health insurer shall file with the Insurance Commissioner, on or before March 1 each year, an annual report, in a manner and form established by rule promulgated by the Commissioner, demonstrating how the amount and nature of compensation received from pharmaceutical manufacturers, developers or labelers has:

1. Lowered health benefit plan or pharmacy benefit plan premiums for covered persons;

2. Lowered copayment and coinsurance amounts for covered persons; or

3. Expanded pharmacy benefit plan coverage.

D. The annual-report-filing requirement in subsection C of this section shall not begin until March 1, 2021.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6965 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health insurer's pharmacy and therapeutics committee (P&T committee) shall establish a formulary, which shall be a list of prescription drugs, both generic and brand name, used by practitioners to identify drugs that offer the greatest overall value.

B. A health insurer shall prohibit conflicts of interest for members of the pharmacy and therapeutics committee (P&T committee).

1. A person may not serve on a P&T committee if the person is:

a. currently employed or was employed within the preceding year by a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor, or

b. currently receiving compensation, or received compensation within the preceding year, from a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor.

2. A health insurer shall prohibit the P&T committee, and any member of the P&T committee, from receiving any compensation or funding from a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor.

C. A health insurer shall display its formulary on its website to be publicly accessible.

1. The formulary shall be electronically searchable by drug name and any other means required by the Insurance Commissioner, as established by rule.

2. The formulary shall include, at a minimum, the following:

a. an indication of whether each drug on the formulary is preferred under the plan,

b. an indication of whether each drug on the formulary requires prior authorization or has step therapy or quantity limit restrictions,

c. the specific tier the drug falls under, if the health insurer's plan uses a tiered formulary,

d. the amount of the drug copayment, if applicable,

e. the amount of the drug coinsurance, if applicable,

f. whether the drug is subject to a deductible, and if so, the amount of the deductible,

g. whether the drug is included on the health insurer's maximum allowable cost (MAC) list and, if so, the price of the drug as established by the health insurer's MAC list, and

h. for drugs not included on the health insurer's MAC list, the average wholesale price (AWP).

3. The health insurer shall update drugs included on the health insurer's MAC list no less than every seven (7) days.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6966 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner shall have power to examine and investigate into the affairs of every pharmacy benefits manager (PBM) engaged in pharmacy benefits management in this state in order to determine whether such entity is in compliance with the Patient's Right to Pharmacy Choice Act.

B. All PBM files and records shall be subject to examination by the Insurance Commissioner or by duly appointed designees. The Insurance Commissioner, authorized employees and examiners shall have access to any of a PBM's files and records that may relate to a particular complaint under investigation or to an inquiry or examination by the Insurance Department.

C. Every officer, director, employee or agent of the PBM, upon receipt of any inquiry from the Commissioner shall, within thirty (30) days from the date the inquiry is sent, furnish the Commissioner with an adequate response to the inquiry.

D. When making an examination under this section, the Insurance Commissioner may retain subject matter experts, attorneys, appraisers, independent actuaries, independent certified public accountants or an accounting firm or individual holding a permit to practice public accounting, certified financial examiners or other professionals and specialists as examiners, the cost of which shall be borne by the PBM which is the subject of the examination.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6967 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner shall provide for the receiving and processing of individual complaints alleging violations of the provisions of the Patient's Right to Pharmacy Choice Act.

B. The Commissioner shall establish a Right to Patient Choice Advisory Committee to review complaints, hold hearings and subpoena witnesses and records, initiate prosecution, reprimand, place on probation, suspend, revoke, and/or levy fines not to exceed Ten Thousand Dollars ($10,000.00) for each count for which any pharmacy benefits manager (PBM) has violated a provision of this act. The Advisory Committee may impose as part of any disciplinary action the payment of costs expended by the Insurance Department for any legal fees and costs, including but not limited to, staff time, salary and travel expense, witness fees and attorney fees. The Advisory Committee may take such actions singly or in combination, as the nature of the violation requires.

C. The Advisory Committee shall consist of seven (7) persons appointed as follows:

1. Two persons who shall be nominated by the Oklahoma Pharmacists Association;

2. Two consumer members not employed or related to insurance, pharmacy or PBM nominated by the Office of the Governor;

3. Two persons representing the PBM or insurance industry nominated by the Insurance Commissioner; and

4. One person representing the Office of the Attorney General nominated by the Attorney General.

D. Committee members shall be appointed for terms of five (5) years. The terms of the members of the Advisory Committee shall expire on the thirtieth day of June of the year designated for the expiration of the term for which appointed, but the member shall serve until a qualified successor has been duly appointed. No person shall be appointed to serve more than two consecutive terms.

E. Hearings shall be held in the Insurance Commissioner's offices or at such other place as the Insurance Commissioner may deem convenient.

F. The Insurance Commissioner shall issue and serve upon the PBM a statement of the charges and a notice of hearing in accordance with the Administrative Procedures Act, Sections 250.1 through 323 of Title 75 of the Oklahoma Statutes.

G. At the time and place fixed for a hearing, the PBM shall have an opportunity to be heard and to show cause why the Insurance Commissioner or his or her duly appointed hearing examiner should not revoke or suspend the PBM's license and levy administrative fines for each violation. Upon good cause shown, the Commissioner shall permit any person to intervene, appear and be heard at the hearing by counsel or in person.

H. All hearings will be public and held in accordance with, and governed by, Sections 250.1 through 323 of Title 75 of the Oklahoma Statutes.

I. The Insurance Commissioner, upon written request reasonably made by the licensed PBM affected by the hearing, and at such PBM's expense, shall cause a full stenographic record of the proceedings to be made by a competent court reporter.

J. If the Insurance Commissioner determines, based on an investigation of complaints, that a PBM has engaged in violations of this act with such frequency as to indicate a general business practice and that such PBM should be subjected to closer supervision with respect to such practices, the Insurance Commissioner may require the PBM to file a report at such periodic intervals as the Insurance Commissioner deems necessary.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6968 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Documents, materials, reports, complaints or other information in the possession or control of the Insurance Department that are obtained by or disclosed to the Insurance Commissioner or any other person in the course of an evaluation, examination, investigation or review made pursuant to the provisions of the Patient's Right to Pharmacy Choice Act shall be confidential by law and privileged, shall not be subject to open records request, shall

not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action if obtained from the Insurance Commissioner or any employees or representatives of the Insurance Commissioner.

B. Nothing in this section shall prevent the disclosure of a final order issued against a pharmacy benefits manager by the Insurance Commissioner or his or her duly appointed hearing examiner. Such orders shall be open records.

SECTION 12. This act shall become effective November 1, 2019.

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