STATE OF OKLAHOMA

1st Session of the 58th Legislature (2021)

HOUSE BILL 2800 By: Pfeiffer

AS INTRODUCED

An Act relating to insurance; amending Section 5, Chapter 426, O.S.L. 2019 (36 O.S. Supp. 2020, Section 6962), which relates to compliance review; modifying calculation of certain insured's contribution; defining term; and providing an effective date.

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

SECTION 1. AMENDATORY Section 5, Chapter 426, O.S.L. 2019 (36 O.S. Supp. 2020, Section 6962), is amended to read as follows:

Section 6962. A. The Oklahoma Insurance Department shall review and approve retail pharmacy network access for all pharmacy benefits managers (PBMs) to ensure compliance with Section ~~4~~ 6961 of this ~~act~~ title.

B. A PBM, or an agent 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 paid to the pharmacy shall be equal to the reimbursement amount calculated on a per-unit basis using the same generic product identifier or generic code number paid to the PBM-owned or PBM-affiliated pharmacy;

4. Deny a pharmacy the opportunity to participate in any pharmacy network at 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 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. 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. to correct errors identified in an audit, so long as the audit was conducted in compliance with Sections 356.2 and 356.3 of Title 59 of the Oklahoma Statutes; or

7. 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 PBM contract shall:

a. not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug from informing, or penalize such pharmacy for informing, an individual of any differential between the individual's out-of-pocket cost or coverage with respect to acquisition of the drug and the amount an individual would pay to purchase the drug directly, and

b. ensure that any entity that provides pharmacy benefits management services under a contract with any such

health plan or health insurance coverage does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing, or penalize such pharmacy for informing, a covered individual of any differential between the individual's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage.

2. A pharmacy benefits manager's 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.

3. A pharmacy benefits manager shall establish and maintain an electronic claim inquiry processing system using the National Council for Prescription Drug Programs' current standards to communicate information to pharmacies submitting claim inquiries.

C. 1. When calculating an insured's contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or any other cost-sharing requirement, the insurer or pharmacy benefits manager

shall include any cost-sharing amount paid by the insured or on the insured's behalf for a prescription drug that is either of the following:

a. without a generic equivalent, or

b. with a generic equivalent where the insured has obtained access to the prescription drug though any of the following:

(1) prior authorization from the insurer or pharmacy benefits manager, or

(2) a step therapy protocol, or

(3) the exception or appeals process of the insurer or pharmacy benefits manager.

2. For the purposes of this subsection, the term "generic equivalent" means a drug that has an identical amount of the same active ingredients in the same dosage form; meets applicable standards of strength, quality, and purity according to the United States Pharmacopeia or other nationally recognized compendium; and which, if administered in the same amount, would provide comparable therapeutic effects. For purposes of this section, the term generic equivalent does not include a drug that is listed by the United States Food and Drug Administration as having unresolved bioequivalence concerns according to the Administration's most recent publication of approved drug products with therapeutic equivalence evaluations.

SECTION 2. This act shall become effective November 1, 2021.

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