STATE OF OKLAHOMA

1st Session of the 59th Legislature (2023)

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 2853 By: Wallace

COMMITTEE SUBSTITUTE

An Act relating to health care; creating the Oklahoma Rebate Pass-Through and PBM Meaningful Transparency Act of 2023; amending 59 O.S. 2021, Sections 357 and 358, which relate to definitions; modifying definitions, procedures, and penalties; creating duties; creating licensing application requirements; amending 36 O.S. 2021, Section 6960, as amended by Section 1, Chapter 38, O.S.L. 2022 (36 O.S. Supp. 2022, Section 6960), which relates to definitions; defining terms; creating PBM disclosures; amending 36 O.S. 2021, Section 6962, as amended by Section 2, Chapter 38, O.S.L. 2022 (36 O.S. Supp. 2022, Section 6962), which relates to pharmacy benefits manager compliance; creating duties; amending 36 O.S. 2021, Section 6964, which relates to a formulary for prescription drugs; creating agency duties; providing cost sharing calculation methodology, limitations, and requirements; creating penalties; clarifying authority to take certain actions; prohibiting the disclosure of certain information; declaring that certain information not be considered public record; providing for noncodification; 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 not to be codified in the Oklahoma Statutes reads as follows:

This act shall be known and may be cited as the "Oklahoma Rebate Pass-Through and PBM Meaningful Transparency Act of 2023".

SECTION 2. AMENDATORY 59 O.S. 2021, Section 357, is amended to read as follows:

Section 357. As used in this act:

1. "Covered entity" means a nonprofit hospital or medical service organization, insurer, health coverage plan or health maintenance organization; a health program administered by the state in the capacity of provider of health coverage; or an employer, labor union, or other entity organized in the state that provides health coverage to covered individuals who are employed or reside in the state. This term does not include a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, disability income, or other limited benefit health insurance policies and contracts that do not include prescription drug coverage;

2. "Covered individual" means a member, participant, enrollee, contract holder or policy holder or beneficiary of a covered entity who is provided health coverage by the covered entity. A covered individual includes any dependent or other person provided health coverage through a policy, contract or plan for a covered individual;

3. "Department" means the Oklahoma Insurance Department;

4. "Maximum allowable cost" or "MAC" means the list of drug products delineating the maximum per-unit reimbursement for multiple-source prescription drugs, medical product or device;

5. "Multisource drug product reimbursement" (reimbursement) means the total amount paid to a pharmacy inclusive of any reduction in payment to the pharmacy, excluding prescription dispense fees;

6. "Pharmacy benefits management" means a service provided to covered entities to facilitate the provision of prescription drug benefits to covered individuals within the state, including negotiating pricing and other terms with drug manufacturers and providers. Pharmacy benefits management may include any or all of the following services:

a. claims processing, performance of drug utilization review, processing of drug prior authorization requests, retail network management and payment of claims to pharmacies for prescription drugs dispensed to covered individuals,

b. clinical formulary development and management services,

c. rebate contracting and administration,

d. certain patient compliance, therapeutic intervention and generic substitution programs, ~~or~~

e. disease management programs,

f. adjudication of appeals and grievances related to the prescription drug benefit, or

g. controlling the cost of prescription drugs;

7. "Pharmacy benefits manager" or "PBM" means a person, business or other entity that, either directly or through an intermediary, 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 an agency of this state. PBM does not include a Pharmacy Services Administrative Organization;

8. "Plan sponsor" means the employers, insurance companies, unions and health maintenance organizations or any other entity responsible for establishing, maintaining, or administering a health benefit plan on behalf of covered individuals; and

9. "Provider" means a pharmacy licensed by the State Board of Pharmacy, or an agent or representative of a pharmacy, including, but not limited to, the pharmacy's contracting agent, which dispenses prescription drugs or devices to covered individuals.

SECTION 3. AMENDATORY 59 O.S. 2021, Section 358, is amended to read as follows:

Section 358. A. In order to provide pharmacy benefits management or any of the services included under the definition of

pharmacy benefits management in this state, a pharmacy benefits manager or any entity acting as one in a contractual or employment relationship for a covered entity shall first obtain a license from the Oklahoma Insurance Department, and the Department may charge a fee for such licensure.

B. The Department shall establish, by regulation, licensure procedures, required disclosures for pharmacy benefits managers (PBMs) and other rules as may be necessary for carrying out and enforcing the provisions of this act. The licensure procedures shall, at a minimum, include the completion of an application form that shall include ~~the name and address of an agent for service of process, the payment of a requisite fee, and evidence of the procurement of a surety bond~~ the following:

1. The name, address, and telephone contact number of the PBM;

2. The name and address of the PBM's agent for service of process in the state;

3. The name and address of each person with management or control over the PBM;

4. Evidence of the procurement of a surety bond;

5. The name and address of each person with a beneficial ownership interest in the PBMs;

6. In the case of a PBM applicant that is a partnership or other unincorporated association, limited liability corporation, or

corporation, and has five or more partners, members, or stockholders:

a. the applicant shall specify its legal structure and the total number of partners, members, or stockholders,

b. the applicant shall specify the name, address, usual occupation, and professional qualifications of the five partners, members, or stockholders with the five largest ownership interests in the PBM, and

c. the applicant shall agree that, upon request by the Department, it shall furnish the Department with information regarding the name, address, usual occupation, and professional qualifications of any other partners, members, or stockholders;

7. A signed statement indicating that the PBM has not been convicted of a felony and has not violated any of the requirements of the Oklahoma Pharmacy Act and the Patient's Right to Pharmacy Choice Act, or, if the applicant cannot provide such a statement, a signed statement describing all relevant convictions or violations; and

8. Any other information the Commissioner deems necessary to review.

C. The Department may subpoena witnesses and information. Its compliance officers may take and copy records for investigative use

and prosecutions. Nothing in this subsection shall limit the Office of the Attorney General from using its investigative demand authority to investigate and prosecute violations of the law.

D. The Department may suspend, revoke or refuse to issue or renew a license for noncompliance with any of the provisions hereby established or with the rules promulgated by the Department; for conduct likely to mislead, deceive or defraud the public or the Department; for unfair or deceptive business practices or for nonpayment of a renewal fee or fine. The Department may also levy administrative fines for each count of which a PBM has been convicted in a Department hearing.

SECTION 4. AMENDATORY 36 O.S. 2021, Section 6960, as amended by Section 1, Chapter 38, O.S.L. 2022 (36 O.S. Supp. 2022, Section 6960), is amended to read as follows:

Section 6960. For purposes of the Patient's Right to Pharmacy Choice Act:

1. "Administrative fees" means fees or payments from pharmaceutical manufacturers to, or otherwise retained by, a pharmacy benefits manager (PBM) or its designee pursuant to a contract between a PBM or affiliate and the manufacturer in connection with the PBM's administering, invoicing, allocating, and collecting the rebates;

2. "Aggregate retained rebate percentage" means the percentage of all rebates received by a PBM from all pharmaceutical

manufacturers which is not passed on to the PBM's health plan or health insurer clients. Aggregate retained rebate percentage shall be expressed without disclosing any identifying information regarding any health plan, prescription drug, or therapeutic class, and shall be calculated by dividing:

a. the aggregate dollar amount of all rebates that the PBM received during the prior calendar year from all pharmaceutical manufacturers and did not pass through to the PBM's health plan or health insurer clients, by

b. the aggregate dollar amount of all rebates that the pharmacy benefits manager received during the prior calendar year from all pharmaceutical manufacturers;

3. "Defined cost sharing" means a deductible payment or coinsurance amount imposed on an enrollee for a covered prescription drug under the enrollee's health plan;

4. "Formulary" means a list of prescription drugs, as well as accompanying tiering and other coverage information, that has been developed by an issuer, a health plan, or the designee of a health insurer or health plan, which the health insurer, health plan, or designee of the health insurer or health plan references in determining applicable coverage and benefit levels;

5. "Generic equivalent" means a drug that is designated to be therapeutically equivalent, as indicated by the United States Food and Drug Administration's "Approved Drug Products with Therapeutic

Equivalence Evaluations"; provided, however, that a drug shall not be considered a generic equivalent until the drug becomes nationally available;

6. "Health insurer" means any corporation, association, benefit society, exchange, partnership or individual subject to state law requires insurance and licensed ~~by~~ under the Oklahoma Insurance Code;

7. "Health insurer administrative service fees" means fees or payments from a health insurer or a designee of the health insurer to, or otherwise retained by, a PBM or its designee pursuant to a contract between a PBM or affiliate, and the health insurer or designee of the health insurer in connection with the PBM managing or administering the pharmacy benefit and administering, invoicing, allocating, and collecting rebates;

~~2.~~ 8. "Health insurer payor" means a health insurance company, health maintenance organization, union, hospital and medical services organization or any entity providing or administering a self-funded health benefit plan;

9. "Health plan" means a policy, contract, certification, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services;

~~3.~~ 10. "Mail-order pharmacy" means a pharmacy licensed by this state that primarily dispenses and delivers covered drugs via common carrier;

~~4.~~ 11. "Pharmacy benefits manager" or "PBM" means a person that, either directly or through an intermediary, performs pharmacy benefits management, as defined in paragraph 6 of Section 357 of Title 59 of the Oklahoma Statutes, and any other person acting for such person under 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. PBM does not include a Pharmacy Services Administrative Organization;

12. "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;

13. "Price protection rebate" means a negotiated price concession that accrues directly or indirectly to the health insurer, or other party on behalf of the health insurer, in the event of an increase in the wholesale acquisition of a drug above a specified threshold;

~~5.~~ 14. "Provider" means a pharmacy, as defined in Section 353.1 of Title 59 of the Oklahoma Statutes or an agent or representative of a pharmacy;

15. "Rebates" means:

a. negotiated price concessions including, but not limited to, base price concessions (whether described as a rebate or otherwise) and reasonable estimates of any price protection rebates and performance-based price concessions that may accrue directly or indirectly to a health insurer, health plan, or PBM during the coverage year from a manufacturer, dispensing pharmacy, or other party in connection with the dispensing or administration of a prescription drug, and

b. reasonable estimates of any price concessions, fees, and other administrative costs that are passed through, or are reasonably anticipated to be passed through, to a health insurer, health plan, or PBM and serve to reduce the health insurer, health plan, or PBM's liabilities for a prescription drug;

~~6.~~ 16. "Retail pharmacy network" means retail pharmacy providers contracted with a PBM in which the pharmacy primarily fills and sells prescriptions via a retail, storefront location;

~~7.~~ 17. "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;

~~8.~~ 18. "Spread pricing" means a prescription drug pricing model utilized by a pharmacy benefits manager in which the PBM charges a health benefit plan a contracted price for prescription drugs that differs from the amount the PBM directly or indirectly pays the pharmacy or pharmacist for providing pharmacy services;

~~9.~~ 19. "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

~~10.~~ 20. "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 5. AMENDATORY 36 O.S. 2021, Section 6962, as amended by Section 2, Chapter 38, O.S.L. 2022 (36 O.S. Supp. 2022, 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 6961 of this 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 provider the opportunity to participate in any pharmacy network at preferred participation status if the provider is willing to accept the terms and conditions that the PBM has established for other providers as a condition of preferred network participation status;

5. Deny, limit or terminate a provider'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;

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

8. ~~Conduct or practice~~ Either directly or through an intermediary, agent, or affiliate, engage in, facilitate, or enter into a contract with another person involving spread pricing, as defined in Section ~~1~~ 6960 of this ~~act~~ title, in this state; ~~or~~

9. Charge a pharmacist or pharmacy a fee related to participation in a retail pharmacy network including but not limited to the following:

a. an application fee,

b. an enrollment or participation fee,

c. a credentialing or re-credentialing fee,

d. a change of ownership fee, or

e. a fee for the development or management of claims processing services or claims payment services; or

10. Prohibit or penalize a pharmacy or pharmacist for:

a. disclosing to an individual information regarding the existence and clinical efficacy of a generic equivalent that would be less expensive to the enrollee:

(1) under his or her health plan prescription drug benefit, or

(2) outside his or her health plan prescription drug benefit, without requesting any health plan reimbursement, than the drug that was originally prescribed, or

b. selling to an individual, instead of a particular prescribed drug, a therapeutically equivalent drug that would be less expensive to the enrollee:

(1) under his or her health plan prescription drug benefit, or

(2) outside his or her health plan prescription drug benefit, without requesting any health plan reimbursement, than the drug that was originally prescribed.

C. The prohibitions under this section shall apply to contracts between pharmacy benefits managers and providers 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 provider 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.

D. A pharmacy benefits manager shall:

1. 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;

2. Fully disclose to insurers, self-funded employers, unions or other PBM clients the existence of the respective aggregate prescription drug discounts, rebates received from drug manufacturers and pharmacy audit recoupments;

3. Provide the Insurance Commissioner, insurers, self-funded employer plans and unions unrestricted audit rights of and access to the respective PBM pharmaceutical manufacturer and provider contracts, plan utilization data, plan pricing data, pharmacy utilization data and pharmacy pricing data;

4. Maintain, for no less than three (3) years, documentation of all network development activities including but not limited to contract negotiations and any denials to providers to join networks. This documentation shall be made available to the Commissioner upon request;

5. Report to the Commissioner, ~~on a quarterly basis~~ in a manner and form prescribed by the Commissioner, along with any applicable fees set by the Commissioner, a report on the first day of each

calendar year, containing aggregate information for the prior calendar year. The report shall include the following information as it pertains to the PBM's contracts with insurers in the state, broken out for each health insurer ~~payor, on the following information~~:

a. the aggregate amount of rebates ~~received by~~ the PBM received from all pharmaceutical manufacturers,

b. the aggregate amount of rebates distributed to the appropriate health insurer ~~payor~~,

c. the aggregate amount of rebates that the PBM received from all pharmaceutical manufacturers and did not pass through to health insurers,

d. the aggregate amount of rebates passed on to the enrollees of each health insurer ~~payor~~ at the point of sale that reduced the ~~applicable deductible, copayment, coinsure or other~~ defined cost sharing amount of the enrollee,

~~d.~~

e. the aggregate amount of all administrative fees the PBM received,

f. the aggregate amount of health insurer administrative service fees that the PBM received,

g. the aggregate amount of all administrative fees that the PBM received from all pharmaceutical manufacturers and did not pass through to health insurers,

h. the aggregate retained rebate percentage, across all the PBM's contractual or other relationships with all health insurers, the highest aggregate retained rebate percentage, the lowest aggregate retained rebate percentage, and the mean aggregate retained rebate percentage,

i. the individual and aggregate amount paid by the health insurer ~~payor~~ to the PBM for pharmacy services itemized by pharmacy, drug product and service provided, and

~~e.~~

j. the individual and aggregate amount a PBM paid a provider for pharmacy services itemized by pharmacy, drug product and service provided.

The Department shall publish in a timely manner the information that it receives under paragraph 5 of this subsection on a publicly available website; provided that such information shall be made available in a form that does not disclose the identity of a specific health plan or the identity of a specific manufacturer, the prices charged for specific drugs or classes of drugs, or the amount of any rebates provided for specific drugs or classes of drugs.

E. For each of the PBM's contracts or other relationships with a health plan, a PBM shall publish on an easily accessible website the health plan formulary, and timely notification of formulary changes and/or product exclusions.

F. The PBM and the Department shall not publish or otherwise disclose any information that would reveal the identity of a specific health plan, the price(s) charged for a specific drug or class of drugs, the amount of any rebates provided for a specific drug or class of drugs, the manufacturer, or that would otherwise have the potential to compromise the financial, competitive, or proprietary nature of the information. Any such information shall be protected from disclosure as confidential and proprietary information, is not a public record as defined in the Oklahoma Open Records Act, Section 24A.1 et seq. of Title 51 of the Oklahoma Statutes, and shall not be disclosed directly or indirectly. A PBM shall impose the confidentiality protections of this section on any vendor or downstream third party that performs health care or administrative services on behalf of the PBM and that may receive or have access to rebate information.

SECTION 6. AMENDATORY 36 O.S. 2021, Section 6964, is amended to read as follows:

Section 6964. A. A health ~~insurer's~~ insurer or its agent's, including pharmacy benefits managers, 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 P&T committee.~~ The P&T committee shall review the formulary annually and must meet the following requirements:

1. ~~A person may not serve on a P&T committee if the person is currently employed or was employed within the preceding year by a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor.~~ A majority of P&T committee members shall be practicing physicians, practicing pharmacists, or both, and shall be licensed in Oklahoma;

2. ~~A health insurer shall require any member of the P&T committee to disclose any compensation or funding from a pharmaceutical manufacturer, developer, labeler, wholesaler or distributor. Such P&T committee member shall be recused from voting on any product manufactured or sold by such pharmaceutical manufacturer, developer, labeler, wholesaler or distributor.~~ P&T committee members shall practice in various clinical specialties that adequately represent the needs of health plan enrollees, and there shall be an adequate number of high-volume specialists and specialists treating rare and orphan diseases;

3. The P&T committee shall meet no less frequently than on a quarterly basis;

4. P&T committee formulary development shall be conducted pursuant to a transparent process, and formulary decisions and rationale shall be documented in writing, with any records and documents relating to the process available upon request to the health plan, subject to the conditions in subsection C of this section. In the case of P&T committee decisions that relate to Medicaid managed care organizations' prescription drug coverage policies, if the P&T committee relies upon any third party to provide cost-effectiveness analysis or research, the P&T committee shall:

a. disclose to the health benefit plan, the state, and the general public the name of the relevant third party, and

b. provide a process through which patients and providers potentially impacted by the third party's analysis or research may provide input to the P&T committee;

5. Specialists with current clinical expertise who actively treat patients in a specific therapeutic area, and the specific conditions within a therapeutic area, shall participate in formulary decisions regarding each therapeutic area and specific condition;

6. The P&T committee shall base its clinical decisions on the strength of scientific evidence, standards of practice, and nationally accepted treatment guidelines;

7. The P&T committee shall consider whether a particular drug has a clinically meaningful therapeutic advantage over other drugs in terms of safety, effectiveness, or clinical outcome for patient populations who may be treated with the drug;

8. The P&T committee shall evaluate and analyze treatment protocols and procedures related to the health plan's formulary at least annually;

9. The P&T committee shall review formulary management activities, including exceptions and appeals processes, prior authorization, step therapy, quantity limits, generic substitutions, therapeutic interchange, and other drug utilization management activities for clinical appropriateness and consistency with industry standards and patient and provider organization guidelines;

10. The P&T committee shall annually review and provide a written report to the pharmacy benefits manager on:

a. the percentage of prescription drugs on formulary subject to each of the types of utilization management described in paragraph 9 of this subsection,

b. rates of adherence and nonadherence to medicines by therapeutic area,

c. rates of abandonment of medicines by therapeutic area,

d. recommendations for improved adherence and reduced abandonment,

e. recommendations for improvement in formulary management practices consistent with patient and provider organization and other clinical guidelines; provided that the report shall be subject to the conditions in subsection C of this section;

11. The P&T committee shall review and make a formulary decision on a new U.S. Food and Drug Administration approved drug within ninety (90) days of such drug's approval, or shall provide a clinical justification if this time frame is not met;

12. The P&T committee shall review procedures for medical review of, and transitioning new plan enrollees to, appropriate formulary alternatives to ensure that such procedures appropriately address situations involving enrollees stabilized on drugs that are not on the health plan formulary (or that are on formulary but subject to prior authorization, step therapy, or other utilization management requirements).

C. The health insurer, its agents, including pharmacy benefits managers, and the Department shall not publish or otherwise disclose any confidential, proprietary information, including, but not limited to, any information that would reveal the identity of a specific health plan, the prices charged for a specific drug or class of drugs, the amount of any rebates provided for a specific drug or class of drugs, the manufacturer, or that would otherwise have the potential to compromise the financial, competitive, or

proprietary nature of the information. Any such information shall be protected from disclosure as confidential and proprietary information, is not a public record as defined in the Oklahoma Open Records Act, Section 24A.1 et seq. of Title 51 of the Oklahoma Statutes, and shall not be disclosed directly or indirectly. A health insurer shall impose the confidentiality protections of this section on any vendor or downstream third party that performs health care or administrative services on behalf of the pharmacy benefits manager that may receive or have access to rebate information.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6962.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An enrollee's defined cost sharing for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to at least eighty-five percent (85%) of all rebates received, or to be received, in connection with the dispensing or administration of the prescription drug.

B. For any violation of this section, the Insurance Commissioner may subject a PBM to an administrative penalty of not less than One Hundred Dollars ($100.00) nor more than Ten Thousand Dollars ($10,000.00) for each occurrence. Such administrative penalty may be enforced in the same manner in which civil judgments may be enforced.

C. Nothing in subsections A and B of this section shall preclude a PBM from decreasing an enrollee's defined cost sharing by an amount greater than that required under subsection A of this section.

D. In implementing the requirements of this section, the state shall only regulate a PBM to the extent permissible under applicable law.

E. In complying with the provisions of this section, a PBM or its agents shall not publish or otherwise reveal information regarding the actual amount of rebates a PBM receives on a product or therapeutic class of products, manufacturer, or pharmacy-specific basis. Such information is protected as a trade secret, is not a public record as defined in the Oklahoma Open Records Act, Section 24A.1 et seq. of Title 51 of the Oklahoma Statutes, and shall not be disclosed directly or indirectly, or in a manner that would allow for the identification of an individual product, therapeutic class of products, or manufacturer, or in a manner that would have the potential to compromise the financial, competitive, or proprietary nature of the information. A PBM shall impose the confidentiality protections of this section on any vendor or downstream third party that performs health care or administrative services on behalf of the insurer that may receive or have access to rebate information.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6970 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. For purposes of this section:

1. "Defined cost sharing" means a deductible payment or coinsurance amount imposed on an enrollee for a covered prescription drug under the enrollee's health plan;

2. "Insurer" means any health insurance issuer that is subject to state law regulating insurance and offers health insurance coverage, as defined in 42 U.S.C., Section 300gg-91, or any state or local governmental employer plan;

3. "Price protection rebate" means a negotiated price concession that accrues directly or indirectly to the insurer, or other party on behalf of the insurer, in the event of an increase in the wholesale acquisition cost of a drug above a specified threshold;

4. "Rebate" means:

a. negotiated price concessions including, but not limited to, base price concessions (whether described as a rebate or otherwise) and reasonable estimates of any price protection rebates and performance-based price concessions that may accrue directly or indirectly to the insurer during the coverage year from a manufacturer, dispensing pharmacy, or other

party in connection with the dispensing or administration of a prescription drug, and

b. reasonable estimates of any negotiated price concessions, fees, and other administrative costs that are passed through, or are reasonably anticipated to be passed through, to the insurer and serve to reduce the insurer's liabilities for a prescription drug.

B. An enrollee's defined cost sharing for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to at least eighty-five percent (85%) of all rebates received, or to be received, in connection with the dispensing or administration of the prescription drug.

C. For any violation of this section, the Insurance Commissioner may subject an insurer to an administrative penalty of not less than One Hundred Dollars ($100.00) nor more than Ten Thousand Dollars ($10,000.00) for each occurrence. Such administrative penalty may be enforced in the same manner in which civil judgments may be enforced.

D. Nothing in subsections A through C of this section shall preclude an insurer from decreasing an enrollee's defined cost sharing by an amount greater than that required under subsection B of this section.

E. In implementing the requirements of this section, the state shall only regulate an insurer to the extent permissible under applicable law.

F. In complying with the provisions of this section, an insurer or its agents shall not publish or otherwise reveal information regarding the actual amount of rebates an insurer receives on a product or therapeutic class of products, manufacturer, or pharmacy-specific basis. Such information is protected as a trade secret, is not a public record as defined in the Oklahoma Open Records Act, Section 24A.1 et seq. of Title 51 of the Oklahoma Statutes, and shall not be disclosed directly or indirectly, or in a manner that would allow for the identification of an individual product, therapeutic class of products, or manufacturer, or in a manner that would have the potential to compromise the financial, competitive, or proprietary nature of the information. An insurer shall impose the confidentiality protections of this section on any vendor or downstream third party that performs health care or administrative services on behalf of the insurer and that may receive or have access to rebate information.

SECTION 9. This act shall become effective November 1, 2023.

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