

1 **SENATE FLOOR VERSION**

2 April 11, 2023

3 ENGROSSED HOUSE
4 BILL NO. 2853

By: Wallace and Caldwell (Chad)
of the House

5 and

6 Montgomery, Rogers, Hicks,
7 Kirt, Kidd, Murdock,
8 Stanley, Standridge, and
9 Garvin of the Senate

10 An Act relating to health care; creating the Oklahoma
11 Rebate Pass-Through and PBM Meaningful Transparency
12 Act of 2023; amending 59 O.S. 2021, Sections 357 and
13 358, which relate to definitions; modifying
14 definitions, procedures, and penalties; creating
15 duties; creating licensing application requirements;
16 amending 36 O.S. 2021, Section 6960, as amended by
17 Section 1, Chapter 38, O.S.L. 2022 (36 O.S. Supp.
18 2022, Section 6960), which relates to definitions;
19 defining terms; creating PBM disclosures; amending 36
20 O.S. 2021, Section 6962, as amended by Section 2,
21 Chapter 38, O.S.L. 2022 (36 O.S. Supp. 2022, Section
22 6962), which relates to pharmacy benefits manager
23 compliance; creating duties; amending 36 O.S. 2021,
24 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:

1 SECTION 1. NEW LAW A new section of law not to be
2 codified in the Oklahoma Statutes reads as follows:

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

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

7 Section 357. As used in this act:

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

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

1 3. "Department" means the Oklahoma Insurance Department;

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

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

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

- 14 a. claims processing, performance of drug utilization
15 review, processing of drug prior authorization
16 requests, retail network management and payment of
17 claims to pharmacies for prescription drugs dispensed
18 to covered individuals,
- 19 b. clinical formulary development and management
20 services,
- 21 c. rebate contracting and administration,
- 22 d. certain patient compliance, therapeutic intervention
23 and generic substitution programs, ~~or~~
- 24 e. disease management programs,

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

3 g. controlling the cost of prescription drugs;

4 7. "Pharmacy benefits manager" or "PBM" means a person,
5 business or other entity that, either directly or through an
6 intermediary, performs pharmacy benefits management. The term
7 includes a person or entity acting for a PBM in a contractual or
8 employment relationship in the performance of pharmacy benefits
9 management for a managed care company, nonprofit hospital, medical
10 service organization, insurance company, third-party payor, or a
11 health program administered by an agency of this state. PBM does
12 not include a Pharmacy Services Administrative Organization;

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

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

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

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

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

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

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

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

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

19 4. Evidence of the procurement of a surety bond;

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

22 6. In the case of a PBM applicant that is a partnership or
23 other unincorporated association, limited liability corporation, or
24

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 ~~2.~~ 8. "Health insurer payor" means a health insurance company,
16 health maintenance organization, union, hospital and medical
17 services organization or any entity providing or administering a
18 self-funded health benefit plan;

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

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1 ~~3.~~ 10. "Mail-order pharmacy" means a pharmacy licensed by this
2 state that primarily dispenses and delivers covered drugs via common
3 carrier;

4 ~~4.~~ 11. "Pharmacy benefits manager" or "PBM" means a person
5 that, either directly or through an intermediary, performs pharmacy
6 benefits management, as defined in paragraph 6 of Section 357 of
7 Title 59 of the Oklahoma Statutes, and any other person acting for
8 such person under a contractual or employment relationship in the
9 performance of pharmacy benefits management for a managed-care
10 company, nonprofit hospital, medical service organization, insurance
11 company, third-party payor or a health program administered by a
12 department of this state. PBM does not include a Pharmacy Services
13 Administrative Organization;

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

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

22 ~~5.~~ 14. "Provider" means a pharmacy, as defined in Section 353.1
23 of Title 59 of the Oklahoma Statutes or an agent or representative
24 of a pharmacy;

1 15. "Rebates" means:

- 2 a. negotiated price concessions including, but not
3 limited to, base price concessions (whether described
4 as a rebate or otherwise) and reasonable estimates of
5 any price protection rebates and performance-based
6 price concessions that may accrue directly or
7 indirectly to a health insurer, health plan, or PBM
8 during the coverage year from a manufacturer,
9 dispensing pharmacy, or other party in connection with
10 the dispensing or administration of a prescription
11 drug, and
- 12 b. reasonable estimates of any price concessions, fees,
13 and other administrative costs that are passed
14 through, or are reasonably anticipated to be passed
15 through, to a health insurer, health plan, or PBM and
16 serve to reduce the health insurer, health plan, or
17 PBM's liabilities for a prescription drug;

18 ~~6.~~ 16. "Retail pharmacy network" means retail pharmacy
19 providers contracted with a PBM in which the pharmacy primarily
20 fills and sells prescriptions via a retail, storefront location;

21 ~~7.~~ 17. "Rural service area" means a five-digit ZIP code in
22 which the population density is less than one thousand (1,000)
23 individuals per square mile;

1 ~~8.~~ 18. "Spread pricing" means a prescription drug pricing model
2 utilized by a pharmacy benefits manager in which the PBM charges a
3 health benefit plan a contracted price for prescription drugs that
4 differs from the amount the PBM directly or indirectly pays the
5 pharmacy or pharmacist for providing pharmacy services;

6 ~~9.~~ 19. "Suburban service area" means a five-digit ZIP code in
7 which the population density is between one thousand (1,000) and
8 three thousand (3,000) individuals per square mile; and

9 ~~10.~~ 20. "Urban service area" means a five-digit ZIP code in
10 which the population density is greater than three thousand (3,000)
11 individuals per square mile.

12 SECTION 5. AMENDATORY 36 O.S. 2021, Section 6962, as
13 amended by Section 2, Chapter 38, O.S.L. 2022 (36 O.S. Supp. 2022,
14 Section 6962), is amended to read as follows:

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

19 B. A PBM, or an agent of a PBM, shall not:

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

23 2. Charge a pharmacist or pharmacy a fee related to the
24 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;

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

- 4 a. the original claim was submitted fraudulently, or
- 5 b. to correct errors identified in an audit, so long as
- 6 the audit was conducted in compliance with Sections
- 7 356.2 and 356.3 of Title 59 of the Oklahoma Statutes;

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

11 8. ~~Conduct or practice~~ Either directly or through an
12 intermediary, agent, or affiliate, engage in, facilitate, or enter
13 into a contract with another person involving spread pricing, as
14 defined in Section ~~4~~ 6960 of this ~~act~~ title, in this state; ~~or~~

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

- 18 a. an application fee,
- 19 b. an enrollment or participation fee,
- 20 c. a credentialing or re-credentialing fee,
- 21 d. a change of ownership fee, or
- 22 e. a fee for the development or management of claims
- 23 processing services or claims payment services; or

24 10. Prohibit or penalize a pharmacy or pharmacist for:

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

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

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

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

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

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

20 C. The prohibitions under this section shall apply to contracts
21 between pharmacy benefits managers and providers for participation
22 in retail pharmacy networks.

23 1. A PBM contract shall:
24

- 1 a. not restrict, directly or indirectly, any pharmacy
2 that dispenses a prescription drug from informing, or
3 penalize such pharmacy for informing, an individual of
4 any differential between the individual's out-of-
5 pocket cost or coverage with respect to acquisition of
6 the drug and the amount an individual would pay to
7 purchase the drug directly, and
- 8 b. ensure that any entity that provides pharmacy benefits
9 management services under a contract with any such
10 health plan or health insurance coverage does not,
11 with respect to such plan or coverage, restrict,
12 directly or indirectly, a pharmacy that dispenses a
13 prescription drug from informing, or penalize such
14 pharmacy for informing, a covered individual of any
15 differential between the individual's out-of-pocket
16 cost under the plan or coverage with respect to
17 acquisition of the drug and the amount an individual
18 would pay for acquisition of the drug without using
19 any health plan or health insurance coverage.

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

3 D. A pharmacy benefits manager shall:

4 1. Establish and maintain an electronic claim inquiry
5 processing system using the National Council for Prescription Drug
6 Programs' current standards to communicate information to pharmacies
7 submitting claim inquiries;

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

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

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

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

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

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

8 b. the aggregate amount of rebates distributed to the
9 appropriate health insurer ~~payer,~~

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

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

18 ~~d.~~

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

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

23

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

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

10 i. the individual and aggregate amount paid by the health
11 insurer ~~payer~~ to the PBM for pharmacy services
12 itemized by pharmacy, drug product and service
13 provided, and

14 ~~e.~~

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

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

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

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

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

22 Section 6964. A. A health ~~insurer's~~ insurer or its agent's,
23 including pharmacy benefits managers, pharmacy and therapeutics
24 committee (P&T committee) shall establish a formulary, which shall

1 be a list of prescription drugs, both generic and brand name, used
2 by practitioners to identify drugs that offer the greatest overall
3 value.

4 ~~B. A health insurer shall prohibit conflicts of interest for~~
5 ~~members of the P&T committee.~~ The P&T committee shall review the
6 formulary annually and must meet the following requirements:

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

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

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

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

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

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

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

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

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

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

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

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

- 16 a. the percentage of prescription drugs on formulary
17 subject to each of the types of utilization management
18 described in paragraph 9 of this subsection,
- 19 b. rates of adherence and nonadherence to medicines by
20 therapeutic area,
- 21 c. rates of abandonment of medicines by therapeutic area,
- 22 d. recommendations for improved adherence and reduced
23 abandonment,

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

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

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

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

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

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

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

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

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

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

8 E. In complying with the provisions of this section, a PBM or
9 its agents shall not publish or otherwise reveal information
10 regarding the actual amount of rebates a PBM receives on a product
11 or therapeutic class of products, manufacturer, or pharmacy-specific
12 basis. Such information is protected as a trade secret, is not a
13 public record as defined in the Oklahoma Open Records Act, Section
14 24A.1 et seq. of Title 51 of the Oklahoma Statutes, and shall not be
15 disclosed directly or indirectly, or in a manner that would allow
16 for the identification of an individual product, therapeutic class
17 of products, or manufacturer, or in a manner that would have the
18 potential to compromise the financial, competitive, or proprietary
19 nature of the information. A PBM shall impose the confidentiality
20 protections of this section on any vendor or downstream third party
21 that performs health care or administrative services on behalf of
22 the insurer that may receive or have access to rebate information.

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

4 A. For purposes of this section:

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

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

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

17 4. "Rebate" means:

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

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

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

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

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

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

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

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

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

21 COMMITTEE REPORT BY: COMMITTEE ON RETIREMENT AND INSURANCE
22 April 11, 2023 - DO PASS
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