

STATE OF OKLAHOMA

2nd Session of the 58th Legislature (2022)

HOUSE BILL 3492

By: McEntire

AS INTRODUCED

An Act relating to healthcare; creating the Oklahoma Rebate Pass Through and PBM Meaningful Transparency Act of 2022; amending 59 O.S. 2021, Sections 357 and 358, which relate to definitions; modifying definitions; creating duties; creating licensing application requirements; amending 36 O.S. 2021, Section 6960, which relates to definitions; defining terms; creating PBM disclosures; amending 36 O.S. 2021, 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; creating PBM fairness in cost sharing; creating penalties; creating insurer fairness in cost sharing; 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 2022".

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

Section 357. As used in this act:

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

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

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

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

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

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

- 7 a. claims processing, performance of drug-utilization
8 review, processing of drug prior authorization
9 requests, retail network management and payment of
10 claims to pharmacies for prescription drugs dispensed
11 to covered individuals,
- 12 b. clinical formulary development and management
13 services,
- 14 c. rebate contracting and administration,
- 15 d. certain patient compliance, therapeutic intervention
16 and generic substitution programs, ~~or~~
- 17 e. disease management programs,
- 18 f. adjudication of appeals and grievances related to the
19 prescription drug benefit, and/or
- 20 g. controlling the cost of prescription drugs;

21 7. "Pharmacy benefits manager" or "PBM" means a person,
22 business or other entity that, either directly or through an
23 intermediary, performs pharmacy benefits management. The term
24 includes a person or entity acting for a PBM in a contractual or

1 employment relationship in the performance of pharmacy benefits
2 management for a managed care company, nonprofit hospital, medical
3 service organization, insurance company, third-party payor, or a
4 health program administered by an agency of this state;

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

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

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

15 Section 358. A. In order to provide pharmacy benefits
16 management or any of the services included under the definition of
17 pharmacy benefits management in this state, a pharmacy benefits
18 manager or any entity acting as one in a contractual or employment
19 relationship for a covered entity shall first obtain a license from
20 the Oklahoma Insurance Department, and the Department may charge a
21 fee for such licensure.

22 B. The Department shall establish, by regulation, licensure
23 procedures, required disclosures for pharmacy benefits managers
24 (PBMs) and other rules as may be necessary for carrying out and

1 enforcing the provisions of this act. The licensure procedures
2 shall, at a minimum, include the completion of an application form
3 that shall include ~~the name and address of an agent for service of~~
4 ~~process, the payment of a requisite fee, and evidence of the~~
5 ~~procurement of a surety bond~~ the following:

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

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

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

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

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

14 6. In the case of a PBM applicant that is a partnership or
15 other unincorporated association, limited liability corporation or
16 corporation, and has five or more partners, members, or
17 stockholders:

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

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

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

6 7. A signed statement indicating that the PBM has not been
7 convicted of a felony and has not violated any of the requirements
8 of the Oklahoma Pharmacy Act and the Patient's Right to Pharmacy
9 Choice Act, or, if the applicant cannot provide such a statement, a
10 signed statement describing the relevant conviction(s) or
11 violation(s).

12 C. The Department may subpoena witnesses and information. Its
13 compliance officers may take and copy records for investigative use
14 and prosecutions. Nothing in this subsection shall limit the Office
15 of the Attorney General from using its investigative demand
16 authority to investigate and prosecute violations of the law.

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

SECTION 4. AMENDATORY 36 O.S. 2021, 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;

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

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

10 5. "Generic equivalent" means a drug that is designated to be
11 therapeutically equivalent, as indicated by the United States Food
12 and Drug Administration's "Approved Drug Products with Therapeutic
13 Equivalence Evaluations"; provided, however, that a drug shall not
14 be considered a generic equivalent until the drug becomes nationally
15 available;

16 6. "Health insurer" means any corporation, association, benefit
17 society, exchange, partnership or individual licensed by the
18 Oklahoma Insurance Code;

19 7. "Health insurer administrative service fees" means fees or
20 payments from a health insurer or a designee of the health insurer
21 to, or otherwise retained by, a PBM or its designee pursuant to a
22 contract between a PBM or affiliate, and the health insurer or
23 designee of the health insurer in connection with the PBM managing
24

1 or administering the pharmacy benefit and administering, invoicing,
2 allocating and collecting rebates;

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

7 ~~2.~~ 9. "Mail-order pharmacy" means a pharmacy licensed by this
8 state that primarily dispenses and delivers covered drugs via common
9 carrier;

10 ~~3.~~ 10. "Pharmacy benefits manager" or "PBM" means a person
11 that, either directly or through an intermediary, performs pharmacy
12 benefits management, as defined in paragraph 6 of Section 357 of
13 Title 59 of the Oklahoma Statutes and any other person acting for
14 such person under a contractual or employment relationship in the
15 performance of pharmacy benefits management for a managed-care
16 company, nonprofit hospital, medical service organization, insurance
17 company, third-party payor or a health program administered by a
18 department of this state;

19 ~~4.~~ 11. "Pharmacy and therapeutics committee" or "P&T committee"
20 means a committee at a hospital or a health insurance plan that
21 decides which drugs will appear on that entity's drug formulary;

22 12. "Price-protection rebate" means a negotiated-price
23 concession that accrues directly or indirectly to the health
24 insurer, or other party on behalf of the health insurer, in the

1 event of an increase in the wholesale acquisition of a drug above a
2 specified threshold;

3 13. "Rebates" means:

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

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

18 ~~5.~~ 14. "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 ~~6.~~ 15. "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 ~~7.~~ 16. "Suburban service area" means a five-digit ZIP code in
2 which the population density is between one thousand (1,000) and
3 three thousand (3,000) individuals per square mile; and

4 ~~8.~~ 17. "Urban service area" means a five-digit ZIP code in
5 which the population density is greater than three thousand (3,000)
6 individuals per square mile.

7 SECTION 5. NEW LAW A new section of law to be codified
8 in the Oklahoma Statutes as Section 6962.1 of Title 36, unless there
9 is created a duplication in numbering, reads as follows:

10 A. Beginning on January 1, 2022, and on an annual basis
11 thereafter, a pharmacy benefits manager (PBM) shall provide the
12 Insurance Department with a report containing the following
13 information from the prior calendar year as it pertains to pharmacy
14 benefits provided by health insurers to enrollees in the state:

15 1. The aggregate dollar amount of all rebates that the PBM
16 received from all pharmaceutical manufacturers;

17 2. The aggregate dollar amount of all administrative fees that
18 the PBM received;

19 3. The aggregate dollar amount of all issuer administrative
20 service fees that the PBM received;

21 4. The aggregate dollar amount of all rebates that the PBM
22 received from all pharmaceutical manufacturers and did not pass
23 through to health plans or health insurers;

1 5. The aggregate dollar amount of all administrative fees that
2 the PBM received from all pharmaceutical manufacturers and did not
3 pass through to health plans or health insurers;

4 6. The aggregate-retained rebate percentage; and

5 7. Across all of the PBM's contractual or other relationships
6 with all health plans or health insurers, the highest aggregate-
7 retained rebate percentage, the lowest aggregate-retained rebate
8 percentage, and the mean aggregate-retained rebate percentage.

9 B. The Department shall publish in a timely manner the
10 information that it receives under subsection A of this section on a
11 publicly available website; provided that such information shall be
12 made available in a form that does not disclose the identity of a
13 specific health plan or the identity of a specific manufacturer, the
14 prices charged for specific drugs or classes of drugs, or the amount
15 of any rebates provided for specific drugs or classes of drugs.

16 C. The PBM and the Department shall not publish or otherwise
17 disclose any information that would reveal the identity of a
18 specific health plan, the price(s) charged for a specific drug or
19 class of drugs, the amount of any rebates provided for a specific
20 drug or class of drugs, the manufacturer, or that would otherwise
21 have the potential to compromise the financial, competitive, or
22 proprietary nature of the information. Any such information shall
23 be protected from disclosure as confidential and proprietary
24 information, is not a public record as defined in the Oklahoma Open

1 Records Act, Section 24A.1 et seq. of Title 51 of the Oklahoma
2 Statutes, and shall not be disclosed directly or indirectly. A PBM
3 shall impose the confidentiality protections of this section on any
4 vendor or downstream third party that performs health care or
5 administrative services on behalf of the PBM and that may receive or
6 have access to rebate information.

7 SECTION 6. AMENDATORY 36 O.S. 2021, Section 6962, is
8 amended to read as follows:

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

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

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

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

- 19 a. the submission of a claim,
20 b. enrollment or participation in a retail pharmacy
21 network, or
22 c. the development or management of claims processing
23 services or claims payment services related to
24 participation in a retail pharmacy network;

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

8 4. Deny a pharmacy the opportunity to participate in any
9 pharmacy network at preferred participation status if the pharmacy
10 is willing to accept the terms and conditions that the PBM has
11 established for other pharmacies as a condition of preferred network
12 participation status;

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

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

- 20 a. the original claim was submitted fraudulently, or
- 21 b. to correct errors identified in an audit, so long as
- 22 the audit was conducted in compliance with Sections
- 23 356.2 and 356.3 of Title 59 of the Oklahoma Statutes;

24 ~~or~~

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

4 8. Contractually prohibit or penalize a pharmacy or pharmacist
5 for:

6 a. disclosing to an individual information regarding the
7 existence and clinical efficacy of a generic
8 equivalent that would be less expensive to the
9 enrollee,

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

12 (2) outside his or her health plan prescription drug
13 benefit, without requesting any health plan
14 reimbursement,

15 than the drug that was originally prescribed, or

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

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

21 (2) outside his or her health plan prescription drug
22 benefit, without requesting any health plan
23 reimbursement,

24 than the drug that was originally prescribed.

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

4 1. A PBM contract shall:

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

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

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

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

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

16 SECTION 7. AMENDATORY 36 O.S. 2021, Section 6964, is
17 amended to read as follows:

18 Section 6964. A. A health ~~insurer's~~ insurer or its agent's,
19 including pharmacy benefits managers, pharmacy and therapeutics
20 committee (P&T committee) shall establish a formulary, which shall
21 be a list of prescription drugs, both generic and brand name, used
22 by practitioners to identify drugs that offer the greatest overall
23 value.

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

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

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

20 ~~3. The P&T committee must meet no less frequently than on a~~
21 quarterly basis;

22 ~~4. P&T committee formulary development must be conducted~~
23 pursuant to a transparent process, and formulary decisions and
24 rationale must be documented in writing, with any records and

1 documents relating to the process available upon request to the
2 health plan, subject to the conditions in subsection C of this
3 section. In the case of P&T committee decisions that relate to
4 Medicaid managed care organizations' prescription drug coverage
5 policies, if the P&T committee relies upon any third party to
6 provide cost-effectiveness analysis or research, the P&T committee
7 must:

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

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

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

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

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

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

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

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

12 a. the percentage of prescription drugs on formulary
13 subject to each of the types of utilization management
14 described in paragraph 9 of this subsection,
15 b. rates of adherence and nonadherence to medicines by
16 therapeutic area,
17 c. rates of abandonment of medicines by therapeutic area,
18 d. recommendations for improved adherence and reduced
19 abandonment,
20 e. recommendations for improvement in formulary
21 management practices consistent with patient, and
22 provider organization and other clinical guidelines; provided that
23 the report shall be subject to the conditions in subsection C of
24 this section;

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

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

12 C. The health insurer, its agents, including pharmacy benefits
13 managers, and the Department shall not publish or otherwise disclose
14 any confidential, proprietary information, including, but not
15 limited to, any information that would reveal the identity of a
16 specific health plan, the prices charged for a specific drug or
17 class of drugs, the amount of any rebates provided for a specific
18 drug or class of drugs, the manufacturer, or that would otherwise
19 have the potential to compromise the financial, competitive, or
20 proprietary nature of the information. Any such information shall
21 be protected from disclosure as confidential and proprietary
22 information, is not a public record as defined in the Oklahoma Open
23 Records Act, Section 24A.1 et seq. of Title 51 of the Oklahoma
24 Statutes, and shall not be disclosed directly or indirectly. A

1 health insurer shall impose the confidentiality protections of this
2 section on any vendor or downstream third party that performs health
3 care or administrative services on behalf of the pharmacy benefits
4 manager that may receive or have access to rebate information.

5 SECTION 8. NEW LAW A new section of law to be codified
6 in the Oklahoma Statutes as Section 6962.2 of Title 36, unless there
7 is created a duplication in numbering, reads as follows:

8 A. 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 B. For any violation of this section, the Insurance
14 Commissioner may subject a PBM to an administrative penalty of not
15 less than One Hundred Dollars (\$100.00) nor more than Five Thousand
16 Dollars (\$5,000.00) for each occurrence. Such administrative
17 penalty may be enforced in the same manner in which civil judgments
18 may be enforced.

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

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

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

19 SECTION 9. NEW LAW A new section of law to be codified
20 in the Oklahoma Statutes as Section 6970 of Title 36, unless there
21 is created a duplication in numbering, reads as follows:

22 A. For purposes of this section:
23
24

- 1 1. "Defined cost sharing" means a deductible payment or
2 coinsurance amount imposed on an enrollee for a covered prescription
3 drug under the enrollee's health plan;
- 4 2. "Insurer" means any health insurance issuer that is subject
5 to state law regulating insurance and offers health insurance
6 coverage, as defined in 42 U.S.C., Section 300gg-91, or any state or
7 local governmental employer plan;
- 8 3. "Price-protection rebate" means a negotiated price
9 concession that accrues directly or indirectly to the insurer, or
10 other party on behalf of the insurer, in the event of an increase in
11 the wholesale acquisition cost of a drug above a specified
12 threshold;
- 13 4. "Rebate" means:
- 14 a. negotiated price concessions including, but not
15 limited to, base price concessions (whether described
16 as a rebate or otherwise) and reasonable estimates of
17 any price-protection rebates and performance-based
18 price concessions that may accrue directly or
19 indirectly to the insurer during the coverage year
20 from a manufacturer, dispensing pharmacy, or other
21 party in connection with the dispensing or
22 administration of a prescription drug, and
- 23 b. reasonable estimates of any negotiated price
24 concessions, fees, and other administrative costs that

1 are passed through, or are reasonably anticipated to
2 be passed through, to the insurer and serve to reduce
3 the insurer's liabilities for a prescription drug.

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

9 C. For any violation of this section, the Insurance
10 Commissioner may subject an insurer to an administrative penalty of
11 not less than One Hundred Dollars (\$100.00) nor more than Five
12 Thousand Dollars (\$5,000.00) for each occurrence. Such
13 administrative penalty may be enforced in the same manner in which
14 civil judgments may be enforced.

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

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

22 F. In complying with the provisions of this section, an insurer
23 or its agents shall not publish or otherwise reveal information
24 regarding the actual amount of rebates an insurer receives on a

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

14 SECTION 10. This act shall become effective November 1, 2022.

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