

1 ENGROSSED SENATE
2 BILL NO. 721

By: Hicks and Simpson of the
Senate

3 and

4 McEntire of the House
5

6
7 An Act relating to prescription drugs; creating the
8 Access to Lifesaving Medicines Act; defining terms;
9 prohibiting insurers and pharmacy benefit managers
10 from imposing certain cost to an insured; requiring
11 health benefit manager to offer certain discount to
12 certain entities; specifying certain prescription
13 drug cost maximums; authorizing Commissioner to
14 promulgate rules; providing for noncodification;
15 providing for codification; and providing an
16 effective date.

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

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

22 This act shall be known and may be cited as the "Access to
23 Lifesaving Medicines Act".

24 SECTION 2. 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:

As used in this act:

1. "Adjusted out-of-pocket amount" means the co-payment, co-
insurance or other cost sharing obligation the health benefit plan

1 requires the insured to pay at the point of sale for a covered
2 prescription medication otherwise payable, less the pro rata portion
3 of any discounts, rebates and price concessions in connection with
4 the prescription drug;

5 2. "Claim" means any bill, claim or proof of loss made by or on
6 behalf of an insured or a provider to a health insurer or its
7 intermediary, administrator or representative, with which the
8 provider has a provider contract for payment for health care
9 services under any health benefit plan;

10 3. "Commissioner" means the Insurance Commissioner;

11 4. "Excess cost burden" means any co-payments, co-insurance or
12 other cost sharing an insured is required to pay at the point-of-
13 sale to receive a prescription drug or device, that exceeds the
14 health insurer's or pharmacy benefit manager's net cost after
15 applying a pro-rata portion of any discounts, rebates or concessions
16 received from manufacturers, pharmacies or other third parties;

17 5. "Health benefit plan" means any individual or group health
18 benefit plan, subscription contract, evidence of coverage,
19 certificate, health services plan, medical or hospital services
20 plan, accident and sickness insurance policy or certificate, managed
21 care health insurance plan or other similar certificate, policy,
22 contract or arrangement, and any endorsement or rider thereto, to
23 cover all or a portion of the cost of persons receiving covered
24 health care services, which is subject to state regulation and which

1 is required to be offered, arranged or issued in this state. Health
2 benefit plan shall not mean:

3 a. coverage issued pursuant to Title XVIII of the Social
4 Security Act, 42 U.S.C. § 75 1395 et seq., as amended,
5 Title XIX of the Social Security Act, 42 U.S.C. § 1396
6 et seq., as amended, or Title XXI of the Social
7 Security Act, 42 U.S.C. § 1397aa et seq., as amended,
8 5 U.S.C. § 8901 et seq., as amended, or 10 U.S.C. §
9 1071 et seq., as amended or,

10 b. accident only, credit or disability insurance, long-
11 term care insurance, TRICARE supplement, Medicare
12 supplement, or workers' compensation coverages;

13 6. "Health care provider" or "provider" means a person who is
14 licensed, certified or otherwise authorized by the laws of this
15 state as a physician, physician assistant, certified nurse
16 practitioner, advanced practice registered nurse, to include one
17 with a certified specialty, registered nurse or licensed practical
18 nurse, but shall not include a nurse midwife;

19 7. "Health insurer" means any entity subject to the
20 jurisdiction of the Insurance Department and the insurance laws and
21 regulations of this state that contracts or offers to contract to
22 provide, deliver, arrange for, pay for or reimburse any of the costs
23 of health care services including but not limited to a health
24 maintenance organization, a health benefit plan or any other entity

1 providing a plan of health insurance, health benefits or health care
2 services;

3 8. "Insured" means a consumer covered under a health benefit
4 plan with prescription drug coverage that is offered by a health
5 insurer;

6 9. "Maximum allowable claim" means the amount the health
7 insurer or pharmacy benefits manager has agreed to pay a pharmacy,
8 as defined in Section 353.1 of Title 59 of the Oklahoma Statutes,
9 for the prescription medication;

10 10. "Maximum allowable cost" means the maximum dollar amount
11 that a health insurer or its intermediary will reimburse a pharmacy
12 provider for a group of drugs rated as "A", "AB", "NR" or "NA" in
13 the most recent edition of the Approved Drug Products with
14 Therapeutic Equivalence Evaluations, published by the U.S. Food and
15 Drug Administration, or similarly rated by a nationally recognized
16 reference;

17 11. "Point of sale" means the transaction in which goods or
18 services, which shall include but are not limited to prescription
19 medications, medical devices and supplies, are sold to the consumer;

20 12. "Rebate" includes but is not limited to the following:

21 a. negotiated price concessions including but not limited
22 to base rebates and reasonable estimates of any price
23 protection rebates and performance-based rebates that
24 may accrue directly or indirectly to the health

1 insurer or pharmacy benefit manager as a result of
2 point of sale prescription medication claims
3 processing during the coverage year from a
4 manufacturer, dispensing pharmacy or other party to
5 the transaction, or

- 6 b. reasonable estimates of any fees and other
7 administrative costs that are passed through to the
8 health insurer as a result of point of sale
9 prescription medication claims processing and serve to
10 reduce the health insurer's prescription medication
11 liabilities for the coverage year; and

12 13. "Provider contract" means any contract between a provider
13 and a health insurer, or an insurer's network, provider panel,
14 intermediary or representative, relating to the provision of health
15 care services.

16 SECTION 3. NEW LAW A new section of law to be codified
17 in the Oklahoma Statutes as Section 6971 of Title 36, unless there
18 is created a duplication in numbering, reads as follows:

19 A. Health insurers and pharmacy benefit managers that issue,
20 renew, or amend health benefit plans with prescription drug coverage
21 in this state are prohibited from imposing excess cost burden on an
22 insured.

23 B. When contracting with a health insurer or health benefit
24 plan to administer pharmacy benefits, a pharmacy benefits manager

1 shall offer the carrier or health plan the option of extending
2 point-of-sale rebates to enrollees of the plan.

3 C. Prescription drug cost sharing for an insured shall be the
4 lesser of:

5 1. The applicable co-payment for the prescription medication
6 that would be payable in the absence of this section;

7 2. The maximum allowable cost;

8 3. The maximum allowable claim;

9 4. The adjusted out-of-pocket amount as determined pursuant to
10 Section 2 of this act;

11 5. The amount an insured would pay for the prescription
12 medication if they purchased it without using their health benefit
13 plan or any other source of prescription medication benefits or
14 discounts; or

15 6. The amount the pharmacy will be reimbursed for the
16 prescription medication by the health insurer or pharmacy benefit
17 manager.

18 D. The Insurance Commissioner shall promulgate rules and
19 regulations to implement the provisions of this section.

20 SECTION 4. This act shall become effective November 1, 2021.

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