STATE OF OKLAHOMA

1st Session of the 58th Legislature (2021)

SENATE BILL 721 By: Hicks

AS INTRODUCED

An Act relating to prescription drugs; creating the Access to Lifesaving Medicines Act; defining terms; prohibiting insurers and pharmacy benefit managers from imposing certain cost to an insured; requiring certain monies be given to an insured; authorizing certain entities to charge transaction fee pursuant to certain contracts; specifying certain prescription drug cost maximums; authorizing Commissioner to promulgate rules; 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 "Access to Lifesaving Medicines Act".

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:

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

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

3. “Commissioner” means the Insurance Commissioner;

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

5. “Health benefit plan” means any individual or group health benefit plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to

cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in this state. Health benefit plan shall not mean:

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

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

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

7. "Health insurer" means any entity subject to the jurisdiction of the Insurance Department and the insurance laws and regulations of this state that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs

of health care services including but not limited to a health maintenance organization, a health benefit plan or any other entity providing a plan of health insurance, health benefits or health care services;

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

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

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

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

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

a. negotiated price concessions including but not limited to base rebates and reasonable estimates of any price

protection rebates and performance-based rebates that may accrue directly or indirectly to the health insurer or pharmacy benefit manager as a result of point of sale prescription medication claims processing during the coverage year from a manufacturer, dispensing pharmacy or other party to the transaction, or

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

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

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

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

B. All discounts, rebates, price concessions and fees related to a prescription medication claim shall be passed to the insured at point of sale and shall not be retained by the health insurer or pharmacy benefit manager. Health insurers and pharmacy benefit managers may retain transaction fees for each pharmacy claim processed. Transaction fee amounts shall be established in provider contracts.

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

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

2. The maximum allowable cost;

3. The maximum allowable claim;

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

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

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

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

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

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