Oklahoma

Oklahoma - HB 2800

Sponsor: Representative John Pfeiffer (R)

Actions:
03/11/2021 Failed upon originating chamber deadline
02/02/2021 Referred to House Rules Committee
01/21/2021 Introduced

Summary: Summary for 1/21/2021 Version

This measure amends Oklahoma Code relating to copay accumulator requirement.

This measure is applicable to pharmacy benefit managers, health insurers, and prescription drug manufacturers and distributors.

This measure provides that when calculating an enrollee's contribution to any of-of-pocket maximum, deductible, copayment, or coinsurance, the insurer or PBM is required to include any cost-sharing amount paid by the enrollee for a prescription drug that is:

1. Without a generic equivalent; or
2. With a generic equivalent that requires the enrollee to obtain (a.) prior authorization; (b.) step therapy; or (c.) the exception or appeals process of the PBM or insurer.

If enacted, this measure will take effect on November 1, 2021.

Bill Links 1/21/2021 Version

Oklahoma - HB 3492

Sponsor: Representative Marcus McEntire (R)

Actions:
02/16/2022 Withdrawn; referred to the House Rules Committee
02/08/2022 Referred to House Appropriations and Budget Committee
01/20/2022 Prefiled

Summary: Summary of 1/20/2022 Version

This measure creates the "Oklahoma Rebate Pass-Through and PBM Meaningful Transparency Act of 2022", which provides licensure and reporting requirements for pharmacy benefit managers. The measure allows pharmacists to disclose to a patient, information regarding the availability of a generic equivalent that would be less expensive under their prescription drug plan.

This measure is applicable to pharmacy benefits managers.

The measure amends the definition of a PBM to include the following services that a PBM provides such as performance of drug utilization review and processing of drug prior authorization requests. It also includes the adjudication of appeals regarding an individual's prescription drug benefit, and the controlling cost of prescription drugs.

Licensure
In order to provide pharmacy benefits management services, the PBM must obtain a license from the Oklahoma Insurance Department. The application form must include the name and address of the PBM, the address of the PBM's agent, the name and address of each person with management or control over the PBM, evidence of procurement of a surety bond, and the name and address of each person with a beneficial ownership interest in the PBM.

In the case of a PBM applicant that is a partnership or other unincorporated association, limited liability company, or corporation, and has five or more partners, members, or stockholders, the applicant will have to specify its legal structure and the total number of partners.
This section also requires 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.

Reporting Requirements
Beginning on January 1, 2023, and annually after, a PBM must provide the Insurance Department with a report containing the following information from the previous year as it relates to pharmacy benefits provided by health insurers to enrollees in the state:
1 The aggregate dollar amount of all rebates that the PBM received from all pharmaceutical manufacturers
2. The aggregate dollar amount of all administrative fees that the PBM received
3. The aggregate dollar amount of all issuers administrative service fees that the PBM received
4. The aggregate dollar amount of all rebates that the PBM received from all pharmaceutical manufacturers and did not pass through to health plans or health insurers
5. The aggregate dollar amount of all administrative fees that the PBM received from all pharmaceutical manufacturers and did not pass through to health plans or health insurers
6. The aggregate retained rebate percentage
7. Across all of the PBM's contractual or other relationships with all health plans or health insurers, the highest aggregate retained rebate percentage, the lowest aggregate retained rebate percentage, and the mean aggregate retained rebate percentage

This information will be made available on the website, it will not disclose the identity of any specific health plans or manufacturers. This also includes 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.

Retail Pharmacy Network Access
A PBM may not prohibit a pharmacy or pharmacist from disclosing to individual information regarding the existence and clinical efficacy of a generic equivalent that would be less expensive to the patient under their prescription drug plan, or outside of their plan. They will not be prohibited from selling to an individual, instead of a particular prescribed drug, a therapeutically equivalent.
For each of the PBM's contracts or other relationships with a health plan, a PBM must publish the health plan formulary and timely notification of formulary changes and/or product exclusions on their website.

Formulary

A PBM, pharmacy and therapeutics (P&T) will establish a formulary that is composed of prescription drugs, brand names, and generic. A majority of P&T committee members must be practicing physicians, practicing pharmacists, or both. They must be licensed to practice in this state. Members must practice in various clinical specialties, that represent the needs of health plan enrollees, and there must be an adequate number of high-volume specialists and specialists treating rare and orphan diseases.
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 must: disclose third parties, and the process through which patients are impacted by third-party's analysis or research.

The committee must rely on specialists with current clinical expertise who actively treat patients in a specific therapeutic area. The P&T committee must review the 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 patient and provider organization guidelines.

This measure will take effect on November 1, 2022.

Bill Links 1/20/2022 Version

Oklahoma - HB 3493

Sponsor: Representative Marcus McEntire (R)

Actions:
02/16/2022 Withdrawn from committee; Referred to House Rules Committee
02/07/2022 Introduced; Referred to House Appropriations and Budget Committee
01/20/2022 Prefiled

Summary: Summary of 1/20/2022 Version

This measure creates the "Oklahoma Rebate Pass-Through and PBM Meaningful Transparency Act of 2022", which provides licensure and reporting requirements for pharmacy benefit managers. The measure allows pharmacists to disclose to a patient, information regarding the availability of a generic equivalent that would be less expensive under their prescription drug plan.

This measure is applicable to pharmacy benefits managers.

The measure amends the definition of a PBM to include the following services that a PBM provides such as performance of drug utilization review and processing of drug prior authorization requests. It also includes the adjudication of appeals regarding an individual's prescription drug benefit, and the controlling cost of prescription drugs.

Licensure
In order to provide pharmacy benefits management services, the PBM must obtain a license from the Oklahoma Insurance Department. The application form must include the name and address of the PBM, the address of the PBM's agent, the name and address of each person with management or control over the PBM, evidence of procurement of a surety bond, and the name and address of each person with a beneficial ownership interest in the PBM.

In the case of a PBM applicant that is a partnership or other unincorporated association, limited liability company, or corporation, and has five or more partners, members, or stockholders, the applicant will have to specify its legal structure and the total number of partners.
This section also requires 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.

Reporting Requirements
Beginning on January 1, 2023, and annually after, a PBM must provide the Insurance Department with a report containing the following information from the previous year as it relates to pharmacy benefits provided by health insurers to enrollees in the state:
1 The aggregate dollar amount of all rebates that the PBM received from all pharmaceutical manufacturers
2. The aggregate dollar amount of all administrative fees that the PBM received
3. The aggregate dollar amount of all issuer administrative service fees that the PBM received
4. The aggregate dollar amount of all rebates that the PBM received from all pharmaceutical manufacturers and did not pass through to health plans or health insurers
5. The aggregate dollar amount of all administrative fees that the PBM received from all pharmaceutical manufacturers and did not pass through to health plans or health insurers
6. The aggregate retained rebate percentage
7. Across all of the PBM's contractual or other relationships with all health plans or health insurers, the highest aggregate retained rebate percentage, the lowest aggregate retained rebate percentage, and the mean aggregate retained rebate percentage

This information will be made available on the website, it will not disclose the identity of any specific health plans or manufacturers. This also includes 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.

Retail Pharmacy Network Access
A PBM may not prohibit a pharmacy or pharmacist from disclosing to individual information regarding the existence and clinical efficacy of a generic equivalent that would be less expensive to the patient under their prescription drug plan, or outside of their plan. They will not be prohibited from selling to an individual, instead of a particular prescribed drug, a therapeutically equivalent.

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

Formulary
A PBM, pharmacy and therapeutics (P&T) will establish a formulary that is composed of prescription drugs, brand names, and generic. 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. The committee will review the formulary annually. Formulary development must be conducted in a transparency process.

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 must: disclose third

parties, and the process through which patients are impacted by third-party's analysis or research.
The committee must rely on specialists with current clinical expertise who actively treat patients in a specific therapeutic area. The P&T committee must review the 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 patient and provider organization guidelines.

This measure will take effect on November 1, 2022.

Bill Links 1/20/2022 Version

Oklahoma - HB 4052

Sponsor: Mr. Martin Garber Jr.

Actions:
03/02/2022 Hearing Held; Substitute Adopted; Passed Committee
02/16/2022 Hearing Held
02/07/2022 Introduced; Referred to House Public Health Committee
01/20/2022 Prefiled

Summary: Summary of 3/2/2022 Version

This measure will prohibit pharmacy benefit managers from refusing to pay a provider for providing physician-administered drugs to insured individuals.

This measure is applicable to pharmacy benefits managers.

Under this measure, pharmaceutical drug plans and pharmacy benefit managers in this state may not refuse to authorize, approve, or pay a participating provider for providing covered physician-administered drugs to insured individuals. All white bagged drugs must meet supply chain security controls set by the federal Drug Supply Chain and Security Act.

Plan providers may not require a patient to self-administer injectable drugs against a provider's recommendation and will not require patients to pay additional fees beyond their cost-sharing obligations.

Any payer in violation of this measure will be fined $5,000 but not more than $10,000 per violation.

Health care facilities and providers are immune from civil liability for any loss or harm due to health insurance plans utilizing white bagged drugs caused by an act or omission by the facility or provider that was not an act of gross negligence.

"White bagged drugs" means the distribution of patient-specific medication from a pharmacy, typically a specialty pharmacy, to the physician's office, hospital, or clinic for administration.

This measure will take effect on November 1, 2022.

Bill Links [3/2/2022 Version]
[1/20/2022 Version]

Oklahoma - HB 4087

Sponsor: Representative Kevin Wallace (R)

Actions:
03/01/2022 Hearing Held; Amended; Passed Committee; Title Stricken
02/23/2022 Hearing Held
02/10/2022 Referred to House Appropriations and Budget Committee
02/07/2022 Introduced
01/20/2022 Prefiled

Summary: Summary 1/20/2022 Version

This measure creates the "Oklahoma Rebate Pass-Through and PBM Meaningful Transparency Act of 2022", which provides licensure and reporting requirements for pharmacy benefit managers. The measure allows pharmacists to disclose to a patient, information regarding the availability of a generic equivalent that would be less expensive under their prescription drug plan.

This measure is applicable to pharmacy benefits managers.

The measure amends the definition of a PBM to include the following services that a PBM provides such as performance of drug utilization review and processing of drug prior authorization requests. It also includes the adjudication of appeals regarding an individual's prescription drug benefit, and the controlling cost of prescription drugs.

Licensure
In order to provide pharmacy benefits management services, the PBM must obtain a license from the Oklahoma Insurance Department. The application form must include the name and address of the PBM, the address of the PBM's agent, the name and address of each person with management or control over the PBM, evidence of procurement of a surety bond, and the name and address of each person with a beneficial ownership interest in the PBM.

In the case of a PBM applicant that is a partnership or other unincorporated association, limited liability company, or corporation, and has five or more partners, members, or stockholders, the applicant will have to specify its legal structure and the total number of partners.

This section also requires 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.

Reporting Requirements
Beginning on January 1, 2023, and annually after, a PBM must provide the Insurance Department with a report containing the following information from the previous year as it relates to pharmacy benefits provided by health insurers to enrollees in the state:

1 The aggregate dollar amount of all rebates that the PBM received from all pharmaceutical manufacturers
2. The aggregate dollar amount of all administrative fees that the PBM received
3. The aggregate dollar amount of all issuers administrative service fees that the PBM received
4. The aggregate dollar amount of all rebates that the PBM received from all pharmaceutical manufacturers and did not pass through to health plans or health insurers
5. The aggregate dollar amount of all administrative fees that the PBM received from all pharmaceutical manufacturers and did not pass through to health plans or health insurers
6. The aggregate retained rebate percentage
7. Across all of the PBM's contractual or other relationships with all health plans or health insurers, the highest aggregate retained rebate percentage, the lowest aggregate retained rebate percentage, and the mean aggregate retained rebate percentage

This information will be made available on the website, it will not disclose the identity of any specific health plans or manufacturers. This also includes 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.

Retail Pharmacy Network Access
A PBM may not prohibit a pharmacy or pharmacist from disclosing to individual information regarding the existence and clinical efficacy of a generic equivalent that would be less expensive to the patient under their prescription drug plan, or outside of their plan. They will not be prohibited from selling to an individual, instead of a particular prescribed drug, a therapeutically equivalent.

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

Formulary
A PBM, pharmacy and therapeutics (P&T) will establish a formulary that is composed of prescription drugs, brand names, and generic. A majority of P&T committee members must be practicing physicians, practicing pharmacists, or both. They must be licensed to practice in this state. Members must practice in various clinical specialties, that represent the needs of health plan enrollees, and there must be an adequate number of high-volume specialists and specialists treating rare and orphan diseases.

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 must: disclose third parties, and the process through which patients are impacted by third-party’s analysis or research.

The committee must rely on specialists with current clinical expertise who actively treat patients in a specific therapeutic area. The P&T committee must review the 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 patient and provider organization guidelines.

This measure will take effect on November 1, 2022.

Bill Links 1/20/2022 Version

Oklahoma - SB 1324

Sponsor:

Actions:
03/02/2022 Hearing Held; Substituted; Passed Committee
02/22/2022 Referred to Senate Appropriations Committee
02/21/2022 Hearing held; amended; passed committee
02/08/2022 Referred to Senate Retirement and Insurance Committee
01/19/2022 Prefiled

Summary: Summary of 3/2/2022 Version

This measure will establish regulations and compliance measures regarding pharmacy benefits managers. The measure lists prohibited PBM practices, requires publication of data, and review formulary management activities.

This measure is applicable to pharmacy benefits managers.

Under this measure, a PBM contract must not prohibit or penalize a pharmacy from disclosing a generic equivalent that would be less expensive to the patient under their health plan prescription drug benefit or outside of their health plan's prescription drug benefits, without requesting any health plan reimbursement, than the drug that was originally prescribed. They may not prevent a pharmacy from selling a therapeutically equivalent drug.

For each of the PBM's contracts or other relationships with a health plan, a PBM must publish on their website the health plan formulary and timely notification of formulary changes and product exclusions.

A pharmacy and Therapeutics Committee (P&T) of a health insurer or its PBM must establish a formulary. The committee will review the formulary annually. The committee will meet the following requirements:

1. A majority of P&T committee members must be practicing physicians, practicing pharmacists, or both, and shall be licensed in this state
2. Practice in various clinical specialties that properly represent the needs of the health plan enrollees and there must be an appropriate number of high-volume specialists and specialists treating rare or orphan diseases
3. Must meet on a quarterly basis
4. The committee's formulary development must be conducted pursuant to a transparent process, and formulary decisions and rationale shall be documented in writing.
5. If the committee relies upon any third party to provide cost-effectiveness analysis or research for a Medicaid Managed Care organization's prescription drug policy, the committee must disclose the process through which patients and providers potentially impacted by the third party's analysis or research may provide input to the P&T committee.
6. The P&T committee will base its clinical decisions on the strength of scientific evidence, standards of practice, and nationally accepted treatment guidelines
7. They will consider whether the drug has a clinically meaningful therapeutic advantage over other drugs in terms of safety, effectiveness, or clinical outcome for the patient
8. They will evaluate and analyze treatment protocols and procedures related to the health plan's formulary annually.
9. 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.

The health insurer, its agents including pharmacy benefits managers, and the Insurance Department may not publish or otherwise disclose any confidential, proprietary information including but not limited to any information that would disclose the identity of a specific health plan, the price or 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.

The definition of “record” is updated to not include the Patient’s Right to Pharmacy Choice Act, any information that might compromise the financial, competitive, or proprietary nature of a specific drug or class of drugs.

This measure also provides licensure requirements which must include the name, address, and phone contact number of the PBM. It must include the name and address of each person within management or control over the PBM. If the PBM applicant is a partnership or other unincorporated association, limited liability company, or corporation, and has five or more partners, members, or stockholders, the applicant must:

1. specify its legal structure and the total number of its partners, members, or stockholders
2. 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
3. provide the Department with information regarding the name, address, usual occupation, and professional qualifications of any other partners, members, or stockholders

A PBM must provide a signed statement indicating that the PBM has not been convicted of a felony.

This measure will take effect on November 1, 2022.

Bill Links 3/2/2022 Version
2/21/2022 Version
1/19/2022 Version

Oklahoma - SB 1360

Sponsor: Senator Lonnie Paxton (R)

Actions: 01/18/2022 Prefiled

Summary: Summary of 1/18/2022 Version

This measure repeals the existing Oklahoma Statute relating to public health and safety provisions for the certification and requirement of long-term care, psychiatric, and chemical dependency facilities.

This measure is applicable to long-term, psychiatric, and chemical dependency facilities.

This measure repeals the following provisions of Oklahoma Statue 63 for long-term care, psychiatric, and chemical dependency facilities by removing:

(i) The section title, purpose, definition, and the State Commissioner of Health process to renew, deny, modify, suspend, and revoke certificates and establish standards and requirements for long-term care, psychiatric, and chemical dependency facilities.

(ii) Certification of need requirement and exemptions for developing or certifying a long-term facility under the Long-Term Care Certification of Need Act and psychiatric and chemical dependency facilities under the Psychiatric and Chemical Dependency Facility Certificate of Need Act.

(iii) Fees required for each application seeking certification of need.

(iv) Investigations required by the State Commissioner of Health for the approval of a certificate of need.

(v) Investigations required for a not-for-profit applicant seeking to receive a certificate of need to establish a life care community.

(vi) Appeal process for applications or any party seeking to overturn the final decision of the State Department of Health.

(vii) Timeline for submitting a certificate of need for the construction or establishment of a service or the expansion of an existing service.

(viii) The State Board of Health rules and regulations in accordance with the provisions of the Long-term Certificate of Need Act.

(ix) Decision granting or denying a certificate of need for a new long-term care facility and psychiatric or chemical dependency facility.

(x) Penalties for an individual who develops or begins a long-term care, psychiatric, or chemical dependency facility without first obtaining a certificate of need.

If enacted, this measure takes effect on November 1, 2022.

Bill Links 1/18/2022 Version

Oklahoma - SB 1394

Sponsor: Senator Dave Rader (R)

Actions: 02/07/2022 Introduced; Referred to Senate Health and Human Services Committee
01/19/2022 Prefiled

Summary: Summary for 1/19/2022 Version

This measure repeals the certificate of need requirements for long-term care facilities as well as psychiatric and chemical dependency facilities.

This measure takes effect November 1, 2022.

Bill Links 1/19/2022 Version

Oklahoma - SB 1409

Sponsor: Senator Zack Taylor (R)

Actions: 02/07/2022 Introduced; Referred to Senate Retirement and Insurance Committee
01/19/2022 Prefiled

Summary:

Bill Links 1/19/2022 Version