STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

HOUSE BILL 3368 By: McEntire

AS INTRODUCED

An Act relating to health insurance; creating the Patients Pay Less Act; providing for noncodification; limiting cost sharing; regulating pharmacy benefits managers; promulgating rules; providing definitions; limiting cost sharing; regulating health insurers and administrators; amending 36 O.S. 2021, Section 6960, as amended by Section 1, Chapter 38, O.S.L. 2022 (36 O.S. Supp. 2023, Section 6960), which relates to Patient's Right to Pharmacy Choice Act definitions; adding definitions; 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 "Patients Pay Less Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6962.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The annual limitation on cost sharing provided for under 42 U.S.C., Section 18022(c)(1) shall apply to all health care services

covered under any health plan offered or issued by a health insurer in this state, including a health plan administered by a pharmacy benefits manager.

B. A pharmacy benefits manager shall not directly or indirectly set, alter, implement, or condition the terms of health plan coverage, including the benefit design, based in part or entirely on information about the availability or amount of financial or product assistance available for a prescription drug.

C. Annually by December 31, a pharmacy benefits manager shall certify to the Insurance Commissioner that it has fully and completely complied with the requirements of this section throughout the prior calendar year. Such certification must be signed by the chief executive officer or chief financial officer of the pharmacy benefits manager.

D. This section shall apply with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 2025.

E. In implementing the requirements of this section, the state shall only regulate a health insurer, health plan, or pharmacy benefits manager to the extent permissible under applicable law.

F. The Insurance Department may promulgate rules to effectuate the provisions of this section.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6969 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Notwithstanding any other provision of law, for purposes of the Patients Pay Less Act:

1. "Administrator" has the same meaning as that term is defined in Section 1442 of Title 36 of the Oklahoma Statutes, with respect to any person who administers a health plan subject to the insurance laws and rules of insurance in this state or subject to the jurisdiction of the Insurance Department;

2. "Cost sharing" means any copayment, coinsurance, deductible, or other similar charges required of an enrollee for a health care service covered by a health plan, including a prescription drug, and paid by or on behalf of such enrollee;

3. "Enrollee" means any individual entitled to health care services from a health insurer;

4. "Health care service" means an item or service furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability;

5. "Health insurer" has the same meaning as that term is defined in Section 6960 of Title 36 of the Oklahoma Statutes;

6. "Health plan" means a policy, contract, certification, or agreement offered or issued by a health insurer to provide, deliver,

arrange for, pay for, or reimburse any of the costs of health care services; and

7. "Person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not-for-profit corporation, unincorporated organization, government, or governmental subdivision or agency.

B. The annual limitation on cost sharing provided for under 42 U.S.C., Section 18022(c)(1) shall apply to all health care services covered under any health plan offered or issued by a health insurer in this state.

C. A health insurer or administrator shall not directly or indirectly set, alter, implement, or condition the terms of health plan coverage, including the benefit design, based in part or entirely on information about the availability or amount of financial or product assistance available for a prescription drug.

D. Annually by December 31, each health insurer or administrator must certify to the Insurance Commissioner that it has fully and completely complied with the requirements of this section throughout the prior calendar year. Such certification must be signed by the chief executive officer or chief financial officer of the health insurer or administrator.

E. This section shall apply with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 2025.

F. In implementing the requirements of this section, the state shall only regulate a health insurer, health plan, or administrator to the extent permissible under applicable law.

G. The Insurance Department may promulgate rules to effectuate the provisions of this section.

SECTION 4. AMENDATORY 36 O.S. 2021, Section 6960, as amended by Section 1, Chapter 38, O.S.L. 2022 (36 O.S. Supp. 2023, Section 6960), is amended to read as follows:

Section 6960. ~~For~~ Notwithstanding any other provision of law, for purposes of the Patient's Right to Pharmacy Choice Act:

1. "Cost sharing" means any copayment, coinsurance, deductible, or other similar charges required of an enrollee for a health care service covered by a health plan, including a prescription drug, and paid by or on behalf of such enrollee;

2. "Enrollee" means any individual entitled to health care services from a health insurer;

3. "Health care service" means an item or service furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability;

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

~~2.~~ 5. "Health insurer payor" means a health insurance company, health maintenance organization, union, hospital and medical services organization or any entity providing or administering a self-funded health benefit plan;

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

~~3.~~ 7. "Mail-order pharmacy" means a pharmacy licensed by this state that primarily dispenses and delivers covered drugs via common carrier;

~~4.~~ 8. "Pharmacy benefits manager" or "PBM" means a person that, either directly or through an intermediary, performs pharmacy benefits management, as defined in paragraph 6 of Section 357 of Title 59 of the Oklahoma Statutes, and any other person acting for such person under a contractual or employment relationship in the performance of pharmacy benefits management for a managed-care company, nonprofit hospital, medical service organization, insurance company, third-party payor or a health program administered by a department of this state;

9. "Person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not-for-profit corporation, unincorporated organization, government, or governmental subdivision or agency;

~~5.~~ 10. "Provider" means a pharmacy, as defined in Section 353.1 of Title 59 of the Oklahoma Statutes or an agent or representative of a pharmacy;

~~6.~~ 11. "Retail pharmacy network" means retail pharmacy providers contracted with a PBM in which the pharmacy primarily fills and sells prescriptions via a retail, storefront location;

~~7.~~ 12. "Rural service area" means a five-digit ZIP code in which the population density is less than one thousand (1,000) individuals per square mile;

~~8.~~ 13. "Spread pricing" means a prescription drug pricing model utilized by a pharmacy benefits manager in which the PBM charges a health benefit plan a contracted price for prescription drugs that differs from the amount the PBM directly or indirectly pays the pharmacy or pharmacist for providing pharmacy services;

~~9.~~ 14. "Suburban service area" means a five-digit ZIP code in which the population density is between one thousand (1,000) and three thousand (3,000) individuals per square mile; and

~~10.~~ 15. "Urban service area" means a five-digit ZIP code in which the population density is greater than three thousand (3,000) individuals per square mile.

SECTION 5. This act shall become effective November 1, 2024.

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