BILL SUMMARY
1st Session of the 57th Legislature

Bill No.:	**HB2632**
Version:	**CS**
Request Number:	**8368**
Author:	**Rep. Echols**
Date:	**3/6/2019**
Impact:	**OID: Estimated $350,000 annually to non-appropriated agency. OMES: EGID currently estimates a total Negative fiscal impact of $7.2 Million.**

Research Analysis

The CS for HB 2632 creates the "Patient's Right to Pharmacy Choice Act" for the purpose of establishing uniform access to a pharmacy provider. The measure:

- Imposes access standards on retail pharmacy networks based on the location of individuals in the benefit plan;
- Directs the Oklahoma Insurance Department to review and approve retail pharmacy network access for all benefit plans;
- Prohibits certain actions by pharmacy benefit managers;
- Requires health insurers to monitor covered individual's access to prescription drug benefits;
- Requires health benefit plans and pharmacy benefit plans to retain any compensation remitted by a pharmaceutical manufacturer, developer or labeler for the purpose of lowering costs or expanding benefit coverage;
- Requires benefit plans to file a report with the Insurance Commissioner describing any compensation received and demonstrate how it was used to lower costs or expand coverage;
- Requires health insurers to adopt a formulary and sets minimum standards;
- Authorizes the Insurance Commissioner to monitor pharmacy benefits managers to ensure compliance with the provisions of the act; and
- Directs the Commissioner to establish a process for receiving and reviewing complaints alleging violations of the act.

Prepared By: Marcia Johnson

Fiscal Analysis

After analysis, the measure as written, per the Oklahoma Insurance Department, a non-appropriated agency, "significantly increases the duties of the agency as they relate to the regulation of Pharmacy Benefits Managers." The new duties would require specific technical expertise and a number of new FTEs. It is not possible to know how many new employees would be required, but it is safe to assume that the Department would need additional legal staff, regulatory staff, and at least one person with pharmacy benefits expertise. The agency conservatively estimates that these needs would cost at least $350,000 annually.

OMES estimates there will be an additional annual cost of $7.2 million to implement the program for HealthChoice. According to the agency:

The Employees Group Insurance Division (EGID) has reviewed HB2632 as it concerns the State of Oklahoma's self-funded health plan, HealthChoice. EGID has engaged their Pharmacy Consultant, Aon, and Pharmacy Benefits Manager (PBM), CVS Caremark, to provide impact statements for HB2632. Those impact statements, along with additional information from internal EGID personnel, are summarized below.

EGID currently estimates a total negative fiscal impact of $7.2 million. The specific areas of concern are listed below.

Page 5, (Lines 17-20): This section is vague, and as such, it is difficult to predict the impact. It appears that this section is stating PBM's and Plans must treat in-network and out-of-network providers the same and pay them the same.

> Impact: This section would require HealthChoice to pay out-of-network providers the same rates as in-network providers. This would remove any incentive for providers to be a part of the network and accept network reimbursement rates, and would subject members to balance billing by the out-of-network providers.
>
> This section also removes incentives for providers to be in-network. If providers move out-of-network HealthChoice would lose the ability to prevent fraud, waste, and abuse with these providers, as there would no longer be any contractual relationship.

Page 5, (Lines 21-23) through Page 6, (Lines 1-2) & Page 9, (Lines 19-24): These sections essentially create an Any Willing Provider (AWP) mandate for pharmacies.

> Impact: These sections would preclude HealthChoice from continuing to utilize an exclusive arrangement with CVS Specialty for specialty medications.
>
> HealthChoice currently utilizes an exclusive arrangement with CVS Specialty to provide specialty medications to HealthChoice's members. This exclusive arrangement results in HealthChoice receiving significantly better discount rates for specialty medications than HealthChoice could obtain with an open or AWP network arrangement. As a result, this section would result in a large negative fiscal impact to HealthChoice.

Page 7, (Lines 6-12): This section prohibits a PBM from reimbursing a pharmacy or pharmacist in the state an amount less than the amount the PBM reimburses a pharmacy under common ownership with a PBM.

> Impact: This section does NOT differentiate between independent pharmacies and chain pharmacies within the State of Oklahoma. Due to this, this section would require HealthChoice to reimburse all chain pharmacies in Oklahoma at the same rate as the pharmacies under common ownership with a PBM.
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> HealthChoice currently has favorable reimbursement rates with large chain pharmacies in Oklahoma. These rates would be compromised because of this section and would result in HealthChoice paying more for prescriptions filled at these pharmacies. This would result in a large negative fiscal impact to HealthChoice.

Page 7, (Lines 13-17): This section would require a health plan/PBM to allow any pharmacy the opportunity to participate in any pharmacy network at standard or preferred participation.

Impact: This section also creates an Any Willing Provider (AWP) requirement for pharmacies. This would preclude HealthChoice from continuing to utilize an exclusive arrangement with CVS Specialty for specialty medications.

HealthChoice currently utilizes an exclusive arrangement with CVS Specialty to provide specialty medications to HealthChoice's members. This exclusive arrangement results in HealthChoice receiving significantly better discount rates for specialty medications than HealthChoice could obtain with an open or AWP network arrangement. As a result, this section would result in a large negative fiscal impact to HealthChoice.

Page 7, (Lines 22-24): This section prohibits a PBM from charging different copayments/coinsurance based on the pharmacy utilized by a member.

Impact: This section does not currently affect HealthChoice; however, this section would prevent HealthChoice from incentivizing members to use lower-cost providers.

This section is the opposite of free market and would prohibit HealthChoice from creating any pharmacy programs/offerings equivalent to the current HealthChoice Select program, which reduces members' out-of-pocket costs for out-patient medical procedures if they choose to utilize low-cost providers.

Page 11, (Starting at line 10) - Page 12 (ending on line 8): This section specifies requirements for a health insurer's P&T committee and sets rules on who can serve on the P&T committee.

Impact: This section goes well beyond the P&T committee standards established under Medicare Part D and the ACA. It is not uncommon for P&T committee members to have research relationships with pharmaceutical companies, which would be prohibited under this section.

This section would effectively require HealthChoice, or HealthChoice's PBM, to establish a separate P&T committee for HealthChoice. This would be costly and result in a large administrative burden on HealthChoice. As a result, this section would have a negative fiscal impact to HealthChoice.

Prepared By: Jenny Mobley

Other Considerations

None.