BILL SUMMARY
1st Session of the 57th Legislature

Bill No.:	**SB 841**
Version:	**ENGR**
Request Number:	**NA**
Author:	**Rep. McEntire**
Date:	**4/8/2019**
Impact:	**OMES/EGID: $7.2 million anticipated**

Research Analysis

SB 841 creates the Prescription Access and Affordability Act. The measure requires pharmacy networks to comply with certain access standards. For a benefit plan's Suburban Service Area, at least 90% of covered persons must live within a 7 mile radius of a preferred participating pharmacy. For a benefit plan's Rural Service Area, at least 70% must live within a 15 mile radius of a participating pharmacy and at least 70% must live within an 18 mile radius of a preferred participating pharmacy. Mail order pharmacies may not be used to meet these accessibility requirements.

Pharmacy benefit managers (PBMs) are prohibited from certain actions, including using misleading advertisements, charging a pharmacy/pharmacist fees related to claims resolution, reimbursing a pharmacy/pharmacist less than a pharmacy/pharmacist owned by the PBM for the same services, denying a pharmacy the opportunity to participate in any pharmacy network, imposing on covered individuals any monetary advantage or penalty, retroactively denying or reducing reimbursement, or failing to make a payment to a pharmacy/pharmacist in the event the pharmacy/pharmacist is terminated from the network. The measure also prohibits contracts between PBMs and pharmacists/pharmacies from prohibiting disclosure of certain information to patients and to the Insurance Commissioner, law enforcement, and federal officials.

The measure requires all compensation remitted by a manufacturer, developer, or labeler to a PBM or health plan to be used to lower premiums, lower copayment and/or coinsurance amounts, or expand coverage. A health insurer must file with the Commissioner by March 1 every year, beginning in 2021, a report regarding the use of remitted compensation.

A health insurer's Pharmacy and Therapeutics committee must establish a formulary including minimum information set forth regarding the coverage of a drug. The formulary must be posted on the insurer's website. The committee members must not possess any conflicts of interest.

The measure directs the Commissioner to establish the Prescription Access and Affordability Advisory Committee to review complaints, hold hearings, and penalize violations, including license suspension, license revocation, or a fine not to exceed $10,000. The Committee will consist of seven members: two nominated by the Oklahoma Pharmacists Association, two consumer members nominated by the Governor, two representing PBMs nominated by the Commissioner, and one nominated by the Attorney General. Terms may not exceed two consecutive terms of five years. The measure outlines procedures of the hearings and confidentiality of documents received by the Insurance Department pursuant to this act.

Prepared By: Anna Rouw

Fiscal Analysis

The measure concerns the State of Oklahoma's self-funded health plan, HealthChoice. The Employees Group Insurance Division (EGID) of OMES has an anticipated negative fiscal impact of $7.2 million. See other considerations for the agency breakdown.

Prepared By: Jenny Mobley

Other Considerations

EGID has engaged their Pharmacy Consultant, Aon, and Pharmacy Benefits Manager (PBM), CVS Caremark, to provide impact statements. Additional information from internal EGID personnel follows with specific areas of concern.

Page 5, (Lines 7-13): 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. As written, the section would require HealthChoice to reimburse all chain pharmacies in Oklahoma at the same rate as the pharmacies under common ownership with a PBM.

HealthChoice currently has favorable reimbursement rates with large chain pharmacies in Oklahoma. Current 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 5, (Lines 14-19): 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 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 Health Choice'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 5, (Lines 20-22): 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, would prevent HealthChoice from incentivizing members to use lower-cost providers.

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

Page 8, (Lines 11-23), Page 9 (Lines 1-5): 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.