SENATE CHAMBER

STATE OF OKLAHOMA

DISPOSITION

■ FLOOR AMENDMENT No. 1

☐ COMMITTEE AMENDMENT

(Date)

I move to amend Senate Bill No. 993, by substituting the attached floor substitute (Request # 1843) for the title, enacting clause and entire body of the measure.

Submitted by:

Senator Gollihare

I hereby grant permission for the floor substitute to be adopted.

Senator Coleman, Chair (required)

Senator Alvord

Senator Brooks

Senator Grellner

Senator Guthrie

Senator Paxton, President Pro Tempore

Senator Mann

Senator Pugh

Senator Reinhardt

Senator Standridge

Senator Weaver

Senator Daniels, Majority Floor Leader

Note: Business and Insurance committee majority requires six (6) members' signatures.

Gollihare-CAD-FS-SB993
3/12/2025 1:56 PM

(Floor Amendments Only) Date and Time Filed: 3/18/25 2:01pm JD

☐ Untimely ☐ Amendment Cycle Extended ☐ Secondary Amendment

STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

FLOOR SUBSTITUTE
FOR
SENATE BILL NO. 993

By: Gollihare and Jech of the Senate

and

Stinson of the House

FLOOR SUBSTITUTE

An Act relating to pharmacy benefits managers; amending 59 O.S. 2021, Sections 356.1, 356.2, 356.3, as amended by Sections 1, 2, and 3, Chapter 332, O.S.L. 2024, and 356.4 (59 O.S. Supp. 2024, Sections 356.1, 356.2, and 356.3), which relate to definitions, pharmacy audit requirements, appeals process, and prohibited extrapolation audit; modifying notice contents; prohibiting assessment of certain fines under certain circumstances; expanding certain claim limits; establishing requirements for preliminary audit findings reports; requiring provision of certain final audit results within a certain time period; updating statutory reference; requiring certain notification to Attorney General in certain circumstances; expanding requirement for initiation of certain audit; lengthening time period for certain preliminary report; allowing certain extension request; shortening certain time period for certain final report; establishing requirements for audit findings report; modifying definition; defining terms; requiring certain tolling in certain declared disaster; providing certain exceptions; amending 59 O.S. 2021, Sections 357, 358, and 360, as amended by Sections 4, 5, and 6, Chapter 332, O.S.L. 2024 (59 O.S. Supp. 2024, Sections 357, 358, and 360), which relate to definitions, pharmacy benefits management licensure, and pharmacy benefits manager contractual

duties; modifying notice contents; defining terms; updating statutory references; requiring certain time period of tolling in certain declared disaster; requiring certain documented proof by certain pharmacy benefits managers; establishing certain denial for certain appeals; prohibiting certain collection of additional monies by certain pharmacy benefits managers; establishing certain filing period after lifting of disaster declaration; prohibiting certain denials; updating statutory language; providing for codification; and declaring an emergency.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 59 O.S. 2021, Section 356.1, as amended by Section 1, Chapter 332, O.S.L. 2024 (59 O.S. Supp. 2024, Section 356.1), is amended to read as follows:

Section 356.1. A. For purposes of the Pharmacy Audit Integrity Act~~, "pharmacy benefits manager"~~:

1. "Audit" means any review, inspection, or analysis conducted by a pharmacy benefits manager (PBM) or its representative of a pharmacy's records, practices, or compliance with contractual obligations;

2. "Disaster declaration" and "declared disaster" mean a declaration issued by the Governor or the President of the United States for an event that qualifies as a disaster including, but not limited to, a flood, tornado, earthquake, wildfire, terrorist attack, or other catastrophic event; and

3. "Pharmacy benefits manager" or "PBM" shall have the same meaning as in Section 6960 of Title 36 of the Oklahoma Statutes.

B. The purpose of the Pharmacy Audit Integrity Act is to establish minimum and uniform standards and criteria for the audit of pharmacy records by or on behalf of certain entities.

C. The Pharmacy Audit Integrity Act shall apply to any audit of the records of a pharmacy conducted by a managed care company, nonprofit hospital, medical service organization, insurance company, third-party payor, pharmacy benefits manager, a health program administered by a department of this state, or any entity that represents these companies, groups, or departments.

D. The Attorney General may promulgate rules to implement the provisions of the Pharmacy Audit Integrity Act.

SECTION 2. AMENDATORY 59 O.S. 2021, Section 356.2, as amended by Section 2, Chapter 332, O.S.L. 2024 (59 O.S. Supp. 2024, Section 356.2), is amended to read as follows:

Section 356.2. A. The entity conducting an audit of a pharmacy shall:

1. Identify and specifically describe the audit and appeal procedures in the pharmacy contract. Prescription claim documentation and ~~record-keeping~~ recordkeeping requirements shall not exceed the requirements set forth by the Oklahoma Pharmacy Act or other applicable state or federal laws or regulations;

2. Give the pharmacy written notice by certified letter to the pharmacy and the pharmacy's contracting agent, including identification of specific prescription numbers ~~and~~, fill dates, drug names, and National Drug Code (NDC) numbers to be audited, at least fourteen (14) calendar days prior to conducting the audit, including, but not limited to, an on-site audit, a desk audit, or a wholesale purchase audit, request for documentation related to the dispensing of a prescription drug, or any reimbursed activity by a pharmacy provider; provided, however, that wholesale purchase audits shall require a minimum of thirty (30) calendar days' written notice. For an on-site audit, the audit date shall be the date the on-site audit occurs. For all other audit types, the audit date shall be the date the pharmacy provides the documentation requested in the audit notice. The pharmacy shall have the opportunity to reschedule the audit no more than seven (7) calendar days from the date designated on the original audit notification;

3. Not interfere with the delivery of pharmacist services to a patient and shall utilize every reasonable effort to minimize inconvenience and disruption to pharmacy operations during the audit process;

4. Conduct any audit involving clinical or professional judgment by means of or in consultation with a licensed pharmacist;

5. Not consider as fraud any clerical or ~~record-keeping~~ recordkeeping error, such as a typographical error, scrivener's

error or computer error, including, but not limited to, a miscalculated day supply, incorrectly billed prescription written date or prescription origin code, and such errors shall not be subject to recoupment. The pharmacy shall have the right to submit amended claims electronically to correct clerical or ~~record-keeping~~ recordkeeping errors in lieu of recoupment. To the extent that an audit results in the identification of any clerical or ~~record-keeping~~ recordkeeping errors such as typographical errors, scrivener's errors or computer errors in a required document or record, the pharmacy shall not be subject to recoupment of funds by the pharmacy benefits manager unless the pharmacy benefits manager can provide proof of intent to commit fraud. A person shall not be subject to criminal penalties for errors provided for in this paragraph without proof of intent to commit fraud;

6. Permit a pharmacy to use the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of validating the pharmacy record with respect to orders or refills of a legend or narcotic drug;

7. Not include the dispensing fee amount or the actual invoice cost of the prescription dispensed in a finding of an audit recoupment unless a prescription was not actually dispensed or a physician denied authorization of a dispensing order;

8. Audit each pharmacy under identical standards, regularity and parameters as other similarly situated pharmacies and all pharmacies owned or managed by the pharmacy benefits manager conducting or having conducted the audit;

9. Not exceed one (1) year from the date the claim was submitted to or adjudicated by a managed care company, nonprofit hospital or medical service organization, insurance company, third-party payor, pharmacy benefits manager, a health program administered by a department of this state, or any entity that represents the companies, groups, or departments for the period covered by an audit;

10. Not schedule or initiate an audit during the first seven (7) calendar days of any month unless otherwise consented to by the pharmacy;

11. Disclose to any plan sponsor whose claims were included in the audit any money recouped in the audit;

12. Not require pharmacists to break open packaging labeled "for single-patient-use only". Packaging labeled "for single-patient-use only" shall be deemed to be the smallest package size available; ~~and~~

13. Upon recoupment of funds from a pharmacy, refund first to the patient the portion of the recovered funds that were originally paid by the patient, provided such funds were part of the recoupment; and

14. Not assess a fine, penalty, or any other financial requirement on the pharmacy or pharmacist for any prescription audited unless there is a valid recoupment under the Pharmacy Audit Integrity Act.

B. 1. Any entity that conducts wholesale purchase review during an audit of a pharmacist or pharmacy shall not require the pharmacist or pharmacy to provide a full dispensing report. Wholesaler invoice reviews shall be limited to verification of purchase inventory specific to the pharmacy claims paid by the health benefits plan or pharmacy benefits manager conducting the audit.

2. Any entity conducting an audit shall not identify or label a prescription claim as an audit discrepancy when:

a. the National Drug Code for the dispensed drug is in a quantity that is a subunit or multiple of the drug purchased by the pharmacist or pharmacy as supported by a wholesale invoice,

b. the pharmacist or pharmacy dispensed the correct quantity of the drug according to the prescription, and

c. the drug dispensed by the pharmacist or pharmacy shares all but the last two digits of the National Drug Code of the drug reflected on the supplier invoice.

3. An entity conducting an audit shall accept as evidence, subject to validation, to support the validity of a pharmacy claim related to a dispensed drug:

a. redacted copies of supplier invoices in the pharmacist's or pharmacy's possession, or

b. invoices and any supporting documents from any supplier as authorized by federal or state law to transfer ownership of the drug acquired by the pharmacist or pharmacy.

4. An entity conducting an audit shall provide, no later than five (5) calendar days after the date of a request by the pharmacist or pharmacy, all supporting documents the pharmacist's or pharmacy's purchase suppliers provided to the health benefits plan issuer or pharmacy benefits manager.

C. A pharmacy shall be allowed to provide the pharmacy's computerized patterned medical records or the records of a hospital, physician, or other authorized practitioner of the healing arts for drugs or medicinal supplies written or transmitted by any means of communication for purposes of supporting the pharmacy record with respect to orders or refills of a legend or narcotic drug.

D. The ~~entity conducting the audit shall not audit more than fifty prescriptions, with specific date of service, per calendar year~~ PBM or its agent shall not exceed an annual limit of one hundred prescription claims with a specific prescription number and

date of fill per calendar year. The annual limit to the number of prescription claims audited shall be inclusive of all audits by a PBM or its agent, including any prescription-related documentation requests from the health insurer, pharmacy benefits manager or any third-party company conducting audits on behalf of any health insurer or pharmacy benefits manager during a calendar year. Notwithstanding the annual limit on the number of prescription claims per calendar year pursuant to this section, no PBM or its agent shall exceed more than fifty prescription claims with a specific prescription number and date of fill on an individual audit.

E. If paper copies of records are requested by the entity conducting the audit, the entity shall pay twenty-five cents ($0.25) per page to cover the costs incurred by the pharmacy. The entity conducting the audit shall provide the pharmacy with accurate instructions, including any required form for obtaining reimbursement for the copied records.

F. The entity conducting the audit shall:

1. Deliver a preliminary audit findings report to the pharmacy and the pharmacy's contracting agent within forty-five (45) calendar days of conducting the audit;

2. Allow the pharmacy at least ninety (90) calendar days following receipt of the preliminary audit findings report in which to produce documentation to address any discrepancy found during the

audit; provided, however, a pharmacy may request an extension, not to exceed an additional forty-five (45) calendar days;

3. Deliver a final audit findings report to the pharmacy and the pharmacy's contracting agent signed by the auditor within ten (10) calendar days after receipt of additional documentation provided by the pharmacy, as provided for in Section 356.3 of this title;

4. Allow the pharmacy to reverse and resubmit claims electronically within thirty (30) calendar days of receipt of the final audit report in lieu of the auditing entity recouping discrepant claim amounts from the pharmacy;

5. Not recoup any disputed funds until after final disposition of the audit findings, including the appeals process as provided for in Section 356.3 of this title; ~~and~~

6. Not accrue interest during the audit and appeal period;

7. Ensure that each preliminary audit findings report required by this section includes:

a. specific prescription numbers, fill dates, drug names, and NDC numbers, and

b. the date of receipt of documents from the pharmacy, the pharmacy's contracting agent, or any other source associated with the audit.

~~G. Each entity conducting an audit shall provide a copy of the final audit results, and a final audit report upon request, after completion of any review process to the plan sponsor~~

In addition to the requirements for a preliminary audit findings report in this paragraph, the final audit findings report shall include any additional documentation that was submitted to the auditing entity;

8. Provide the plan sponsor a copy of the final audit results within thirty (30) calendar days of the final disposition of the audit; and

9. At the request of the plan sponsor, provide a copy of the final audit findings report within thirty (30) calendar days of the request.

~~H.~~ G. 1. The full amount of any recoupment on an audit shall be refunded to the plan sponsor. Except as provided for in paragraph 2 of this subsection, a charge or assessment for an audit shall not be based, directly or indirectly, on amounts recouped.

2. This subsection does not prevent the entity conducting the audit from charging or assessing the responsible party, directly or indirectly, based on amounts recouped if both of the following conditions are met:

a. the plan sponsor and the entity conducting the audit have a contract that explicitly states the percentage charge or assessment to the plan sponsor, and

b. a commission to an agent or employee of the entity conducting the audit is not based, directly or indirectly, on amounts recouped.

~~I.~~ H. Unless superseded by state or federal law, auditors shall only have access to previous audit reports on a particular pharmacy conducted by the auditing entity for the same pharmacy benefits manager, health plan or insurer. An auditing vendor contracting with multiple pharmacy benefits managers or health insurance plans shall not use audit reports or other information gained from an audit on a pharmacy to conduct another audit for a different pharmacy benefits manager or health insurance plan.

~~J. Sections A through I~~

I. Paragraph 2 of subsection A of this section through subsection D of this section, and paragraph 1 through paragraph 7 of subsection F of this section shall not apply to any audit initiated based on ~~or that involves~~ suspicion of fraud, willful misrepresentation, or abuse.

~~K.~~ J. If the Attorney General, after notice and opportunity for hearing, finds that the entity conducting the audit failed to follow any of the requirements pursuant to the Pharmacy Audit Integrity Act, the audit shall be considered null and void. Any monies recouped from a null and void audit shall be returned to the affected pharmacy within fourteen (14) calendar days. Any violation

of this section by a pharmacy benefits manager or auditing entity shall be deemed a violation of the Pharmacy Audit Integrity Act.

SECTION 3. AMENDATORY 59 O.S. 2021, Section 356.3, as amended by Section 3, Chapter 332, O.S.L. 2024 (59 O.S. Supp. 2024, Section 356.3), is amended to read as follows:

Section 356.3. A. Each entity conducting an audit shall establish a written appeals process under which a pharmacy may appeal an unfavorable preliminary audit report and/or final audit report to the entity.

B. Following an appeal, if the entity finds that an unfavorable audit report or any portion thereof is unsubstantiated, the entity shall dismiss the audit report or the unsubstantiated portion of the audit report without any further action.

C. Any final audit report, following the final audit appeal period, with a finding of fraud or willful misrepresentation shall be referred to the district attorney having proper jurisdiction or the Attorney General for prosecution upon completion of the appeals process. If a finding of fraud or willful misrepresentation is referred to a district attorney under this subsection, the auditing entity shall notify the Attorney General as to whom the referral was made and the date the referral was made.

D. For any audit initiated based on ~~or that involves~~ suspicion of fraud, willful misrepresentation, or abuse, the auditing entity shall provide, in writing, at the time of the audit, a clear and

conspicuous declaration to the pharmacy being audited that the audit is being conducted under suspicion of fraud, willful misrepresentation, or abuse and a statement of facts that supports the reasonable suspicion. The entity conducting an audit based on suspicion of fraud, willful misrepresentation, or abuse shall provide a copy of the clear and conspicuous declaration required by this subsection to the pharmacy's contracting agent by certified mail within five (5) business days of notifying the pharmacy of an audit pursuant to this section.

E. The entity conducting an audit based on suspicion of fraud, willful misrepresentation, or abuse shall:

1. Deliver a preliminary findings report to the pharmacy and the pharmacy's contracting agent within ninety (90) calendar days of notification of the audit;

2. Allow the pharmacy at least ninety (90) calendar days following the receipt of the preliminary audit findings report in which to produce documentation to address any discrepancy found during the audit. A pharmacy may request an extension, not to exceed an additional forty-five (45) calendar days;

3. Deliver a final audit findings report to the pharmacy and the pharmacy's contracting agent signed by the auditor within thirty (30) calendar days after receipt of additional documentation provided by the pharmacy;

4. Allow the pharmacy to reverse and resubmit claims electronically within thirty (30) calendar days of receipt of the final audit report in lieu of the auditing entity recouping discrepant claim amounts from the pharmacy;

5. Not recoup any disputed funds until after the final disposition of the audit findings, including the appeals process pursuant to this section;

6. Not accrue interest during the audit and appeal period;

7. Ensure that each preliminary audit findings report submitted pursuant to this section includes:

a. specific prescription numbers, fill dates, drug names, and NDC numbers, and

b. the date of receipt of documents from the pharmacy, the pharmacy's contracting agent, or any other source associated with the audit;

8. Ensure that each final audit findings report includes any additional documentation that was submitted to the auditing entity;

9. Provide the plan sponsor a copy of the final audit results within thirty (30) calendar days of the final disposition of the audit; and

10. At the request of the plan sponsor, provide a copy of the final audit report within thirty (30) calendar days of the request.

F. Any entity conducting an audit that is based on ~~or involves~~ suspicion of fraud, willful misrepresentation, or abuse shall provide to the Office of the Attorney General:

1. Notice at least two (2) calendar days prior to beginning performance of an audit pursuant to this section;

2. A preliminary report within ~~thirty (30) calendar days of performing the audit~~ five (5) business days of providing a copy of the preliminary report to the pharmacy and the pharmacy's contracting agent pursuant to this section. The auditing entity may request an extension from the Attorney General, not to exceed an additional ninety (90) calendar days; and

3. A final report within ~~thirty (30)~~ ten (10) calendar days following the closure of the final appeal period for an audit performed pursuant to this section.

a. The final report for the Office of the Attorney General shall include the name of each plan sponsor whose claims were included in the audit recover, the amount of funds recouped on behalf of the plan, the date the plan sponsor was notified of the recoupment, the date the plan sponsor was paid any recoupment, and the name and contact information for the representative of the plan sponsor who was notified of the recoupment at issue in an audit pursuant to this section.

b. The auditing entity may request an extension from the Attorney General, not to exceed an additional ten (10) calendar days.

~~F.~~ G. The Attorney General, authorized employees, and examiners shall have access to any pharmacy benefits manager's files and records that may relate to ~~an~~ any audit including, but not limited to, an audit that is based on ~~or involves~~ suspicion of fraud, willful misrepresentation, or abuse.

~~C.~~ H. The Attorney General may levy a civil or administrative fine ~~of~~ not less than One Hundred Dollars ($100.00) and not greater than Ten Thousand Dollars ($10,000.00) for each violation of this section and assess any other penalty or remedy authorized by law.

SECTION 4. AMENDATORY 59 O.S. 2021, Section 356.4, is amended to read as follows:

Section 356.4. A. For the purposes of the Pharmacy Audit Integrity Act, "extrapolation audit" means an audit of a sample of prescription drug benefit claims submitted by a pharmacy to the entity conducting the audit that is then used to estimate audit results for a larger batch or group of claims not reviewed by the auditor, including refills not listed in the written notification in accordance with paragraph 2 of subsection A of Section 356.2 of this title.

B. The entity conducting the audit shall not use the ~~accounting~~ practice of extrapolation in calculating recoupments or penalties for audits.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 356.6 of Title 59, unless there is created a duplication in numbering, reads as follows:

A. Notwithstanding any other provision of law, the ability of a pharmacy benefits manager (PBM) to initiate, continue, or conclude an audit of a pharmacy shall be tolled for the duration of a declared disaster and for an additional period of thirty (30) calendar days following the termination of a declared disaster.

Such requirement shall apply only to the pharmacies located within the geographical boundaries of the county or counties affected by the declared disaster.

B. The provisions of this section shall apply to all PBMs operating within this state, and to all audits conducted pursuant to contracts between PBMs and pharmacies.

C. This section shall not apply to:

1. Audits conducted for suspected fraudulent activity if documented evidence of such activity exists; or

2. Audits required to comply with federal or state law unrelated to the contractual relationship between a PBM and a pharmacy.

D. Nothing in this section shall be construed to prohibit a pharmacy from voluntarily agreeing to continue or complete an audit during the tolling period, provided such agreement is documented in writing and signed by both parties.

E. A PBM may submit a request to the Attorney General to continue or complete an audit during the tolling period, which the Attorney General may grant at his or her sole discretion. Any PBM granted such permission by the Attorney General shall do so pursuant to the requirements of this act.

SECTION 6. AMENDATORY 59 O.S. 2021, Section 357, as amended by Section 4, Chapter 332, O.S.L. 2024 (59 O.S. Supp. 2024, Section 357), is amended to read as follows:

Section 357. A. As used in Sections 357 through 360 of this title and Section 8 of this act:

1. "Covered entity" means a nonprofit hospital or medical service organization, for-profit hospital or medical service organization, insurer, health benefit plan, health maintenance organization, health program administered by the state in the capacity of providing health coverage, or an employer, labor union, or other group of persons that provides health coverage to persons in this state. This term does not include a health benefit plan that provides coverage only for accidental injury, specified disease, hospital indemnity, disability income, or other limited

benefit health insurance policies and contracts that do not include prescription drug coverage;

2. "Covered individual" means a member, participant, enrollee, contract holder or policy holder or beneficiary of a covered entity who is provided health coverage by the covered entity. A covered individual includes any dependent or other person provided health coverage through a policy, contract or plan for a covered individual;

3. "Department" means the Insurance Department;

4. "Maximum allowable cost", "MAC", or "MAC list" means the list of drug products delineating the maximum per-unit reimbursement for multiple-source prescription drugs, medical product, or device;

5. "Multisource drug product reimbursement" (reimbursement) means the total amount paid to a pharmacy inclusive of any reduction in payment to the pharmacy, excluding prescription dispense fees;

6. "Office" means the Office of the Attorney General;

7. "Pharmacy benefits management" means a service provided to covered entities to facilitate the provision of prescription drug benefits to covered individuals within the state, including negotiating pricing and other terms with drug manufacturers and providers. Pharmacy benefits management may include any or all of the following services:

a. claims processing, retail network management and payment of claims to pharmacies for prescription drugs dispensed to covered individuals,

b. clinical formulary development and management services, or

c. rebate contracting and administration;

8. "Pharmacy benefits manager" or "PBM" means a person, business, or other entity that performs pharmacy benefits management. The term shall include <u>any business or entity licensed by the Insurance Department to perform PBM services, or</u> a person or entity acting on behalf of a PBM in 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 an agency or department of this state;

9. "Plan sponsor" means the employers, insurance companies, unions and health maintenance organizations or any other entity responsible for establishing, maintaining, or administering a health benefit plan on behalf of covered individuals; and

10. "Provider" means a pharmacy licensed by the State Board of Pharmacy, or an agent or representative of a pharmacy, including, but not limited to, the pharmacy's contracting agent, which dispenses prescription drugs or devices to covered individuals.

B. Nothing in the definition of pharmacy benefits management or pharmacy benefits manager in the Patient's Right to Pharmacy Choice Act, Pharmacy Audit Integrity Act, ~~or~~ Sections 357 through 360 of this title, or Section 8 of this act shall deem an employer a ~~"pharmacy benefits manager"~~ pharmacy benefits manager of its own self-funded health benefit plan, except, to the extent permitted by applicable law, where the employer, without the utilization of a third party and unrelated to the employer's own pharmacy:

~~a. negotiates~~

1. Negotiates directly with drug manufacturers~~,~~;

~~b. processes~~

2. Processes claims on behalf of its members~~,~~; or

~~c. manages~~

3. Manages its own retail network of pharmacies.

SECTION 7. AMENDATORY 59 O.S. 2021, Section 358, as amended by Section 5, Chapter 332, O.S.L. 2024 (59 O.S. Supp. 2024, Section 358), is amended to read as follows:

Section 358. A. In order to provide pharmacy benefits management or any of the services included under the definition of pharmacy benefits management in this state, a pharmacy benefits manager or any entity acting as one in a contractual or employment relationship for a covered entity shall first obtain a license from the Insurance Department, and the Department may charge a fee for such licensure.

B. The Department shall establish, by regulation, licensure procedures, required disclosures for pharmacy benefits managers (PBMs) and other rules as may be necessary for carrying out and enforcing the provisions of this title. The licensure procedures shall, at a minimum, include the completion of an application form that shall include the name and address of an agent for service of process, the payment of a requisite fee, and evidence of the procurement of a surety bond.

C. The Department or the Office of the Attorney General may subpoena witnesses and information. Its compliance officers may take and copy records for investigative use and prosecutions. Nothing in this subsection shall limit the Office of the Attorney General from using its investigative demand authority to investigate and prosecute violations of the law.

D. The Department may suspend, revoke or refuse to issue or renew a license for noncompliance with any of the provisions hereby established or with the rules promulgated by the Department; for conduct likely to mislead, deceive or defraud the public or the Department; for unfair or deceptive business practices or for nonpayment of an application or renewal fee or fine. The Department may also levy administrative fines for each count of which a PBM has been convicted in a Department hearing.

E. 1. The Office of the Attorney General, after notice and opportunity for hearing, may instruct the Insurance Commissioner

that the PBM's license be censured, suspended, or revoked for conduct likely to mislead, deceive, or defraud the public or the State of Oklahoma; or for unfair or deceptive business practices, or for any violation of the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, ~~or~~ Sections 357 through 360 of this title, or Section 8 of this act. The Office of the Attorney General may also levy administrative fines for each count of which a PBM has been convicted following a hearing before the Attorney General. If the Attorney General makes such instruction, the Commissioner shall enforce the instructed action within thirty (30) calendar days.

2. In addition to or in lieu of any censure, suspension, or revocation of a license by the Commissioner, the Attorney General may levy a civil or administrative fine ~~of~~ not less than One Hundred Dollars ($100.00) and not greater than Ten Thousand Dollars ($10,000.00) for each violation of this subsection and/or assess any other penalty or remedy authorized by this section. For purposes of this section, each day a PBM fails to comply with an investigation or inquiry may be considered a separate violation.

F. The Attorney General may promulgate rules to implement the provisions of Sections 357 through 360 of this title and Section 8 of this act.

SECTION 8. AMENDATORY 59 O.S. 2021, Section 360, as amended by Section 6, Chapter 332, O.S.L. 2024 (59 O.S. Supp. 2024, Section 360), is amended to read as follows:

Section 360. A. The pharmacy benefits manager shall, with respect to contracts between a pharmacy benefits manager and a provider, including a pharmacy service administrative organization:

1. Include in such contracts the specific sources utilized to determine the maximum allowable cost (MAC) pricing of the pharmacy, update MAC pricing at least every seven (7) calendar days, and establish a process for providers to readily access the MAC list specific to that provider;

2. In order to place a drug on the MAC list, ensure that the drug is listed as "A" or "B" rated in the most recent version of the ~~FDA's~~ United States Food and Drug Administration (FDA) Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, and the drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;

3. Ensure dispensing fees are not included in the calculation of MAC price reimbursement to pharmacy providers;

4. Provide a reasonable administration appeals procedure to allow a provider, a provider's representative and a pharmacy service administrative organization to contest reimbursement amounts within fourteen (14) calendar days of the final adjusted payment date. The pharmacy benefits manager shall not prevent the pharmacy or the pharmacy service administrative organization from filing reimbursement appeals in an electronic batch format. The pharmacy

benefits manager must respond to a provider, a provider's representative and a pharmacy service administrative organization who have contested a reimbursement amount through this procedure within ten (10) calendar days. The pharmacy benefits manager must respond in an electronic batch format to reimbursement appeals filed in an electronic batch format. The pharmacy benefits manager shall not require a pharmacy or pharmacy services administrative organization to log into a system to upload individual claim appeals or to download individual appeal responses. If a price update is warranted, the pharmacy benefits manager shall make the change in the reimbursement amount, permit the dispensing pharmacy to reverse and rebill the claim in question, and make the reimbursement amount change retroactive and effective for all contracted providers; ~~and~~

5. If a below-cost reimbursement appeal is denied, the PBM shall provide the reason for the denial, including the National Drug Code (NDC) number from, and the name of, the specific national or regional wholesalers doing business in this state where the drug is currently in stock and available for purchase by the dispensing pharmacy at a price below the PBM's reimbursement price. The PBM shall include documented proof from the specific national or regional wholesalers doing business in this state showing that the drug is currently in stock and available for purchase by the dispensing pharmacy at a price below the PBM's reimbursement price. If the NDC number provided by the pharmacy benefits manager is not

available below the acquisition cost obtained from the pharmaceutical wholesaler from whom the dispensing pharmacy purchases the majority of the prescription drugs that are dispensed, the pharmacy benefits manager shall immediately adjust the reimbursement amount, permit the dispensing pharmacy to reverse and rebill the claim in question, and make the reimbursement amount adjustment retroactive and effective for all contracted providers;

6. Any appeal that results in an increase in the reimbursement from the PBM that continues to be below the pharmacy's acquisition cost shall be considered a denial under this section. Any denial of an appeal shall follow the requirements of paragraph 5 of this subsection; and

7. The PBM shall not require a pharmacy to collect additional monies following a successful below-cost reimbursement appeal from any person or entity other than the PBM who adjudicated the drug claim, including the patient or plan sponsor.

B. The reimbursement appeal requirements in this section shall apply to all drugs, medical products, or devices reimbursed according to any payment methodology, including, but not limited to:

1. Average acquisition cost, including the National Average Drug Acquisition Cost;

2. Average manufacturer price;

3. Average wholesale price;

4. Brand effective rate or generic effective rate;

5. Discount indexing;

6. Federal upper limits;

7. Wholesale acquisition cost; and

8. Any other term that a pharmacy benefits manager or an insurer of a health benefit plan may use to establish reimbursement rates to a pharmacist or pharmacy for pharmacist services.

C. The pharmacy benefits manager shall not place a drug on a MAC list, unless there are at least two therapeutically equivalent, multiple-source drugs, generally available for purchase by dispensing retail pharmacies from national or regional wholesalers.

D. In the event that a drug is placed on the FDA Drug Shortages Database, pharmacy benefits managers shall reimburse claims to pharmacies at no less than the wholesale acquisition cost for the specific NDC number being dispensed.

E. The pharmacy benefits manager shall not require accreditation or licensing of providers, or any entity licensed or regulated by the State Board of Pharmacy, other than by the State Board of Pharmacy or federal government entity as a condition for participation as a network provider.

F. A pharmacy or pharmacist may decline to provide the pharmacist clinical or dispensing services to a patient or pharmacy benefits manager if the pharmacy or pharmacist is to be paid less than the pharmacy’s cost for providing the pharmacist clinical or dispensing services.

G. The pharmacy benefits manager shall provide a dedicated telephone number, email address and names of the personnel with decision-making authority regarding MAC appeals and pricing.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 360.1 of Title 59, unless there is created a duplication in numbering, reads as follows:

A. If a disaster declaration is issued for a county in this state, the time period for a provider, a provider's representative, or a pharmacy service administrative organization to file a below-cost reimbursement appeal pursuant to Section 360 of Title 59 of the Oklahoma Statutes shall be tolled for the duration of the disaster declaration.

B. Upon the expiration of the disaster declaration, the tolling of the filing period for below-cost reimbursement appeals shall continue for an additional thirty (30) calendar days. Afterward, the time period for filing a below-cost reimbursement appeal, as otherwise provided under state law, shall resume.

C. The tolling provisions of this section shall apply only to continuing counties included in the declared disaster area and to below-cost reimbursement appeals arising from claims impacted during the time period of the declared disaster.

D. A pharmacy benefits manager (PBM) shall not deny a below-cost reimbursement appeal on timeliness if such appeal is filed during the tolled period provided in this section.

E. The Attorney General may promulgate rules to implement the provisions of this act.

SECTION 10. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

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