

STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

COMMITTEE SUBSTITUTE
FOR ENGROSSED
SENATE BILL NO. 789

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Hines, Sacchieri, Goodwin,
Reinhardt, Hall, Gillespie,
and Bergstrom of the Senate

and

Stinson, Marti, Moore and
Stewart of the House

COMMITTEE SUBSTITUTE

[pharmacy benefit managers - pharmacy audit -
records - network sharing - reimbursement rates -
fee increase - contracts - penalties - effective
date]

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

2 SECTION 1. AMENDATORY 59 O.S. 2021, Section 356.2, as
3 amended by Section 2, Chapter 332, O.S.L. 2024 (59 O.S. Supp. 2024,
4 Section 356.2), is amended to read as follows:

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

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

12 2. Give the pharmacy written notice by certified letter to the
13 pharmacy and the pharmacy's contracting agent, including
14 identification of specific prescription numbers and fill dates to be
15 audited, at least fourteen (14) calendar days prior to conducting
16 the audit, including, but not limited to, an on-site audit, a desk
17 audit, or a wholesale purchase audit, request for documentation
18 related to the dispensing of a prescription drug or any reimbursed
19 activity by a pharmacy provider; provided, however, that wholesale
20 purchase audits shall require a minimum of thirty (30) calendar
21 days' written notice. For an on-site audit, the audit date shall be
22 the date the on-site audit occurs. For all other audit types, the
23 audit date shall be the date the pharmacy provides the documentation
24 requested in the audit notice. The pharmacy shall have the

1 opportunity to reschedule the audit no more than seven (7) calendar
2 days from the date designated on the original audit notification;

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

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

9 5. Not consider as fraud any clerical or record-keeping error,
10 such as a typographical error, scrivener's error or computer error,
11 including, but not limited to, a miscalculated day supply,
12 incorrectly billed prescription written date or prescription origin
13 code, and such errors shall not be subject to recoupment. The
14 pharmacy shall have the right to submit amended claims
15 electronically to correct clerical or record-keeping errors in lieu
16 of recoupment. To the extent that an audit results in the
17 identification of any clerical or record-keeping errors such as
18 typographical errors, scrivener's errors or computer errors in a
19 required document or record, the pharmacy shall not be subject to
20 recoupment of funds by the pharmacy benefits manager unless the
21 pharmacy benefits manager can provide proof of intent to commit
22 fraud. A person shall not be subject to criminal penalties for
23 errors provided for in this paragraph without proof of intent to
24 commit fraud;

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

6 7. Permit a pharmacy to use drug purchase records without
7 limitation of date or source to validate the dispensing of a
8 prescription drug or a controlled dangerous substance, provided the
9 drug purchase was done in accordance with state or federal law;

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

14 ~~8.~~ 9. Audit each pharmacy under identical standards, regularity
15 and parameters as other similarly situated pharmacies and all
16 pharmacies owned or managed by the pharmacy benefits manager
17 conducting or having conducted the audit;

18 ~~9.~~ 10. Not exceed one (1) year from the date the claim was
19 submitted to or adjudicated by a managed care company, nonprofit
20 hospital or medical service organization, insurance company, third-
21 party payor, pharmacy benefits manager, a health program
22 administered by a department of this state, or any entity that
23 represents the companies, groups, or departments for the period
24 covered by an audit;

~~10.~~ 11. Not schedule or initiate an audit during the first seven (7) calendar days of any month unless otherwise consented to by the pharmacy;

~~11.~~ 12. Disclose to any plan sponsor whose claims were included in the audit any money recouped in the audit;

~~12.~~ 13. 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.~~ 14. 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.

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 without limitation to date or source of purchase.

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

1 purchased by the pharmacist or pharmacy as supported
2 by a wholesale invoice,

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

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

10 3. An entity conducting an audit shall accept as evidence,
11 without limitation on date or source of purchase subject to
12 validation, to support the validity of a pharmacy claim related to a
13 dispensed drug:

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

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

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

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

7 D. The entity conducting the audit shall not audit more than
8 fifty prescriptions, with specific date of service, per calendar
9 year. The annual limit to the number of prescription claims audited
10 shall be inclusive of all audits, including any prescription-related
11 documentation requests from the health insurer, pharmacy benefits
12 manager or any third-party company conducting audits on behalf of
13 any health insurer or pharmacy benefits manager during a calendar
14 year.

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

21 F. The entity conducting the audit shall:

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

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

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

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

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

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

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

22 H. 1. The full amount of any recoupment on an audit shall be
23 refunded to the plan sponsor. Except as provided for in paragraph 2
24

1 of this subsection, a charge or assessment for an audit shall not be
2 based, directly or indirectly, on amounts recouped.

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

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

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

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

21 J. Sections A through I of this section shall not apply to any
22 audit initiated based on or that involves fraud, willful
23 misrepresentation, or abuse.

1 K. If the Attorney General, after notice and opportunity for
2 hearing, finds that the entity conducting the audit failed to follow
3 any of the requirements pursuant to the Pharmacy Audit Integrity
4 Act, the audit shall be considered null and void. Any monies
5 recouped from a null and void audit shall be returned to the
6 affected pharmacy within fourteen (14) calendar days. Any violation
7 of this section by a pharmacy benefits manager or auditing entity
8 shall be deemed a violation of the Pharmacy Audit Integrity Act.

9 SECTION 2. AMENDATORY 59 O.S. 2021, Section 357, as
10 amended by Section 4, Chapter 332, O.S.L. 2024 (59 O.S. Supp. 2024,
11 Section 357), is amended to read as follows:

12 Section 357. A. As used in Sections 357 through 360 of this
13 title:

14 1. "Covered entity" means a nonprofit hospital or medical
15 service organization, for-profit hospital or medical service
16 organization, insurer, health benefit plan, health maintenance
17 organization, health program administered by the state in the
18 capacity of providing health coverage, or an employer, labor union,
19 or other group of persons that provides health coverage to persons
20 in this state. This term does not include a health benefit plan
21 that provides coverage only for accidental injury, specified
22 disease, hospital indemnity, disability income, or other limited
23 benefit health insurance policies and contracts that do not include
24 prescription drug coverage;

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

7 3. "Department" means the Insurance Department;

8 4. "Effective rate contracting" means any agreement or
9 arrangement between a pharmacy or contracting agent acting on behalf
10 of a pharmacy and a pharmacy benefits manager for pharmaceuticals
11 based on the effective rate of payment rather than a predetermined
12 fixed price or fixed discount percentage;

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

16 ~~5.~~ 6. "Multisource drug product reimbursement" (reimbursement)
17 means the total amount paid to a pharmacy inclusive of any reduction
18 in payment to the pharmacy, excluding prescription dispense fees and
19 professional fees;

20 ~~6.~~ 7. "Office" means the Office of the Attorney General;

21 ~~7.~~ 8. "Pharmacy benefits management" means a service provided
22 to covered entities to facilitate the provision of prescription drug
23 benefits to covered individuals within the state, including
24 negotiating pricing and other terms with drug manufacturers and

1 providers. Pharmacy benefits management may include any or all of
2 the following services:

- 3 a. claims processing, retail network management and
4 payment of claims to pharmacies for prescription drugs
5 dispensed to covered individuals,
- 6 b. clinical formulary development and management
7 services, or
- 8 c. rebate contracting and administration;

9 ~~8.~~ 9. "Pharmacy benefits manager" or "PBM" means a person,
10 business, or other entity that performs pharmacy benefits
11 management. The term shall include a person or entity acting on
12 behalf of a PBM in a contractual or employment relationship in the
13 performance of pharmacy benefits management for a managed care
14 company, nonprofit hospital, medical service organization, insurance
15 company, third-party payor, or a health program administered by an
16 agency or department of this state;

17 ~~9.~~ 10. "Plan sponsor" means the employers, insurance companies,
18 unions and health maintenance organizations or any other entity
19 responsible for establishing, maintaining, or administering a health
20 benefit plan on behalf of covered individuals; and

21 ~~10.~~ 11. "Provider" means a pharmacy licensed by the State Board
22 of Pharmacy, or an agent or representative of a pharmacy, including,
23 but not limited to, the pharmacy's contracting agent, which
24 dispenses prescription drugs or devices to covered individuals.

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

9 a. negotiates directly with drug manufacturers,

10 b. processes claims on behalf of its members, or

11 c. manages its own retail network of pharmacies.

12 SECTION 3. AMENDATORY 59 O.S. 2021, Section 360, as
13 amended by Section 6, Chapter 332, O.S.L. 2024 (59 O.S. Supp. 2024,
14 Section 360), is amended to read as follows:

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

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

23 2. In order to place a drug on the MAC list, ensure that the
24 drug is listed as "A" or "B" rated in the most recent version of the

1 FDA's Approved Drug Products with Therapeutic Equivalence
2 Evaluations, also known as the Orange Book, and the drug is
3 generally available for purchase by pharmacies in the state from
4 national or regional wholesalers and is not obsolete;

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

7 4. Provide a reasonable administration appeals procedure to
8 allow a provider, a provider's representative and a pharmacy service
9 administrative organization to contest reimbursement amounts within
10 fourteen (14) calendar days of the final adjusted payment date. The
11 pharmacy benefits manager shall not prevent the pharmacy or the
12 pharmacy service administrative organization from filing
13 reimbursement appeals in an electronic batch format. The pharmacy
14 benefits manager must respond to a provider, a provider's
15 representative and a pharmacy service administrative organization
16 who have contested a reimbursement amount through this procedure
17 within ten (10) calendar days. The pharmacy benefits manager must
18 respond in an electronic batch format to reimbursement appeals filed
19 in an electronic batch format. The pharmacy benefits manager shall
20 not require a pharmacy or pharmacy services administrative
21 organization to log into a system to upload individual claim appeals
22 or to download individual appeal responses. If a price update is
23 warranted, the pharmacy benefits manager shall make the change in
24 the reimbursement amount, permit the dispensing pharmacy to reverse

1 and rebill the claim in question, and make the reimbursement amount
2 change retroactive and effective for all contracted providers; and

3 5. If a below-cost reimbursement appeal is denied, the PBM
4 shall provide the reason for the denial, including the National Drug
5 Code (NDC) number from, and the name of, the specific national or
6 regional wholesalers doing business in this state where the drug is
7 currently in stock and available for purchase by the dispensing
8 pharmacy at a price below the PBM's reimbursement price. If the NDC
9 number provided by the pharmacy benefits manager is not available
10 below the acquisition cost obtained from the pharmaceutical
11 wholesaler from whom the dispensing pharmacy purchases the majority
12 of the prescription drugs that are dispensed, the pharmacy benefits
13 manager shall immediately adjust the reimbursement amount, permit
14 the dispensing pharmacy to reverse and rebill the claim in question,
15 and make the reimbursement amount adjustment retroactive and
16 ~~effective~~ in effect for all contracted providers for future claims
17 billed.

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

- 21 1. Average acquisition cost, including the National Average
22 Drug Acquisition Cost;
23 2. Average manufacturer price;
24 3. Average wholesale price;

1 4. Brand effective rate or generic effective rate;

2 5. Discount indexing;

3 6. Federal upper limits;

4 7. Wholesale acquisition cost; and

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

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

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

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

21 F. A pharmacy or pharmacist may decline to provide the
22 pharmacist clinical or dispensing services to a patient or pharmacy
23 benefits manager if the pharmacy or pharmacist is to be paid less
24

1 than the pharmacy's cost for providing the pharmacist clinical or
2 dispensing services.

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

6 H. Any pharmacy benefits manager (PBM) that leases, rents, or
7 otherwise makes its provider network or contracts available to
8 another pharmacy benefits manager shall:

9 1. Provide notice to all contracted providers of the lease
10 arrangement and the responsibilities of each party involved; and

11 2. Provide contact information in each paid or rejected claim
12 response that notifies the provider which contract the claim is
13 adjudicating against, who is processing the claim, and a phone
14 number to address provider issues; and

15 3. Transmit the network reimbursement identification
16 information with each claim response in NCPDP field 545-2F.

17 I. Any pharmacy benefits manager (PBM) that leases, rents, or
18 otherwise makes its provider network or contracts available to
19 another pharmacy benefits manager shall not combine any Employee
20 Retirement Income Security Act (ERISA) or government plans with any
21 non-ERISA or nongovernment plans.

22 J. The PBM shall, with respect to contracts between a PBM and a
23 provider, including contracts with pharmacy service administrative
24 organizations, ensure that reimbursement to pharmacies for each drug

1 dispensed is one hundred six percent (106%) of the National Average
2 Drug Acquisition Cost (NADAC), plus a professional fee of Fifteen
3 Dollars (\$15.00). The NADAC price shall be the price published in
4 effect for the date the drug claim was billed by the pharmacy. If a
5 particular drug does not have a published NADAC price, the
6 reimbursement shall be one hundred ten percent (110%) of the
7 wholesale acquisition cost (WAC) plus a professional fee of Fifteen
8 Dollars (\$15.00) for generic drugs and one hundred (100%) percent of
9 the WAC plus a professional fee of Fifteen Dollars (\$15.00) for
10 brand-name drugs. The professional fee shall automatically increase
11 on January 1 of each year at a percentage equal to the inflation
12 rate measured by the Consumer Price Index for the previous twelve-
13 month period. The reimbursement methodology in this paragraph shall
14 not apply to prescription drugs processed in accordance with Section
15 50 of Title 85A of the Oklahoma Statutes or to prescription drugs
16 processed in accordance with Title 317:30-5-78 of the Oklahoma
17 Administrative Code.

18 K. 1. Effective rate contracting is hereby prohibited in all
19 agreements between pharmacies or contracting agents acting on behalf
20 of a pharmacy and a PBM or third-party payers. No PBM or third-
21 party payer shall enter into any contract that establishes payment
22 for services or medications based on an effective rate of
23 reimbursement.

1 2. Any PBM or third-party payer found to be in violation of
2 this section shall be subject to penalties, including, but not
3 limited to, fines, revocation of licensure, or other disciplinary
4 actions.

5 L. The provisions of this section shall not be waived, voided,
6 or nullified by contract.

7 SECTION 4. This act shall become effective November 1, 2025.

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9 60-1-13587 TJ 04/22/25