STATE OF OKLAHOMA

2nd Session of the 60th Legislature (2026)

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 1500 By: Jech

COMMITTEE SUBSTITUTE

An Act relating to pharmacy benefits managers; amending 59 O.S. 2021, Section 357, as last amended by Section 2, Chapter 414, O.S.L. 2025 (59 O.S. Supp. 2025, Section 357), which relates to definitions; defining terms; updating statutory references; updating statutory language; prohibiting certain payment from being conditioned on certain provisions; prohibiting certain provider from bearing certain risks; requiring certain payor to remit certain payment within certain time frame; requiring certain payor to provide providers with certain accounting; establishing certain requirements for certain accounting; prohibiting certain payor from certain actions; requiring certain payments made outside of certain time frame to accrue interest; authorizing the Attorney General to levy certain fines; establishing certain contracts as void; allowing the Attorney General to promulgate rules; making certain claims applicable to certain provisions; providing for codification; and providing an effective date.

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

SECTION 1. AMENDATORY 59 O.S. 2021, Section 357, as last amended by Section 2, Chapter 414, O.S.L. 2025 (59 O.S. Supp. 2025, Section 357), is amended to read as follows:

Section 357. A. As used in Sections 357 through ~~360~~ 360.1 of this title:

1. "Clean claim" means a claim that is submitted in accordance with all applicable billing requirements, contains all information reasonably necessary for adjudication, and is not subject to an unresolved eligibility or coverage dispute at the time of submission;

2. "Claim" means a request for payment or reimbursement submitted by a provider for prescription drugs, pharmacy-dispensed medical supplies or devices, professional pharmacy services, or manufacturer coupon, copay-assistance, discount card, or other similar transactions;

3. "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.~~ 4. "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.~~ 5. "Department" means the Insurance Department;

~~4.~~ 6. "Effective rate contracting" means any agreement or arrangement between a pharmacy or contracting agent acting on behalf of a pharmacy and a pharmacy benefits manager for pharmaceuticals based on the effective rate of payment rather than a predetermined fixed price or fixed discount percentage;

~~5.~~ 7. "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~~ products, or ~~device~~ devices;

~~6.~~ 8. "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 and professional fees;

~~7.~~ 9. "Office" means the Office of the Attorney General;

~~8.~~ 10. "Payor" means any person or entity that adjudicates processes, administers, controls, or funds payment or reimbursement of a pharmacy claim including, but not limited to:

a. pharmacy benefits managers,

b. health insurers,

c. health maintenance organizations,

d. third-party administrators,

e. self-funded or fully insured health benefit plans,

f. government health programs,

g. manufacturer coupon card, copay-assistance, or patient assistance programs,

h. discount card, voucher, rebate, or similar program administrators, and

i. any affiliate, agent, or contractor acting on behalf of an entity provided in this paragraph.

Payor does not include a covered individual;

11. "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;

~~9.~~ 12. "Pharmacy benefits manager" or "PBM" means a person, business, or other entity that performs pharmacy benefits management. The term shall include 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;

~~10.~~ 13. "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~~

~~11.~~ 14. "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; and

15. "Receipt" means the date on which a pharmacy claim is first received by a payor or any agent of the payor, regardless of internal routing or processing.

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~~ 360.1 of this title shall deem an employer a "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 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 360.2 of Title 59, unless there is created a duplication in numbering, reads as follows:

A. Payment to a provider for a claim shall not be conditioned upon post-transaction reconciliation, manufacturer funding cycles, or internal settlement between program sponsors, administrators, or affiliates.

B. A provider shall not bear the risk of delayed or failed funding between a manufacturer, administrator, or other third party after a claim is adjudicated or accepted at the point of sale.

C. A payor shall remit full payment for a clean claim no later than thirty (30) calendar days after the earlier of the receipt of the clean claim or the adjudication of the claim. Nothing in this subsection shall prohibit or discourage payment in a shorter time

period, including expedited payment of electronically submitted claims.

D. A payor shall provide a provider with a clear, accurate, and individualized accounting of all payments made to the provider for claims. The accounting shall be provided in a readable, itemized format, including electronic remittance advice or other electronic format commonly used in the pharmacy industry, and shall not require the provider to aggregate, infer, or reconstruct claim-level payment information. Such accounting shall be provided with each payment or remittance and shall be presented at a claim-by-claim level that reasonably allows the provider to identify:

1. A unique claim identifier or prescription number;

2. The date of service or dispensing date;

3. The total amount paid for the claim by the payor;

4. The total amount paid for the claim by the covered individual or plan member;

5. The total amount paid to the pharmacy for reimbursement;

6. Any amounts withheld, reduced, or adjusted, including the reason for such adjustment;

7. Any fees, assessments, or offsets applied to the claim;

8. The identity of the payor or program responsible for the payment, including identification of any manufacturer coupon, copay-assistance, or discount card program involved;

9. The final payment date for the claim; and

10. Any interest paid on a claim pursuant to subsection F of this section.

E. A payor shall not:

1. Bundle or net multiple claims in a manner that obscures claim-level payment information;

2. Provide only summary, aggregate, or plan-level payment data in lieu of individualized claim accounting;

3. Condition access to individualized claim accounting on additional fees, portal subscriptions, or contractual waivers;

4. Delay payment of an adjudicated or accepted claim beyond the time frames established pursuant to subsection C of this section;

5. Retroactively reprice, reverse, or withhold payment after adjudication, except as otherwise expressly permitted by state law;

6. Condition or withhold payment based on audits conducted after adjudication;

7. Extend payment timelines through contract, policy, program terms, or operating rules inconsistent with subsection C of this section; or

8. Shift payment risk to a provider due to internal disputes, funding delays, or administrative issues of the payor or the payor's affiliates.

F. Any payment not made within the time frame set forth in subsection C of this section shall automatically accrue interest beginning on the day after the expiration of such time frame. Such

interest shall accrue at a rate of ten percent (10%) per thirty (30) days, calculated solely on the unpaid amount owed by the payor to the provider. Interest assessed pursuant to this subsection shall be non-waivable and shall be paid in addition to the underlying claim amount.

G. A payor may be subject to any fines, penalties, and remedies provided by state law. The Attorney General may levy a civil or administrative fine not less than One Hundred Dollars ($100.00) and not more than Ten Thousand Dollars ($10,000.00) per each violation of this act.

H. Any contract, agreement, policy, or program term that waives, limits, or extends the rights or timelines established pursuant to this act shall be void and unenforceable.

I. The Attorney General may promulgate any rules necessary to enforce the provisions of this act.

J. This section shall be applicable to all claims paid on or after the effective date of this act regardless of the date a contract or program was executed or the payment methodology or reimbursement model used by the payor.

SECTION 3. This act shall become effective November 1, 2026.

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