STATE OF OKLAHOMA

2nd Session of the 60th Legislature (2026)

SENATE BILL 2074 By: Alvord

AS INTRODUCED

An Act relating to pharmacy benefits managers; amending 59 O.S. 2021, Sections 357, as last amended by Section 2, Chapter 414, O.S.L. 2025, and 360, as last amended by Section 8, Chapter 300, O.S.L. 2025 (59 O.S. Supp. 2025, Sections 357 and 360), which relate to definitions and pharmacy benefits manager contractual duties to provider; defining term; prohibiting certain pharmacy benefits manager from refusing to accept certain documentation; requiring certain adjusted reimbursement amount if certain appeal is approved; allowing certain provider to request certain reversal or rebilling; requiring certain information to be included in certain appeal; requiring certain adjustments to include certain claim-level details within certain time period; prohibiting certain reimbursement amounts; updating statutory references; updating statutory language; 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. "Acquisition cost" means the total amount paid by a provider to acquire a drug, medical product, or device at the time of purchase as evidenced by verifiable purchase documentation such as an invoice or electronic price file. Acquisition cost shall include purchase price, procurement fees, and associated shipping or handling charges and shall not include any post-purchase rebates, discounts, or credits that are not guaranteed and applied at the time of sale;

2. "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.~~ 3. "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.~~ 4. "Department" means the Insurance Department;

~~4.~~ 5. "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.~~ 6. "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.~~ 7. "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.~~ 8. "Office" means the Office of the Attorney General;

~~8.~~ 9. "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.~~ 10. "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.~~ 11. "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.~~ 12. "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~~ 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. AMENDATORY 59 O.S. 2021, Section 360, as last amended by Section 8, Chapter 300, O.S.L. 2025 (59 O.S. Supp. 2025, Section 360), is amended to read as follows:

Section 360. A. The pharmacy benefits manager (PBM) 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

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~~ PBM shall 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~~ PBM shall respond in an electronic batch format to reimbursement appeals filed in an electronic batch format. The ~~pharmacy benefits manager~~ PBM 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. A PBM shall not refuse to accept additional documentation from

providers after the appeal submission. If a price update is warranted, the ~~pharmacy benefits manager~~ PBM 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;

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~~.~~;

6. If the NDC number provided by the ~~pharmacy benefits manager~~ PBM 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~~ PBM 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;~~

effective for all prescriptions of the appealed drug, medical product, or device for patients covered under the same Bank Identification Number (BIN) and Processor Control Number (PCN), retroactive to the initially appealed claim's date of service. A PBM shall notify the provider that an increase has been granted because of a reimbursement appeal. If a claim subject to an approved appeal is not reversed and reprocessed within thirty (30) calendar days after the final appeal determination, the PBM shall remit to the provider the full reimbursement amount required by the approved appeal, including any retroactive adjustments and shall not require the provider to refund or otherwise return any portion of the reimbursement paid for that claim;

~~6.~~ 7. 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~~ paragraphs 5 and 6 of this subsection; ~~and~~

~~7.~~ 8. 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; and

9. Any adjustment to provider reimbursement shall be accompanied by complete claim-level detail sufficient to reconcile the adjustment, including identification of the original claim

payment values and the revised values for all affected fields. An adjustment for which such claim-level detail is not provided contemporaneously shall be deemed incomplete.

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~~ PBM 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~~ PBM 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~~ PBMs 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~~ PBM 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~~ PBM shall provide a dedicated telephone number, email address and names of the personnel with decision-making authority regarding MAC appeals and pricing.

H. A PBM shall not reimburse a provider for a prescription drug or pharmacy service in an amount less than the national average drug acquisition cost for the prescription drug or pharmacy service at the time the drug is administered or dispensed, plus a professional dispensing fee of no less than the Medicaid fee-for-service professional dispensing fee rate established under rules promulgated by the Oklahoma Health Care Authority Board. If the national average drug acquisition cost is not available at the time a drug is administered or dispensed, a PBM shall not reimburse in an amount

that is less than the wholesale acquisition cost of the drug pursuant to 42 U.S.C., Section 1395w-3a(c)(6)(B), and shall reimburse a professional dispensing fee of no less than the rate established by the Board.

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

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