Frequently Asked Questions ("FAQ")
PBM Reporting Requirements

Pharmacy Benefit Managers' reporting requirements are mandated by the Oklahoma Patients Right to Pharmacy Choice Act, 36 O.S. §§ 6958 – 6968.

1. **We previously dealt with the Oklahoma Insurance Department. What has changed?**

   Effective November 1, 2023, authority to enforce the Oklahoma Patient's Right to Pharmacy Choice Act, 36 O.S. §§ 6958, was transferred from the Oklahoma Insurance Department ("OID") to the Oklahoma Office of the Attorney General ("OAG"). The Attorney General's Pharmacy Benefit Management Compliance and Enforcement Unit ("OAG PBM Unit") is committed to investigating and prosecuting violations of the Oklahoma Patients Right to Pharmacy Choice Act, 36 O.S. §§ 6958 – 6968 and the Pharmacy Audit Integrity Act, 59 O.S. §§ 356 – 356.5.

   You may submit complaints to the OAG PBM Unit by visiting www.oag.ok.gov/pbm.

2. **What is the role of the Oklahoma Insurance Department as it relates to PBMs?**

   The OID is responsible for handling all licensing applications and renewals, including the collection of any licensing fees.

   The OAG is responsible for the enforcement of Oklahoma PBM laws that do not deal with the licensing application or renewal process.

3. **Are PBMs required to regularly report anything to the Oklahoma Office of the Attorney General?**

   Under the Patient's Right to Pharmacy Choice Act, two types of reports must be submitted to the Attorney General's Office.

   Network Access Reports: PBMs operating in Oklahoma must report on the adequacy of its retail pharmacy network ("Network Access Reports"). A PBM can find details of the standards with which PBMs must comply under 36 O.S. § 6961. The report shall detail the PBM's retail pharmacy networks and the access provided to covered individuals under 36 O.S. § 6961(A). Each PBM is required to submit its Network Access Report to the OAG no later than 45 days following the

end of the second and fourth quarter of each calendar year. The Attorney General shall review and approve network access. *See* 36 O.S. § 6962. www.oag.ok.gov/pbm.

Quarterly Data Reports: PBMs operating in Oklahoma must report to the OAG PBM Unit rebates and reimbursement data on a quarterly basis. The Quarterly Data Report includes both aggregates for each health insurer payor and individual amounts paid to the reimbursement of an individual pharmacy claim.

The template for the Quarterly Data Report can be downloaded from the Attorney General's website by visiting . The first sheet, www.oag.ok.gov/pbm. The template is comprised of two separate sheets. The first sheet, titled "REBATES (Aggregate)," seeks aggregate information for each health insurer payor doing business with the PBM. In addition to the payor name and identifying numbers, the template has spaces to report the total amount of rebates received, the amount of the rebates that are "passed through" to the health insurer payor, and the amount of the rebates that are passed to the insured or its members.

Sheet 1 - REBATES (Aggregate)	
Field Name	
Payor Name	The name of the health insurer payor
Group Number	The prescription group number denotes which group plan the member falls under. Typically, this number will represent the payor group, but an individual payor could have more than one group number if they have more than one plan. This has also been referred to as the "carrier account group" or "CAG."
RxBIN	The BIN is the 6-digit Bank Identification Number used in electronic claims processing that identifies the insurance company or PBM.
PCN	The Processor Control Number further identifies the health plan for a claim.
Total Rebates	This represents the total dollar amount received in rebates in a given period for claims under a specific Insurer/ Payor or Health plan. **Note: Rebates to Payor + Rebates to Insured + Rebates Retained by PBM = Total Rebates.**
Rebates to Payor	This represents the total dollar amount of the rebates that were paid to the Insurer/Payor/Plan Sponsor, or "passed through to sponsor".
Rebates to Insured	This represents the total dollar amount of the rebates that were paid to the covered party/enrollee of the health plan.

The second sheet, titled “CLAIMS (Individual),” seeks individual claims data for each prescription fill. The purpose of the reporting is not to capture each attempted filing; rather to capture the final result of each prescription claim ie., if an identical claim is filed and paid but reversed, it is not necessary to include all attempted filings on the report. We require the final net result of each paid claim.

Sheet 2 - CLAIMS (Individual)	
Field Name	
Payor Name	The name of the health insurer payor
Group Number	The prescription group number denotes which group plan the member falls under. Typically, this number will represent the payor group, but an individual payor could have more than one group number if they have more than one plan. This has also been referred to as the “carrier account group” or “CAG.”
RxBIN	The BIN is the 6-digit Bank Identification Number used in electronic claims processing that identifies the insurance company or PBM.
PCN	The Processor Control Number further identifies the health plan for a claim.
Pharmacy Name	Name of pharmacy where prescription is filled or dispensed.
Pharmacy NCPDP / NABP	The National Council for Prescription Drug Programs, (NCPDP) is an ANSI-accredited, standards development organization providing healthcare solutions. The NCPDP number (formerly known as the NABP number) is a unique identifier for any licensed pharmacy.
NPI	The National Provider Identification number is a unique id issued to healthcare providers including pharmacies, pharmacists, doctors, hospitals, etc.
Prescription Number	A unique identification number given to each prescription filled by a pharmacy. This number will refer to a specific prescription and its refills.
Claim Number	A unique number given to a pharmacy claim for reimbursement. This number will not be reused for a prescription’s subsequent refills. If Patient A has a maintenance medication filled monthly, there will be one **Rx Number** (Prescription Number) that refers to each occurrence of the dispensed medication. However, each time the prescription is filled, a claim for reimbursement is filed by the pharmacy to the PBM; each claim will be issued a unique **Claim Number**.

Product NDC	The **National Drug Code** is a unique 10-digit, 3-segment number. It is a universal product identifier for human drugs in the United States. The code is present on all nonprescription and prescription medication packages and inserts in the US.
Service Provided	Examples include prescription dispensed or vaccine (injection) administered.
Quantity Dispensed	This field indicates the number of units, grams, milliliters, or other quantity dispensed in the current drug event. If the PDE was for a compounded item, the quantity dispensed is the total of all ingredients.
Days Supply	The intended duration of each prescription fill.
Amount Paid by Insurer	The total amount ($) paid by the insurer/payor to the PBM.
Amount paid to Provider/Pharmacy by PBM	The total amount ($) paid to the Provider/Pharmacy by the PBM.

4. When are each of the required reports due?

a. **Network Access Reports**: are due to the OAG PBM Unit on a semi-annual basis. Network Access Reports are due 45 days following the closure of the covered period. August 15th is the deadline for the period of January 1 through June 30; and February 15th is the deadline for the period of July 1 through December 31. ‘

b. The **Section 6962 Quarterly Data Report** is due to the Attorney General’s Office one-year following the closure of each quarter. To ensure all rebates and post-adjudication adjustments have been made to the claims, the AG’s office has agreed to extend the due dates by a full year.

Quarter	Due Date	Period Covered
Q2 2024	June 30, 2024	4/1/2023 – 6/30/2023
Q3 2024	September 30, 2024	6/30/2023 - 9/30/2023
Q4 2024	December 31, 2024	09/30/2023 - 12/31/2023
Q1 2025	March 30, 2025	01/01/2024 - 3/20/2024

The Attorney General’s Office is not required to grant any extension of the due date. Extensions will not be given without justification shown to the PBM Unit’s Director.

Any PBM who fails to comply with reporting requirements is subject to disciplinary action for violation of the Act and may be subject to license

censure, suspension, revocation, and/or civil fines up to a maximum of $10,000. 36 O.S. § 6966.1(B)(1-2).

5. **Where can I find a template for the reports?**

   The templates for each report can be found on the Attorney General's Office website or by clicking here for the Network Access Report and here for the Section 6962 Quarterly Data Report.

6. **Do the requirements apply to data for all clients including fully insured and self-insured or any client (regardless of location) with members that reside in the state of Oklahoma?**

   The AG's Office takes the position that all claims adjudicated at Oklahoma pharmacies--regardless of whether the plan originated in Oklahoma or not--shall be reported in the quarterly reports.

7. **What if the report files are too large to send via email?**

   We are happy to set up a secure share folder for you to upload your data. Our system includes FEDRAMP and HIPAA compliant encryption. Email us at PBMReporting@oag.ok.gov and let us know the email address of the individual who will be uploading the data. We will set up a private secure folder and send you a link which you can use to upload the data.

   Any additional questions can be sent to PBMReporting@oag.ok.gov and we will respond as soon as possible. Thank you.