CHAPTER 25. OTHER LICENSEES

SUBCHAPTER 3. PRODUCERS, BROKERS, LIMITED LINES PRODUCERS, SERVICE WARRANTIES AND VEHICLE PROTECTION PRODUCT WARRANTORS

365:25-3-13. Surplus line insurance with non-admitted insurer; approval prior to issuance; collection and remittance of taxes; claims for tax adjustments; procedures; forms

(a) ~~**Purpose.** The purpose of this section is to set forth the requirements regarding the procurement of policies from non-admitted carriers.~~

~~(b)~~ **Placement with licensed broker.** No licensed insurance producer, solicitor, broker or general agent shall place, or cause to be placed with any nonadmitted insurer any policy of insurance upon property and/or any other risks, or any insurable interest therein, having a situs in the State of Oklahoma, except through a duly licensed surplus line broker; and, then, any such policy shall only be procured by strict compliance with the applicable statutes of this State and the Rules issued under the authority of the Insurance Department of the State of Oklahoma.

~~(c)~~ (b) **Application for placement.**

(1) After procuring any surplus lines insurance, surplus line brokers shall ~~execute and~~ file information relating to the transaction through the electronic database designated by the Commissioner ~~affidavits and reports with the Insurance Commissioner as required pursuant to Section 1107 of Title 36 on Form SL-3(a-d)~~. All required fields shall be completed and accompanied with an attestation under penalty of perjury that the information submitted is true and correct, and all filings shall be in accordance with any instructions provided by the Department. ~~All Forms SL-3 (a-d)~~ Surplus lines brokers shall ~~be retained~~ retain copies of all filings ~~in the files of the brokers, to support the policy issued thereunder,~~ for a period of not less than three years.

(2) ~~All applications (Form SL-3) shall be completely filled out and verified under oath by the broker submitted for each policy for which approval for issuance is sought; provided, that in~~ In the event any group insurance is determined to constitute a surplus line of insurance, a specific method of reporting additional individual certificates issued or cancelled under such group policy shall be agreed upon between the Insurance Commissioner and the broker concerned.

(3) After procuring surplus lines insurance, an insured filing a direct placement shall ~~execute and~~ file information relating to the transaction through the electronic database designated by the Commissioner ~~file affidavits and reports with the Insurance Commissioner as required by 36 O.S. § 1115 on form DSL-3 (a-d)~~. All required fields shall be completed and accompanied with an attestation under penalty of perjury that the information submitted is true and correct, and all filings shall be in accordance with any instructions provided by the Department.

~~(d)~~ (c) **Broker tax collection and remittance.**

(1) All taxes due on any insurance policy issued as a surplus line policy, through any non-admitted insurer, shall be collected by the surplus line broker who procures such policy's issuance. Such taxes shall, in each instance be collected in full on or before the issuance of the policy to the insured, except as hereinafter expressly provided for by ~~(b)~~ (a) of this section. All such taxes shall be duly remitted to the State of Oklahoma, through the Insurance Commissioner, on or before the end of each month following each calendar quarter by letter of transmittal accompanying such tax remittance.

(2) All premium taxes shall be computed on the total agreed premium due on the policy, applying the rate of tax existing as of the date the premiums in question become payable, which date shall in every instance be deemed to be the date of policy issuance, except in respect to the following specific situations:

(A) A policy issued for a term in excess of one year, with a fixed premium being payable annually, shall be taxed on the first year's premium at the rate effective as of the date of policy issuance. The tax on premiums payable for subsequent years shall be computed at the rate in effect as of the date such subsequent premiums become due and payable, which date shall be deemed for taxation purposes to be the policy anniversary date.

(B) Premium deposits made on policies providing for retrospective premium adjustments shall be deemed to be premiums paid for such policy as of the date of issuance and taxed accordingly, applying the tax rate in effect at date of policy issuance.

(C) Retrospective premium adjustments, made pursuant to the terms of any surplus line policy and requiring the payment of additional premiums by the insured, shall be taxed at the rate effective as of the date such additional premiums become payable, which date shall be deemed to be the date last included in the policy period considered in computing such retrospective premiums. All taxes due to the State of Oklahoma as the result of retrospective premium adjustments shall be collected by the broker concerned and remitted to the Insurance Commissioner within thirty (30) days next succeeding the last date included in the policy period considered in computing such retrospective premium adjustment.

~~(e)~~ (d) **Broker tax refunds; warrants.**

(1) Claims for tax refunds on surplus line policies shall be separately submitted through the electronic database designated by the Commissioner. All required fields shall be completed and accompanied with an attestation under penalty of perjury that the information submitted is true and correct, and the claim shall be in accordance with any instructions provided by the Department. Every ~~such verified~~ claim shall set forth with particularity the circumstances upon which it is predicated. All claims for tax refunds shall be computed at the rate of tax existing at the time the tax in question was paid. ~~Only one claim for tax refund shall be submitted on each Form SL-3(d).~~ Applications for adjustment of erroneously paid taxes shall be deemed to be a claim for tax refund and shall be submitted in the manner prescribed for such claims. ~~Any claim for a tax refund shall be filed following the close of the calendar quarter that contains the policy period considered in computing the tax refund three (3) years from the date of tax payment.~~ The broker shall submit proof of the original payment and proof of the reason for the refund to the Insurance Commissioner. Any claim not filed within this time period shall be barred from ~~ex parte~~ administrative consideration or action by the Insurance Commissioner. ~~Any claim for tax refund which is not timely filed, or any claim for tax refund which is denied by ex parte action of the Insurance Commissioner, may be set down for public hearing upon timely application therefore by the party or parties aggrieved by such claims denial. All applications for hearings involving claims for tax refunds shall be made within the times and in the manner prescribed by statute for other hearings before the Insurance Commissioner.~~

~~(2) All claims for tax refunds shall be promptly acted upon by the Insurance Commissioner. Notice of the allowance or denial of such claims, as are duly submitted in proper form, shall be forwarded to the broker concerned within thirty days next succeeding the receipt of such claims by the Insurance Commissioner.~~

~~(3)~~ (2) All warrants issued in refund of premium taxes upon surplus line policies will be issued in the name of the broker who originally submitted the tax in question.

~~(f)~~ (e) **Direct Placement Tax Collection and Remittance.**

(1) All taxes due on any insurance policy issued as a direct placement surplus lines policy through any non-admitted insurer shall be collected by the affiant or other representative of the insured who procured such policy's issuance. Such taxes shall, in each instance, be collected in full on or before the issuance of the policy to the insured except as hereinafter expressly provided for by ~~Section 365:25-3-13(f)(2)(B)~~ Subsection (e)(2)(B). All such taxes shall be duly remitted to the State of Oklahoma, through the electronic database designated by Insurance Commissioner, within thirty (30) days following the issuance of the policy. The Direct Placement by and Insured Summary shall accompany the tax remittance.

(2) All premium taxes shall be computed on the total agreed premium due on the policy, applying the rate of tax existing as of the date the premiums in question become payable, which date shall in every instance be deemed to be the date of policy issuance, except in respect to the following specific situations:

(A) A policy issued for a term in excess of one year, with a fixed premium being payable annually, shall be taxed on the first year's premium at the rate effective as of the date of policy issuance. The tax on premiums payable for subsequent years shall be computed at the rate in effect as of the date such subsequent premiums become due and payable, which date shall be deemed for taxation purposes to be the policy anniversary date.

(B) Premium deposits made on policies providing for retrospective premium adjustments shall be deemed to be premiums paid for such policy as of the date of issuance and taxed accordingly, applying the tax rate in effect at the date of policy issuance.

(C) Retrospective premium adjustments, made pursuant to the terms of any surplus line policy and requiring the payment of additional premiums by the insured, shall be taxed at the rate effective as of the date such additional premiums become payable, which date shall be deemed to be the date last included in the policy period considered in computing such retrospective premiums. All taxes due to the State of Oklahoma as the result of retrospective premium adjustments shall be collected ~~by the broker concerned~~ and remitted to the Insurance Commissioner within thirty (30) days following the policy period considered in computing such retrospective premium adjustment.

~~(g)~~ (f) **Direct Placement-Tax refunds; warrants.**

(1) Claims for tax refunds on surplus lines policies shall be separately submitted ~~on Form DSL-3d, which shall be prepared under oath and executed by the insured or a representative of the insured~~ through the electronic database designated by the Commissioner. All required fields shall be completed and accompanied with an attestation under penalty of perjury that the information submitted is true and correct, and the claim shall be in accordance with any instructions provided by the Department. Every ~~verified~~ claim shall set forth with particularity the circumstances upon which it is predicated. All claims for tax refunds shall be computed at the rate of tax existing at the time the tax in question was paid. ~~Only one claim for tax refund shall be submitted on each Form DSL-3d.~~ Applications for adjustment of erroneously paid taxes shall be deemed to be a claim for tax refund and shall be submitted in the manner prescribed for such claims. Any claim for tax refund shall be filed within three (3) years from the date of tax payment. The insured or a representative of the insured shall submit proof of the original payment and proof of the reason for the refund to the Insurance Commissioner. Any claim not filed within this time period shall be barred from ~~ex parte~~ administrative consideration or action by the Insurance Commissioner. ~~Any claim for tax refund that is not timely filed, or any claim for tax refund that is denied by ex parte action of the Insurance Commissioner, may be set down for public hearing upon timely application by the party or parties aggrieved by the claim denial. All applications for hearings involving claims for tax refunds shall be made within the times and in the manner prescribed by statute for other hearings before the Insurance Commissioner.~~

~~(2) All claims for tax refunds shall be promptly acted upon by the Insurance Commissioner. Notice of the allowance or denial of such claims, as are duly submitted in proper form, shall be forwarded to the affiant or other representative of the insurance within thirty (30) days next succeeding the receipt of such claims by the Insurance Commissioner.~~

~~(3)~~ (2) All warrants issued in refund of premium taxes upon surplus line policies will be issued in the name of the insured that originally paid the tax in question.

~~(h)~~ (g) **Forms.**

~~(1) Surplus line brokers shall reproduce Forms SL-2 and SL-3 in quantities sufficient for their respective requirements.~~

~~(2)~~ The applications and forms required by this section shall be supplementary and in addition to the Annual Statements and Annual Tax Returns required to be filed by each licensed surplus line broker. The Annual Statements and Annual Tax Returns of all surplus line brokers shall be duly filed, according to 36 O.S. § 1114 upon the forms prescribed for such purposes.

365:25-3-22. Service warranty quarterly statement filings and fees

(a) Service Warranty Associations and insurers for service warranties shall electronically file quarterly statements and the applicable administrative fee amount required pursuant to 15 O.S. § 141.14(D) in the manner and form prescribed the Commissioner on the Department's website.

(b) The filing deadlines for the quarterly statements and fees are as follows:

(i) First Quarter – No later than April 30 of each year

(ii) Second Quarter – No later than July 31 of each year

(iii) Third Quarter – No later than October 31 of each year

(iv) Fourth Quarter – No later than January 31 of each year

SUBCHAPTER 7. COMPANIES

PART 5. OKLAHOMA INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

365:25-7-23. Forms: general requirements

(a) **Forms A, B, C, D, E, and F.** Forms A, B, C, D, E, and F as set forth in Appendices A, B, N, O, Q, and AA of this Chapter, are intended to be guides in the preparation of the statements required by Sections 1633, 1634, 1635 and 1636 of the Act. They are not intended to be blank forms which are to be filled in. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable, or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

(b) **Filing statements.** Statements shall be filed electronically. Third-party verifications sent by the third party may be filed electronically. A copy of a Form B and C shall be filed in each state in which an insurer is authorized to do business, if the Commissioner of that state has notified the insurer of its request in writing, in which case the insurer has thirty (30) days from receipt of the notice to file such form. Appropriate electronic signatures are permitted. The Commissioner may request a wet signature at his or her discretion. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of such power of attorney or other authority shall also be filed with the statement.

(c) **Format of statements.** Electronic statements shall meet all technical requirements of the Commissioner. All copies of any statement, financial statements, or exhibits shall be clear, easily readable and suitable for reproduction. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on copies. Statements shall be in the English language, and monetary values shall be stated in United States Currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into Unites States Currency.

(d) **Hearings on Consolidated Basis.** If an applicant requests a hearing on a consolidated basis under Section 1633(D)(3) of the Act, in addition to filing the Form A with the commissioner, the applicant shall file a copy a Form A with the National Association of Insurance Commissioners in electronic form.

365:25-7-29.1. Transactions subject to prior notice - notice filing (Form D)

(a) An insurer required to give notice of a proposed transaction pursuant to Section 1636 of the Act shall furnish the required information on Form D, hereby made a part of this section, as set forth in Appendix O of this Chapter.

(b) Agreements for cost sharing services and management services shall at a minimum and as applicable:

(1) Identify the person providing services and nature of such services;

(2) Set forth the methods to allocate costs;

(3) Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual;

(4) Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;

(5) State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;

(6) Define records and data of the insurer to include all records and data developed or maintained under or related to the agreement that are otherwise the property of the insurer, in whatever form maintained, including, but not limited to, claims and claims files, policyholder lists, application files, litigation files, premium records, rate books, underwriting manuals, personnel records, financial records or similar records within the possession, custody or control of the affiliate;

(7) Specify that all records and data of the insurer are and remain the property of the insurer, and:

(A) Are subject to control of the insurer;

(B) Are identifiable; and

(C) Are segregated from all other persons' records and data or are readily capable of segregation at no additional cost to the insurer;

(8) State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;

(9) Include standards for termination of the agreement with and without cause;

(10) Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services and for any actions by the affiliate that violate provisions of the agreement required in subsection (b)(11), (b)(12), (b)(13), (b)(14), and (b)(15) of this rule;

(11) Specify that if the insurer is placed in supervision, seizure, conservatorship, or receivership pursuant to Articles 18 or 19 of Title 36:

(A) All of the rights of the insurer under the agreement extend to the receiver or Commissioner to the extent permitted by law;

(B) All records and data of the insurer shall be identifiable and segregated from all other persons' records and data or readily capable of segregation at no additional cost to the receiver or the Commissioner;

(C) A complete set of records and data of the insurer will immediately be made available to the receiver or the Commissioner, shall be made available in a usable format, and shall be turned over to the receiver or Commissioner immediately upon the receiver or the Commissioner's request, and the cost to transfer data to the receiver or the Commissioner shall be fair and reasonable; and,

(D) The affiliated person(s) will make available all employees essentials to the operations of the insurer and the services associated therewith for the immediate continued performance of the essential services ordered or directed by the receiver or Commissioner;

(12) Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed into supervision, seizure, conservatorship, or receivership pursuant to Article 18 or 19 of Title 36;

(13) Specify that the affiliate will provide the essential services for a minimum period of time after termination of the agreement, if the insurer is placed into supervision, seizure, conservatorship, or receivership pursuant to Article 18 or 19 of Title 36, as ordered or directed

by the receiver or Commissioner. Performance of the essential services will continue to be provided without regard to pre-receivership unpaid fees, so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, Commissioner, or supervising court;

(14) Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure, notwithstanding supervision, seizure, conservatorship, or receivership pursuant to Article 18 or 19 of Title 36, and will make them available to the receiver or Commissioner as ordered or directed by the receiver or Commissioner for so long as the affiliate continues to receive timely payment for post-receivership services rendered, and unless released by the receiver, Commissioner, or supervising court; and

(15) Specify that, in furtherance of the cooperation between the receiver and the affected guaranty association(s) and subject to the receiver's authority over the insurer, if the insurer is placed into supervision, seizure, conservatorship, or receivership pursuant to Article 18 or 19 of Title 36, and portions of the insurer's policies or contracts are eligible for coverage by one or more guaranty associations, the affiliate's commitments under subsections (b)(11), (b)(12), (b)(13), and (b)(14) of this rule will extend to such guaranty association(s).

SUBCHAPTER 15. CAPTIVE INSURANCE COMPANIES REGULATION

365:25-15-1.1. Definitions

The following words and terms, when used in this subchapter and the Oklahoma Captive Insurance Company Act, shall have the following meaning, unless the context clearly indicates otherwise:

"Business plan" means the business activity of the company designed to accomplish its stated purpose. At a minimum, it must include the following:

(A) identity of the ownership and management;
(B) the type and expected volume of business to be written;
(C) details of any reinsurance agreements to be entered into;
(D) details of any management services or tax allocation agreements; and
(E) financial projections as required per subsection (a)(1)(G) above.

"Feasibility study" means an analysis of the owner/insured's risk profile and financial condition. The analysis must include and consider the following issues, but is not limited to:

(A) a detailed analysis as to how the captive will effect risk management and loss control;
(B) risks to be insured;
(C) recommendations and projections by a qualified independent actuary or any other person approved by the Commissioner of recommended premiums, losses, expenses and retentions;
(D) tax projections;
(E) domicile options that address the impact on operating costs and tax issues;
(F) comparison of a captive program with other viable risk financing alternatives;
(G) five-year pro forma financial statements and projections, analysis of the financial impact of establishing a captive, of any form; and
(H) identification of management procedures, underwriting procedures, managerial oversight methods, investment policies, and reinsurance agreements.

SUBCHAPTER 29. PHARMACY BENEFIT MANAGERS

365:25-29-7.1. Retail pharmacy network access - audit [REVOKED]

~~(a) Standards:~~

~~(1) 36 O.S. §6960 of the act defines " retail pharmacy network" as meaning retail pharmacy providers contracted with a PBM in which the pharmacy primarily fills and sells prescriptions via a retail, storefront location.~~

~~(2) The act draws no distinction between regular or specialty drugs, both being prescription medications, therefore, specialty drugs fall within the contemplation of the act.~~

~~(3) Pharmacy benefits managers shall not in any manner on any material, including but not limited to mail and ID cards, include the name of any pharmacy, hospital or other providers unless it specifically lists all pharmacies, hospitals and providers.~~

~~(4) For purposes of determining compliance with 36 O.S. § 6961(A) of the act, mileage shall be calculated using distance map and driving directions.~~

~~(b) A PBM's retail pharmacy network access shall be monitored for compliance with the act by those insurers that utilize the services of such PBM. Health insurers are required to maintain retail pharmacy network access in conformity with the requirements set forth in 36 O.S. § 6961 of the act. Each calendar day in a single zip code where a PBM or Insurer has failed to comply with an applicable provision of 36 O.S. § 6961 shall be deemed an instance of violation.~~

~~(1) In conformity with these requirements, each health insurer that utilizes the services of a PBM licensed in this state shall, on a semi-annual basis, complete and submit to the Department its network adequacy audit of the PBMs with which the insurer contracts and/or partners to serve the insurer's members within the State of Oklahoma in a searchable format, in a manner which allows for the data to be organized. A health insurer's Geo Access report shall be submitted in the form and manner prescribed by the Commissioner on the Department website and shall be submitted to the Department every April 30 and October 31 of each calendar year.~~

~~(A) A health insurer's GeoAccess report due in April of a calendar year shall cover the time-period of July 1 through December 31 of the immediately preceding calendar year.~~

(B) A health insurer's GeoAccess report due in October of a calendar year shall cover the reporting time-period of January 1 through June 30 of the same calendar year in which the report is due.

(c) PBMs doing business in the State of Oklahoma are required to maintain retail pharmacy network access in conformity with the requirements set forth in 36 O.S. § 6961 of the act. The Department is required by 36 O.S. § 6962 to review and approve retail pharmacy network access for all Oklahoma licensed PBMs. Each calendar day in a single zip code where a PBM has failed to comply with an applicable provision of 36 O.S. § 6961 shall be deemed an instance of violation.

(1) In conformity with these requirements, each PBM licensed in the State shall, on a semi-annual basis, complete and submit to the Department its Oklahoma PBM Semi-Annual Retail Pharmacy Network Access Report in a searchable format, in a manner which allows for the data to be organized. A PBMs Geo Access report shall be in the form and manner prescribed by the Commissioner on the Department website and shall be due every January 31 and July 31 of each calendar year.

(A) A PBM's GeoAccess report due in January of a calendar year shall cover the reporting time-period of July 1 through December 31 of the immediately preceding calendar year.

(B) A PBM's GeoAccess report due in July of a calendar year shall cover the reporting time-period of January 1 through June 30 of the same calendar year in which the report is due.

365:25-29-8. PBM to file certain financial statements with the Commissioner

(a) Before May 1 of each year, every PBM providing pharmacy benefits management shall submit to the Insurance Commissioner a report, which includes the most recently concluded fiscal year-end financial statements for the PBM and report of covered lives, signed by an Executive Officer of the PBM attesting to the accuracy of the information contained in the report form prescribed by the Commissioner. The report shall be audited by an independent certified public accountant (CPA) and prepared using generally accepted accounting principles (GAAP). The report may be supplemented by any additional information required by the Insurance Commissioner.

(b) The Commissioner may extend the time prescribed for filing annual or other reports or exhibits of any kind for good cause shown. However, the Commissioner shall not extend the time for filing annual statements beyond ninety (90) days after the time prescribed by this Section.

365:25-29-10. Penalty for noncompliance

(a) After notice and opportunity for hearing as provided for in OAC 365:1-7, and upon determining that the PBM has violated any of the provisions of the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, 59 O.S. §§ 357-360 of the Oklahoma Statutes, or this Subchapter, the Commissioner may censure a PBM, may suspend or revoke a PBM's license. In addition to or in lieu of any censure, suspension or revocation of a license, the Commissioner or the Pharmacy Choice Commission may assess and levy a civil fine of not less than One Hundred Dollars ($100.00) and not greater than Ten Thousand Dollars ($10,000.00) for each violation of a provision of the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, Sections 357 through 360 of Title 59 of the Oklahoma Statues, or this Subchapter. Each day that a pharmacy benefits manager conducts business in the State of Oklahoma without a license shall be deemed to be an instance of violation. The payment of the penalty may be enforced in the same manner as civil judgments may be enforced.

(b) After notice and opportunity for hearing as provided for in OAC 365:1-7, and upon determining that the health insurer has violated any of the provisions of 36 O.S. §§ 6958-6968 of the Oklahoma Statutes, the Commissioner may suspend or revoke a health insurer's certificate of authority license or assess a civil penalty of not less than One Hundred Dollars ($100.00) no more than Ten Thousand Dollars ($10,000.00) for each instance of violation, or both. The payment of the penalty may be enforced in the same manner as civil judgments may be enforced.

(c) Every health insurer and PBM upon receipt of any inquiry from the Commissioner or the Commissioner's representative shall, within twenty (20) days from the date of inquiry, furnish the Commissioner or the Commissioner's representative with an adequate response to the inquiry.

365:25-29-14. Inquiry/complaint handling process [REVOKED]

(a) Complaints alleging failure by the PBM to comply with the act, shall be made in writing to the Commissioner, supported by evidentiary materials. All complaints must include a completed "PBM Complaint Form" as promulgated by the Commissioner.

(b) All audits of PBMs by health insurers shall include a review of complaints against the PBM to determine compliance with the terms of the contract between the PBM and the complainant.

(c) PBMs must provide the complainant with a written notice as to the final disposition of the complaint.

(d) As part of its response to the Department in connection with every complaint, the PBM must provide a statement to the Department that the complaint was carefully reviewed and could not be resolved under the terms and conditions of the contract.

365:25-29-15. Examinations and investigations of PBMs and health insurers

The Commissioner shall have power and authority to examine and investigate the affairs of every PBM engaged in pharmacy benefits management in the state in order to determine whether it is in compliance with all applicable provisions of Title 15, Title 36 and Title 59 of the Oklahoma Statutes that fall under the regulatory jurisdiction of the Insurance Commissioner and Title 365 of the Oklahoma Administrative Code and may take disciplinary action to enforce the same.

365:25-29-16. Transparency requirements and aggregate reporting [REVOKED]

Each PBM licensed in the state shall, on a quarterly basis submit its Oklahoma Pharmacy Benefit Managers Quarterly Data Report to the Department in a searchable format, in a manner which allows for the data to be organized, in a manner and form that is prescribed by the Commissioner on the Department website.

(1) A PBM Quarterly Report shall be due from each PBM every January 31, April 30, July 31, and October 31 of every calendar year.

(2) Each report shall cover the three months immediately preceding the month in which the report is due and all requested information shall be filled in as and where indicated on the form.