HB1808 POLPCS1 Carl Newton-TJ
2/17/2025 2:26:15 pm

# COMMITTEE AMENDMENT

HOUSE OF REPRESENTATIVES
State of Oklahoma

SPEAKER:

CHAIR:

I move to amend HB1808
Of the printed Bill

Page _____ Section _____ Lines _____
Of the Engrossed Bill

By deleting the content of the entire measure, and by inserting in lieu thereof the following language:

**AMEND TITLE TO CONFORM TO AMENDMENTS**

Amendment submitted by: Carl Newton

Adopted: _____

_____
Reading Clerk

STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

PROPOSED POLICY
COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 1808 By: Newton

PROPOSED POLICY COMMITTEE SUBSTITUTE

An Act relating to health insurance; providing definitions; providing enforcement by the Attorney General; promulgating rules; providing for step-therapy protocols for prescription drugs; providing for prior authorization requests; providing for legislative intent; providing standards for fair contracts; providing for codification; and providing an effective date.

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

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6110 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this section:

1. "Health benefit plan" means a health benefit plan as defined pursuant to Section 6060.4 of this title;

2. "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a physical, dental,

behavioral, or mental health condition or substance use disorder, including procedures, products, devices, and medications; and

3. "Readily available" means that the medication is not listed on a national drug shortage list, including lists maintained by the United States Food and Drug Administration and by the American Society of Health-System Pharmacists.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6110.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

1. A health insurance or other health benefit plan offered by a health insurer or by a pharmacy benefit manager on behalf of a health insurer that provides coverage for prescription drugs and uses step-therapy protocols shall:

a. not require failure, including discontinuation due to lack of efficacy or effectiveness, diminished effect, or an adverse event, on the same medication on more than one occasion for insureds who are continuously enrolled in a plan offered by the insurer or its pharmacy benefit manager, and

b. grant an exception to its step-therapy protocols upon request of an insured or the insured's treating health care professional under the same time parameters as set forth for prior authorization requests if any one or more of the following conditions apply:

(1) the prescription drug required under the step-therapy protocol is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured,

(2) the prescription drug required under the step-therapy protocol is expected to be ineffective based on the insured's known clinical history, condition, and prescription drug regimen,

(3) the insured has already tried the prescription drugs on the protocol, or other prescription drugs in the same pharmacologic class or with the same mechanism of action, which have been discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event, regardless of whether the insured was covered at the time on a plan offered by the current insurer or its pharmacy benefit manager,

(4) the insured is stable on a prescription drug selected by the insured's treating health care professional for the medical condition under consideration, or

(5) the step-therapy protocol or a prescription drug required under the protocol is not in the patient's best interests because it will:

(a) pose a barrier to adherence,

(b) likely worsen a comorbid condition, or

(c) likely decrease the insured's ability to achieve or maintain reasonable functional ability.

2. Nothing in this subsection shall be construed to prohibit the use of tiered co-payments for members or subscribers not subject to a step-therapy protocol.

3. Notwithstanding any provision of paragraph 1 of this subsection to the contrary, a health insurance or other health benefit plan offered by an insurer or by a pharmacy benefit manager on behalf of a health insurer that provides coverage for prescription drugs shall not utilize a step-therapy, "fail first", or other protocol that requires documented trials of a medication, including a trial documented through a "MedWatch", FDA Form 3500, before approving a prescription for the treatment of substance use disorder.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6110.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. For urgent prior authorization requests, a health plan shall approve, deny, or inform the insured or health care provider if any information is missing from a prior authorization request

from an insured or a prescribing health care provider within twenty-four (24) hours following receipt.

2. If a health plan informs an insured or a health care provider that more information is necessary for the health plan to make a determination on the request, the health plan shall have twenty-four (24) hours to approve or deny the request upon receipt of the necessary information.

B. For nonurgent prior authorization requests:

1. A health plan shall approve or deny a completed prior authorization request from an insured or a prescribing health care provider within two (2) business days following receipt;

2. A health plan shall acknowledge receipt of the prior authorization request within twenty-four (24) hours following receipt and shall inform the insured or health care provider at that time if any information is missing that is necessary for the health plan to make a determination on the request; and

3. If a health plan notifies an insured or a health care provider that more information is necessary pursuant to paragraph 2 of this subsection, the health plan shall have twenty-four (24) hours to approve or deny the request upon receipt of the necessary information.

C. If a health plan does not, within the time limits set forth in this section, respond to a completed prior authorization request, acknowledge receipt of the request for prior authorization, or

request missing information, the prior authorization request shall be deemed to have been granted.

D. Prior authorization approval for a prescribed treatment, service, or course of medication shall be valid for the duration of a prescribed or ordered course of treatment or one (1) year, whichever is longer.

E. For an insured who is stable on a treatment, service, or course of medication, as determined by a health care provider, that was approved for coverage under a previous health plan, a health plan shall not restrict coverage of that treatment, service, or course of medication for at least ninety (90) days upon the insured's enrollment in the new health plan.

F. A health insurance or other health benefit plan offered by a health insurer or by a pharmacy benefit manager on behalf of a health insurer shall cover, without requiring prior authorization, at least one readily available asthma controller medication from each class of medication and mode of administration.

G. Prior authorization approval for a prescribed or ordered treatment, service, or course of medication shall be valid for the duration of the prescribed or ordered treatment, service, or course of medication or one (1) year, whichever is longer; provided, however, that for a prescribed or ordered treatment, service, or course of medication that continues for more than one (1) year, a

health plan shall not require renewal of the prior authorization approval more frequently than once every five (5) years.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6110.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Department shall adopt rules, bulletins, or other guidance that prohibits carriers from imposing prior authorization requirements for any generic medication or for any treatment or medication, or for any category of these, that have low variation across health care providers and denial rates of less than ten percent (10%) across carriers.

B. In developing its rules, bulletins, or other guidance, the Department may rely on prior authorization data submitted by the health plans.

C. It is the intent of the Legislature that the rules, bulletins, or other guidance that the Department develops pursuant to this subsection should be designed to apply to frequently used medications, especially those ordered by primary care providers, and to achieve consistency in prior authorization exemptions across health plans in order to meaningfully reduce the administrative burden on health care providers.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6110.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

For any violation of the provisions of this act or any rule adopted pursuant thereto, the Insurance Commissioner may, upon notice and hearing, subject a person or entity to a civil fine of not less than One Hundred Dollars ($100.00) nor more than One Thousand Dollars ($1,000.00) for each occurrence.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6110.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

This act provides prior authorization and step-therapy protocol for prescription drugs. This act shall not apply to any type of medical condition procedure.

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

60-1-12587 TJ 02/11/25