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 OVERSIGHT
COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 1808 By: Newton

PROPOSED OVERSIGHT COMMITTEE SUBSTITUTE

An Act relating to health insurance; creating the Ensuring Transparency in Prescription Drugs Prior Authorization Act; defining terms; requiring disclosure and review of prior authorization for prescription drugs; requiring certain personnel make adverse determinations; requiring consultation prior to adverse determination; requiring certain criteria for reviewing physicians; providing an exception for prior authorization; prohibiting certain retrospective denial; providing for length of prior authorization; providing for length of prior authorization in special circumstances; providing continuity of care; providing standard for transmission of authorization; providing for failure to comply; providing for noncodification; 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 not to be codified in the Oklahoma Statutes reads as follows:

This act shall be known and may be cited as the "Ensuring Transparency in Prescription Drugs Prior Authorization Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.50 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. "Adverse determination" means a determination by a health carrier, pharmacy benefits manager (PBM), or its designee utilization review entity that a prescription drug that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health plan's or PBM's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested prescription drug or payment for the prescription drug is therefore denied, reduced, or terminated as defined by Section 6475.3 of Title 36 of the Oklahoma Statutes;

2. "Chronic condition" means a condition that lasts one (1) year or more and requires ongoing medical attention or limits activities of daily living or both;

3. "Clinical criteria" means the written policies, written screening procedures, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and any other criteria or rationale used by the utilization review entity to determine the necessity and appropriateness of prescription drugs;

4. "Emergency health care services", with respect to an emergency medical condition as defined in 42 U.S.C.A., Section 300gg-111, means:

a. a medical screening examination, as required under Section 1867 of the Social Security Act, 42 U.S.C., Section 1395dd, or as would be required under such section if such section applied to an independent, freestanding emergency department, that is within the capability of the emergency department of a hospital or of an independent, freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

b. within the capabilities of the staff and facilities available at the hospital or the independent, freestanding emergency department, as applicable, such further medical examination and treatment as are required under Section 1395dd of the Social Security Act, or as would be required under such section if such section applied to an independent, freestanding emergency department, to stabilize the patient, regardless of the department of the hospital in which such further examination or treatment is furnished, as defined by 42 U.S.C.A., Section 300gg-111;

5. "Emergency Medical Treatment and Active Labor Act" or "EMTALA" means Section 1867 of the Social Security Act and associated regulations;

6. "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents, as defined by Section 6592.1 of Title 36 of the Oklahoma Statutes;

7. "Health care provider" means any person or other entity who is licensed pursuant to the provisions of Title 59 or Title 63 of the Oklahoma Statutes, or pursuant to the definition in Section 1-1708.1C of Title 63 of the Oklahoma Statutes;

8. "Health plan" means a health benefit plan as defined by Section 6060.4 of Title 36 of the Oklahoma Statutes;

9. "Licensed mental health professional" means:

a. a psychiatrist who is a diplomate of the American Board of Psychiatry and Neurology,

b. a psychiatrist who is a diplomate of the American Osteopathic Board of Neurology and Psychiatry, or

c. a physician licensed pursuant to the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act or the Oklahoma Osteopathic Medicine Act;

10. "Medically necessary" means drugs prescribed by a health care provider that are:

a. appropriate for the symptoms and diagnosis or treatment of the enrollee's condition, illness, disease, or injury,

b. in accordance with standards of good medical practice,

c. not primarily for the convenience of the enrollee or the enrollee's health care provider, and

d. the most appropriate supply and prescription drug that can safely be provided to the enrollee as defined by Section 6592 of Title 36 of the Oklahoma Statutes;

11. "Notice" means communication delivered either electronically or through the United States Postal Service or common carrier;

12. "Pharmacist" means a person licensed by the Board of Pharmacy to engage in the practice of pharmacy;

13. "PBM" means a pharmacy benefits manager as defined by Section 357 of Title 59 of the Oklahoma Statutes;

14. "Physician" means an allopathic or osteopathic physician licensed by the State of Oklahoma or another state to practice medicine;

15. "Prior authorization" means the process by which utilization review entities determine the medical necessity and medical appropriateness of otherwise covered prescription drug prior to the dispensing of such prescription drug. The term shall include

"authorization", "pre-certification", and any other term that would be a reliable determination by a health benefit plan;

16. "Urgent prescription drug" means a prescription drug with respect to which the application of the time periods for making an urgent care determination, which, in the opinion of a physician with knowledge of the enrollee's medical condition:

a. could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function, or

b. in the opinion of a physician with knowledge of the claimant's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; and

17. "Utilization review entity" means an individual or entity that performs prior authorization for a health benefit plan as defined by Section 6060.4 of Title 36 of the Oklahoma Statutes.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.51 of Title 36, unless there is created a duplication in numbering, reads as follows:

A utilization review entity shall make any current prescription drug prior authorization requirements and restrictions, including written clinical criteria, readily accessible on its website to enrollees and health care providers. Prior authorization

requirements shall be described in detail but also in easily understandable language.

Any health plan shall make any current prescription drug plan formulary readily accessible on its website to enrollees and health care providers.

All health benefit plans shall submit an HTML link for the plan's formulary, to the Insurance Commissioner, on or before October 1 of each year. The Commissioner shall issue guidance and standardized reporting requirements to ensure compliance with the provisions of this section. Any confidential or trade secret information shall be redacted prior to submission to the Commissioner. No later than December 31, 2025, and by December 31 of each year thereafter, the Commissioner shall make available to the public the reports submitted by insurers, as required by this section.

If a utilization review entity intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review entity shall ensure that the new or amended requirement or restriction is not implemented unless the utilization review entity's website has been updated to reflect the new or amended requirement or restriction.

If a utilization review entity intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review entity shall

provide contracted health care providers credentialed to prescribe the drug, or enrollees who have a chronic condition and are already receiving the prescription drug which the prior authorization changes will impact, notice of the new or amended requirement or restriction no less than sixty (60) days before the requirement or restriction is implemented.

Provided the provisions of this section do not violate any applicable law, regulation, or the Oklahoma Medicaid State Plan.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.52 of Title 36, unless there is created a duplication in numbering, reads as follows:

A utilization review entity shall ensure that all adverse determinations include alternative prescription drugs covered by the health plan's formulary and are made by a physician, pharmacist, or licensed mental health professional. The physician, pharmacist, or licensed mental health professional shall:

1. Possess a current and valid nonrestricted license in any United States jurisdiction;

2. Have the appropriate training, knowledge, or expertise to apply appropriate clinical guidelines to the health care service being requested; and

3. Make the adverse determination under the clinical direction provided by the committee or board responsible for developing policies for drug use, evaluating clinical appropriateness, and

ensuring effective drug use when reviewing prescription drug prior authorizations to enrollees of Oklahoma. All such medical directors shall be physicians licensed in any United States jurisdiction.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.53 of Title 36, unless there is created a duplication in numbering, reads as follows:

A utilization review entity shall ensure that all appeals are reviewed by a physician, pharmacist, or licensed mental health professional. The physician, pharmacist, or licensed mental health professional shall:

1. Possess a current and valid unrestricted license in any United States jurisdiction;

2. Be of the same or similar specialty as a physician, pharmacist, or licensed mental health professional who typically manages the medical condition or disease, which means that the physician either maintains board certification for the same or similar specialty as the medical condition in question or whose training and experience:

a. includes treating the condition,

b. includes treating complications that may result from the service or procedure, and

c. is sufficient for the physician, pharmacist, or licensed mental health professional to determine if

the service or procedure is medically necessary or clinically appropriate,

except for appeals coming from a licensed mental health professional, which may be conducted by another licensed mental health professional as opposed to a physician, or for appeals coming from a pharmacist, which may be conducted by another licensed pharmacist as opposed to a physician;

3. Not have been directly involved in making the adverse determination;

4. Not have any financial interest in the outcome of the appeal; and

5. Consider all known clinical aspects of the health care service under review, including, but not limited to, a review of those medical records which are pertinent and relevant to the active condition provided to the utilization review entity by the enrollee's health care provider, or a health care facility, and any pertinent medical literature provided to the utilization review entity by the health care provider.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.54 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If a utilization review entity requires prior authorization of a prescription drug, the utilization review entity shall make a prior authorization or adverse determination and notify the enrollee

and the enrollee's health care provider of the prior authorization or adverse determination in accordance with the time frames set forth below:

1. For purposes of approving prior authorization for urgent prescription drugs, within twenty-four (24) hours of obtaining all necessary information to make the prior authorization or adverse determination; or

2. For purposes of approving prior authorization for non-urgent prescription drugs, within four (4) business days of obtaining all necessary information to make the prior authorization or adverse determination.

For purposes of this section, "necessary information" includes, but is not limited to, the results of any face-to-face clinical evaluation or second opinion that may be required.

B. For those health care providers that submit all necessary information through the utilization review entity's authorized prior authorization system, prescription drugs are deemed authorized if a utilization review entity fails to comply with the deadlines set forth in this section.

C. In the notification to the health care provider that a prior authorization has been approved, the utilization review entity shall include in such notification the duration of the prior authorization or the date by which the prior authorization will expire.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.55 of Title 36, unless there is created a duplication in numbering, reads as follows:

A utilization review entity shall not require prior authorization for prescription drugs administered as a part of the provision of emergency health care services.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.56 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If a prior authorization is required for a prescription drug for the treatment of a chronic condition of an enrollee, and the enrollee remains on the same health plan, then the prior authorization shall remain valid for three (3) years from the date the health care provider receives the prior authorization approval, unless clinical criteria changes, the enrollee's health plan removes the generic prescription drug from the formulary, or moves the prescription drug to a less preferred tier status on its formulary.

B. This section shall not apply to prior authorizations approved for:

1. A prescription drug that is an opioid or is a controlled substance that is prohibited from being dispensed without a prescription under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C., Section 301 et seq., as amended; or

2. A prescription drug for the treatment of weight loss.

C. Provided the provisions of this section do not violate any applicable law, regulation, or the Oklahoma Medicaid State Plan.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.57 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. On receipt of information documenting a prior authorization from the enrollee or from the enrollee's health care provider, a utilization review entity shall honor a prior authorization granted to an enrollee from a previous utilization review entity for at least the initial sixty (60) days of an enrollee's coverage under a new health plan.

B. During the time period described in subsection A of this section, a utilization review entity may perform its own review to grant a prior authorization or make an adverse determination.

C. A utilization review entity shall continue to honor a prior authorization it has granted to an enrollee when the enrollee changes products under the same health insurance company for the initial sixty (60) days of an enrollee's coverage under the new product unless the service is no longer a covered service under the new product.

D. During the time period described in subsection C of this section, a utilization review entity may simultaneously perform a review to grant a prior authorization or to make an adverse determination.

E. Provided the provisions of this section do not violate any applicable law, regulation, or the Oklahoma Medicaid State Plan.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.58 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Insurance Commissioner may, if the Commissioner finds that any person or organization has violated the provisions of this act, impose a penalty of not more than Five Thousand Dollars ($5,000.00) for each such violation. Such penalties may be in addition to any other penalty provided by law.

No penalty shall be imposed except upon written order of the Commissioner or the appointed independent hearing examiner, stating the findings of the Commissioner or the appointed independent hearing examiner after the notice and opportunity for a hearing in accordance with Article II of the Administrative Procedures Act.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.59 of Title 36, unless there is created a duplication in numbering, reads as follows:

This act shall apply to the Oklahoma Medicaid State Plan.

SECTION 12. This act shall become effective November 1, 2025.

60-1-13058 TJ 03/04/25