SENATE CHAMBER

STATE OF OKLAHOMA

DISPOSITION

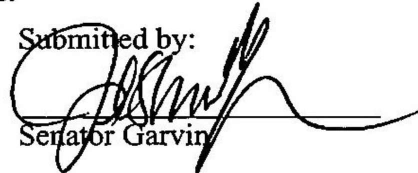
■ FLOOR AMENDMENT No. 1 ____________

☐ COMMITTEE AMENDMENT ____________

(Date)

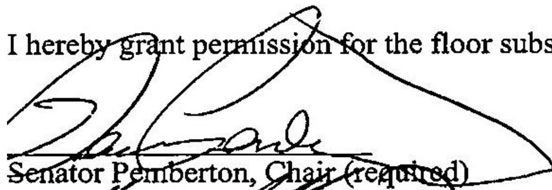
I move to amend Senate Bill No. 441 by substituting the attached floor substitute (Request No. 3639) for the title, enacting clause and entire body of the measure.

Submitted by:



Senator Garvin

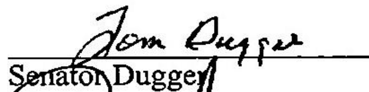
I hereby grant permission for the floor substitute to be adopted.



Senator Pemberton, Chair (required)

Senator Jett

Senator Coleman



Senator Dugger

Senator Garvin

Senator Treat, President Pro Tempore

Senator Hamilton

Senator Matthews

Senator Prieto

Senator Woods

Senator Young

Senator McCortney, Majority Floor Leader

Note: Retirement and Insurance committee majority requires six (6) members' signatures.

Garvin-RD-FS-SB441
3/12/2024 9:55 AM

(Floor Amendments Only) Date and Time Filed: 3-12-24 10:20am

☐ Untimely ☐ Amendment Cycle Extended ☐ Secondary Amendment

STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

FLOOR SUBSTITUTE
FOR
SENATE BILL NO. 441 By: Garvin of the Senate

and

Newton of the House

FLOOR SUBSTITUTE

[prior authorization - criteria - notice - determination - appeal - payment - time period - plans - violations - codification - 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 6476.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

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

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6476.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

For the purposes of this act:

1. "Adverse determination" means an adverse determination as defined pursuant to Section 6475.3 of Title 36 of the Oklahoma Statutes;

2. "Chronic condition" means a condition lasting at least one (1) year that requires ongoing medical attention, limits activities of daily living, or both;

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

4. "Emergency health care services" means emergency services as defined pursuant to 42 U.S.C., Section 300gg-111;

5. "Enrollee" means an enrollee as defined pursuant to Section 6592 of Title 36 of the Oklahoma Statutes;

6. "Health benefit plan" means a health benefit plan as defined by Section 6060.4 of Title 36 of the Oklahoma Statutes, provided that the term shall not include a contracted entity as defined by Section 4002.2 of Title 56 of the Oklahoma Statutes or other insurance carriers subject to the Long-Term Care Insurance Act;

7. "Health care provider" means a health care provider as defined pursuant to Section 1-1708.1C of Title 63 of the Oklahoma Statutes;

8. "Health care service" or "health care services" means health care services as defined pursuant to Section 1-1708.1C of Title 63 of the Oklahoma Statutes, provided:

a. the term shall also include mental health and substance use disorder services, as defined in Section 6060.10 of Title 36 of the Oklahoma Statutes, and the provision of durable medical equipment, and

b. the term shall not include the provision, administration, or prescription of pharmaceutical products or services;

9. "Licensed mental health professional" means a licensed mental health professional as defined pursuant to Section 1-103 of Title 43A of the Oklahoma Statutes;

10. "Medically necessary" means medically necessary as such term is defined in Section 6592 of Title 36 of the Oklahoma Statutes;

11. "Notice" means communication delivered either electronically or by mail;

12. "Physician" means an allopathic or osteopathic physician licensed by this state or another state to practice medicine;

13. "Prior authorization" means the process by which a health benefit plan or the designated utilization review entity determines the medical necessity or medical appropriateness of an otherwise covered health care service prior to rendering the health care service, and shall include any other applicable term that would deem a reliable determination by a health benefit plan or utilization review entity;

14. "Urgent health care service" means a health care service that, 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. 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

15. "Utilization review entity" means an individual or entity that performs the prior authorization process on behalf of a health benefit plan.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6476.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A utilization review entity shall make current 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 and in written, easily understandable language.

B. A utilization review entity shall not implement any new or amended prior authorization requirement or restriction unless the

utilization review entity's website has been updated to reflect the new or amended requirement or restriction.

C. A utilization review entity shall provide notice of the new or amended requirement or restriction to contracted health care providers credentialed to perform the service at the subject of the requirement or restriction, and enrollees who have a chronic condition and are actively receiving the service for which the requirement or restriction will impact, at least sixty (60) days before the requirement or restriction is implemented.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6476.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

A utilization review entity shall require all adverse determinations to be made by a physician or licensed mental health professional. The physician or mental health professional shall:

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

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

3. Make the adverse determination under the clinical direction of a medical director of the utilization review entity who is responsible for the provisions of reviewing health care services to enrollees in this state. Medical directors for a utilization review

entity 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 6476.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

All appeals of a prior authorization determination issued by a utilization review entity shall be reviewed by a physician or licensed mental health professional. The physician or 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 who typically manages the medical condition or disease at the subject of the prior authorization appeal. The physician shall maintain 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 services or procedures used to treat the condition, and

c. is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate;

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 6476.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. For plan years beginning on or after January 1, 2027, any health benefit plan offered, issued, or renewed in this state shall implement and maintain a Prior Authorization Application Programming Interface (API) as prescribed in 45 C.F.R., Part 156.

B. Not later than July 1, 2027, health care providers shall have electronic health records or practice management systems that are compatible with the API.

C. On and after the effective date of this act, a utilization review entity shall provide health care providers with the following communication standards during the prior authorization process:

1. Utilization review entity staff shall be available not less than eight (8) hours a day during normal business hours for inbound telephone calls regarding prior authorization issues;

2. A utilization review entity shall provide staff availability to receive inbound communication regarding prior authorization issues after normal business hours; and

3. Health care providers shall have the opportunity to discuss a prior authorization denial with an appropriate reviewer.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6476.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If a utilization review entity requires prior authorization for a health care service, the utilization review entity shall make such authorization or an adverse determination and notify the enrollee and the requesting health care provider of the prior authorization or adverse determination within the following time frame:

1. For urgent health care services, within seventy-two (72) hours of obtaining all necessary information to make the prior authorization or adverse determination; or

2. For non-urgent health care services, within seven (7) days of obtaining all necessary information to make the prior authorization or adverse determination.

B. If a utilization review entity fails to comply with the time frames set forth in subsection A of this section, and the health care provider has submitted all necessary information electronically, the health care service shall be authorized.

C. The utilization review entity shall include with an approved prior authorization notification the duration of the prior authorization or the date by which the prior authorization shall expire.

D. For the purposes of this section, "necessary information" shall include but not be limited to the result of any face-to-face clinical evaluation or second opinion that may be required.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6476.8 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. No utilization review entity shall require prior authorization for pre-hospital transportation, emergency health care services, or for transfers between health care facilities as required by the federal Emergency Medical Treatment and Labor Act.

B. A utilization review entity shall allow an enrollee and the health care provider of the enrollee a minimum of twenty-four (24) hours following an emergency admission or the provision of emergency health care services for the enrollee or health care provider to notify the utilization review entity of the admission or provision of services. If the admission or health care service occurs on a

holiday or weekend, a utilization review entity shall not require notification until the next business day after the admission or provision of services.

C. Emergency health care services shall be covered in accordance with the requirements set forth in Section 6907 of Title 36 of the Oklahoma Statutes.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6476.9 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. No health benefit plan may revoke, limit, condition, or restrict a prior authorization if care is provided within forty-five (45) business days from the date the health care provider received the prior authorization, provided that the enrollee is eligible for the care or service on the day it is provided.

B. A health benefit plan shall pay any contracted health care provider at the contracted payment rate for a health care service provided by the provider per a prior authorization, unless:

1. The health care provider knowingly or materially misrepresented the health care service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment from a utilization review entity;

2. The health care service was not a covered benefit on the date that the service was provided to the enrollee;

3. The health care provider was no longer contracted with the health benefit plan on the date that the care was provided;

4. The provider failed to meet the timely filing requirements of the utilization review entity; or

5. The patient was no longer eligible for health care coverage on the date that care was provided.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6476.10 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as provided for in subsection B of this section, prior authorization for a health care service shall remain valid for not less than six (6) months from the date the health care provider receives the prior authorization approval, unless the clinical criteria changes and notice of the change in clinical criteria is provided pursuant to Section 3 of this act.

B. 1. If a prior authorization is required for inpatient care for the treatment of a chronic condition, the prior authorization shall remain valid for not less than fourteen (14) calendar days from the date the health care provider received the prior authorization approval.

2. If an enrollee requires inpatient care beyond the length of stay that was previously approved by the utilization review entity, then the entity shall evaluate any prior authorization requests for the continuation of inpatient care according to the provisions of

1 this act. An entity shall not use stricter clinical criteria to
2 determine medical necessity and appropriateness of the continuation
3 of inpatient care than the criteria used to evaluate the initial
4 request for authorization of inpatient care. The entity shall
5 review any relevant and pertinent literature or data provided by the
6 health care provider to determine the medical necessity and
7 appropriateness of the requested length of stay and continuation of
8 inpatient care.

9 3. If a utilization review entity fails to respond to a health
10 care provider's timely prior authorization request for the
11 continuation of inpatient care before the termination of the
12 previously approved length of stay, then the health benefit plan
13 shall continue to compensate the provider at the contracted rate for
14 inpatient care provided until the entity issues its determination on
15 the prior authorization request.

16 4. If a utilization review entity issues an adverse
17 determination to a health care provider's prior authorization
18 request for continuation of inpatient care, and the health care
19 provider appeals the adverse determination in accordance with the
20 provisions of this act, then the health benefit plan shall continue
21 to compensate the health care provider at the contracted rate for
22 inpatient care provided until the appeal is finalized.

23 C. Nothing in this section shall be construed to require a
24 health benefit plan to cover care, treatment, or services for a

health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6476.11 of Title 36, unless there is created a duplication in numbering, reads as follows:

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

C. A utilization review entity shall continue to honor an approved prior authorization 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.

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

59-2-3639 RD 3/12/2024 10:56:26 AM