STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

HOUSE BILL 3190 By: Newton

AS INTRODUCED

An Act relating to health insurance; creating the Ensuring Transparency in Prior Authorization Act; defining terms; requiring disclosure and review of prior authorization; requiring certain personnel make adverse determinations; requiring consultation prior to adverse determination; requiring certain criteria for reviewing physicians; establishing certain obligations for utilization review entity in certain circumstances; providing an exception for prior authorization; prohibiting certain retrospective denial; providing for length of prior authorization; providing for length of prior authorization in certain circumstances; providing continuity of care; providing standard for transmission of authorization; providing for failure to comply; providing for severability; 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 may be known and 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 6570.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. "Adverse determination" means a decision by a utilization review entity that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary, or are experimental or investigational; and benefit coverage is therefore denied, reduced, or terminated. A decision to deny, reduce, or terminate services that are not covered for reasons other than their medical necessity or experimental or investigational nature is not an "adverse determination" for purposes of this act;

2. "Authorization" means a determination by a utilization review entity that a health care service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness, and that payment will be made for that health care service;

3. "Chronic condition" means a diagnosis of a disease dependent on duration, a condition lasting twelve (12) months or longer, and its effect on the patient based on one or both of the following criteria:

a. the condition results in the need for ongoing intervention with medical products, treatment, services, and special equipment, or

b. the condition places limitations on self-care, independent living, and social interactions;

4. "Clinical criteria" means the written policies, written screening procedures, drug formularies or lists of covered drugs, 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 health care services;

5. "Emergency health care services" means those health care services that are provided in an emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

a. placing the patient's health in serious jeopardy,

b. serious impairment to bodily function, or

c. serious dysfunction of any bodily organ or part;

6. "Enrollee" means an individual eligible to receive health care service benefits from a health insurer pursuant to a health plan or other health insurance coverage. The term enrollee includes an enrollee's legally authorized representative;

7. "Health care services" means health care procedures, treatments, or services:

a. provided by a facility licensed in Oklahoma, or

b. provided by a doctor of medicine, a doctor of osteopathy, or within the scope of practice for which a health care professional is licensed in Oklahoma.

The term "health care service" also includes the provision, administration or prescription of pharmaceutical products or services or durable medical equipment;

8. "Medically necessary health care services" means health care services that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

a. in accordance with generally accepted standards of medical practice,

b. clinically appropriate in terms of type, frequency, extent, site, and duration, and,

c. not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider;

9. "Medication for opioid use disorder (MOUD)" means the use of medications, commonly in combination with counseling and behavioral therapies, to provide a comprehensive approach to the treatment of opioid use disorder. FDA-approved medications used to treat opioid addiction include methadone; buprenorphine, alone or in combination

with naloxone; and extended-release injectable naltrexone. Types of behavioral therapies include individual therapy, group counseling, family behavior therapy, motivational incentives, and other modalities;

10. "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs SCRIPT Standard Version 2017071, or the most recent standard adopted by the United States Department of Health and Human Services (HHS). Subsequently released versions of the NCPDP SCRIPT Standard may be used;

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

12. "Primary care provider" means a health care professional that works in family medicine, general internal medicine, or general pediatrics who provides definitive care to the undifferentiated patient at the point of first contact, and takes continuing responsibility for providing the patient's comprehensive care. This care may include chronic, preventive and acute care in both inpatient and outpatient settings;

13. "Prior authorization" means the process by which utilization review entities determine the medical necessity and/or medical appropriateness of otherwise covered health care services prior to the rendering of such health care services. Prior authorization also includes any health insurer's or utilization review entity's requirement that an enrollee or health care provider

notify the health insurer or utilization review entity prior to providing a health care service;

14. "Urgent health care service" means a health care service with respect to which the application of the time periods for making a non-expedited prior authorization, 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. could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

For the purpose of this act, urgent health care service shall include mental and behavioral health care services.

15. "Utilization review entity" means an individual or entity that performs prior authorization for one or more of the following:

a. an employer with employees in Oklahoma who are covered under a health benefit plan or health insurance policy,

b. an insurer that writes health insurance policies,

c. a preferred provider organization, or health maintenance organization, or

d. any other individual or entity that provides, offers to provide, or administers hospital, outpatient,

medical, prescription drug, or other health benefits to a person treated by a health care professional in Oklahoma under a policy, plan or contract.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

A utilization review entity shall make any current prior authorization requirements and restrictions readily accessible on its website to enrollees, health care professionals, and the general public. This includes the written clinical criteria. Requirements shall be described in detail but also in easily understandable language.

1. 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 is not implemented unless the utilization review entity's website has been updated to reflect the new or amended requirement or restriction.

2. 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 or enrollees written notice of the new or amended requirement or amendment no less than

sixty (60) days before the requirement or restriction is implemented.

3. Entities using prior authorization shall make statistics available regarding prior authorization approvals and denials on there website in a readily accessible format.

They should include categories for:

a. physician specialty,

b. medication or diagnostic test/procedure,

c. indication offered,

d. reason for denial,

e. if appealed,

f. if approved or denied on appeal, and

g. the time between submission and response.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

A utilization review entity must ensure that all adverse determinations are made by a physician. The physician must:

1. Possess a current and valid nonrestricted license to practice medicine in Oklahoma;

2. Be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request;

3. Have experience treating patients with the medical condition or disease for which the health care service is being requested; and

4. Make the adverse determination under the clinical direction of one of the utilization review entity's medical directors who is responsible for the provision of health care services provided to enrollees of Oklahoma. All such medical directors must be physicians licensed in Oklahoma.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

If a utilization review entity questions the medical necessity of a health care service, the utilization review entity must notify the enrollee's physician that medical necessity is being questioned. Prior to issuing an adverse determination, the enrollee's physician must have the opportunity to discuss the medical necessity of the health care service on the telephone with the physician who will be responsible for determining authorization of the health care service under review.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

A utilization entity must ensure that all appeals are reviewed by a physician. The physician must:

1. Possess a current and valid nonrestricted license to practice medicine in Oklahoma;

2. Be currently in active practice in the same or similar specialty as a physician who typically manages the medical condition or disease for at least five (5) consecutive years;

3. Be knowledgeable of, and have experience providing, the health care services under appeal;

4. Not be employed by a utilization review entity or be under contract with the utilization review entity other than to participate in one or more of the utilization review entity's health care provider networks or to perform reviews of appeals, or otherwise have any financial interest in the outcome of the appeal;

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

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

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

If a utilization review entity requires prior authorization of a health care service, the utilization review entity must 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 within forty-eight (48) hours of obtaining all necessary information to make the prior authorization or adverse determination. For purposes of this section, "necessary information" includes the results 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 6570.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A utilization review entity cannot require prior authorization for pre-hospital transportation or for the provision of emergency health care services.

B. A utilization review entity shall allow an enrollee and the enrollee's health care provider a minimum of twenty-four (24) hours following an emergency admission or 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 health care services. If the admission or health care service occurs on a holiday or weekend, a utilization review entity cannot require notification until the next business day after the admission or provision of the health care services.

C. A utilization review entity shall cover emergency health care services necessary to screen and stabilize an enrollee. If a health care provider certifies in writing to a utilization review entity within seventy-two (72) hours of an enrollee's admission that the enrollee's condition required emergency health care services, that certification will create a presumption that the emergency health care services were medically necessary and such presumption may be rebutted only if the utilization review entity can establish, with clear and convincing evidence, that the emergency health care services were not medically necessary.

D. The medical necessity or appropriateness of emergency health care services cannot be based on whether those services were provided by participating or nonparticipating providers. Restrictions on coverage of emergency health care services provided by nonparticipating providers cannot be greater than restrictions that apply when those services are provided by participating providers.

E. If an enrollee receives an emergency health care service that requires immediate post-evaluation or post-stabilization services, a utilization review entity shall make an authorization determination within sixty (60) minutes of receiving a request; if the authorization determination is not made within sixty (60) minutes, such services shall be deemed approved.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.8 of Title 36, unless there is created a duplication in numbering, reads as follows:

A utilization review entity may not require prior authorization for the provision of MOUD.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.9 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A utilization review entity may not 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.

B. A utilization review entity must pay a health care provider at the contracted payment rate for a health care service provided by the health care provider per a prior authorization unless:

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

2. The health care service was no longer a covered benefit on the day it was provided;

3. The health care provider was no longer contracted with the patient's health insurance plan on the date the care was provided;

4. The health care provider failed to meet the utilization review entity's timely filing requirements;

5. The utilization review entity does not have liability for a claim; or

6. The patient was no longer eligible for health care coverage on the day the care was provided.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.10 of Title 36, unless there is created a duplication in numbering, reads as follows:

A prior authorization shall be valid for one (1) year from the date the health care provider receives the prior authorization and the authorization period shall be effective regardless of any changes in dosage for a prescription drug prescribed by the health care provider.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.11 of Title 36, unless there is created a duplication in numbering, reads as follows:

If a utilization review entity requires a prior authorization for a health care service for the treatment of a chronic or long-term care condition, the prior authorization shall remain valid for the length of the treatment and the utilization review entity may not require the enrollee to obtain a prior authorization again for the health care service.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.12 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.

C. If there is a change in coverage of, or approval criteria for, a previously authorized health care service, the change in coverage or approval criteria does not affect an enrollee who received prior authorization before the effective date of the change for the remainder of the enrollee's plan year.

D. 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.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.13 of Title 36, unless there is created a duplication in numbering, reads as follows:

No later than January 1, 2025, the payer must accept and respond to prior authorization requests under the pharmacy benefit through a secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions. Facsimile, propriety payer portals, electronic forms, or any other technology not directly integrated with a physician's electronic health record/electronic prescribing system shall not be considered secure electronic transmission.

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.14 of Title 36, unless there is created a duplication in numbering, reads as follows:

Health care services are deemed authorized if a utilization review entity fails to comply with the requirements of this act. Any failure by a utilization review entity to comply with the deadlines and other requirements specified in this act will result in any health care services subject to review to be automatically deemed authorized by the utilization review entity.

SECTION 16. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6570.15 of Title 36, unless there is created a duplication in numbering, reads as follows:

If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

SECTION 17. This act shall become effective November 1, 2024.

59-2-8957 TJ 12/29/23