SENATE FLOOR VERSION
February 20, 2024

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

and

Newton of the House

[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 a decision by a utilization review entity on a prior authorization request that the health care

services furnished or proposed to be furnished to an enrollee are not medically necessary or are experimental or investigational, and coverage by the health benefit plan is therefore denied, reduced, or terminated. The term adverse determination shall not include any decision to deny, reduce, or terminate services that are not covered for reasons other than medical necessity or the nature of the service;

2. "Chronic condition" means a diagnosis of a disease or condition lasting not less than twelve (12) months based on:

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

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

3. "Emergency health care services" means health care services provided in a general medical surgical hospital, critical access hospital, or emergency hospital, as such terms are defined in Section 1-701 of Title 63 of the Oklahoma Statutes, that is licensed by the State Department of Health to evaluate and stabilize medical conditions of a recent and onset severity, including severe pain, regardless of the final diagnosis that is given, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or

injury is of such a nature that failure to get immediate medical care could:

a. place the individual's health in serious jeopardy, or

b. result in serious impairment, dysfunction, or disfigurement of a bodily function, bodily organ, or bodily part;

4. "Health benefit plan" means a health benefit plan as defined pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes;

5. "Health care provider" or "provider" means a health care provider as defined pursuant to Section 6571 of Title 36 of the Oklahoma Statutes;

6. "Health care service" or "health care services" means health care services as defined pursuant to Section 1219.6 of Title 36 of the Oklahoma Statutes;

7. "Medications for opioid use disorder" or "MOUD" means the use of medications, commonly in combination with counseling and behavioral therapies, to treat opioid use disorder. MOUD shall include medications approved by the United States Food and Drug Administration for use to treat opioid addiction including methadone, buprenorphine administered alone or in combination with naloxone, and extended-release injectable naltrexone;

8. "National Council for Prescription Drug Programs SCRIPT Standard Version" or "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs SCRIPT Standard Version

2017071 or any subsequently released version, or the most recent standard adopted by the United States Department of Health and Human Services;

9. “Prior authorization” means the utilization review process that occurs following a request from a health care provider for determining medical necessity of an otherwise covered health care service, as required by the health benefit plan;

10. “Urgent health care service” means a health care service that, if the application of a time period for a non-expedited prior authorization request were applied, in the opinion of the requesting physician, could:

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

b. subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review;

11. “Utilization review” means utilization review as defined pursuant to Section 6475.3 of Title 36 of the Oklahoma Statutes; and

12. “Utilization review entity” means an individual or entity that conducts 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. Any utilization review entity used by a health benefit plan shall make current prior authorization requirements and restrictions readily accessible on its website to enrollees, health care providers, and the general public. Requirements and restrictions shall be described in detail and in written, easily understandable language.

B. If a utilization review entity intends to implement or amend the prior authorization requirements or restrictions of the health benefit plan, the utilization review entity shall provide written notice to health care providers of the new or amended requirement or restriction not less than sixty (60) days before the requirement or restriction is implemented. Prior to implementation, the entity shall ensure that the new or amended requirement or restriction is reflected on the websites of the entity and the health benefit plan.

C. A utilization review entity making determinations on behalf of a health benefit plan shall make statistics regarding prior authorization approvals and denials available and readily accessible on its website to enrollees, health care providers, and the general public. Entities shall include the following information regarding approved or denied prior authorization requests:

1. Physician specialty;

2. Medication or diagnostic test or procedure;

3. Determination of the prior authorization request;

4. Reason for denial;

5. If an adverse determination has been appealed;

6. If an appeal of an adverse determination is approved or denied; and

7. The length of time between submission to and responses from a utilization review entity.

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. Prior to issuance of an adverse determination on a prior authorization request, the utilization review entity shall provide the opportunity to the requesting physician to discuss the medical necessity of the health care service verbally by telephone or electronic means.

B. A physician shall make any adverse determination to be issued by a utilization review entity. The physician shall:

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

2. Be of the same specialty as a health care provider who would typically provide the health care service involved in the request; and

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

C. A physician making an adverse determination under subsection B of this section shall make the determination under the clinical direction of a medical director of the utilization review entity or health benefit plan who is responsible for the provision of health care services provided to enrollees in this state.

D. Any appeal of an adverse determination issued by a utilization review entity shall be conducted by an independent review organization set forth in the Uniform Health Carrier External Review Act.

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:

A. Except as otherwise provided for in this section, if a utilization review entity requires an approved prior authorization request of a health care service, the utilization review entity shall make a determination on the request and notify the enrollee and the enrollee's health care provider within forty-eight (48) hours of obtaining all necessary information to make such determination.

B. 1. Utilization review of emergency health care services shall comply with the federal No Surprises Act, Pub. L. 116-260.

2. A utilization review entity shall not require an approved prior authorization request for pre-hospital transportation or prior to the provision of emergency health care services.

3. 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 rendering emergency health care services for the enrollee or health care provider to notify the utilization review entity of the admission or rendering of emergency health care services. If the admission or emergency 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 rendering of the emergency health care services.

4. A health benefit plan shall cover, and a utilization review entity shall approve, a prior authorization request for 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, such certification shall establish 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.

5. If an enrollee of a health benefit plan receives an emergency health care service that requires immediate post-evaluation or post-stabilization services, a utilization review entity shall make a prior authorization determination within sixty (60) minutes of receiving a request. If a determination is not made within the time frame provided in this paragraph, the authorization request shall be deemed approved.

C. No utilization review entity may require a prior authorization request for the provision of MOUD.

D. A utilization review entity shall issue a determination on a prior authorization request concerning urgent care services and notify the enrollee and the requesting health care provider of the determination not less than twenty-four (24) hours after receiving all necessary information to complete the prior authorization review for the requested health care services.

E. For the purposes of this section, "necessary information" shall include but not be limited to the results of any face-to-face clinical evaluations or second opinions.

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. No utilization review entity may revoke, limit, condition, or restrict an approved prior authorization request if care is

provided within forty-five (45) business days from the date the health care provider received approval for the prior authorization.

B. A utilization review entity shall not deny or reduce payment for a health care service exempted from a prior authorization requirement pursuant to this act, including a health care service performed or supervised by another health care provider when the health care provider who ordered the service received the prior authorization exemption, unless the rendering provider:

1. Knowingly or materially misrepresented the health care service in a request for payment submitted to the health benefit plan with the specific intent to deceive or obtain an unlawful payment from the health benefit plan;

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

3. The 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;

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 date that care was provided.

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. Except as provided for in subsection B of this section, an approved prior authorization request shall be valid for one (1) year from the date that the health care provider receives an approved prior authorization determination. For prior authorization requests approved regarding prescription drugs prescribed to an enrollee, the approved request shall be effective regardless of any changes in dosage.

B. If a utilization review entity approves a prior authorization request for the treatment of a chronic or long-term care condition, the prior authorization request shall remain effective and valid for the duration of the treatment and the utilization review entity shall not require the enrollee or provider to obtain a subsequent prior authorization approval for the health care service.

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. 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 subsection, 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 health care service, the change in coverage or approval criteria shall not affect an enrollee who received an approved prior authorization request before the effective date of the change for the remainder of the plan year.

D. A utilization review entity shall continue to honor an approved prior authorization request when the enrollee changes products or plans within the same health benefit plan.

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:

No later than January 1, 2025, any health benefit plan offering pharmacy benefits shall accept and respond to prior authorization requests regarding pharmacy benefits through a secure electronic transmission pursuant to standards for transaction under the NCPDP SCRIPT Standard. Facsimile, propriety payer portals, electronic forms, or any other technology not directly integrated with a physician's electronic health record or electronic prescribing system shall not be considered secure electronic transmission.

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:

Any failure by a utilization review entity to comply with the provisions of this act shall result in any pending prior authorization requests to be automatically deemed approved by the utilization review entity.

SECTION 11. This act shall become effective November 1, 2024.

COMMITTEE REPORT BY: COMMITTEE ON RETIREMENT AND INSURANCE
February 20, 2024 - DO PASS AS AMENDED BY CS