

HOUSE OF REPRESENTATIVES
CONFERENCE COMMITTEE REPORT

Mr. President:
Mr. Speaker:

The Conference Committee, to which was referred

HB1808

By: Newton of the House and Rader of the Senate

Title: Health insurance; creating the Ensuring Transparency in Prescription Drugs Prior Authorization Act; determination; consultation; prior authorization; effective date.





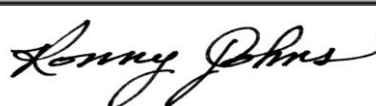






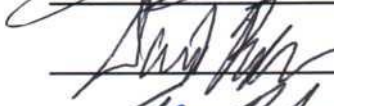
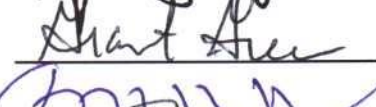

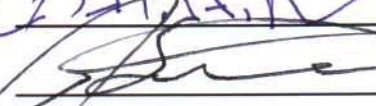
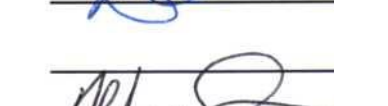
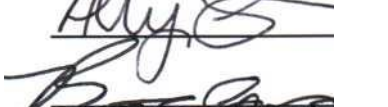
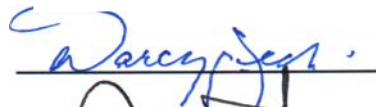
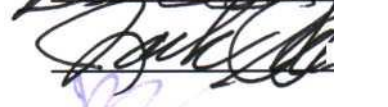
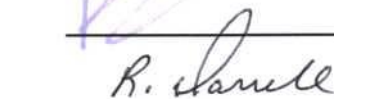



Together with Engrossed Senate Amendments thereto, beg leave to report that we have had the same under consideration and herewith return the same with the following recommendations:

1. That the Senate recede from its amendment; and
2. By adopting the following conference committee amendment to restore the title to read as follows:

"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."

Respectfully submitted,

HB1808 CCR (A)
HOUSE CONFEREES

Adams, Stacy		Alonso Sandoval, Arturo	
Banning, Chris	_____	Blancett, Meloyde	_____
Burns, Ty		Gann, Tom	_____
Hall, Rob	_____	Hill, Brian	
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Maynard, Cody	_____	Menz, Annie	_____
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e		Reinhardt	
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Green	_____		
Hall		Ste	
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HB1808 CCR A
House Action

Date

Senate Action

Date

AUTHOR(s)/COAUTHOR(s) CURRENTLY IN THE QUEUE for HB1808

As of 5/21/2025 10:44:07 AM

Add as coauthor Representative Menz

Add as coauthor Representative Alonso-Sandoval

1 ENGROSSED SENATE AMENDMENT
TO
2 ENGROSSED HOUSE
BILL NO. 1808

By: Newton, Deck, Pae, Miller,
Munson, Dempsey, and Lawson
of the House

and

Rader of the Senate

[health insurance - Ensuring Transparency in
Prescription Drugs Prior Authorization Act -
disclosure and review of prior authorization for
prescription drugs - adverse determinations -
consultation - reviewing physicians - exception -
retrospective denial - continuity of care -
transmission of authorization - noncodification -
codification - effective date]

AUTHOR: Add the following Senate Coauthor: Stanley

AMENDMENT NO. 1. Page 1, strike the enacting clause

1 Passed the Senate the 8th day of May, 2025.

2
3 _____
4 Presiding Officer of the Senate

5 Passed the House of Representatives the ____ day of _____,
6 2025.

7
8 _____
9 Presiding Officer of the House
10 of Representatives

1 ENGROSSED HOUSE
2 BILL NO. 1808

By: Newton, Deck, Pae, Miller,
Munson, Dempsey, and Lawson
of the House

3
4 and

Rader of the Senate

5
6
7 [health insurance - Ensuring Transparency in
8 Prescription Drugs Prior Authorization Act -
9 disclosure and review of prior authorization for
10 prescription drugs - adverse determinations -
11 consultation - reviewing physicians - exception -
12 retrospective denial - continuity of care -
13 transmission of authorization - noncodification -
14 codification - effective date]
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17

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

19 SECTION 1. NEW LAW A new section of law not to be
20 codified in the Oklahoma Statutes reads as follows:

21 This act shall be known and may be cited as the "Ensuring
22 Transparency in Prescription Drugs Prior Authorization Act".
23
24

1 SECTION 2. NEW LAW A new section of law to be codified

2 in the Oklahoma Statutes as Section 6570.50 of Title 36, unless
3 there is created a duplication in numbering, reads as follows:

4 As used in this act:

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

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

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

22 4. "Emergency health care services", with respect to an
23 emergency medical condition as defined in 42 U.S.C.A., Section
24 300gg-111, means:

- 1 a. a medical screening examination, as required under
2 Section 1867 of the Social Security Act, 42 U.S.C.,
3 Section 1395dd, or as would be required under such
4 section if such section applied to an independent,
5 freestanding emergency department, that is within the
6 capability of the emergency department of a hospital
7 or of an independent, freestanding emergency
8 department, as applicable, including ancillary
9 services routinely available to the emergency
10 department to evaluate such emergency medical
11 condition, and
- 12 b. within the capabilities of the staff and facilities
13 available at the hospital or the independent,
14 freestanding emergency department, as applicable, such
15 further medical examination and treatment as are
16 required under Section 1395dd of the Social Security
17 Act, or as would be required under such section if
18 such section applied to an independent, freestanding
19 emergency department, to stabilize the patient,
20 regardless of the department of the hospital in which
21 such further examination or treatment is furnished, as
22 defined by 42 U.S.C.A., Section 300gg-111;
- 23
24

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

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

7 7. "Health care provider" means any person or other entity who
8 is licensed pursuant to the provisions of Title 59 or Title 63 of
9 the Oklahoma Statutes, or pursuant to the definition in Section 1-
10 1708.1C of Title 63 of the Oklahoma Statutes;

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

13 9. "Licensed mental health professional" means:

- 14 a. a psychiatrist who is a diplomate of the American
15 Board of Psychiatry and Neurology,
- 16 b. a psychiatrist who is a diplomate of the American
17 Osteopathic Board of Neurology and Psychiatry, or
- 18 c. a physician licensed pursuant to the Oklahoma
19 Allopathic Medical and Surgical Licensure and
20 Supervision Act or the Oklahoma Osteopathic Medicine
21 Act;

22 10. "Medically necessary" means drugs prescribed by a health
23 care provider that are:
24

- 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 a. includes treating the condition,

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

22 c. is sufficient for the physician, pharmacist, or
23 licensed mental health professional to determine if
24

1 the service or procedure is medically necessary or
2 clinically appropriate,
3 except for appeals coming from a licensed mental health
4 professional, which may be conducted by another licensed mental
5 health professional as opposed to a physician, or for appeals coming
6 from a pharmacist, which may be conducted by another licensed
7 pharmacist as opposed to a physician;

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

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

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

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

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

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

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

8 2. For purposes of approving prior authorization for nonurgent
9 prescription drugs, within four (4) business days of obtaining all
10 necessary information to make the prior authorization or adverse
11 determination.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 A. 1. The Insurance Commissioner may, if the Commissioner
7 finds that any person or organization has violated the provisions of
8 this act, impose a penalty of not more than Five Thousand Dollars
9 (\$5,000.00) for each such violation. Such penalties may be in
10 addition to any other penalty provided by law.

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

16 B. 1. The Attorney General may, if the Attorney General finds
17 that a pharmacy benefits manager has violated the provisions of this
18 act, impose a penalty of not more than Five Thousand Dollars
19 (\$5,000.00) for each such violation. Such penalties may be in
20 addition to any other penalty provided by law.

21 2. No penalty shall be imposed except upon written order of the
22 Attorney General or the appointed independent hearing examiner,
23 stating the findings of the Attorney General or the appointed
24 independent hearing examiner after the notice and opportunity for a

1 hearing in accordance with Article II of the Administrative
2 Procedures Act.

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

6 This act shall apply to the Oklahoma Medicaid State Plan.

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

8 Passed the House of Representatives the 24th day of March, 2025.

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Presiding Officer of the House
of Representatives

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13 Passed the Senate the _____ day of _____, 2025.

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Presiding Officer of the Senate

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