SENATE FLOOR VERSION
April 10, 2025

ENGROSSED HOUSE
BILL NO. 1811 By: Newton of the House

and

Jech of the Senate

An Act relating to insurance; amending Section 10, Chapter 303, O.S.L. 2024 (36 O.S. Supp. 2024, Section 6570.9), which relates to treatment of chronic conditions and validity period for prior authorization of inpatient and non-inpatient care; modifying timeframe; and providing an effective date.

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

SECTION 1. AMENDATORY Section 10, Chapter 303, O.S.L. 2024 (36 O.S. Supp. 2024, Section 6570.9), is amended to read as follows:

Section 6570.9. A. If a prior authorization is required for a health care service, other than for inpatient care, for the treatment of a chronic condition of an enrollee, then the prior authorization shall remain valid for at least six (6) months from the date the health care provider receives the prior authorization

approval, unless clinical criteria changes and notice of the change in clinical criteria is provided as stipulated in this act.

B. If a prior authorization is required for inpatient acute care for the treatment of a chronic condition of an enrollee, then the prior authorization shall remain valid for at least fourteen (14) calendar days from the date the health care provider receives the prior authorization approval.

1. If an enrollee requires inpatient care beyond the length of stay that was previously approved by the utilization review entity, then the utilization review entity shall evaluate any prior authorization requests for the continuation of inpatient care according to the provisions of this act. A utilization review entity shall not use any stricter criteria to determine medical necessity and appropriateness of the continuation of inpatient care as the utilization review entity used to evaluate the initial request for authorization of inpatient care. A utilization review entity shall review any relevant and pertinent literature or data provided by the health care provider to determine the medical necessity and appropriateness of the requested length of stay and/or continuation of inpatient care. A prior authorization for the continuation of inpatient care shall remain valid for a maximum of fourteen (14) calendar days from the date the health care provider receives the prior authorization approval.

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

For the purposes of this section, a timely request for continuation of inpatient care means a request that is submitted at least ~~seventy-two (72)~~ twenty-four (24) hours prior to the termination of the previously approved prior authorization and includes all necessary information for the utilization review entity to make a determination.

3. If a utilization review entity issues an adverse determination to a health care provider's prior authorization request for continuation of inpatient acute care and the health care provider appeals the adverse determination according to the provisions of this act, then the health benefit plan shall continue to compensate the health care provider at the contracted rate for inpatient care provided until the appeal has been finalized.

C. This section does not require a 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 2. This act shall become effective November 1, 2025.

COMMITTEE REPORT BY: COMMITTEE ON BUSINESS AND INSURANCE
April 10, 2025 - DO PASS