STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

HOUSE BILL 1808 By: Newton

AS INTRODUCED

An Act relating to health insurance; providing definitions; providing cost-sharing requirements; providing enforcement by the Attorney General; promulgating rules; providing for step-therapy protocols for prescription drugs; providing requirements for processing claims; providing for downcoding; providing for prior authorization requests; providing for legislative intent; providing standards for fair contracts; 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 to be codified in the Oklahoma Statutes as Section 6110 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this section:

1. "Cost sharing" means the share of costs covered by a health plan for which an insured is financially responsible, including deductibles, coinsurance, co-payments, and similar charges. It shall not include premiums, balance billing amount for out-of-network providers, or the cost of noncovered health care services;

2. "Health benefit plan" means any individual or group health insurance policy, any hospital or medical service corporation, or health maintenance organization subscriber contract, or any other plan offered, issued, or renewed for any person in this state by a health plan or other payer. The term does not include benefit plans providing coverage for a specific disease or other limited benefit coverage;

3. "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a physical, dental, behavioral, or mental health condition or substance use disorder, including procedures, products, devices, and medications; and

4. "Readily available" means that the medication is not listed on a national drug shortage list, including lists maintained by the United States Food and Drug Administration and by the American Society of Health-System Pharmacists.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6110.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health plan or other payer shall:

1. Pay a health care provider the full amount due for health care services under the terms of a health benefit plan, including any cost sharing;

2. Have the sole responsibility for collecting cost sharing from an insured; and

3. Upon request of an insured, collect cost sharing throughout the plan year in increments defined by the health plan or other payer.

B. A health plan or other payer shall not:

1. Withhold any amount for cost sharing from the payment to a health care provider; or

2. Require a health care provider to offer additional discounts to insureds outside the terms of the health care contract between the health plan or other payer and the health care provider.

C. Any value of a co-payment assistance coupon or similar assistance program shall be applied to an enrollee's annual cost-sharing requirement and may be paid directly to the health plan or other payer on the insured's behalf.

D. A health plan or other payer shall not cancel the health benefit plan of an insured who does not remit or otherwise pay a cost-sharing amount due for services rendered.

E. Any expenses related to implementation of this section by a health plan or other payer shall not be used as justification to increase premiums or decrease payments to a health care provider.

F. A violation of this section is an unfair or deceptive act or practice. All remedies, penalties, and authority granted to the Attorney General shall be available to enforce this section.

G. The Oklahoma Insurance Department may adopt rules as needed to implement and administer this section.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6110.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

1. A health insurance or other health benefit plan offered by a health insurer or by a pharmacy benefit manager on behalf of a health insurer that provides coverage for prescription drugs and uses step-therapy protocols shall:

a. not require failure, including discontinuation due to lack of efficacy or effectiveness, diminished effect, or an adverse event, on the same medication on more than one occasion for insureds who are continuously enrolled in a plan offered by the insurer or its pharmacy benefit manager, and

b. grant an exception to its step-therapy protocols upon request of an insured or the insured's treating health care professional under the same time parameters as set forth for prior authorization requests if any one or more of the following conditions apply:

(1) the prescription drug required under the step-therapy protocol is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured,

(2) the prescription drug required under the step-therapy protocol is expected to be ineffective

based on the insured's known clinical history, condition, and prescription drug regimen,

(3) the insured has already tried the prescription drugs on the protocol, or other prescription drugs in the same pharmacologic class or with the same mechanism of action, which have been discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event, regardless of whether the insured was covered at the time on a plan offered by the current insurer or its pharmacy benefit manager,

(4) the insured is stable on a prescription drug selected by the insured's treating health care professional for the medical condition under consideration, or

(5) the step-therapy protocol or a prescription drug required under the protocol is not in the patient's best interests because it will:

(a) pose a barrier to adherence,

(b) likely worsen a comorbid condition, or

(c) likely decrease the insured's ability to achieve or maintain reasonable functional ability.

2. Nothing in this subsection shall be construed to prohibit the use of tiered co-payments for members or subscribers not subject to a step-therapy protocol.

3. Notwithstanding any provision of paragraph 1 of this subsection to the contrary, a health insurance or other health benefit plan offered by an insurer or by a pharmacy benefit manager on behalf of a health insurer that provides coverage for prescription drugs shall not utilize a step-therapy, "fail first", or other protocol that requires documented trials of a medication, including a trial documented through a "MedWatch", FDA Form 3500, before approving a prescription for the treatment of substance use disorder.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6110.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. For urgent prior authorization requests, a health plan shall approve, deny, or inform the insured or health care provider if any information is missing from a prior authorization request from an insured or a prescribing health care provider within twenty-four (24) hours following receipt.

2. If a health plan informs an insured or a health care provider that more information is necessary for the health plan to make a determination on the request, the health plan shall have

twenty-four (24) hours to approve or deny the request upon receipt of the necessary information.

B. For nonurgent prior authorization requests:

1. A health plan shall approve or deny a completed prior authorization request from an insured or a prescribing health care provider within two (2) business days following receipt;

2. A health plan shall acknowledge receipt of the prior authorization request within twenty-four (24) hours following receipt and shall inform the insured or health care provider at that time if any information is missing that is necessary for the health plan to make a determination on the request; and

3. If a health plan notifies an insured or a health care provider that more information is necessary pursuant to paragraph 2 of this subsection, the health plan shall have twenty-four (24) hours to approve or deny the request upon receipt of the necessary information.

C. If a health plan does not, within the time limits set forth in this section, respond to a completed prior authorization request, acknowledge receipt of the request for prior authorization, or request missing information, the prior authorization request shall be deemed to have been granted.

D. Prior authorization approval for a prescribed treatment, service, or course of medication shall be valid for the duration of

a prescribed or ordered course of treatment or one (1) year, whichever is longer.

E. For an insured who is stable on a treatment, service, or course of medication, as determined by a health care provider, that was approved for coverage under a previous health plan, a health plan shall not restrict coverage of that treatment, service, or course of medication for at least ninety (90) days upon the insured's enrollment in the new health plan.

F. A health insurance or other health benefit plan offered by a health insurer or by a pharmacy benefit manager on behalf of a health insurer shall cover, without requiring prior authorization, at least one readily available asthma controller medication from each class of medication and mode of administration.

G. Prior authorization approval for a prescribed or ordered treatment, service, or course of medication shall be valid for the duration of the prescribed or ordered treatment, service, or course of medication or one (1) year, whichever is longer; provided, however, that for a prescribed or ordered treatment, service, or course of medication that continues for more than one (1) year, a health plan shall not require renewal of the prior authorization approval more frequently than once every five (5) years.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6110.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Department shall adopt rules, bulletins, or other guidance that prohibits carriers from imposing prior authorization requirements for any generic medication or for any admission, item, service, treatment, procedure, or medication, or for any category of these, that have low variation across health care providers and denial rates of less than ten percent (10%) across carriers.

B. In developing its rules, bulletins, or other guidance, the Department may rely on prior authorization data submitted by the health plans.

C. It is the intent of the Legislature that the rules, bulletins, or other guidance that the Department develops pursuant to this subsection should be designed to apply to frequently used medications and services, especially those ordered by primary care providers, and to achieve consistency in prior authorization exemptions across health plans in order to meaningfully reduce the administrative burden on health care providers.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6110.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Required information.

1. Each contracting entity shall provide and each health care contract shall obligate the contracting entity to provide participating health care providers information sufficient for the

participating provider to determine the compensation or payment terms for health care services, including all of the following:

a. the manner of payment, such as fee-for-service, capitation, case rate, or risk,

b. the fee-for-service dollar amount allowable for each CPT code for those CPT codes that a provider in the same specialty typically uses or that the requesting provider actually bills. Fee schedule information may be provided electronically, at the election of the contracting entity, but a provider may elect to receive a paper copy of the fee schedule information instead of the electronic version, and

c. a clearly understandable, readily available mechanism, such as a specific website address, that includes the following information:

(1) the name of the commercially available claims editing software product that the health plan, contracting entity, covered entity, or payer uses,

(2) the specific standard that the entity uses for claim edits and how those claim edits are supported by those specific standards,

(3) payment percentages for modifiers, and

(4) any significant edits, as determined by the health plan, contracting entity, covered entity, or payer, added to the claims software product, which are made at the request of the health plan, contracting entity, covered entity, or payer, and which have been approved by the Commissioner, and

d. any policies for prepayment or post-payment audits, or both, including whether the policies include limits on the number of medical records a contracting entity may request for audit in any calendar year.

B. If a contracting entity uses policies or manuals to augment the content of the contract with a health care provider, the contracting entity shall ensure that those policies or manuals contain sufficient information to allow providers to understand and comply with the content. The contracting entity shall treat any new policy or manual, and any change to an existing policy or manual, as a contract amendment and shall comply with the requirements for contract amendments.

1. For any new policy or manual, or any change to an existing policy or manual, the contracting entity shall do all of the following:

a. provide notice of the new policy, manual, or change to each participating provider in writing not fewer than sixty (60) days prior to the effective date of the

policy, manual, or change, which notice shall be conspicuously entitled "Notice of Policy Change" and shall include:

(1) a summary of the new policy, manual, or change,

(2) an explanation of the policy, manual, or change,

(3) the effective date of the policy, manual, or change, and

(4) a notice of the right to object in writing to the policy, manual, or change, along with a timeframe for objection and where and how to send the objection.

b. provide the participating provider sixty (60) days after receiving the notice and summary to object in writing to the new policy, manual, or change. If the participating provider objects to the new policy, manual, or change, the contracting entity shall provide an initial substantive response to the objection within thirty (30) days following the contracting entity's receipt of the written objection, and the contracting entity shall work together with the provider to achieve a reasonable resolution to the objection within sixty (60) days following the provider's receipt of contracting entity's initial substantive response. If the provider is not

satisfied with the proposed resolution, the provider may pursue any remedy available to the provider under the health care contract or under applicable law.

C. For purposes of this section, a health care contract is deemed to be amended when a contracting entity institutes a new policy or manual, or amends an existing policy or manual that is incorporated into a contract by reference, and the new or amended policy or manual impacts the health care provider's reimbursement.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6110.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

For any violation of the provisions of this act or any rule adopted pursuant thereto, the Insurance Commissioner may, upon notice and hearing, subject a person or entity to a civil fine of not less than One Hundred Dollars ($100.00) nor more than One Thousand Dollars ($1,000.00) for each occurrence.

SECTION 8. This act shall become effective November 1, 2025.

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