OKLAHOMA INSURANCE DEPARTMENT
Insurance Commissioner, Glen Mulready
400 NE 50th Street
Oklahoma City, OK 73105
405.521.2746
405.522.0125
oid.ok.gov
Legal Division

BULLETIN NO. 2025-04

TO: **All Health Insurance Companies, HMOs, and Other Interested Parties**

RE: **House Bills 1808 and 1811 (2025 Session)**

FROM: **Glen Mulready, Insurance Commissioner**

DATE: **September 30, 2025**

Disclaimer: The purpose of this bulletin is to inform all health insurers licensed in Oklahoma of specific legislative changes for 2025. The Department's intent is to help licensees be aware of changes that establish substantive mandates or require implementation changes. This bulletin is not intended to include every legislative change made in 2025. Please refer to the Oklahoma Supreme Court Network (OSCN) webpage to view all changes.

House Bill 1808

HB 1808 creates the Ensuring Transparency in Prescription Drugs Prior Authorization Act, to be found at 36 O.S. §§ 6570.50 through 6570.59.

HB 1808 requires that a utilization review entity make any current prescription drug prior authorization requirements and restrictions, including written clinical criteria, in detail but in an easily understandable language, readily accessible on its website to enrollees and health care providers. Additionally, health plans shall make any current prescription drug plan formularies readily accessible on its website to enrollees and health care providers. "Prescription plan drug formularies", while not defined in statute, shall include, but not be limited to, coverage of generic and brand name prescription drugs, cost sharing, and restrictions.

No later than October 1, 2026, all health benefit plans shall submit a secured webpage link for the plan's formulary to the Insurance Commissioner and thereafter annually on or before October 1. The secured webpage link for the plan's formulary shall be submitted via the SERFF portal found at www.SERFF.com under TOI: UR Certificate and with Filing Description as "Formulary Webpage". To comply with HB 1808, the Oklahoma Insurance Department will make any submitted formularies available to the public on its website beginning no later than December 31, 2025, and will update thereafter annually. To support the intent of HB 1808, and to increase transparency, all health plans are encouraged to voluntarily submit current formularies via the SERFF portal prior to December 31, 2025.

If a utilization review entity intends to implement a new, or amend an existing, prior authorization requirement or restriction, said new or amended requirement shall not be implemented unless the utilization review entity's website has been updated to reflect the same. Further, notice to contracted health care providers credentialed to prescribe the drug and enrollees who have a chronic condition and are already receiving the drug shall be given notice no less than sixty (60) days before the requirement of restriction is implemented. Updating of the utilization review entity's website solely shall not constitute proper notice to contracted health care providers or enrollees with chronic conditions.

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

1) Possess a current and valid license in any U.S. jurisdiction;

2) Have appropriate training, knowledge, or expertise to apply the appropriate clinical guidelines; and

3) Make the adverse determination under the clinical direction provided by the committee or board, responsible for developing policies for drug use, evaluating clinical appropriateness, and ensuring effective drug use when reviewing prescription drug prior authorizations to enrollees of Oklahoma.

The term "committee or board" shall encompass any health plan medical policy team so long as said team is responsible for the same elements of the review.

Likewise, any appeals shall be reviewed by a physician, pharmacist, or licensed mental health professional. The physician, pharmacist, or licensed mental health professional shall:

1) Possess a current and valid license in any U.S. jurisdiction;

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

    a) includes treating the condition,

    b) includes treating complications that may result from the service or procedure, and

    c) is sufficient for the physician, pharmacist, or licensed mental health professional to determine if the service or procedure is medically necessary or clinically appropriate, except for appeals coming from a licensed mental health

professional, which may be conducted by another licensed mental health professional as opposed to a physician, or for appeals coming from a pharmacist, which may be conducted by another licensed pharmacist as opposed to a physician;

3) Not have been directly involved in making the adverse determination;

4) Not have any financial interest in the outcome of the appeal; and

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

If a utilization review entity requires prior authorization of a prescription drug, the utilization review entity shall make a prior authorization or adverse determination and notify the enrollee and the enrollee's health care provider within twenty-four (24) hours of obtaining all necessary information for urgent prescription drugs or within four (4) business days for nonurgent prescription drugs. A utilization review entity shall not require prior authorization for prescription drugs administered as a part of the provision of emergency health care services.

If a prior authorization is required for a prescription drug for the treatment of a chronic condition of an enrollee, other than opioids or weight loss drugs, and the enrollee remains on the same health plan, then the prior authorization shall remain valid for three (3) years from the date the health care provider receives the prior authorization approval, unless clinical criteria changes, the enrollee's health plan removes the generic prescription drug from the formulary, or moves the prescription drug to a less preferred tier status on its formulary.

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. Additionally, 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 for the initial sixty (60) days of an enrollee's coverage under the new product unless the service is no longer a covered service under the new product.

Finally, HB 1808 authorizes the Insurance Commissioner to impose a penalty of not more than Five Thousand Dollars ($5,000) for each violation of this Act.

HB 1808 becomes effective November 1, 2025.

House Bill 1811

HB 1811 relates to the treatment of chronic conditions and the validity period for prior authorization of inpatient and non-inpatient care. The bill amends language found at 36 O.S. § 6570.9(B)(2), reducing the amount of time a health care provider has to timely submit a prior authorization request for continued inpatient care for a chronic condition from seventy-two (72) hours to twenty-four (24) hours prior to the termination of the previously approved prior authorization.

HB 1811 becomes effective on November 1, 2025.

Questions concerning this bulletin should be directed to the Oklahoma Insurance Department's Legal Division at 405-522-4805 or by email to Tyler.Trammell@oid.ok.gov. Any questions concerning the filing of the secured webpage link for the plan's formulary through SERFF may be directed towards Lien Skaggs at Lien.Skaggs@oid.ok.gov.