States Target Health Insurers' 'Prior Authorization' Red Tape

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Which states have banned noncompetes?

Pharmacy Benefit Managers Balk at Rehearing Oklahoma Law Ruling

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Oklahoma Wants Redo in Appeal Over Pharmacy Benefit Manager Law

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Average annual healthcare cost in all 50 states

10th Circ.’s Okla. PBM Ruling Could Curtail State Regulation

U.S. appeals court strikes down key provisions in Oklahoma law that regulates PBMs

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AdventHealth-MultiPlan suit spotlights out-of-network pay fight

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SB 845

provides that if an insured person who has a high deductible health plan self-pays a claim for a covered service, the paid claim shall count towards the insured’s deductible, regardless of whether or not the service was provided by an in-network or out-of-network provider. A high deductible health plan shall notify its insureds that cash-pay may be lower than insurancenegotiated prices.

SB 756

provides that a contracted entity that uses a prior authorization process for health care services may not require a participating provider to obtain prior authorization for a particular health care service if, in the most recent 6-month evaluation period the contracted entity has approved or would have approved not less than 90% of the prior authorization requests submitted by the provider for the particular health care service. Contracted entities may evaluate participating providers to determine whether the provider qualifies for the exemption. The exemption shall remain in effect until the 13th day after the date the contracted entity notifies the provider of the contracted entity’s determination to rescind the exemption, though the provider may appeal the decision. Contracted entities may only rescind exemptions under certain conditions outlined in the measure. If the appeal carries through, the contracted entity is prohibited from rescinding the exemption until the next evaluation period. A contracted entity may not retroactively deny a health care service on the basis of a rescission of an exemption.