STATE OF OKLAHOMA

2nd Session of the 60th Legislature (2026)

SENATE BILL 1646 By: Gollihare

AS INTRODUCED

An Act relating to health insurance; defining terms; requiring health benefit plan to provide coverage for medically necessary treatment of mental health and substance use disorders; prohibiting certain limitations on benefits or coverage; prohibiting certain rescission or modification of authorization; requiring compliance with certain out-of-network care requirements under certain conditions; requiring provision of meaningful benefits under specified conditions; specifying procedures and minimum criteria for certain determination; establishing requirements and procedures related to utilization review; requiring and prohibiting application of certain criteria; specifying requirements for certain authorizations; prohibiting adoption of certain policy terms; authorizing promulgation of certain rules; authorizing certain enforcement by the Insurance Commissioner; specifying applicability of act; providing certain construction; 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 6060.11c of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in this section:

1. A "core treatment" for a condition or disorder is a standard treatment or course of treatment, therapy, service, or intervention indicated by generally accepted standards of mental health and substance use disorder care;

2. "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health and substance use disorder care include published peer-reviewed scientific studies and medical literature and recommendations of nonprofit health care provider professional associations including, but not limited to, patient placement criteria and clinical practice guidelines;

3. "Health benefit plan" has the same meaning as provided in Section 6060.4 of Title 36 of the Oklahoma Statutes;

4. "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

a. in accordance with the generally accepted standards of mental health and substance use disorder care,

b. clinically appropriate in terms of type, frequency, extent, site, and duration, and

c. not primarily for the economic benefit of the health benefit plan or purchaser or for the convenience of the patient, treating physician, or other health care provider;

5. "Mental health and substance use disorder" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly

understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties;

6. "Nonprofit health care provider professional association" means a not-for-profit health care provider professional association or specialty society that is generally recognized by clinicians practicing in the relevant clinical specialty and that issues peer-reviewed guidelines, criteria, or other clinical recommendations developed through a transparent process;

7. "Utilization review" means prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively, or concurrent with the provision of health care services to insureds, or for out-of-network services required pursuant to 6060.11a of Title 36 of the Oklahoma Statutes; and

8. "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a health benefit plan, or any entity acting on the health benefit plan's behalf, to conduct utilization review.

B. 1. Every health benefit plan issued, amended, or renewed in this state that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders including services that are

consistent with criteria, guidelines, or consensus recommendations from nationally recognized not-for-profit clinical specialty associations of the relevant behavioral, mental health, or substance use disorder specialty.

2. A health benefit plan shall not limit benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute treatment at any level of care placement.

3. All utilization review concerning service intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed with mental health and substance use disorders shall be conducted in accordance with the requirements of subsection C of this section.

4. A health benefit plan that authorizes a specific type of treatment by a provider pursuant to this section shall not rescind or modify the authorization or payment after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the health benefit plan's subsequent rescission, cancellation, or modification of the insured's or policyholder's contract, or the health benefit plan's subsequent determination that it did not make an accurate determination of the insured's or policyholder's eligibility.

5. If services for the medically necessary treatment of a mental health or substance use disorder are not available in-

network, the health benefit plan shall comply with the out-of-network care requirements provided by Section 6060.11a of Title 36 of the Oklahoma Statutes.

6. If a health benefit plan provides any benefits for a mental health or substance use disorder in any classification of benefits, it shall provide meaningful benefits for that mental health or substance use disorder in every classification in which medical or surgical benefits are provided in accordance with 45 C.F.R., Section 146.136. For purposes of this paragraph, whether the benefits provided are meaningful benefits shall be determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification. At a minimum, the health benefit plan shall provide coverage of benefits for that condition or disorder in each classification in which the health benefit plan provides benefits for one or more medical conditions or surgical procedures. The health benefit plan shall not be deemed to provide meaningful benefits unless it provides benefits for a core treatment for that condition or disorder in each classification in which the health benefit plan provides benefits for a core treatment for one or more medical conditions or surgical procedures. If there is no core treatment for a covered mental health condition or substance use disorder with respect to a classification, the health benefit plan is not required to provide benefits for a core treatment for such condition or disorder in that classification, but shall provide

benefits for such condition or disorder in every classification in which medical or surgical benefits are provided.

C. 1. In conducting utilization review, a health benefit plan that provides hospital, medical, or surgical coverage, or an entity acting on the health benefit plan's behalf, shall not deviate from, or apply criteria that deviates from, current generally accepted standards of mental health and substance use disorder care as defined in subsection A of this section. All denials and appeals shall be reviewed by a professional with the same level of education and experience as the provider requesting coverage.

2. In conducting utilization review of all covered health care services and benefits for the screening, diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, a health benefit plan shall apply the relevant level of care placement criteria and practice guidelines set forth in the most recent versions of such criteria and practice guidelines, developed by the nonprofit health care provider professional association for the relevant clinical specialty.

3. In conducting utilization review relating to service intensity or level of care placement, continued stay, transfer or discharge, or any other patient care decisions that are within the scope of the sources specified in subsection B of this section, a health benefit plan shall not apply different, additional, conflicting, or more restrictive utilization review criteria than

the criteria and guidelines set forth in those sources. For all service intensity or level of care placement, continued stay, or transfer or discharge decisions, the health benefit plan shall authorize placement at the level of care consistent with the insured's score using the relevant level of care placement criteria and guidelines as specified in subsection B of this section. If that level of placement is not available, the health benefit plan shall authorize the next highest level of care. If the health benefit plan's application of the relevant age-appropriate criteria is not consistent with the service intensity or level of care placement requested by the covered person or his or her provider, any adverse benefit determination notice shall include full details of the health benefit plan's assessment under the relevant criteria to the provider and the covered person.

D. A health benefit plan shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

E. 1. The Insurance Commissioner may promulgate rules to implement and enforce the provisions of this section including, but not limited to, rules to:

a. address health benefit plan utilization review compliance in accordance with subsection C of this section,

b. specify data testing requirements to determine plan design and application of parity compliance for nonquantitative treatment limitations using outcomes data, and

c. set standard definitions for coverage requirements, including processes, strategies, evidentiary standards, and other factors.

2. If the Commissioner determines that a health benefit plan has violated this section, the Commissioner may, after appropriate notice and opportunity for hearing by order, assess a civil penalty not to exceed Five Thousand Dollars ($5,000.00) for each violation or, if a violation was willful, a civil penalty not to exceed Ten Thousand Dollars ($10,000.00) for each violation. The civil penalties authorized under this paragraph are not exclusive and may be sought and employed in combination with any other remedies available to the Commissioner under the Oklahoma Insurance Code.

F. 1. This section applies to:

a. all health care services and benefits for the screening, diagnosis, prevention, and treatment of mental health and substance use disorders covered by an insurance policy, and

b. a health benefit plan that covers hospital, medical, or surgical expenses and conducts utilization review as defined in this section, and any entity or

contracting provider that performs utilization review or utilization management functions on a health benefit plan's behalf.

2. This section applies only to covered benefits. Nothing in this section shall be construed to expand or alter the benefits available to the insured or policyholder under an insurance policy.

3. Nothing in this section shall be construed to supersede, limit, or otherwise affect the provisions of Section 2607.1 of Title 63 of the Oklahoma Statutes.

SECTION 2. This act shall become effective January 1, 2027.

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