STATE OF OKLAHOMA

2nd Session of the 60th Legislature (2026)

SENATE BILL 1673 By: McIntosh

AS INTRODUCED

An Act relating to health benefit plans; creating the Prosthetic Access and Accountability Act of 2026; providing short title; defining terms; providing certain goal of treatment for certain health benefit plan; prohibiting certain treatment from being withheld based on certain factors; establishing certain medical necessity; presuming certain denials to be invalid; requiring certain health benefit plan to ensure certain access to care; requiring reimbursement for certain care; establishing certain liability due to certain denial or delay; establishing certain rebuttable presumption in certain case; establishing certain liability; prohibiting certain provider to be held liable due to certain denial, modification, or override; requiring Insurance Commissioner to promulgate certain rules and regulations; requiring Commissioner to enforce certain provisions; requiring Commissioner to investigate certain complaints; requiring Commissioner to maintain and publish certain report; establishing certain fines and penalties; requiring certain requests to be reviewed within certain time frame; requiring certain automatic approval in certain scenarios; allowing certain enrollee to bring certain civil action; providing for noncodification; 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 not to be codified in the Oklahoma Statutes reads as follows:

This act shall be known and may be cited as the "Prosthetic Access and Accountability Act 2026".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.23 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in this act:

1. "Covered prosthetic benefit" means any prosthesis, orthosis, or related service listed as a covered benefit under the enrollee's health benefit plan including, but not limited to, benefits listed under durable medical equipment, orthotics, and assistive devices;

2. "Health benefit plan" means the same as defined in Section 4405.1 of Title 36 of the Oklahoma Statutes;

3. "Orthosis" means the same as defined in Section 3002 of Title 59 of the Oklahoma Statutes;

4. "Orthotist" means the same as defined in Section 3002 of Title 59 of the Oklahoma Statutes;

5. "Physician-prescribed device" means any prosthetic or orthosis device ordered by a provider who is licensed in this state to prescribe prosthetics;

6. "Prosthesis" means the same as defined in Section 3002 of Title 59 of the Oklahoma Statutes;

7. "Prosthetist" means the same as defined in Section 3002 of Title 59 of the Oklahoma Statutes; and

8. "Unreasonable delay" means any failure to approve, deny, or respond to a coverage request within two (2) business days if marked urgent by the prescribing provider, and within ten (10) business days for standard requests.

B. 1. For a health benefit plan offered in this state that includes covered prosthetic benefits, the goal of treatment shall be the restoration of physical function to the greatest extent possible, as determined by the treating provider. Treatment shall not be withheld due to discrimination based on disability.

2. Medical necessity shall be based on the patient's functional goals and shall not be limited by diagnosis, age, disability, or generalized coverage tiers. Medical necessity shall be determined by the enrollee's treating provider to meet the medical needs of the enrollee and return to or maintain full functional abilities including activities of daily living, essential job-related activities, showering and bathing, and physical activities.

3. Denials based on cost or classification as deluxe, convenience, or nonessential shall be presumed invalid if the physician-prescribed device was prescribed to meet documented functional needs.

C. A health benefit plan that covers prosthetic benefits shall ensure access to medically necessary clinical care and to prostheses

and orthoses from an adequate number of orthotists and prosthetists within the network in this state. If covered prosthetic benefits are unavailable from an in-network provider due to the geographic location of the patient, the health benefit plan shall provide processes to refer a member to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate less member cost sharing determined on an in-network basis.

D. 1. A health benefit plan that covers prosthetic benefits and denies or unreasonably delays a physician-prescribed device shall be liable for any personal injury, financial loss, or harm proximately caused by the denial or delay.

2. If an enrollee suffers a fall, injury, hospitalization, or other adverse health event during a period in which a physician-prescribed device was denied or delayed, a rebuttable presumption of health benefit plan negligence shall apply. The health benefit plan shall be liable for:

a. compensatory damages, including medical costs and lost income,

b. noneconomic damages for pain, suffering, or diminished quality of life to the full extent of current law, and

c. punitive damages in cases of bad faith or willful disregard of medical judgment.

E. If a health benefit plan or utilization reviewer denies, modifies, or overrides a claim for a physician-prescribed device and the patient experiences harm as a result, the insurer shall assume medical liability as if it were the treating provider. Such liability includes adherence to the standard of care under this act, and any applicable governance of provider conduct. A provider shall not be held liable for any harm resulting from an insurer's denial, modification, or override of the claim for a physician-prescribed device.

F. The Insurance Commissioner shall have the authority to promulgate rules and regulations for the implementation of this act.

G. The Commissioner shall:

1. Enforce the provisions of this section;

2. Investigate complaints related to this section; and

3. Maintain and publish annual reports on covered prosthetic benefit denials, appeals, and adverse patient outcomes, provided no information in this subsection is in violation of the Health Insurance Portability and Accountability Act of 1996.

H. Health benefit plans in violation of this section may be subject to:

1. Fines of up to Five Thousand Dollars ($5,000.00) per violation;

2. Daily penalties of One Thousand Dollars ($1,000.00) for unreasonable delays; or

3. Revocation or suspension of certificate of authority in repeated cases.

I. Coverage requests for prostheses and orthoses shall be reviewed within two (2) business days if marked urgent by the prescribing provider, or within ten (10) business days for standard requests. Failure to respond in writing within such time frames shall result in automatic approval of the request.

J. Any enrollee harmed by violation of this section shall have the right to bring a civil action in district court including, but not limited to, for actual damages, injunctive relief, and attorney fees.

SECTION 3. This act shall become effective January 1, 2027.

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