STATE OF OKLAHOMA

2nd Session of the 60th Legislature (2026)

HOUSE BILL 4462 By: Newton

AS INTRODUCED

An Act relating to health insurance; providing definitions; establishing that non-urgent care prior authorization requests shall be deemed approved if the utilization review organization fails to take certain action; granting the utilization review organization additional time for decision if network provider is requested to provide additional information; providing requirements for additional information requests; requiring network provider to submit new prior authorization request if they fail to provide all clinical information; requiring network providers to submit non-urgent care requests at least six days before scheduled health care service; establishing that urgent care prior authorization requests shall be deemed approved if the utilization review organization fails to take certain action; requiring network provider to submit additional information within twenty four hours of receiving request; directing utilization review organizations to ensure requests for prior authorization are made by physician or other competent health care professional; requiring utilization review organizations to include certain information with notice of adverse determination; requiring utilization review organizations to ensure adverse determinations are made by qualified physicians; directing utilization review organizations to make appeals process readily accessible on website; requiring response to appeals within certain timeframe; requiring appeals to be decided by physician other than physician who made original adverse determination; directing insurers to exempt certain network providers from obtaining prior authorization for covered health care services; clarifying that exemption shall be effective for

succeeding year upon determination by utilization review organization; permitting insurers to rescind exemption for certain actions by health care professional; permitting insurers to automatically renew exemption if certain conditions are met; directing insurers to make written notice of a decision granting or declining renewal of an exemption; providing required contents for notice of rescission or declination of exemption; requiring insurer afford a health care professional reasonable opportunity to challenge grounds for a decision; directing for reconsideration to be performed by qualified physician; clarifying decision on reconsideration is final; requiring information be held in strictest confidence; clarifying health care professional whose exemption was rescinded or not renewed for certain reasons remains automatically eligible for an exemption; establishing that these exemptions do not apply to experimental health care services; granting the Oklahoma Insurance Commissioner rule making authority; 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 6567.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. "Additional business day" means the first weekday not designated as a state or federal holiday;

2. "Adverse determination" means a determination by a utilization review organization that a request for coverage of a benefit under a health benefit plan does not meet the insurer's policies or guidelines for medical necessity or appropriateness,

including treatment setting, level of care, or effectiveness. The term includes a denial, reduction, termination, or modification of the benefit requested or payment therefor;

3. "Artificial intelligence" means a machine-based system that may include software or physical hardware that performs tasks, based upon data set inputs, which requires human-like perception, cognition, planning, learning, communication, or physical action and which is capable of improving performance based upon learned experience without significant human oversight toward influencing real or virtual environments;

4. "Enrollee" means an individual who contracts for, subscribes, or participates as a dependent under a health benefit plan;

5. "Health benefit plan" means:

a. any plan, policy, or contract issued, delivered, or renewed in this state that provides medical benefits that include payment or reimbursement for hospitalization, physician care, treatment, surgery, therapy, drugs, equipment, and other medical expenses, regardless of whether the plan is for a group or an individual, and

b. the term does not include accident-only, specified disease, individual hospital indemnity, credit, dental-only, Medicare supplement, long-term care,

disability income, or other limited benefit health insurance policies, or coverage issued as supplemental to liability insurance, workers' compensation, or automobile medical payment insurance;

6. "Health care professional" means a physician or other health care provider who is licensed by an occupational licensing board under Title 59 or Title 63 of the Oklahoma Statutes.

7. "Health care service" means diagnosing, testing, monitoring, or treating a human disease, disorder, syndrome, or illness that may include, but not be limited to, hospitalization, physician care, treatment, surgery, therapy, drugs, or medical equipment;

8. "Insurer" means any entity that issues, delivers, or renews a health benefit plan, a health maintenance organization, or a nonprofit health care service;

9. "Medical necessity" means the question of whether a health care service is medically necessary;

10. "Network providers" means facilities and health care professionals who, pursuant to a contract with the insurer, have agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayments, coinsurance, or deductibles, directly or indirectly, from the insurer;

11. "Prior authorization" means a written or oral determination made by a utilization review organization that a

health care service is a benefit covered under the applicable health benefit plan which, under the enrollee's clinical circumstances, is medically necessary or satisfies another requirement imposed by the insurer or utilization review organization, and thus satisfies the requirements for payment or reimbursement;

12. "Urgent care request" means a request for prior authorization of a health care service for which the time period for making a nonurgent determination of prior authorization could result in at least one of the following outcomes for the enrollee:

a. death,

b. permanent impairment of health,

c. inability to regain maximum bodily function, or

d. severe pain that cannot be adequately managed; and

13. "Utilization review organization" means the entity that makes determinations of prior authorization, which may be the insurer or other entity that is a designated contractor or agent of the insurer.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6567.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A prior authorization request that has not been submitted as an urgent care request is deemed approved if, within seventy-two (72) hours plus, if applicable, one (1) additional business day,

after the date and time of submission of the request, the utilization review organization fails to do one of the following:

1. Approve, deny, or fail in any way to acknowledge the request;

2. Request from the network provider all additional information needed to make a determination; or

3. Except for a prior authorization request for a prescription drug, fails to notify the network provider that a determination of prior authorization is delayed because the question of medical necessity is difficult to resolve.

B. 1. If a network provider is requested to provide additional information, whether in the form of additional documentation or in the circumstances described in paragraph 2 of this subsection, the utilization review organization shall have an additional seventy-two (72) hours plus, if applicable, one (1) additional business day, after the date and time of submission of the additional information in which to make its decision or the prior authorization request is deemed approved; and

2. A request for additional information under paragraph 1 of this subsection shall include, in the case of a question of medical necessity which is difficult to resolve, all of the following:

a. a direct phone number to the utilization review organization,

b. hours of availability of the utilization review organization's physician or other health care professional who has authority to make the prior authorization determination, and

c. a statement that there is an opportunity to discuss the medical necessity of the health care service directly with the physician or other health care professional who has authority to make the prior authorization determination.

C. Failure by the network provider to submit all clinical information, including its response to a request for additional information, within six (6) calendar days after the date of the initial submission of the request shall necessitate the network provider to request a new prior authorization.

D. A network provider shall submit a request for a prior authorization that is not an urgent care request at least six (6) calendar days before the scheduled health care service.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6567.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A prior authorization request that is submitted as an urgent care request is deemed approved if, within twenty-four (24) hours after the date and time of submission of the request, the utilization review organization fails to do one of the following:

1. Approve or deny the request; or

2. Request from the network provider all additional information needed to make a determination.

B. 1. A network provider shall submit additional information requested by the utilization review organization within twenty-four (24) hours of receiving a request for additional information; and

2. The prior authorization request is deemed approved by the utilization review organization if it fails to grant or deny the request or otherwise respond to the submission of additional information by the network provider within twenty-four (24) hours after the date and time of submission of the requested additional information.

C. Failure by the network provider to submit all clinical information in response to a request for additional information by the utilization review organization within twenty-four (24) hours after the date and time of the request shall necessitate the network provider to request a new prior authorization.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6567.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

A utilization review organization shall ensure that all determinations on requests for prior authorization are made by a physician or other health care professional who is competent to evaluate and reject, if appropriate, any recommendation or

conclusion of artificial intelligence, based upon all relevant factors that include, but are not limited to, the enrollee's clinical circumstances, the information submitted by the network provider, and all applicable criteria, policies, and guidelines.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6567.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. When a utilization review organization issues an adverse determination in response to a request for prior authorization, it shall send a notification of its determination to both the network provider and enrollee, which shall include all of the following information:

1. The reasons for the adverse determination and, if applicable, relevant evidence-based criteria, including a description of missing or insufficient documentation, or lack of coverage under the health benefit plan;

2. Instructions on how to appeal the determination; and

3. Additional documentation or other information necessary to support the appeal.

B. In addition to the requirement of Section 4 of this act, a utilization review organization shall ensure that all adverse determinations are made by a physician who meets all of the following requirements:

1. Possesses a current, nonrestricted license to practice medicine issued by an occupational licensure board in any state or territory of the United States;

2. Is board-eligible for certification or has equivalent clinical practice experience in the same specialty as the physician or other health care professional who would typically provide the health care service for which prior authorization is requested;

3. Makes determinations under the supervision of a medical director who is a current, licensed physician in the State of Oklahoma; and

4. Receives compensation or payment from the utilization review organization which is in no way increased or enhanced by making an adverse determination.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6567.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A utilization review organization shall make its process for appealing an adverse determination on a request for prior authorization readily accessible on its website to its network providers and enrollees.

B. When an appeal is received from a network provider or enrollee on an adverse determination on a request for prior authorization, a utilization review organization shall send a

notification to both the network provider and enrollee confirming, reversing, or modifying the adverse determination within:

1. Seventy-two (72) hours plus, if applicable, one (1) additional business day, for a nonurgent request; or

2. Twenty-four (24) hours for an urgent request.

C. A utilization review organization shall ensure that all appeals from adverse determinations are decided by a physician other than the physician who made the adverse determination and who meets the requirements of paragraphs 1 through 4 of subsection B of Section 5 of this act.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6567.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Beginning January 1, 2027, an insurer shall exempt a health care professional who is a network provider from obtaining prior authorization for a health care service covered under a health benefit plan when all of the following requirements are met:

1. The health care service is otherwise subject to a prior authorization requirement as a precondition to approval for payment or reimbursement;

2. The health care professional provided the health care service to at least seven different patients during the year 2025; and

3. Prior authorization was approved, based upon the medical necessity criteria used by the utilization review organization, for ninety percent (90%) or more of the requests made by the health care professional for the health care service.

B. The exemption provided in this section shall be effective for the succeeding year upon determination by the utilization review organization.

C. 1. Notwithstanding subsection B of this section, an insurer may rescind the exemption at any time if the health care professional knowingly and materially misrepresents the health care service, including a substantial failure to provide the health care service, in a claim made with the specific intent to deceive the insurer and obtain an unlawful payment or reimbursement;

2. Notwithstanding subsection B of this section, an insurer may rescind the exemption no less than ninety (90) days after the exemption takes effect if the insurer or utilization review organization detects an increase in claims for payment or reimbursement for the health care service for which the exemption is granted that is disproportionate or anomalous to the health care professional's historic rate of providing the health care service; and

3. An insurer shall give written notice to a health care professional that the exemption is being rescinded no less than twenty (20) days in advance of the effective date of the rescission.

D. 1. An insurer may automatically renew an exemption from prior authorization for a health care service for a succeeding year if the health care professional submits fewer than seven (7) claims for payment or reimbursement for the health care service during the current exemption year, or for any other reason in the insurer's discretion;

2. a. an insurer may retrospectively review the health care professional's provision of the health care service during the exemption year, using a review period of at least nine (9) months, as a condition for renewing the exemption for the succeeding year,

b. pursuant to a retrospective review, an insurer may decline to renew the exemption on any of the following grounds:

(1) the review discloses that less than ninety percent (90%) of the claims paid or reimbursed would meet the medical necessity criteria used by the utilization review organization, or

(2) the review discloses a claim or a pattern that would be grounds for rescission of the exemption as described in subsection c of this section; and

3. An insurer shall make efforts to ensure that written notice of a decision granting or declining renewal of an exemption is provided to a health care professional who has a current exemption

no later than at least thirty (30) days before the one-year exemption period expires.

E. 1. When an insurer rescinds or declines to renew an exemption from prior authorization for a health care service, it shall send written notice of its decision to the health care professional, which shall include:

a. the reason for the decision, and

b. instructions on how to submit a request for reconsideration of the decision;

2. A health care professional may submit a request for reconsideration of a decision to rescind or decline renewal of an exemption within twenty (20) days of receiving notice of the health insurer's decision;

3. a. an insurer shall afford a health care professional a reasonable opportunity, including by a meeting or informal hearing conducted in person or electronically, to challenge the grounds for a decision to rescind or decline renewal of an exemption, to include the presentation of any relevant documentation such as clinical records or claims data as may be relevant to the reason for the insurer's decision, and

b. reconsideration of a decision to decline renewal which involves the issue of medical necessity shall be

performed on behalf of the insurer by a physician who meets the requirements of subsection B of Section 5 of this act;

4. A decision by a health insurer on reconsideration, affirming or denying its rescission or nonrenewal, is final;

5. All information, including, but not limited to, oral or written communications, clinical records, supporting documentation, up to the reason for rescinding or declining to renew an exemption, or any decision on a request for reconsideration, shall be held in the strictest confidence by both the insurer and the health care professional, subject to any of the following:

a. reporting by an insurer of the facts of a case described in paragraph 1 of subsection C of this section to the commissioner, an occupational licensing board, or law enforcement,

b. disclosure to a third party by mutual, written agreement of the insurer and the health care professional, subject to the federal Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. Section 1320d et seq., or

c. use by the insurer or health care provider as necessary to invoke or enforce any provision under a network provider contract.

F. A health care professional who has been granted an

exemption from prior authorization for a health care service which has been rescinded or not renewed, and who is otherwise a network provider, remains automatically eligible to receive an exemption for a subsequent year for any health care service he or she provides which may qualify for exemption, unless an exemption was rescinded in a case described in paragraph 1 of subsection C of this section.

G. An exemption from prior authorization under this section shall not apply to any health care service that is deemed by the health care insurer to be experimental.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6567.8 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Oklahoma Insurance Commissioner may adopt any rules necessary to implement and enforce this act.

SECTION 9. This act shall become effective November 1, 2026.

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