

COMMITTEE AMENDMENT
HOUSE OF REPRESENTATIVES
State of Oklahoma

SPEAKER:

CHAIR:

I move to amend HB1853 _____
Of the printed Bill
Page _____ Section _____ Lines _____
Of the Engrossed Bill

By deleting the content of the entire measure, and by inserting in lieu thereof the following language:
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AMEND TITLE TO CONFORM TO AMENDMENTS

Adopted: _____

Amendment submitted by: Suzanne Schreiber

Reading Clerk

1 STATE OF OKLAHOMA

2 1st Session of the 60th Legislature (2025)

3 PROPOSED OVERSIGHT
4 COMMITTEE SUBSTITUTE
5 FOR
6 HOUSE BILL NO. 1853

By: Schreiber

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8 PROPOSED OVERSIGHT COMMITTEE SUBSTITUTE

9 An Act relating to medical expenses; defining terms;
10 authorizing individuals to pay for medical expenses
11 out-of-pocket; directing insurance providers to count
12 certain payments toward deductibles, coinsurance, and
13 copayments; providing for documentation requirements;
14 providing for codification; and providing an
15 effective date.

16 BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

17 SECTION 1. NEW LAW A new section of law to be codified
18 in the Oklahoma Statutes as Section 6060.50 of Title 36, unless
19 there is created a duplication in numbering, reads as follows:

20 As used in this section:

21 1. "Health care service" means any services provided by a
22 health care provider, or by an individual working for or under the
23 supervision of a health care provider, that relate to the diagnosis,
24 assessment, prevention, treatment, or care of any human illness,

1 disease, injury, or condition, as defined by paragraph 2 of Section
2 1-1708.1C of Title 63 of the Oklahoma Statutes.

3 The term also includes the provision of mental health and
4 substance use disorder services, as defined by Section 6060.10 of
5 Title 36 of the Oklahoma Statutes, and the provision of durable
6 medical equipment. The term does not include the provision,
7 administration, or prescription of pharmaceutical products or
8 services; and

9 2. "Health benefit plan" means any insurance company or health
10 maintenance organization which issues insurance coverage to a
11 resident of this state. The term "health benefit plan" shall not
12 include:

13 a. a plan that provides coverage:

- 14 (1) only for a specified disease or diseases or under
15 an individual limited benefit policy,
16 (2) only for accidental death or dismemberment,
17 (3) only for dental or vision care,
18 (4) a hospital confinement indemnity policy,
19 (5) disability income insurance or a combination of
20 accident-only and disability income insurance, or
21 (6) as a supplement to liability insurance,

22 b. any health plan offered by a contracted entity, as
23 defined in Section 4002.2 of Title 56 of the Oklahoma
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1 Statutes, that provides coverage to members of the
2 state Medicaid program,

3 c. a Medicare supplemental policy as defined by Section
4 1882(g) (1) of the Social Security Act (42 U.S.C.,
5 Section 1395ss),

6 d. workers' compensation insurance coverage,

7 e. medical payment insurance issued as part of a motor
8 vehicle insurance policy,

9 f. a long-term care policy, including a nursing home
10 fixed indemnity policy, unless a determination is made
11 that the policy provides benefit coverage so
12 comprehensive that the policy meets the definition of
13 a health benefit plan, or

14 g. short-term health insurance issued on a nonrenewable
15 basis with a duration of six (6) months or less.

16 SECTION 2. NEW LAW A new section of law to be codified
17 in the Oklahoma Statutes as Section 6060.51 of Title 36, unless
18 there is created a duplication in numbering, reads as follows:

19 A. An enrollee may choose to pay for a health care service out-
20 of-pocket from a licensed health care provider. If an enrollee
21 negotiates for a lower cost from a licensed health care provider
22 than the average allowed amount paid by the carrier to a network
23 provider for a covered health care service, and the enrollee pays
24 for the health care service out-of-pocket, the enrollee may send

1 documentation, which may be sent electronically, to the carrier,
2 that provides the following:

3 1. The health care service the enrollee or patient received and
4 the licensed health care provider's name and contact information;

5 2. If an order is required by the enrollee's policy, the order
6 from the health care provider given to the enrollee or patient and
7 the final bill or statement for the health care service; and

8 3. The negotiated cost of the health care service that the
9 enrollee received:

10 a. the enrollee paid out-of-pocket for the health care
11 services received, and

12 b. the health care entity is not making a claim against
13 the carrier for payment for the health care service
14 provided to the enrollee or patient.

15 B. A carrier that receives the documentation described in
16 subsection A of this section shall count the full amount that the
17 enrollee paid out-of-pocket toward the enrollee's deductible,
18 coinsurance, copayment, or other cost-sharing amount:

19 1. If the health care service is included under the enrollee's
20 health benefit plan; and

21 2. The enrollee negotiated for a lower cost for the health care
22 service than the average allowed amount paid by the carrier to
23 network providers for that covered health care service.

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1 C. The amount of the enrollee's out-of-pocket cost shall be
2 attributed to the in-network deductible, coinsurance, copayment, or
3 other cost-sharing amount, if the provider was an in-network
4 provider, and to the out-of-network deductible, if the provider was
5 an out-of-network provider.

6 D. The amount counted toward an enrollee's out-of-pocket
7 deductible, coinsurance, copayment, or other cost-sharing amount
8 must not exceed the total amount that the covered person is required
9 to pay out-of-pocket during a contractually agreed upon period of
10 time for health care services that are included under the covered
11 person's insurance plan, and does not carry over once a new contract
12 or agreement period for the insurance plan begins.

13 SECTION 3. This act shall become effective November 1, 2025.

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