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:

AMEND TITLE TO CONFORM TO AMENDMENTS

Amendment submitted by: Suzanne Schreiber

Adopted: _____

_____
Reading Clerk

STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

PROPOSED POLICY
COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 1853 By: Schreiber

PROPOSED POLICY COMMITTEE SUBSTITUTE

An Act relating to medical expenses; defining terms; authorizing individuals to pay for medical expenses out-of-pocket; directing insurance providers to count certain payments toward deductibles, coinsurance, and copayments; providing for documentation requirements; 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 6060.50 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health benefit plan delivered, issued for delivery or renewed in this state on or after January 1, 1998, that provides benefits for the dependents of an insured individual shall provide coverage for each child of the insured, from birth through the date the child is eighteen (18) years of age for:

1. Immunization against:

a. diphtheria,

b. hepatitis B,

c. measles,

d. mumps,

e. pertussis,

f. polio,

g. rubella,

h. tetanus,

i. varicella,

j. haemophilus influenzae type B, and

k. hepatitis A; and

2. Any other immunization subsequently required for children by the State Board of Health.

B. Benefits required pursuant to subsection A of this section shall not be subject to a deductible, co-payment, or coinsurance requirement.

C. 1. For purposes of this section, "health benefit plan" means group hospital coverage, individual and group medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement or employee

self-insured plan as permitted under Employee Retirement Income Security Act of 1974.

2. The term "health benefit plan" shall not include:

a. a plan that provides coverage:

(1) only for a specified disease or diseases or under an individual limited benefit policy,

(2) only for accidental death or dismemberment,

(3) only for dental or vision care,

(4) a hospital confinement indemnity policy,

(5) disability income insurance or a combination of accident-only and disability income insurance, or

(6) as a supplement to liability insurance,

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

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

d. workers' compensation insurance coverage,

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

f. a long-term care policy, including a nursing home fixed indemnity policy, unless a determination is made

that the policy provides benefit coverage so comprehensive that the policy meets the definition of a health benefit plan, or

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

D. As used in this section:

1. "Health care provider" means any person or other entity who is licensed pursuant to the provisions of Title 59 or Title 63 of the Oklahoma Statutes, or pursuant to the definition in Section 1-1708.1C of Title 63 of the Oklahoma Statutes; and

2. "Health care service" means any services provided by a health care provider, or by an individual working for or under the supervision of a health care provider, that relate to the diagnosis, assessment, prevention, treatment, or care of any human illness, disease, injury, or condition, as defined by paragraph 2 of Section 1-1708.1C of Title 63 of the Oklahoma Statutes.

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

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

A. An enrollee may choose to pay for a health care service out-of-pocket from a health care provider. If an enrollee negotiates for a lower cost from a health care provider than the average allowed amount paid by the carrier to a network provider for a comparable health care service, and the enrollee pays for the health care service out-of-pocket, the enrollee may send documentation, which may be sent electronically, to the carrier, that provides the following:

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

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

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

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

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

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

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

2. If the enrollee negotiated for a lower cost for the health care service than the average allowed amount paid by the carrier to network providers for that comparable health care service.

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

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

60-1-12574 TJ 02/13/25