STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 1853 By: Schreiber

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:

As used in this section:

1. "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; and

2. "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. 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. 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,

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

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.

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 licensed health care provider. If an enrollee obtains a medically necessary health care service covered by the enrollee's health benefit plan and negotiates for a lower price from a licensed health care provider than the average allowed amount established by the enrollee's health benefits plan for the covered

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 licensed health care provider's name and contact information;

2. If a health care provider's 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;

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; and

4. The health care provider shall accept the enrollee's payment as payment in full and shall not bill the enrollee or the health benefit plan for any balance between the amount collected from the enrollee and the provider's billed charge for the service.

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, and annual maximum out-of-pocket expense:

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

2. The enrollee negotiated for a lower cost for the health care service than the average allowed amount established by the enrollee's health benefit plan for that covered health care service.

C. The amount of the enrollee's out-of-pocket cost shall be attributed to the in-network deductible, and annual maximum out-of-pocket expense, if the provider was an in-network provider, and to the out-of-network deductible, and annual maximum out-of-pocket expense if the provider was an out-of-network provider.

D. The amount counted toward an enrollee's applicable out-of-pocket deductible, and annual maximum out-of-pocket expense shall not exceed the total amount that the enrollee 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.

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