ENGROSSED SENATE
BILL NO. 515

By: Frix, Bullard, Bergstrom, Jett, Grellner, Murdock, and Deevers of the Senate

and

Schreiber of the House

An Act relating to health care services; defining terms; authorizing certain enrollee to send certain documentation to certain carrier; requiring certain health care provider to accept certain enrollee's payment as payment in full; prohibiting certain health care provider from billing certain enrollee or health benefit plan for certain amount; requiring certain carrier to count certain amount toward certain enrollee's deductible and out-of-pocket expense on certain occasion; directing certain costs to be attributed to certain deductible; prohibiting certain amount from exceeding certain total amount; 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 6060.51 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this section:

1. "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 Oklahoma Employees Insurance Plan, and coverage provided by a multiple employer welfare arrangement. The term 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) for a hospital confinement indemnity policy,

(5) for 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;

2. "Health care provider" means the same as defined in Section 1219.6 of Title 36 of the Oklahoma Statutes; and

3. "Health care service" means any service provided by a health care provider, or by an individual working for or under the supervision of a health care provider, that relates to the diagnosis, assessment, prevention, treatment, or care of any human illness, disease, injury, or condition.

The term shall also include mental health and substance use disorder services, as defined by Section 6060.10 of Title 36 of the Oklahoma Statutes, and durable medical equipment as defined by Section 375.2 of Title 59 of the Oklahoma Statutes. The term shall not include the 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 6060.52 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An enrollee may choose to pay out of pocket for a health care service from a health care provider. If an enrollee obtains a medically necessary health care service covered by his or her health benefit plan and negotiates for a price lower than the average allowed amount established by the benefit plan and provided to the enrollee upon request, and the enrollee pays out of pocket for the health care service, the enrollee may electronically send documentation to the carrier that provides the following:

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

2. If an order by the health care provider is required by the 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 and that:

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. The health care provider shall accept the payment from the enrollee 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 billed charge for the service by the provider.

C. 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 deductible and annual maximum out-of-pocket expense if:

1. The health care service is covered under the health benefit plan of the enrollee; and

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

D. The amount of the 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.

E. The amount counted toward an 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 health benefit plan of the enrollee, and shall not carry over once a new contract or agreement period for the plan begins.

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

Passed the Senate the 25th day of March, 2025.

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Presiding Officer of the Senate

Passed the House of Representatives the ____ day of _____, 2025.

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Presiding Officer of the House of Representatives