SENATE FLOOR VERSION
March 6, 2025
AS AMENDED

SENATE BILL NO. 1047

By: McIntosh, Bullard, Grellner, and Standridge of the Senate

and

Newton of the House

[health insurance - billing procedure - reimbursement - cost incurrence - rule promulgation - verification - fines and fees - codification - 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 6063 of Title 36, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Oklahoma Surprise Medical Billing Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6063.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this section:

1. "Surprise bill" means a bill issued by an out-of-network provider or out-of-network facility to an enrollee of a health benefit plan for health care services in an amount that exceeds the

enrollee's cost-sharing obligation applicable for the same health care services if the services had been provided by an in-network provider or in-network facility and are rendered in the following circumstances:

a. emergency care provided by an out-of-network provider or out-of-network facility, or

b. nonemergency health care services rendered by an out-of-network provider at an in-network facility;

2. "Claim" means a request from a provider for payment for health care services rendered to the enrollee of a health benefit plan;

3. "Covered person" means:

a. an enrollee, policyholder, or subscriber,

b. the enrolled dependent of an enrollee, policyholder, or subscriber, or

c. another individual participating in a health benefit plan;

4. "Health benefit plan" means a health benefit plan as defined pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes;

5. "Health care service" means any service, supply, or procedure rendered for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or other disease, including physical or behavioral health services, to the extent it is covered by a health benefit plan;

6. “Emergency care” means a health care procedure, treatment, service, or ambulance transportation service delivered to a covered person after the sudden onset of medical or behavioral health condition symptoms of sufficient severity that, without immediate medical attention, regardless of eventual diagnosis, could be expected by a reasonable layperson to result in impairment of a person’s physical or mental health, the health or safety of a fetus or pregnant person, bodily function of a bodily organ or part, or disfigurement to a person;

7. “Minimum benefit standard” means the eightieth percentile of all allowed amounts for the same or similar health care service furnished by an in-network provider or in-network facility as reported in an independent benchmarking database maintained by a nonprofit organization specified by the Insurance Commissioner. The nonprofit organization shall not be financially affiliated with a health benefit plan or provider. The calculation of the eightieth percentile of all allowed amounts shall be reflected by claims paid during the most recent calendar year;

8. “Provider” means a health care professional that is not a facility and is licensed to furnish health care services in this state;

9. “In-network provider” means a provider that is under express contract with a health benefit plan or a health benefit plan’s

contractor or subcontractor providing health care services to enrollees of the plan;

10. "Out-of-network provider" means a provider that is not contracted with a health benefit plan for network participation;

11. "Facility" means a licensed entity providing health care services, including:

a. a general, special, psychiatric, or rehabilitation hospital,

b. an ambulatory surgical center,

c. a cancer treatment center,

d. a birth center,

e. an inpatient, outpatient, or residential drug and alcohol treatment center,

f. a laboratory, diagnostic, or other outpatient medical service or testing center,

g. a health care provider's office or clinic,

h. an urgent care center, or

i. any other therapeutic health care setting;

12. "In-network facility" means a facility that is under express contract with a health insurance carrier or a health insurance carrier's contractor or subcontractor to provide health care services to enrollees of a plan;

13. "Out-of-network facility" means a facility that is not contracted with a health benefit plan for network participation;

14. "Allowed amount" means the contractually agreed-upon amount paid by a health benefit plan to an in-network provider or in-network facility in the health benefit plan network; and

15. "Health insurance carrier" or "carrier" means an entity subject to state insurance laws, including a health insurance company, a health maintenance organization, a hospital and health service corporation, a provider service network, a nonprofit health care plan, or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for, or reimburse any cost of health care services, or that provides, offers, or administers a health benefit policy or managed health care plan in this state.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6063.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An out-of-network provider or out-of-network facility shall not surprise bill a covered person for emergency care. If a covered person pays an out-of-network provider or out-of-network facility an amount that is greater than allowed by this section, the out-of-network provider or out-of-network facility shall render a refund to the covered person within thirty (30) days.

B. A health insurance carrier shall directly reimburse an out-of-network provider or out-of-network facility for emergency care at

the minimum benefit standard, or a mutually agreed upon amount, no later than:

1. Thirty (30) days after the date the health benefit plan receives an electronic clean claim for such care that includes all information necessary for the carrier to pay the claim; or

2. Forty-five (45) days after the date the carrier receives a nonelectronic clean claim for such care that includes all information necessary for the carrier to pay the claim.

C. A health insurance carrier shall ensure that a covered person who is rendered emergency care by an out-of-network provider or out-of-network facility shall incur no greater cost-sharing obligations than the covered person would have incurred if those health care services were rendered by an in-network provider or in-network facility.

D. An out-of-network provider shall not surprise bill a covered person for health care services that are not emergency care and are rendered at an in-network facility. If a covered person pays an out-of-network provider an amount that is greater than allowed by this section, the out-of-network provider shall render a refund to the covered person within thirty (30) days.

E. A health insurance carrier shall directly reimburse an out-of-network provider for health care services that are not emergency care and are rendered at an in-network facility the minimum benefit standard, or mutually agreed to amount, no later than:

1. Thirty (30) days after the date the carrier receives an electronic clean claim for such services that includes all information necessary for the carrier to pay the claim; or

2. Forty-five (45) days after the date the carrier receives a nonelectronic clean claim for such services that includes all information necessary for the carrier to pay the claim.

F. A health insurance carrier shall ensure that a covered person who is rendered health care services that are not emergency care by an out-of-network provider at an in-network facility shall incur no greater cost-sharing obligations than the covered person would have incurred if those health care services were rendered by an in-network provider.

G. The Insurance Commissioner shall promulgate rules for verifying the minimum benefit standard which may be requested by an out-of-network provider or out-of-network facility that has rendered health care services in accordance with this act.

1. Verification of the minimum benefit standard shall only be requested if reimbursement has been received from a carrier and no more than thirty (30) days have elapsed since the date payment was received.

2. Request for verification of the minimum benefit standard may be requested for bundled claims provided none of the claims were paid more than thirty (30) days since the date payment was received.

3. The Insurance Commissioner shall ensure that verification of the minimum benefit standard is provided to an out-of-network provider or out-of-network facility no later than fifteen (15) days after a request has been initiated.

4. If the Insurance Commissioner determines that the amount reimbursed by the carrier is less than the minimum benefit standard, the carrier shall be required to compensate the out-of-network provider or out-of-network facility the difference between the amount initially paid and the verified minimum benefit standard no later than fifteen (15) days after the date the Insurance Commissioner has verified the minimum benefit standard.

H. A health insurance carrier that fails to reimburse for health care services at the minimum benefit standard shall be subject to a penalty that is calculated as the difference between the minimum benefit standard and the amount billed by the out-of-network provider or out-of-network facility that requested verification of the minimum benefit standard. Fifty percent (50%) of the calculated penalty shall be made payable to the out-of-network provider or out-of-network facility and the remaining fifty percent (50%) shall be made payable to the Oklahoma Health Insurance High Risk Pool.

A carrier may be subject to additional fines and penalties, as determined by the Commissioner, if a pattern of underpayment has been determined.

SECTION 4. This act shall become effective November 1, 2025.

COMMITTEE REPORT BY: COMMITTEE ON BUSINESS AND INSURANCE
March 6, 2025 - DO PASS AS AMENDED