

STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

SENATE BILL 1047

By: McIntosh

AS INTRODUCED

An Act relating to health insurance; creating the Oklahoma Surprise Medical Billing Act; providing short title; defining terms; disallowing certain billing procedure; requiring reimbursement for certain health care service; prohibiting cost incurrence greater than certain cost-sharing obligation; directing rule promulgation; requiring certain verification; providing for fines and fees; 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 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 1. "Surprise bill" means a bill issued by an out-of-network
2 provider or out-of-network facility to an enrollee of a health
3 benefit plan for health care services in an amount that exceeds the
4 enrollee's cost-sharing obligation applicable for the same health
5 care services if the services had been provided by an in-network
6 provider or in-network facility and are rendered in the following
7 circumstances:

- 8 a. emergency care provided by an out-of-network provider
- 9 or out-of-network facility, or
- 10 b. nonemergency health care services rendered by an out-
- 11 of-network provider at an in-network facility;

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

15 3. "Covered person" means:

- 16 a. an enrollee, policyholder, or subscriber,
- 17 b. the enrolled dependent of an enrollee, policyholder,
- 18 or subscriber, or
- 19 c. another individual participating in a health benefit
- 20 plan;

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

23 5. "Health care service" means any service, supply, or
24 procedure rendered for the diagnosis, prevention, treatment, cure,

1 or relief of a health condition, illness, injury, or other disease,
2 including physical or behavioral health services, to the extent it
3 is covered by a health benefit plan;

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

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

22 8. "Provider" means a health care professional that is not a
23 facility and is licensed to furnish health care services in this
24 state;

1 9. "In-network provider" means a provider that is under express
2 contract with a health benefit plan or a health benefit plan's
3 contractor or subcontractor providing health care services to
4 enrollees of the plan;

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

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

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

11 b. an ambulatory surgical center,

12 c. a cancer treatment center,

13 d. a birth center,

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

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

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

19 h. an urgent care center, or

20 i. any other therapeutic health care setting;

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

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

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

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

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

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

1 B. A health insurance carrier shall directly reimburse an out-
2 of-network provider or out-of-network facility for emergency care at
3 the minimum benefit standard, or a mutually agreed upon amount, no
4 later than:

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

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

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

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

23 E. A health insurance carrier shall directly reimburse an out-
24 of-network provider for health care services that are not emergency

1 care and are rendered at an in-network facility the minimum benefit
2 standard, or mutually agreed to amount, no later than:

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

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

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

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

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

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

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

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

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

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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.

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