STATE OF OKLAHOMA

2nd Session of the 60th Legislature (2026)

SENATE BILL 1953 By: Murdock

AS INTRODUCED

An Act relating to health insurance; creating the Employer Health Plan Transparency Act; providing short title; defining terms; prohibiting certain health plan from entering into certain contract; prohibiting certain contract provisions from limiting or denying certain information; prohibiting certain contracts from containing certain provisions; prohibiting certain contracts from prohibiting or penalizing certain health plans in certain situations; requiring certain contracts in violation of certain provisions to be void; requiring certain insurer or provider to provide certain information consistent with certain Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements; requiring certain health plan to comply with certain HIPAA requirements; construing provisions; requiring certain claims to be made in accordance with certain regulations; requiring certain information to be unmodified; requiring certain notices to be in certain formats; requiring certain disclosures by certain issuers or providers; requiring itemization of certain costs; requiring certain supports; requiring submission of certain annual declaration; requiring certain submission in certain situations; allowing Insurance Commissioner to asses certain civil penalties; allowing Commissioner to issue certain orders; allowing certain action against license in certain situations; prohibiting certain issuer or provider from retaliating against certain persons; requiring Commissioner to promulgate rules and regulations; providing for noncodification; 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 not to be codified in the Oklahoma Statutes reads as follows:

This act shall be known as and may be cited as the "Employer Health Plan Transparency Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5410 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. "Auditable material" means claims and encounter information or data and any documentation supporting claim payments, including medical records;

2. "Claims and encounter information or data" means all documents, including electronically stored information containing claim files, encounter data, remittance and electronic funds transfer files, medical records supporting payment information, policy and contract documents, and all documents or electronically stored information containing information pursuant to 29 U.S.C., Section 1185m(a)(1)(B);

3. "Covered service provider" means a service provider that enters into a contract with a regulated health plan and reasonably expects One Thousand Dollars ($1,000.00) or more in compensation to be received in connection with providing, delivering, arranging for,

paying for, or reimbursing any of the costs of health care services regardless of whether such services will be performed or compensation received by the covered service provider, an affiliate, or a subcontractor;

4. "Electronic funds transfer" means the electronic message a health insurance issuer or covered service provider sends to a financial institution to order the financial institution to electronically transfer funds to a health care provider's account to pay for health care services;

5. "Electronic remittance advice" means a digital document that a health insurance issuer or covered service provider sends to a health care provider that supplies information about the payment to the health care provider, including any adjustments to claims and other payments based on factors including, but not limited to, any adjustments to claims or other payments based on factors such as contractual agreements, patient benefit coverage, expected co-payments or coinsurance, and capitation payments;

6. "Encounter data" means the information relating to the receipt of any items or service by an enrollee under a contract between an employee and a regulated health plan;

7. "Group health plan" means an employee welfare benefit plan that provides medical care to employees or their dependents directly or through insurance or reimbursement. Group health plan shall not include Medicare supplement or accident only, fixed indemnity,

limited benefit, credit, dental, vision, specified disease, or Tricare supplemental insurance, long-term care or disability income, workers' compensation, or automobile medical payment insurance or self-insured employee welfare benefit plan governed by the provisions of 29 U.S.C., Section 1001 et seq.;

8. "Health care provider" means any person, group, professional corporation, or other organization including, but not limited to, medical clinics, medical groups, home health care agencies, health infusion centers, urgent care centers, or emergency care centers that are licensed or authorized in this state to furnish health care services;

9. "Health care services" means health care related items, products, or services rendered or furnished by a health care provider within the scope of the provider's license, certification, or legal authorization for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease including, but not limited to, durable medical equipment, infusion, imaging, and hospital, medical, surgical, and pharmaceutical services or products;

10. "Health insurance issuer" means any entity subject to the insurance laws and regulations of this state or subject to the jurisdiction of the Insurance Department that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health insurance issuer shall

include a sickness and accident insurance company, health maintenance organization, nonprofit hospital and health service corporation, or other entity providing a plan of health insurance, health benefits, or health services;

11. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191, and all related privacy and security regulations pursuant to the Social Security Act, P.L. No. 74-271, 42 U.S.C., Section 1320d-9;

12. "Public employee health plan" means a governmental plan pursuant to 29 U.S.C., Section 1002(32), which is sponsored by this state or any political subdivision of this state, or a health benefits program administered for the benefit of public employees or eligible retirees;

13. "Regulated health plan" means a group health plan or a public employee health plan as defined by this section; and

14. "Self-insured employee welfare benefit plan" means an employee welfare plan where an employer assumes the financial risk for providing health care benefits to its employees and such arrangement shall be subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C., Section 1001 et seq.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5411 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A regulated health plan shall not enter into, extend, or renew a contract with a health insurance issuer or covered service provider to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services to the regulated health plan's employees or their dependents unless the contract or arrangement provides the regulated health plan access to all claims and encounter information or data, and all documentation supporting claim payments, including medical records and policy documents related to regulated health plan enrollee claims, are sufficient to enable the regulated health plan to comply with applicable law and plan terms and determine accuracy of payments.

B. No contract provision shall unreasonably:

1. Delay a regulated health plan from accessing all claims and encounter information or data of its employees or their dependents, and all documentation supporting claim payments related to regulated health plan enrollee claims, including records and policy documents, more than fifteen (15) days from the date of a request for such information by a regulated health plan to a health insurance issuer;

2. Limit the volume of claims and encounter information or data, and any documentation supporting claim payments of the regulated health plan's employees or their dependents, including medical records and policy documents related to regulated health plan enrollee claims, which a regulated health plan may access

during an audit or pursuant to any request by a regulated health plan to a health insurance issuer for such information or data;

3. Limit the disclosure of the payment arrangements of the health insurance issuer to provide, arrange for, pay for, or reimburse any of the costs of health care services to the regulated health plan's employees or their dependents, including payment calculations and formulas, quality measures, contract terms, payment amounts, incentive measurement periods, and other payment methodologies;

4. Limit a regulated health plan's right to select an auditor to review auditable materials or limit audit frequency to less than once per month;

5. Limit a regulated health plan from accessing claims and encounter information or data;

6. Limit disclosure of fees charged to a regulated health plan related to administration or claims processing, including renegotiation fees or repricing fees;

7. Limit disclosure of information related to overpayments; or

8. Limit public disclosure of de-identified or aggregate information that a regulated health plan receives from a health insurance issuer or covered service provider under this act.

C. No contract between a health insurance issuer or covered service provider and a regulated health plan shall:

1. Contain any provision that unreasonably delays or limits a regulated health plan's access to claims and encounter information or data; or

2. Not prohibit or penalize a regulated health plan for making Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant de-identified or aggregate disclosures of claims and encounter information or data.

D. Any contract in violation of this section shall be void.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5412 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Any health insurance issuer or covered service provider shall provide information to regulated health plans in a manner that is consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules and regulations.

B. A regulated health plan that receives a disclosure under this act from a health insurance issuer or covered service provider shall comply with HIPAA privacy regulations in handling such information, regardless of if HIPAA is applicable to the regulated health plan's activities.

C. Nothing in this act shall be construed to modify HIPAA data privacy requirements related to the creation, receipt, maintenance, or transmission of protected health information.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5413 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. All claims from health care providers shall be made to a regulated health plan in accordance with transaction standards adopted by regulation under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as follows:

1. Institutional, professional, and dental claims shall be made consistent with the format provided in 45 C.F.R., Section 162.1102; or

2. Pharmacy claims shall be made consistent with the National Council for Prescription Drug Programs or any subsequent standard under 45 C.F.R., Section 162.1102.

B. All information provided to a regulated health plan pursuant to this act shall be unmodified copies of the files sent by the health care provider. Claims sent by the health care provider in a physical format shall be converted to the appropriate standard electronic format by the health insurance issuer or covered service provider and made accessible at no cost to the regulated health plan.

C. All claims payments, electronic funds transfers, and electronic remittance advices sent by a health insurance issuer or covered service provider under a contract with a regulated health plan to provide, deliver, arrange for, pay for, or reimburse any of

the costs of health care services shall be made available to a regulated health plan with the format provided in 45 C.F.R., Section 162.1102. Such files shall be unmodified copies of the original information sent by the health insurance issuer or covered service provider to a health care provider, accessible at no cost to a regulated health plan.

D. Any contract between health insurance issuers or covered service providers and a regulated health plan to provide, deliver, arrange for, pay for, or reimburse any costs of health care services shall include disclosures of all calculation formulas, pricing methodologies, and other information used to determine the value of reimbursements.

E. All nonclaim costs charged to a regulated health plan shall be itemized and made available through a web portal, an application programing interface, and a downloadable Comma-Separated Values (.CSV) file.

F. Health insurance issuers or covered service providers shall support automated daily batch delivery of claims, encounters, remittances, and fee files to the regulated health plan.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5414 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. All health insurance issuers and covered service providers offering services to regulated health plans shall submit annually to

the Insurance Department a declaration, under penalty of perjury, warranting compliance with this act, including attestation that:

1. Information pursuant to this act is available upon request and is provided to regulated health plans in a timely manner; and

2. No contract contains terms that restrict or delay a regulated health plan from auditing, reviewing, or accessing information pursuant to this act.

B. A health insurance issuer or covered service provider shall not delegate submission of a declaration pursuant to subsection A of this section to a third party.

C. If a health insurance issuer or covered service provider cannot obtain information necessary to provide the declaration pursuant to subsection A of this section, they may submit a written statement that includes:

1. An explanation of why they were unsuccessful in obtaining such information, including whether auditing or access was limited; and

2. A description of all efforts taken to remove any provisions that violate subsection C of Section 3 of this act.

D. The Insurance Commissioner shall prescribe forms and submission dates necessary to enforce the provisions of this act.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5415 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner may assess a civil penalty not to exceed Ten Thousand Dollars ($10,000.00) per day, per violation of any health insurance issuer or covered service provider for violations of this act.

B. The Commissioner may issue cease-and-desist orders and seek injunctive relief, contract reformation, restitution of improperly charged nonclaim costs or fees, and require corrective action plans for violations of this act.

C. For repeated or willful violations, the Commissioner may take action against a violator’s certificate of authority or license.

D. A health insurance issuer or covered service provider shall not retaliate against any person for good-faith reports or cooperation with the Insurance Department pursuant to this act.

E. The Commissioner shall promulgate rules and regulations to enforce the provisions of this act.

SECTION 8. This act shall become effective November 1, 2026.

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