STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

HOUSE BILL 1853 By: Schreiber

AS INTRODUCED

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, 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:

"Health care service" means a service for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease, including a prescription drug or device, and does not include an emergency medical service.

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 an out-of-network provider. If an enrollee negotiates for a lower cost from an out-of-network provider than the average allowed amount paid by the carrier to a network provider for a comparable 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 health care provider's name and contact information;

2. If an 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 average payments made by the carrier to network entities or providers for comparable health care services if this information is made available to the enrollee pursuant to this part; and

4. 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.

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, coinsurance, copayment, or other cost-sharing amount:

1. If the heath care service is included under the enrollee's health plan; and

2. The enrollee negotiated for a lower cost for the health care service than the average allowed amount paid by the carrier to network providers for that comparable health care service.

C. The amount counted toward an enrollee's out-of-pocket deductible, coinsurance, copayment, or other cost-sharing amount must not exceed the total amount that the covered person 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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