BILL SUMMARY
1st Session of the 60th Legislature

Bill No.:	**HB1853**
Version:	**FULLPCS2**
Request Number:	**13220**
Author:	**Rep. Schreiber**
Date:	**3/6/2025**
Impact:	**$0**

Research Analysis

The second proposed committee substitute for HB 1853 adds that a "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 State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement. The pcs2 also adds that if an enrollee negotiates for a lower price for a medically necessary health care service covered by their health benefit plan, the enrollee may send documentation to the carrier. The health care provider must accept the enrollee's payment as payment in full and must not bill the enrollee or the health benefit plan for any balance between the amount collected and provider's billed charge. A carrier that receives this documentation will count the full amount toward the enrollee's deductible and their annual maximum out-of-pocket expense if certain criteria are met. The out-of-pocket cost will be attributed to the in-network deductible and annual maximum out-of-pocket expense if the provider was in-network and to the annual maximum and the out-of-network deductible if the provider was out-of-network.

HB 1853 provides that an enrollee may choose to pay for a health care service out-of-pocket from a licensed health care provider. If an enrollee negotiates a lower costs than the average allowed amount paid by the carrier to a network provider for a comparable service, and the enrollee pays out-of-pocket, the enrollee may send documentation that provides the information specified in the measure. A carrier that receives this documentation must count the full amount that the enrollee paid out-of-pocket towards their deductible, coinsurance, copayment, or other costs-sharing amount if the service is included in their health plan, they negotiated for a lower costs, and the amount doesn't exceed the total amount that a covered person is required to pay out-of-pocket. The provisions of the measure cover an enrollee who may choose to pay for a health care service out-of-pocket from a licensed health care provider.

Prepared By: Suzie Nahach, House Research Staff

Fiscal Analysis

The FULLPCS2 to HB 1853 authorizes an enrollee to pay for health care services out-of-pocket and for insurance providers to count certain payments towards the enrollee's deductible and annual maximum out-of-pocket expense.

According to officials from the Oklahoma Health Care Authority, they do not expect the HealthChoice plan to incur additional claims if the member makes a direct payment to the provider. However, they did state, an item of concern is the potential for additional

administration or confusion for the health plan to receive claims from the enrollees versus the providers. The requirements of the measure do not apply to the state Medicaid program.

In its current form, HB 1853 is not anticipated to have a direct fiscal impact on the state budget or appropriations.

Prepared By: Alexandra Ladner, House Fiscal Staff

Other Considerations

None.