STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

SENATE BILL 787 By: Weaver

AS INTRODUCED

An Act relating to health care costs; creating the Oklahoma Health Care Cost Containment and Affordability Act; providing short title; defining terms; placing limitations on certain payment rates; prohibiting collections from exceeding certain authorized amounts; providing alternative payment methods; providing exceptions; requiring provision of certain information; exempting certain confidential information; requiring report to certain officials; requiring promulgation of rules; constituting certain violations as unfair trade practices; authorizing enforcement by certain entities; establishing penalties for certain violations; authorizing certain audits; stipulating certain duties; requiring certain filings; requiring certain notice; establishing procedures for approval of certain filings; requiring consideration of certain factors; 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 6013 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 Health Care Cost Containment and Affordability Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6013.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Oklahoma Health Care Cost Containment and Affordability Act:

1. "Health insurance carrier" means an entity subject to the insurance laws and regulations of this state or subject to the jurisdiction of the Insurance Department that offers health insurance, health benefits, or contracts for health care services, including prescription drug coverage, to large groups, small groups, or individuals on or outside the Patient Protection and Affordable Care Act Health Insurance mandate;

2. "Health benefit plan" means a plan, policy, contract, certificate, or agreement entered into, offered, or issued by a health insurance carrier or health plan administrator acting on behalf of a plan sponsor to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including nonfederal governmental plans as defined in 29 U.S.C., Section 1002(32), but excludes any coverage by Medicare, Medicaid, TRICARE, the Veterans Health Administration, the Indian Health Service, and the Federal Employees Health Benefit Program;

3. "Health plan administrator" means a third-party administrator who acts on behalf of a plan sponsor to administer a health benefit plan;

4. "Health system" means:

a. a parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership or other means, or

b. a hospital and any entity affiliated with such hospital through ownership, governance, membership or other means;

5. "Hospital" means a hospital licensed by the State Department of Health;

6. "Hospital-based facility" means a facility that is owned or operated, in whole or in part, by a hospital where hospital or professional medical services are provided;

7. "Health care provider" means an individual, entity, corporation, person, or organization, whether for profit or nonprofit, that furnishes, bills, or is paid for health care service delivery in the normal course of business, and includes, without limitation, health systems, hospitals, and hospital-based facilities;

8. "Price transparency laws" means Section 2718(e) of the Public Health Service Act (PHSA), as amended, and rules adopted by the U.S. Department of Health and Human Services implementing

Section 2718(e) of such act and the Transparency in Health Care Prices Act; and

9. "Transparency in coverage laws" means Section 2715A of the Public Health Service Act, as amended; Section 715 of the Employee Retirement Income Security Act of 1974 (ERISA); Section 9815 of the Internal Revenue Code of 1986, as amended (IRC); and rules adopted by the U.S. Department of Health and Human Services, the U.S. Department of the Treasury, and the U.S. Department of Labor implementing Section 2715A of the PHSA, Section 715 of ERISA, and Section 9815 of the IRC.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6013.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Total payments to any health care provider for inpatient or outpatient hospital services furnished to persons covered by a health benefit plan shall not exceed the lesser of:

1. Two hundred percent (200%) of the amount paid by Medicare for the item or service. If there is no allowable amount in Medicare for this item or service, then two hundred percent (200%) of the amount paid by Medicaid for the same item or service; or

2. The median amount paid by health benefit plans for the same item or service.

B. A health care provider who is reimbursed in accordance with subsection A of this section may not charge or collect from the

patient any amount greater than cost-sharing amounts authorized by the terms of the health benefit plan and allowed under applicable law. The total payment, including amounts paid by the health benefit plan and individual cost-sharing, shall not exceed the amounts stated in subsection A of this section.

C. If a health benefit plan does not reimburse claims on a fee-for-service basis, the payment method used shall conform to the limits specified in subsection A of this section. Such payment methods include, but are not limited to, value-based payments, capitation payments, or bundled payments.

D. The provisions of this section shall not apply to:

1. Critical access hospitals;

2. Federally Qualified Health Centers; or

3. Rural health clinics.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6013.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Health care providers shall provide the State Department of Health the information required by price transparency laws and any such data as the State Department of Health determines is necessary to calculate the growth rates of health care services and to monitor compliance with the payment limits established in this act.

B. Health insurance carriers and the health plan administrator of the state public employee health benefit plan shall provide the

Insurance Department the information required by transparency in coverage laws and any such data as the Insurance Department determines is necessary to calculate the growth rates of health care services, to monitor compliance with the payment limits established in this act, to evaluate compliance with medical loss ratio requirements under applicable federal or state laws, and to review and approve premium rates and growth.

C. The State Department of Health and the Insurance Department shall keep confidential all nonpublic information and documents obtained under this act and shall not disclose the confidential information or documents to any person without the consent of the party that produced the confidential information or documents, except that the information may be disclosed to experts or consultants under contract with the State Department of Health or the Insurance Department, provided that the expert or consultant is bound by the same confidentiality requirements as the state officials. The confidential information and documents shall not be public records and shall be exempt from the Oklahoma Open Records Act.

D. By the last day of February every year, the State Department of Health and the Insurance Department shall each provide an electronic report to the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Governor on trends for providers, health insurance premiums, patient access to

providers, and compliance with this act. The departments may include recommendations for further actions to make health care more affordable and accessible to residents of the state.

E. The State Department of Health may promulgate regulations necessary to implement the requirements of this act, alter or reduce the rate limits set forth in this act, specify the format and content of reports established in this act, and impose penalties for noncompliance consistent with the State Department of Health's authority to regulate health care providers.

F. The Insurance Department and the Insurance Commissioner may promulgate regulations necessary to evaluate the growth or reduction of health insurance premiums, ensure that savings from reductions in provider payments are passed on to consumers, ensure compliance with applicable medical loss ratio requirements under federal and state laws, specify the format and content of reports under this act, and impose penalties for noncompliance consistent with the Insurance Department's and Commissioner's authority to regulate health insurance carriers.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6013.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Any violation of this act shall constitute an unfair trade practice pursuant to Section 1201 et seq. of Title 36 of the

Oklahoma Statutes, which may be enforced by the Insurance Department, the Attorney General, or an aggrieved individual.

B. A health care provider that violates any provision of this act or the rules and regulations adopted pursuant to this act shall:

1. Refund any amount received that is more than the amount set forth in this act to the health benefit plan; and

2. Pay the patient or individual responsible for the patient a penalty of the greater of One Thousand Dollars ($1,000.00) or the amount the health care provider received that is more than the amount set forth in this act.

C. The State Department of Health may audit any health care provider, and the Insurance Department, the Insurance Commissioner, or their designee may audit any health insurance carrier or health plan administrator, for compliance with the requirements of this act. Until the expiration of four (4) years after the furnishing of any services for which an out-of-network payment was charged, billed, or collected, each health care provider, health insurance carrier, or health plan administrator shall make available, upon written request of the State Department of Health, the Insurance Department, the Insurance Commissioner, or their designee, copies of any books, documents, records, or data that are necessary for the purposes of completing the audit.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1613.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. In addition to the purposes pertaining to rates set forth in Section 901.1 of Title 36 of the Oklahoma Statutes, the Insurance Department and Insurance Commissioner shall discharge their powers and duties to:

1. Protect the public interest and the interests of consumers;

2. Encourage the fair treatment of health care providers; and

3. View the health care system as a comprehensive entity, and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, affordability, improved health care quality, and appropriate access.

B. 1. Every health benefit plan shall file with the Insurance Department, either directly or through a licensed rating organization of which it is a member or subscriber, all rates and rating plans, classifications, class rates, rating schedules, loss cost, all other supplementary rate information, and every modification of all such information, which it uses or proposes to use in this state except as otherwise provided in this act.

2. The Insurance Department shall send a notification of filing of rates to any person who submits a written request to be notified of filings pursuant to regulation of the Board.

3. The Attorney General shall be notified in writing within ten (10) days of:

a. filing of rates, whether for prior approval or for immediate use, and

b. certification of completion of a filing.

C. Rates, rating plans, classifications, schedules, loss cost, and other information shall be deemed approved ninety (90) calendar days following certification of completion of the filing as provided in this act unless, within the ninety-calendar-day period:

1. The Insurance Department approves, disapproves, or approves with modification, the filing;

2. The Insurance Department orders a formal hearing on the filing; or

3. The Insurance Commissioner extends such period for one additional ninety-calendar-day period.

D. Any formal hearing ordered by the Insurance Department shall be completed and a written order on the filing issued within one hundred twenty (120) calendar days from the date of the order setting the formal hearing, or the filing shall be deemed approved at the expiration of this period.

E. In discharging the duties to approve, disapprove, modify, or take any other action authorized by law with respect to a health benefit plan’s filing of health insurance rates or rate formulas under this act, the Insurance Department and Insurance Commissioner

shall consider whether the health benefit plan's products are affordable and whether the carrier has implemented effective strategies to enhance the affordability of its products.

F. The Insurance Department and Insurance Commissioner may promulgate regulations to carry out the powers and duties of this section, including without limitation, to implement rate filing requirements, establish affordability standards, impose penalties, and ensure compliance with this section.

G. When investigating rates to determine whether they comply with the provisions of this act, the previously approved filing shall not be changed, altered, amended, or held in abeyance until after completion of the investigation and an opportunity for hearing in accordance with the provisions of this article. Following such hearing, the Insurance Department shall enter its order in accordance with the provisions of this act. The effective date of such order shall not be fewer than thirty (30) days nor more than sixty (60) days after the date of the order unless the Insurance Department determines that, in the public interest, a shorter or longer period is appropriate, provided the filer has adequate time to implement such rate change. Any such order shall apply prospectively only and shall not affect premiums collected on new or renewal policies issued prior to the effective date of the order.

H. If the Department finds that a filing does not meet the requirements of this act, it shall send to the insurer or rating

organization which made such filing, written notice of disapproval of such filing, specifying in what respects it finds that such filing fails to meet the requirements of this act and stating that such filing shall not become effective to the extent disapproved.

I. In determining whether a heath benefit plan's health insurance products are affordable, the Department and Commissioner may consider the following factors:

1. Historical rates of trends for existing products;

2. National medical and health insurance trends, including Medicare trends;

3. Regional medical and health insurance trends;

4. Inflation indices, such as the Consumer Price Index and the medical care component of the Consumer Price Index;

5. Price comparison to other market rates for similar products such as consideration of rate differentials, if any, between not-for-profit and for-profit insurers in other markets;

6. The ability of lower-income individuals to pay for health insurance;

7. Efforts of the health benefit plan to maintain close control over its administrative costs;

8. Implementation of effective strategies by the health benefit plan to enhance the affordability of its products; or

9. Any other relevant affordability factor, measurement, or analysis determined by the Commissioner to be necessary or desirable to carry out the purposes of this act.

SECTION 7. This act shall become effective November 1, 2025.

60-1-1236 CAD 1/19/2025 5:43:18 AM