STATE OF OKLAHOMA

1st Session of the 59th Legislature (2023)

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 254 By: Garvin of the Senate

and

Boatman of the House

COMMITTEE SUBSTITUTE

An Act relating to behavioral health; defining terms; requiring insurer to cover certain out-of-network services at certain cost under certain conditions with certain exceptions; requiring insurer to report certain payments to the Insurance Department; providing for promulgation of rules; 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 6060.11a of Title 36, unless there is created a duplication in numbering, reads as follows:

A. For the purposes of this act:

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

2. "Health care provider" or "provider" means a health care provider as defined pursuant to Section 6571 of Title 36 of the Oklahoma Statutes; and

3. "Timely manner" means:

a. for a request for a routine appointment, a provider's referral for services, the start of a new treatment or medication, or other maintenance services as determined by the Insurance Department, thirty (30) days from the date that the insured requests the appointment, service, or care,

b. for residential care or hospitalization, seven (7) days from the date that the insured first attempts to receive care, and

c. for urgent, emergency, or crisis care, twenty-four (24) hours from the date and time that the insured first attempts to receive care.

B. If the beneficiary of a health benefit plan is unable to obtain covered behavioral health services from an in-network provider on a timely manner as defined in subsection A of this section, such plan shall ensure coverage of the behavioral health services from an out-of-network provider by arranging a network exception with a negotiated rate from an out-of-network provider. Such an agreement between the health benefit plan and the out-of-network provider shall hold the beneficiary harmless for any amount

greater than the in-network cost-sharing amount that the beneficiary would have paid had the same services been received from an in-network provider. In no instance shall the beneficiary pay more than the in-network cost-sharing amount for such services.

C. If coverage is not arranged within the applicable time frame as described in paragraph 3 of subsection A of this section, the beneficiary may seek services from any out-of-network provider regardless of a negotiated network exception and rate. The beneficiary shall pay no more than the same cost-sharing that the beneficiary would pay for the same covered services received from an in-network provider.

D. A plan shall not be held responsible if behavioral health services are available within a timely manner as defined in this section, but the beneficiary chooses to schedule services outside the timely access standard.

E. A health benefit plan that makes a payment to an out-of-network provider pursuant to this section shall report the details of the payment to the Department not later than sixty (60) days from the date that the payment is made.

F. The Department may promulgate rules to effectuate the provisions of this section.

SECTION 2. This act shall become effective November 1, 2023.

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