STATE OF OKLAHOMA

1st Session of the 59th Legislature (2023)

SENATE BILL 254 By: Garvin

AS INTRODUCED

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; directing 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. In the event that an insured is unable to obtain covered behavioral health services in a timely manner and requires care or services from an out-of-network provider, an insurer of a health benefit plan shall charge an insured for the care or services at a cost not to exceed in-network copayments, coinsurance, and deductibles. An insured or sponsor of a health benefit plan shall not be billed by or liable to the plan or out-of-network provider for any amount beyond the cost-sharing amount pursuant to this section.

C. If an insured chooses to schedule an appointment or service with an out-of-network provider outside of the timely standard established in paragraph 3 of subsection A of this section, a plan

shall not be responsible for a reduction in the copayment, coinsurance, or deductible of an out-of-network provider's care or service to an insured.

D. 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.

E. The Department shall promulgate rules to effectuate the provisions of this section.

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

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