ENGROSSED HOUSE
BILL NO. 3483

By: McEntire, Ford, Sanders, West (Tammy), Kerbs, Boles, Baker, Hilbert, Lawson, West (Josh), McDugle, Mize, Fincher, Pae, Virgin and Provenzano of the House

and

McCortney of the Senate

[insurance - creating the Oklahoma Surprise Billing Protection Act - 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 6060.60 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 Surprise Billing Protection Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.61 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Oklahoma Surprise Billing Protection Act:

1. "Allowed amount" means the maximum portion of a billed charge that a health insurance carrier shall pay, including any

applicable covered person cost-sharing responsibility, for a covered health care service or item rendered by a participating provider or by a nonparticipating provider;

2. "Balance billing" means a nonparticipating provider's practice of issuing a bill to a covered person for the difference between the nonparticipating provider's billed charges on a claim and any amount paid by the health insurance carrier as reimbursement for that claim, excluding any cost-sharing amount due from the covered person;

3. "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefits plan;

4. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Insurance Commissioner, that contracts or offers to contract, or enters into an agreement, to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a health insurance company, a health maintenance organization, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services;

5. "Mediation" means a process in which an impartial entity issues a binding determination in a dispute between a health benefit plan issuer or administrator and an out-of-network provider or

facility or the provider or facility's representative to settle a health benefit claim;

6. "Nonparticipating provider" means a provider who is not a participating provider;

7. "Participating provider" means a provider or facility that, under express contract with a health insurance carrier or with a health insurance carrier's contractor or subcontractor, has agreed to provide health care services to covered persons, with an expectation of receiving payment directly or indirectly from the health insurance carrier, subject to cost sharing; and

8. a. "Surprise bill" means a bill that a nonparticipating provider issues to a covered person for health care services rendered in the following circumstances, in an amount that exceeds the covered person's cost-sharing obligation that would apply for the same health care services if these services had been provided by a participating provider:

(1) emergency care provided by the nonparticipating provider, or

(2) health care services, that are not emergency care, rendered by a nonparticipating provider at a participating facility where a participating provider is unavailable, a nonparticipating provider renders unforeseen services, or a

nonparticipating provider renders services for which the covered person has not given specific consent for that nonparticipating provider to render.

b. "Surprise bill" does not mean a bill:

(1) for health care services received by a covered person when a participating provider was available to render the health care services and the covered person knowingly elected to obtain the services from a nonparticipating provider without prior authorization,

(2) received for health care services rendered by a nonparticipating provider to a covered person whose coverage is provided pursuant to a preferred provider plan; provided, that the health care services are not provided as emergency care or for services rendered pursuant to division (2) of subparagraph a of this paragraph, or

(3) received for ambulance services as defined in Section 1-2503 of Title 63 of the Oklahoma Statutes.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.62 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If a health benefit plan issuer or administrator has restricted or prohibited a health care provider or health care facility from billing an insured, participant or enrollee from applicable copayment, coinsurance, and deductible amounts required under the Oklahoma Surprise Billing Protection Act, the Attorney General may bring a civil action in the name of the state to ensure the health care provider, health care facility or administrator may bill an enrollee the applicable copayment, coinsurance, and deductible amounts. If the Attorney General prevails in an action brought against a health benefit plan issuer or administrator, the Attorney General may recover reasonable attorney fees, costs and expenses, including court costs and witness fees incurred in bringing the action.

B. If a health care provider, health care facility or administrator has billed an enrollee an amount greater than the applicable copayment, coinsurance, and deductible amount required under the Oklahoma Surprise Billing Protection Act, the Attorney General may bring a civil action in the name of the state to ensure the enrollee is not responsible for an amount greater than the applicable copayment, coinsurance, and deductible amounts. If the Attorney General prevails in an action brought against a health

benefit plan issuer or administrator, the Attorney General may recover reasonable attorney fees, costs and expenses, including court costs and witness fees incurred in bringing the action.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.63 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health insurance carrier shall reimburse a nonparticipating provider for emergency care necessary to evaluate and stabilize a covered person if a prudent layperson would reasonably believe that emergency care is necessary, regardless of eventual diagnosis.

B. A health insurance carrier shall not require that prior authorization for emergency care be obtained by, or on behalf of, a covered person prior to the point of stabilization of that covered person if a prudent layperson would reasonably believe that the covered person requires emergency care.

C. A health insurance carrier may require an emergency care provider to notify a health insurance carrier of a covered person's admission to the hospital within a reasonable time period after the covered person has been stabilized.

D. The insurer shall make payment required by this section directly to the provider no later than, as applicable:

1. Thirty (30) days after the date the insurer receives an electronic clean claim for those services that includes all information necessary for the insurers to pay the claim; or

2. Forty-five (45) days after the date the insurer receives a nonelectronic clean claim for those services that includes all information necessary for the insurer to pay the claim.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.64 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Other than applicable cost sharing that would apply if a participating provider had rendered the same services, a health insurance carrier shall provide reimbursement for and a covered person shall not be liable for charges and fees for covered nonemergency care rendered by a nonparticipating provider that are delivered when:

1. The covered person at an in-network facility does not have the ability or opportunity to choose a participating provider who is available to provide the covered services; or

2. Medically necessary care is unavailable within a health benefits plan's network; provided, that "medical necessity" shall be determined by a covered person's provider in conjunction with the covered person's health benefits plan and health insurance carrier.

B. At the time a participating facility schedules a procedure or seeks prior authorization from a health carrier for the provision

of nonemergency services to a covered person, the facility shall provide the covered person with an out-of-network services written disclosure that states the following:

1. That certain facility-based providers may be called upon to render care to the covered person during the course of treatment;

2. That those facility-based providers may not have contracts with the covered person's health care and are therefore considered to be out-of-network;

3. That the services therefor will be provided on an out-of-network basis;

4. A description of the range of the charges for the out-of-network services for which the covered person may be responsible;

5. A notification that the covered person may either agree to accept and pay the charges for the out-of-network services, contact the covered person's health carrier for additional assistance or rely on whatever other rights and remedies that may be available; and

6. A statement indicating that the covered person may obtain a list of facility-based providers from his or her health benefits plan that are participating providers and that the covered person may request those participating facility-based providers.

C. Except as set forth in subsection A of this section, nothing in this section shall preclude a nonparticipating provider from surprise billing for nonemergency care provided by a

nonparticipating provider to an individual who has knowingly chosen to receive services from that nonparticipating provider.

D. The insurer shall make payment required by this section directly to the provider no later than, as applicable:

1. Thirty (30) days after the date the insurer receives an electronic clean claim for those services that includes all information necessary for the insurer to pay the claim; or

2. Forty-five (45) days after the date the insurer receives a nonelectronic clean claim for those services that includes all information necessary for the insurer to pay the claim.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.65 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Until November 1, 2023, surprise billing reimbursement shall be:

1. At a rate of one hundred fifty percent (150%) of the Employees Group Insurance Division's (EGID) current contracted rates as of November 1, 2020, or the future adjusted rates, whichever is greater; or

2. At a rate established by a representative data set from a statewide health information exchange (HIE) all-payer claims database.

B. The EGID shall post all current contracted rates on its website in a publicly accessible manner.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.66 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health carrier shall notify the participating provider of the specific covered health care services for which the provider will be responsible, including any limitations or conditions on services.

B. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:

"Provider agrees that in no event, including, but not limited to, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has

agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

C. In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.67 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. By July 1, 2021, the State Department of Health shall require each health facility licensed in this state to post the following in the health facility and on the health facility's website in a publicly accessible manner:

1. The names and hyperlinks for direct access to the websites of all health insurance carriers with which the hospital has a contract for services;

2. A statement that sets forth the following:

a. services may be performed in the hospital by participating providers as well as nonparticipating providers who may separately bill the patient,

b. providers that perform health care services in the hospital may or may not participate in the same health benefits plans as the hospital, and

c. prospective patients should contact their health insurance carriers in advance of receiving services at that hospital to determine whether the scheduled health care services provided in that hospital will be covered at in-network rates; and

3. The rights covered under the Oklahoma Surprise Billing Protection Act.

B. Any written communication, other than a receipt of payment from a provider or health insurance carrier pertaining to a surprise bill, shall clearly state that the covered person is responsible only for payment of applicable in-network, cost-sharing amounts under the covered person's health benefits plan and noncovered services. A collection agency collecting medical debt from Oklahoma residents shall post a notice of consumer rights pursuant to the Oklahoma Surprise Billing Protection Act on its website.

C. When a nonparticipating provider under nonemergency circumstances has advance knowledge that the nonparticipating provider is not contracted with the covered person's health insurance carrier, the nonparticipating provider shall inform the covered person of the nonparticipating provider's nonparticipating

status and advise the covered person to contact the covered person's health insurance carrier to discuss the covered person's options.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.68 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An out-of-network provider, out-of-network facility, and health benefit plan issuer or administrator may request mediation of a settlement of an out-of-network health benefit claim utilizing a fair and impartial mediation entity if:

1. The health benefit claim is for:

a. nonemergency care provided at an out-of-network facility,

b. nonemergency care provided by an out-of-network provider,

c. emergency care provided at an out-of-network facility, or

d. emergency care provided by an out-of-network provider; and

2. The calculated reimbursement rate is disputed.

B. If a person requests mediation under this section, the out-of-network provider, out-of-network facility, or a representative of the provider or facility, and the health benefit plan issuer or the administrator, as appropriate, shall participate in mediation.

C. Nothing in this section shall prohibit a health care provider or facility from utilizing mediation in cases where medical necessity is disputed.

D. The party who requests mediation shall provide written notice on the date mediation is requested to each party.

E. For multiple claims in mediation:

1. The total amount in controversy for multiple claims in one proceeding shall not exceed Five Thousand Dollars ($5,000.00); and

2. The multiple claims in one proceeding shall be limited to the same out-of-network provider or facility and health benefit plan issuer.

SECTION 10. This act shall become effective November 1, 2020.

Passed the House of Representatives the 11th day of March, 2020.

_____
Presiding Officer of the House of Representatives

Passed the Senate the ___ day of _____, 2020.

_____
Presiding Officer of the Senate