STATE OF OKLAHOMA

2nd Session of the 57th Legislature (2020)

SENATE BILL 1696 By: Quinn

AS INTRODUCED

An Act relating to health insurance; creating the Surprise Billing Protection for Oklahomans Act; defining terms; 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 7420 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 "Surprise Billing Protection for Oklahomans Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7421 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. "Allowed amount" means the maximum portion of a billed charge that a health insurance carrier will 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. "Claim" means a request from a provider for payment for health care services rendered;

4. "Co-insurance" means a cost-sharing method that requires a covered person to pay a stated percentage of medical expenses after any deductible amount is paid, provided that co-insurance rates may differ for different types of services under the same health benefits plan;

5. "Copayment" means a cost-sharing method that requires a covered person to pay a fixed dollar amount when health care services are received, with the health insurance carrier paying the balance allowable amount, provided that there may be different copayment requirements for different types of services under the same health benefits plan;

6. "Cost sharing" means a copayment, co-insurance, deductible or any other form of financial obligation of a covered person other than premium or share of premium, or any combination of any of these

financial obligations as defined by the terms of a health benefits plan;

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

8. "Covered person" means:

a. an enrollee, policyholder or subscriber,

b. the enrolled dependent of an enrollee, policyholder or subscriber, or

c. another individual participating in a health benefits plan;

9. "Deductible" means a fixed dollar amount that a covered person may be required to pay during the benefit period before the health insurance carrier begins payment for covered benefits, provided that a health benefits plan may have both individual and family deductibles and separate deductibles for specific services;

10. "Emergency care" means a health care procedure, treatment or service, excluding ambulance transportation service, which procedure, treatment or service is delivered based on the presenting symptoms of the patient arising from any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in

serious jeopardy to the health of the patient, impairment of bodily function or dysfunction of any bodily organ or part;

11. "Facility" means an entity providing a health care service, including:

a. a hospital, as defined in Section 1-701 of Title 63 of the Oklahoma Statutes,

b. an ambulatory surgical center,

c. a cancer treatment center,

d. a birth center,

e. an inpatient, outpatient or residential drug and alcohol treatment center,

f. a laboratory, diagnostic or other outpatient medical service or testing center,

g. a health care provider's office or clinic setting, licensed by the Department of Health, that is separate from an acute care hospital and that provides twenty-four-hour services in an urgent care center, or

h. any other therapeutic health care facility;

12. "Health benefit plan" means a plan that:

a. provides benefits for medical or surgical expenses incurred as a result of a health condition, accident or sickness,

b. is offered by any insurance company, group hospital service corporation, the State and Education Employees

Group Insurance Board or health maintenance organization that delivers or issues for delivery an individual, group, blanket or franchise insurance policy or insurance agreement, a group hospital service contract or an evidence of coverage or, to the extent permitted by the Employee Retirement Income Security Act of 1974, 29 U.S.C., Section 1001 et seq., by a multiple employer welfare arrangement as defined in Section 3 of the Employee Retirement Income Security Act of 1974, or any other analogous benefit arrangement, whether the payment is fixed or by indemnity,

c. the term "health benefit plan" shall not include:

(1) a plan that provides coverage:

(a) only for a specified disease or diseases or under an individual limited benefit policy,

(b) only for accidental death or dismemberment,

(c) only for dental or vision care,

(d) a hospital confinement indemnity policy,

(e) disability income insurance or a combination of accident-only and disability income insurance, or

(f) as a supplement to liability insurance,

(2) a Medicare supplemental policy as defined by Section 1882(g)(1) of the Social Security Act (42 U.S.C., Section 1395ss),

(3) workers' compensation insurance coverage,

(4) medical payment insurance issued as part of a motor vehicle insurance policy,

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless a determination is made that the policy provides benefit coverage so comprehensive that the policy meets the definition of a health benefit plan, or

(6) short-term health insurance issued on a nonrenewable basis with a duration of six (6) months or less;

13. "Inducement" means the act or process of enticing or persuading another person to take a certain course of action;

14. "Network" means the group or groups of participating providers that have been contracted to provide health care services under a network plan;

15. "Nonparticipating provider" means a provider who is not participating in a network of health benefit plan;

16. "Participating provider" means a provider or facility that, under express contract with a health benefit plan or contractor or subcontractor of a plan, has agreed to provide health care services

to covered persons, with an expectation of receiving payment directly or indirectly from the health benefit plan, subject to cost sharing;

17. "Prior authorization" means a pre-service determination made by a health benefit plan regarding a covered person's eligibility for services, medical necessity, benefit coverage and the location or appropriateness of services, pursuant to the terms of coverage of a health benefit plan;

18. "Practitioner" means any person holding a valid license to practice medicine and surgery, osteopathic medicine, chiropractic, podiatric medicine, optometry or dentistry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes;

19. "Stabilize" means to provide emergency care to a patient as may be necessary to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient to a facility or, with respect to emergency labor, to deliver, including the delivery of a placenta; and

20. "Surprise bill" means:

a. 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) nonemergency care, provided by a nonparticipating provider at a participating facility where the covered person has not given specific consent for the nonparticipating provider to provide the services, and

b. the term does not mean:

(1) for health care services received by a covered person when a participating provider was available to provide the health care services and the covered person knowingly elected to obtain the services from a nonparticipating provider, or

(2) a bill received for health care services provided 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 (1) of subparagraph a of this paragraph.

SECTION 3. This act shall become effective November 1, 2020.

57-2-3276 CB 1/16/2020 3:22:21 PM