STATE OF OKLAHOMA

1st Session of the 56th Legislature (2017)

SENATE BILL 788 By: Brown

AS INTRODUCED

An Act relating to health care; creating the Medical Price Transparency Act; providing short title; directing the State Department of Health to publish certain guide; specifying information to be included in certain guide; directing the State Board of Health to promulgate rules; requiring health care facilities to establish certain billing policies; directing certain disclosure and notice; requiring health care facilities to provide certain estimate; directing health care facilities to provide an itemized statement in certain circumstances; providing for violations; permitting certain fee; setting time limit for certain reimbursement; prohibiting nullification by certain contracts; requiring health care facilities to implement procedure for complaints; directing the State Board of Medical Licensure and Supervision to prepare certain guide; directing the State Department of Health to publish certain guide; directing the State Board of Medical Licensure and Supervision to promulgate rules; requiring physicians to establish certain billing policies; directing certain notice; requiring physicians to provide certain estimate; directing physicians to provide an itemized statement in certain circumstances; directing physicians to provide explanation in certain circumstances; providing for certain refund; defining terms; directing health benefit plan issuers to submit certain information to the Insurance Department; directing the Department to set certain requirements; permitting the Department to contract with a party in certain circumstance; providing for confidentiality; directing the Department to publish certain information and reports; directing health benefit plan issuers to file certain report; providing

exceptions; directing health benefit plans to provide certain estimate; directing a health benefit plan issuer to provide certain information to an insured person; directing the Insurance Commissioner to promulgate rules; providing for noncodification; 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 not to be codified in the Oklahoma Statutes reads as follows:

This act shall be known and may be cited as the "Medical Price Transparency Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-150 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The State Department of Health shall publish on the Department's website a Consumer Guide to Health Care Facilities and Health Care. The Department shall include information in the guide concerning health care facility pricing practices and the correlation between a health care facility's average charge for an inpatient admission or outpatient surgical procedure and the actual, billed charge for the admission or procedure, including notice that the average charge for a particular inpatient admission or outpatient surgical procedure will vary from the actual, billed charge for the admission or procedure based on:

1. The medical condition of the person;

2. Any unknown medical conditions of the person;

3. The diagnosis of the person and recommended treatment protocols ordered by the physician providing care to the person; and

4. Other factors associated with the inpatient admission or outpatient surgical procedure.

B. The Department shall include information in the guide to advise consumers that:

1. The average charge for an inpatient admission or outpatient surgical procedure may vary between facilities depending on a health care facility's cost structure, the range and frequency of the services provided, intensity of care, and payor mix;

2. The average charge by a health care facility for an inpatient admission or outpatient surgical procedure will vary from the health care facility's costs or the amount that the health care facility may be reimbursed by a health benefit plan for the admission or surgical procedure;

3. The consumer may be personally liable for payment for an inpatient admission, outpatient surgical procedure or health care service or supply depending on the consumer's health benefit plan coverage;

4. The consumer should contact his or her health benefit plan for accurate information regarding the plan structure, benefit coverage, deductibles, copayments, coinsurance and other plan

provisions that may impact the consumer's liability for payment for an inpatient admission, outpatient surgical procedure or health care service or supply; and

5. The consumer, if uninsured, may be eligible for a discount on health care facility charges based on a sliding fee scale or a written charity care policy established by the health care facility.

C. The Department shall include on the Consumer Guide to Health Care Facilities and Health Care website:

1. An Internet link for consumers to access quality of care data, including, but not limited to:

a. the Hospital Compare website within the United States Department of Health and Human Services website,

b. the Joint Commission on Accreditation of Healthcare Organizations website, and

c. information gathered by the State Department of Health pursuant to the Oklahoma Health Care Information System Act; and

2. A disclaimer noting the websites that are not provided by the state or an agency of the state.

D. The State Board of Health shall promulgate rules as necessary to implement the provisions of this section.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-151 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Each health care facility shall develop, implement and enforce written policies for the billing of health care facility health care services and supplies. The policies must address:

1. Any discounting of health care facility charges to an uninsured consumer;

2. Any discounting of health care facility charges provided to an uninsured consumer or a financially or medically indigent consumer who qualifies for indigent services based on a sliding fee scale or a written charity care policy established by the health care facility and the documented income and other resources of the consumer;

3. The providing of an itemized statement required by subsection E of this section;

4. Whether interest will be applied to any billed service not covered by a third-party payor and the rate of any interest charged;

5. The procedure for handling complaints; and

6. The providing of a conspicuous written disclosure to a consumer at the time the consumer is first admitted to the health care facility or first receives services at the health care facility that:

a. provides confirmation whether the health care facility is a participating provider under the consumer's third-party payor coverage on the date services are to

be rendered based on the information received from the consumer at the time the confirmation is provided, and

b. informs the consumer that a physician or other health care provider who may provide services to the consumer while in the health care facility may not be a participating provider with the same third-party payors as the health care facility.

B. For services provided in an emergency department of a hospital or as a result of an emergent direct admission, the hospital shall provide the written disclosure required by paragraph 6 of subsection A of this section before discharging the patient from the emergency department or hospital, as appropriate.

C. Each health care facility shall post in the general waiting area and in the waiting areas of any off-site or on-site registration, admission or business office a clear and conspicuous notice of the availability of the policies required by subsection A of this section.

D. The health care facility shall provide an estimate of the health care facility's charges for any elective inpatient admission or nonemergency outpatient surgical procedure or other service on request and before the scheduling of the admission or procedure or service. The estimate shall be provided not later than ten (10) business days after the date on which the estimate is requested. The health care facility shall advise the consumer that:

1. The request for an estimate of charges may result in a delay in the scheduling and provision of the inpatient admission, outpatient surgical procedure or other service;

2. The actual charges for an inpatient admission, outpatient surgical procedure or other service will vary based on the person's medical condition and other factors associated with performance of the procedure or service;

3. The actual charges for an inpatient admission, outpatient surgical procedure or other service may differ from the amount to be paid by the consumer or the consumer's third-party payor;

4. The consumer may be personally liable for payment for the inpatient admission, outpatient surgical procedure or other service depending on the consumer's health benefit plan coverage; and

5. The consumer should contact his or her health benefit plan for accurate information regarding the plan structure, benefit coverage, deductibles, copayments, coinsurance and other plan provisions that may impact the consumer's liability for payment for the inpatient admission, outpatient surgical procedure or other service.

E. A health care facility shall provide to the consumer at his or her request an itemized statement of the billed services if the consumer requests the statement not later than one year after the date the person is discharged from the health care facility. The health care facility shall provide the statement to the consumer not

later than ten (10) business days after the date on which the statement is requested.

F. A health care facility shall provide an itemized statement of billed services to a third-party payor who is actually or potentially responsible for paying all or part of the billed services provided to a patient and who has received a claim for payment of those services. To be entitled to receive a statement, the third-party payor must request the statement from the health care facility and must have received a claim for payment. The request must be made not later than one year after the date on which the payor received the claim for payment. The health care facility shall provide the statement to the payor not later than thirty (30) business days after the date on which the payor requests the statement. If a third-party payor receives a claim for payment of part but not all of the billed services, the third-party payor may request an itemized statement of only the billed services for which payment is claimed or to which any deduction or copayment applies.

G. A health care facility in violation of this section is subject to licensing sanctions, including denial, suspension, revocation or refusal to renew the license of the health care facility.

H. If a consumer or a third-party payor requests more than two (2) copies of the statement, the health care facility may charge a

reasonable fee for the third and subsequent copies provided. The fee shall not exceed the sum of:

1. A basic retrieval or processing fee, which shall include the fee for providing the first ten (10) pages of the copies and which shall not exceed Thirty Dollars ($30.00);

2. A charge for each page of:

a. One Dollar ($1.00) for the eleventh through the sixtieth page of the provided copies,

b. Fifty Cents ($0.50) for the sixty-first through the four hundredth page of the provided copies, and

c. Twenty-five Cents ($0.25) for any remaining pages of the provided copies; and

3. The actual cost of mailing, shipping or otherwise delivering the provided copies.

I. If a consumer overpays a health care facility, the health care facility must refund the amount of the overpayment not later than thirty (30) business days after the date the health care facility determines that an overpayment has been made.

J. The provisions of this section may not be waived, voided, or nullified by a contract or an agreement between a health care facility and a consumer.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-152 of Title 63, unless there is created a duplication in numbering, reads as follows:

Except as otherwise provided by law, a health care facility shall establish and implement a procedure for handling consumer complaints and shall make a good faith effort to resolve the complaint in an informal manner based on its complaint procedures. If the complaint cannot be resolved informally, the health care facility shall advise the consumer that a complaint may be filed with the State Department of Health and shall provide the consumer with the mailing address and telephone number of the Department.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-153 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The State Board of Medical Licensure and Supervision shall prepare and make available to the State Department of Health for publication on the Department's website a Consumer Guide to Physicians and Health Care. The Board shall include information in the guide concerning the billing and reimbursement of health care services provided by physicians, including information that advises consumers that:

1. The charge for a health care service or supply will vary based on:

a. the medical condition of the person,

b. any unknown medical conditions of the person,

c. the diagnosis of the person and recommended treatment protocols, and

d. other factors associated with performance of the health care service;

2. The charge for a health care service or supply may differ from the amount to be paid by the consumer or the third-party payor of the consumer;

3. The consumer may be personally liable for payment for the health care service or supply depending on the health benefit plan coverage of the consumer; and

4. The consumer should contact his or her health benefit plan for accurate information regarding the plan structure, benefit coverage, deductibles, copayments, coinsurance and other plan provisions that may impact the consumer's liability for payment for the health care services or supplies.

B. The State Board of Medical Licensure and Supervision shall promulgate rules as necessary to implement the provisions of this section.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-154 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. A physician licensed in this state shall develop, implement and enforce written policies for the billing of health care services and supplies. The policies must address:

1. Any discounting of charges for health care services or supplies provided to an uninsured patient that is not covered by a patient's third-party payor;

2. Any discounting of charges for health care services or supplies provided to an indigent patient who qualifies for services or supplies based on a sliding fee scale or a written charity care policy established by the physician;

3. Whether interest will be applied to any billed health care service or supply not covered by a third-party payor and the rate of any interest charged; and

4. The procedure for handling complaints relating to billed charges for health care services or supplies.

B. Each physician who maintains a waiting area shall post a clear and conspicuous notice of the availability of the policies required by subsection A of this section in the waiting area and in any registration, admission or business office in which patients are reasonably expected to seek service.

C. On the request of a patient who is seeking services that are to be provided on an out-of-network basis or who does not have coverage under a private health benefit plan or government program, a physician shall provide an estimate of the charges for any health care services or supplies. The estimate must be provided not later than ten (10) business days after the date of the request. A physician shall advise the consumer that:

1. The request for an estimate of charges may result in a delay in the scheduling and provision of the services;

2. The actual charges for the services or supplies will vary based on the patient's medical condition and other factors associated with performance of the services;

3. The actual charges for the services or supplies may differ from the amount to be paid by the patient or the patient's third-party payor; and

4. The patient may be personally liable for payment for the services or supplies depending on the patient's health benefit plan coverage.

D. For services provided in an emergency department of a hospital or as a result of an emergent direct admission, the physician shall provide the estimate of charges required by subsection C of this section not later than ten (10) business days after the request or before discharging the patient from the emergency department or hospital, whichever is later, as appropriate.

E. A physician shall provide a patient with an itemized statement of the charges for professional services or supplies not later than ten (10) business days after the date on which the statement is requested if the patient requests the statement not later than one year after the date on which the health care services or supplies were provided.

F. If a patient requests more than two (2) copies of the statement, a physician may charge a reasonable fee for the third and subsequent copies provided. The State Board of Medical Licensure and Supervision shall by rule set the permissible fee a physician may charge for copying, processing and delivering a copy of the statement.

G. On the request of a patient, a physician shall provide, in plain language, a written explanation of the charges for services or supplies previously made on a bill or statement for the patient.

H. If a patient overpays a physician, the physician must refund the amount of the overpayment not later than thirty (30) business days after the date the physician determines that an overpayment has been made.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-155 of Title 63, unless there is created a duplication in numbering, reads as follows:

For purposes of Sections 2 through 6 of this act:

1. "Average charge" means the mathematical average of health care facility charges for an inpatient admission or outpatient surgical procedure and does not include charges for a particular inpatient admission or outpatient surgical procedure that exceeds the average by more than two standard deviations;

2. "Health benefit plan" means a group hospital or medical insurance coverage plan, a not-for-profit hospital or medical

service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Insurance Plan, coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or any other analogous benefit arrangement. The term shall not include short-term, accident, fixed indemnity or specified disease policies, disability income contracts, limited benefit or credit disability insurance, workers' compensation insurance coverage, state Medicaid program coverage, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance;

3. “Health care facility” means:

a. a hospital, general medical surgical hospital, specialized hospital, critical access hospital, emergency hospital, birthing center or day treatment program, as defined by Section 1-701 of Title 63 of the Oklahoma Statutes, and

b. an ambulatory surgical center as defined by Section 2657 of Title 63 of the Oklahoma Statutes;

4. "Health care provider" means a person who is licensed, certified or otherwise authorized by the laws of this state to administer health care in the ordinary course of business or practice of a profession; and

5. "Third-party payor" means any entity, other than a purchaser, which is responsible for payment either to the purchaser or the health care provider for health care services rendered by the health care provider.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6851 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Each health benefit plan issuer shall submit to the Insurance Department, at the time and in the form and manner required by the Department, aggregate reimbursement rates by region paid by the health benefit plan issuer for health care services identified by the Department.

B. The Department shall require that data submitted under this section be submitted in a standardized format to permit comparison of health care reimbursement rates. To the extent feasible, the Department shall develop the data submission requirements as a dollar amount and not by comparison to other standard reimbursement rates, such as Medicare reimbursement rates.

C. The Department shall specify the period for which reimbursement rates must be filed under this section.

D. The Department may contract with a private third party to obtain the data required under this section. If the Department contracts with a third party, the Department may determine the aggregate data to be collected and published under subsection F of

this section. The Department shall prohibit the third-party contractor from selling, leasing or publishing the data obtained by the contractor under this subsection.

E. Except as provided by subsection F of this section, data collected under this section is confidential and not subject to disclosure.

F. The Insurance Department shall publish aggregate health care reimbursement rate information for identified regions of this state derived from the data collected under this section. The published information shall not reveal the name of any health care provider or health benefit plan issuer. The Department may make the aggregate health care reimbursement rate information available through the Department's website.

G. A health benefit plan issuer that fails to submit data as required in accordance with this section shall be subject to a fine to be determined by the Department for each day the health benefit plan issuer fails to submit the data.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6852 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Not later than March 1 of each year, a health benefit plan issuer shall file with the Insurance Department a report relating to the health benefit plan covering the preceding calendar year.

B. The report shall:

1. Be verified by at least two principal officers;

2. Be in a form prescribed by the Department; and

3. Include:

a. a financial statement of the health benefit plan issuer, including its balance sheet and receipts and disbursements for the preceding calendar year, certified by an independent public accountant,

b. the number of individuals enrolled during the preceding calendar year, the number of enrollees as of the end of that year and the number of enrollments terminated during that year, and

c. a statement of:

(1) an evaluation of enrollee satisfaction,

(2) an evaluation of quality of care,

(3) coverage areas,

(4) accreditation status,

(5) premium costs,

(6) plan costs,

(7) premium increases,

(8) the range of benefits provided,

(9) copayments and deductibles,

(10) the accuracy and speed of claims payment by the health benefit plan issuer for the plan,

(11) the credentials of physicians who are preferred providers, and

(12) the number of preferred providers.

C. The annual report filed by the health benefit plan issuer shall be published on the Department's website in a user-friendly format that allows consumers to make direct comparisons of the financial and other data reported by health benefit plan issuers under this section.

D. A health benefit plan issuer providing group coverage of Ten Million Dollars ($10,000,000.00) or less in premiums or individual coverage of Two Million Dollars ($2,000,000.00) or less in premiums is not required to report the data required under subparagraph c of paragraph 3 of subsection B of this section.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6853 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Each health benefit plan that provides health care through a provider network shall disclose to its enrollees that:

1. A health care provider may not be included in the health benefit plan's provider network; and

2. A health care provider described by paragraph 1 of this subsection may balance bill the enrollee for amounts not paid by the health benefit plan. For purposes of this paragraph, "balance bill" means the practice of charging an enrollee in a health benefit plan

that uses a provider network to recover from the enrollee the balance of a non-network health care provider's fee for service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee's health benefit plan.

B. The Insurance Department may prescribe specific requirements for the disclosure required under subsection A of this section. The form of the disclosure must be substantially as follows:

"NOTICE: ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PROVIDERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN."

C. The health benefit plan shall provide the disclosure in writing to each enrollee:

1. In any materials sent to the enrollee in conjunction with issuance or renewal of the plan's insurance policy or evidence of coverage;

2. In an explanation of payment summary provided to the enrollee or in any other analogous document that describes the enrollee's benefits under the plan; and

3. Conspicuously displayed, on any health benefit plan website that an enrollee is reasonably expected to access.

D. A health benefit plan shall clearly identify any health care facilities within the provider network in which health care providers do not participate in the health benefit plan's provider network. Health care facilities identified under this subsection shall be identified in a separate and conspicuous manner in any provider network directory or website directory.

E. Along with any explanation of benefits sent to an enrollee that contains a remark code indicating a payment made to a non-network physician has been paid at the health benefit plan's allowable or usual and customary amount, a health benefit plan must also include the number for the Insurance Department’s Consumer Assistance/Claims Division for complaints regarding payment.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6854 of Title 36, unless there is created a duplication in numbering, reads as follows:

A health benefit plan shall, on the request of an enrollee, provide an estimate of payments that will be made for any health care service or supply and shall also specify any deductibles, copayments, coinsurance or other amounts for which the enrollee is responsible. The estimate must be provided not later than ten (10) business days after the date on which the estimate was requested. A health benefit plan must advise the enrollee that:

1. The actual payment and charges for the services or supplies will vary based upon the enrollee's actual medical condition and other factors associated with performance of medical services; and

2. The enrollee may be personally liable for the payment of services or supplies based upon the enrollee's health benefit plan coverage.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6855 of Title 36, unless there is created a duplication in numbering, reads as follows:

A health benefit plan issuer shall provide to an insured on request information on:

1. Whether a physician or other health care provider is a participating provider in the health benefit plan issuer's preferred provider network;

2. Whether proposed health care services are covered by the health insurance policy;

3. What the insured's personal responsibility will be for payment of applicable copayment or deductible amounts; and

4. Coinsurance amounts owed based on the provider's contracted rate for in-network services or the health benefit plan issuer's usual and customary reimbursement rate for out-of-network services.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6856 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Insurance Commissioner shall promulgate rules as necessary to implement the provisions of Sections 8 through 13 of this act.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6857 of Title 36, unless there is created a duplication in numbering, reads as follows:

For the purposes of Sections 8 through 13 of this act:

1. "Enrollee" means an individual who is eligible to receive health care services through a health benefit plan;

2. “Health benefit plan” means a group hospital or medical insurance coverage plan, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Insurance Plan, coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or any other analogous benefit arrangement. The term shall not include short-term, accident, fixed indemnity or specified disease policies, disability income contracts, limited benefit or credit disability insurance, workers' compensation insurance coverage, state Medicaid program coverage, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance;

3. "Health care provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to

administer health care in the ordinary course of business or practice of a profession; and

4. "Provider network" means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires those enrollees to use health care providers participating in the plan and procedures covered by the plan.

SECTION 15. This act shall become effective November 1, 2017.

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