

1 **SENATE FLOOR VERSION**

2 February 24, 2020

3 **AS AMENDED**

4 SENATE BILL NO. 1868

5 By: David, Bullard, Pemberton
6 and Newhouse of the Senate

7 and

8 Sneed of the House

9 **[health insurance - Oklahoma Out-of-Network and
10 Surprise Billing Act - codification - effective date]**

11 BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

12 SECTION 1. NEW LAW A new section of law to be codified
13 in the Oklahoma Statutes as Section 8000 of Title 36, unless there
14 is created a duplication in numbering, reads as follows:

15 This act shall be known and may be cited as the "Oklahoma Out-
16 of-Network and Surprise Billing Act".

17 SECTION 2. NEW LAW A new section of law to be codified
18 in the Oklahoma Statutes as Section 8001 of Title 36, unless there
19 is created a duplication in numbering, reads as follows:

20 As used in this act,

21 1. "Arbitration" means a process in which an impartial
22 arbitrator issues a binding determination in a dispute between an
23 insurer or administrator and an out-of-network provider, facility,
24

1 or both, or the provider or facility representative to settle a
2 health benefit claim;

3 2. "Balance billing" means the practice by a healthcare
4 provider who does not, or is unable to, participate in the health
5 benefit plan network of an enrollee, and charges the enrollee the
6 difference between the provider fee and the sum of what the health
7 benefit plan of the enrollee pays and what the enrollee is required
8 to pay in applicable deductibles, co-payments, coinsurance or other
9 cost-sharing amounts required by the health benefit plan;

10 3. "Health benefit plan" shall be defined pursuant to
11 subsection C of Section 6060.4 of Title 36 of the Oklahoma Statutes;

12 4. "Insurer" means any entity or insurer authorized to provide
13 health insurance or health benefits pursuant to the laws of this
14 state and any entity or person engaged in the business of making
15 contracts for accident or health insurance;

16 5. "Usual, customary and reasonable rate" means the eightieth
17 percentile of all charges for the particular health care service
18 performed by a healthcare provider in the same or similar specialty
19 and provided in the same geographical area as reported in an
20 independent benchmarking database maintained by a nonprofit
21 organization to be specified by the Insurance Commissioner. The
22 nonprofit organization shall not be financially affiliated with an
23 insurance carrier or health care provider. All health insurance
24 benefit policies must reference the usual, customary and reasonable

1 rate for the purpose of providing an enrollee with reimbursement
2 transparency for out-of-network healthcare providers and facilities.
3 The charges for services reflected by Current Procedural Terminology
4 code, as reflected in the eightieth percentile of charge data
5 supplied by an independent benchmarking database on the effective
6 date of this act, shall constitute the baseline for provider
7 charges. After the effective date of this act, provider charges may
8 change anytime the charge data supplied by an independent
9 benchmarking database changes but may not increase at a rate greater
10 than that of the Consumer Price Index.

11 SECTION 3. NEW LAW A new section of law to be codified
12 in the Oklahoma Statutes as Section 8002 of Title 36, unless there
13 is created a duplication in numbering, reads as follows:

14 A. If a healthcare provider, as defined in paragraph 22 of
15 Section 6902 of Title 36 of the Oklahoma Statutes, healthcare
16 facility or administrator has billed an enrollee an amount greater
17 than the applicable copayment, coinsurance and deductible amount
18 required under this act, the Attorney General may bring a civil
19 action in the name of the state to ensure the enrollee is not
20 responsible for an amount greater than the applicable copayment,
21 coinsurance and deductible amount. If the Attorney General prevails
22 in an action brought against an insurer or administrator, the
23 Attorney General may recover reasonable attorney's fees, costs and
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1 expenses, including court costs, and witness fees incurred in
2 bringing the action.

3 B. If an insurer or administrator has restricted or prohibited
4 a healthcare provider, healthcare facility or both from billing an
5 insured, participant or enrollee the applicable copayment,
6 coinsurance, and deductible amounts required under this act, the
7 Attorney General may bring a civil action in the name of the state
8 to ensure the healthcare provider, healthcare facility, or
9 administrator may bill an enrollee the applicable copayment,
10 coinsurance, and deductible amounts. If the Attorney General
11 prevails in an action brought against an insurer or administrator,
12 the Attorney General may recover reasonable attorney's fees, costs
13 and expenses, including court costs and witness fees incurred in
14 bringing the action.

15 SECTION 4. NEW LAW A new section of law to be codified
16 in the Oklahoma Statutes as Section 8003 of Title 36, unless there
17 is created a duplication in numbering, reads as follows:

18 A. When an enrollee in a health benefit plan that covers
19 emergency services receives the services from an out-of-network
20 provider or facility, the health benefit plan shall ensure that the
21 enrollee is not charged greater out-of-pocket costs for the
22 emergency services than the enrollee would have incurred with an in-
23 network provider or facility.

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1 B. If an enrollee receives covered emergency services by an
2 out-of-network provider, the health benefit plan shall pay the out-
3 of-network provider directly and the initial payment shall be the
4 greater of:

- 5 1. The Medicare rate;
- 6 2. The in-network rate; or
- 7 3. The usual, customary, and reasonable rate.

8 The insurer shall make any payment required by this section
9 directly to the provider not later than:

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

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

16 SECTION 5. NEW LAW A new section of law to be codified
17 in the Oklahoma Statutes as Section 8004 of Title 36, unless there
18 is created a duplication in numbering, reads as follows:

19 A. If an enrollee receives covered non-emergency services at an
20 in-network facility from an out-of-network provider, the carrier
21 shall pay the out-of-network provider directly and initial payment
22 shall be at the usual, customary and reasonable rate or an agreed
23 upon rate, if applicable. The enrollee who receives care shall not
24

1 be responsible for any amount greater than their applicable in-
2 network copay, coinsurance and deductible amount

3 B. The insurer shall make payment required by this section
4 directly to the provider not later than, as applicable:

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

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

11 C. If an enrollee with out-of-network health benefits elects to
12 receive covered non-emergency services at an out-of-network facility
13 from an out-of-network provider, the carrier shall pay the out-of-
14 network provider and facility directly and the initial payment shall
15 be paid at the usual, customary, and reasonable rate or an agreed
16 upon rate. The enrollee who receives care shall not be responsible
17 for any amount greater than their applicable out-of-network copay,
18 coinsurance and deductible amount.

19 D. The insurer shall make payment required by this section
20 directly to the provider and facility not later than, as applicable:

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

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

4 E. Nothing in this section shall be construed to prohibit an
5 out-of-network provider, out-of-network facility or both from
6 accepting less than the usual, customary, and reasonable rate so
7 long as an agreement has been made between the enrollee and out-of-
8 network healthcare provider, out-of-network facility or both.

9 SECTION 6. NEW LAW A new section of law to be codified
10 in the Oklahoma Statutes as Section 8005 of Title 36, unless there
11 is created a duplication in numbering, reads as follows:

12 A. In the case of a healthcare service provided by an out-of-
13 network provider, facility or both, an insurer shall provide written
14 notice in any explanation of benefits provided to the enrollee,
15 healthcare provider or facility. The notice shall include:

16 1. The total amount the healthcare provider and facility may
17 bill the insured under the health benefit plan of the enrollee and
18 an itemization of copayments, coinsurance, deductibles and other
19 amounts included in the total; and

20 2. An explanation of benefits provided to the healthcare
21 provider and facility advising the healthcare provider and facility
22 of the availability of arbitration, pursuant to the provisions of
23 this act.

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1 B. For elective services that are covered by the health benefit
2 plan of an enrollee, an explanation of benefits providing average
3 amounts paid to comparable in-network healthcare providers and
4 facilities for covered services shall be provided to an enrollee if
5 requested.

6 SECTION 7. NEW LAW A new section of law to be codified
7 in the Oklahoma Statutes as Section 8006 of Title 36, unless there
8 is created a duplication in numbering, reads as follows:

9 A. For the purposes of this section, "geozip area" means an
10 area including all zip codes with identical first three digits. For
11 purposes of this section, a healthcare or medical service or supply
12 provided at a location that does not have a zip code shall be
13 considered as provided in the geozip area closest to the location at
14 which the service or supply is provided.

15 B. The Insurance Commissioner shall select an organization to
16 maintain a benchmarking database in accordance with the provisions
17 of this section. The organization shall not:

18 1. Be affiliated with an insurer or administrator or a
19 healthcare practitioner or other healthcare provider; or

20 2. Have any other conflict of interest.

21 C. The benchmarking database shall contain information
22 necessary to calculate, with respect to a healthcare or medical
23 service or supply, for each geozip area in this state:

24

1 1. Percentiles of billed charges for all out-of-network
2 providers and facilities; and

3 2. Percentiles of rates paid to participating providers and
4 facilities.

5 D. The Commissioner may promulgate rules governing the
6 submission of information for the benchmarking database

7 SECTION 8. NEW LAW A new section of law to be codified
8 in the Oklahoma Statutes as Section 8007 of Title 36, unless there
9 is created a duplication in numbering, reads as follows:

10 A. An out-of-network provider, out-of-network facility and
11 insurer or administrator may request arbitration of a settlement of
12 an out-of-network health benefit claim through a portal to be
13 located on the internet website of the Insurance Department if:

14 1. There is an amount billed by the out-of-network provider or
15 out-of-network facility and unpaid by the issuer or administrator of
16 the plan after copayments, coinsurance and deductibles for which an
17 enrollee may not be billed; or

18 2. The required usual, customary and reasonable rate paid by an
19 insurer is deemed unreasonable by the provider or facility; and

20 3. The health benefit claim is for:

21 a. non-Emergency care provided at an out-of-network
22 facility or by an out-of-network provider, or

23 b. emergency care provided at an out-of-network facility
24 or by an out-of-network provider.

1 Nothing in this subsection shall be construed prohibit a
2 healthcare provider, facility or both from utilizing arbitration in
3 cases where medical necessity is disputed.

4 B. If a person or entity requests arbitration under this
5 section, the out-of-network provider, out-of-network facility, or a
6 representative of the provider or facility and the insurer or the
7 administrator, as applicable, shall participate in the arbitration.

8 C. Not later than ninety (90) days after the date an out-of-
9 network provider, out-of-network facility or both receives the
10 initial payment for a health care or medical service or supply, the
11 out-of-network provider, healthcare facility or representative of
12 the out-of-network healthcare provider or out-of-network facility
13 and the insurer or administrator may request arbitration for a
14 settlement of an out-of-network health benefit claim through a form
15 to be located on the internet website of the Insurance Department
16 if:

17 1. There is an amount billed by the out-of-network provider,
18 out-of-network facility or both and unpaid by the issuer or
19 administrator after copayments, coinsurance and deductibles for
20 which an enrollee may not be billed; or

21 2. The required usual, customary and reasonable rate paid by an
22 insurer is deemed unreasonable by the provider or facility; and

23 3. The health benefit claim is for:
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- 1 a. non-emergency care provided at an out-of-network
2 facility or by an out-of-network provider, or
3 b. emergency care provided at an out-of-network facility
4 or by an out-of-network provider.

5 Nothing in this section shall be construed prohibit a healthcare
6 provider, facility or both from utilizing arbitration in cases where
7 medical necessity is disputed.

8 D. 1. If a person or entity requests arbitration, the out-of-
9 network provider, out-of-network facility or an appropriate
10 representative and the insurer or administrator, as appropriate,
11 shall participate in the arbitration.

12 2. The party requesting arbitration shall provide written
13 notice on the date the arbitration is requested in the form and
14 manner prescribed by the Insurance Commissioner to the Insurance
15 Department and each party to be involved in arbitration.

16 3. In an effort to settle the claim before arbitration, all
17 parties shall participate in an informal settlement teleconference
18 not later than thirty (30) days after the date on which the
19 arbitration is requested. An insurer or administrator, as
20 applicable, shall make a reasonable effort to arrange the
21 teleconference.

22 4. The Commissioner shall promulgate rules for submitting
23 multiple claims to arbitration in one proceeding. The rules shall
24 provide that:

- 1 a. the total amount in controversy for multiple claims in
2 one proceeding may not exceed Five Thousand Dollars
3 (\$5,000.00), and
4 b. the multiple claims in one proceeding must be limited
5 to the same out-of-network provider, facility or both
6 and the insurer.

7 SECTION 9. NEW LAW A new section of law to be codified
8 in the Oklahoma Statutes as Section 8008 of Title 36, unless there
9 is created a duplication in numbering, reads as follows:

10 A. If parties do not mutually agree on an arbitrator on or
11 before thirty (30) days after the date the arbitration is requested,
12 the party requesting arbitration shall notify the Insurance
13 Commissioner, and the commissioner shall select an arbitrator from a
14 list of approved arbitrators to be developed by the Commissioner.

15 1. In selecting an arbitrator, the Commissioner shall give
16 preference to an arbitrator who is knowledgeable and experienced in
17 applicable principles of contract and insurance law as well as the
18 healthcare industry.

19 2. In approving an individual as an arbitrator, the
20 Commissioner shall ensure that the individual does not have a
21 conflict of interest that would adversely impact his or her
22 independence and impartiality in rendering a decision in an
23 arbitration. A conflict of interest shall include, but is not
24 limited to, current or recent ownership of or employment of the

1 individual or a close family member in any health benefit plan
2 issuer or administrator or employment as a physician, healthcare
3 practitioner or other healthcare provider. For purposes of this
4 section, "close family member" means a parent, spouse, child or
5 sibling of an individual.

6 B. The Commissioner shall immediately terminate the approval of
7 an arbitrator who no longer meets the requirements adopted by the
8 Commissioner.

9 C. The only issue the arbitrator may determine is the
10 reasonable amount for the healthcare or medical services or supplies
11 provided to the enrollee by an out-of-network provider, out-of-
12 network facility or both.

13 1. The determination must consider:

14 a. whether there is a disparity between the fee billed by
15 the out-of-network provider, out-of-network facility
16 or both,

17 b. fees paid to the out-of-network provider, out-of-
18 network facility or both,

19 c. fees paid by the insurer to reimburse similarly
20 qualified out-of-network providers, facilities or both
21 for the same services or supplies in the same region,

22 d. level of training, education and experience of the
23 out-of-network provider,
24

- 1 e. the usual billed charge of the out-of-network
2 provider, facilities or both for comparable services
3 or supplies with regard to other enrollees for which
4 the provider, facility or both is out-of-network,
5 f. the circumstances and complexity of the particular
6 case of the enrollee, including the time and place of
7 the provision of service or supply,
8 g. individual enrollee characteristics,
9 h. medical journals and peer reviewed articles pertaining
10 to medical necessity,
11 i. percentiles of out-of-network billed charges for the
12 same service or supply performed by a healthcare
13 provider, facility or both in the same or similar
14 specialty and provided in the same geozip as reported
15 in a benchmarking database,
16 j. percentiles of rates for the service or supply paid to
17 participating providers, facilities or both in the
18 same or similar specialty and provided in the same
19 geozip area as reported in a benchmarking database
20 determined by the Commissioner,
21 k. the history of networking contracting between the
22 parties,
23 l. historical data for percentiles, and
24

1 m. any offer made during the informal settlement
2 teleconference

3 D. An out-of-network provider, facility or insurer or
4 administrator shall not file suit for an out-of-network claim until
5 the conclusion of the arbitration on the issue of the amount to be
6 paid for the out-of-network claim.

7 E. The arbitration conducted under this law is not subject to
8 the provisions of Title 12 of the Oklahoma Statutes.

9 SECTION 10. NEW LAW A new section of law to be codified
10 in the Oklahoma Statutes as Section 8009 of Title 36, unless there
11 is created a duplication in numbering, reads as follows:

12 A. The arbitrator shall set a date for submission of all
13 information to be considered by the arbitrator. A party shall not
14 engage in discovery in connection with the arbitration. On
15 agreement of all parties, any deadline may be extended.

16 1. Not later than fifty-one (51) days after the date the
17 arbitration is requested, an arbitrator shall provide the parties
18 with a written decision in which the arbitrator:

- 19 a. determines whether charge of the healthcare provider,
20 facility or both is reasonable, or
21 b. the usual, customary and reasonable rate paid by an
22 insurer is unreasonable, and
23 c. selects the amount determined to be the closest as the
24 binding award; and

1 2. An arbitrator may not modify the binding award amount.

2 B. An arbitrator shall provide written notice, in the form and
3 manner prescribed by the Insurance Commissioner, of the reasonable
4 amount for the services or supplies and the binding award amount.

5 If the parties settle before a decision, the parties shall provide
6 written notice, in the form and manner prescribed by the
7 Commissioner, of the amount of settlement. The Insurance Department
8 shall maintain a record of the notices.

9 C. The decision of the arbitrator is binding.

10 D. Payment shall be made pursuant to the decision of the
11 arbitrator not later than thirty (30) days after the date of the
12 decision. The party not awarded the amount submitted to arbitration
13 shall pay all expenses and fees of the arbitrator.

14 Any party not satisfied with the decision of the arbitrator may
15 file a civil action in the district court where services were
16 conducted or supplies were provided.

17 E. Information submitted to the arbitrator is confidential and
18 not public record.

19 SECTION 11. NEW LAW A new section of law to be codified
20 in the Oklahoma Statutes as Section 8010 of Title 36, unless there
21 is created a duplication in numbering, reads as follows:

22 A. The following constitutes bad faith participation in
23 arbitration:
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1 1. Failing to participate in the informal settlement
2 teleconference;

3 2. Failing to provide information the arbitrator believes
4 necessary to facilitate a decision or agreement; or

5 3. Failing to designate a representative participating in the
6 arbitration with full authority to enter into any agreement.

7 Failure to reach an agreement is not conclusive proof of bad
8 faith participation

9 B. Bad faith participation or otherwise failing to comply with
10 arbitration requirements is grounds for imposition of an
11 administrative penalty by the regulatory agency that issued a
12 license or certificate of authority to the party who committed the
13 violation.

14 C. Except for good cause shown, on a report of an arbitrator
15 and appropriate proof of bad faith participation, the regulatory
16 agency shall impose an administrative penalty.

17 D. The Insurance Commissioner shall promulgate rules regulating
18 the investigation and review of a complaint filed that relates to
19 the settlement of an out-of-network health benefit claim. The rules
20 shall:

21 1. Distinguish between complaints for out-of-network coverage
22 or payment and give priority to investigating allegations of delayed
23 healthcare or medical care;

24 2. Develop a form for filing a complaint; and

1 3. Ensure that a complaint is not dismissed without appropriate
2 consideration.

3 E. The Department and the Oklahoma Medical Board shall both
4 collect and maintain information. Each complaint filed that
5 concerns a claim and arbitration shall include:

6 1. The type of services or supplies that gave rise to the
7 dispute;

8 2. The type of specialty, if any, of the out-of-network
9 provider and/or facility who provided the out-of-network service or
10 supply;

11 3. The county and metropolitan area in which healthcare or
12 medical services were conducted or supplies were provided;

13 4. Whether the healthcare or medical service conducted was or
14 supplies provided were for emergency care; and

15 5. The out-of-network provider, facility or both that the
16 Oklahoma Medical Board requires; or

17 6. Any other information about the insurer or administrator
18 that the commissioner by rule requires;

19 F. All information collected is public information and shall
20 not include personally identifiable information.

21 SECTION 12. NEW LAW A new section of law to be codified
22 in the Oklahoma Statutes as Section 8011 of Title 36, unless there
23 is created a duplication in numbering, reads as follows:

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1 A. Beginning January 1, 2021, the Insurance Department shall
2 conduct a biennial study on the impact of balanced billing. The
3 study shall include:

4 1. Trends and changes in billed amounts;

5 2. Trends and changes in paid amounts;

6 3. Trends and changes in-network participation;

7 4. Trends and changes in paid amounts to network providers and
8 facilities;

9 5. Trends and changes in paid amounts to out-of-network
10 providers and facilities; and

11 6. Number of complaints and the results of claims entering
12 arbitration.

13 B. The Department shall prepare and submit a written report of
14 the results of the study to the Governor, the President Pro Tempore
15 of the Senate, and the Speaker of the House of Representatives no
16 later than December 1 of a year in which a study is conducted.

17 SECTION 13. This act shall become effective November 1, 2020.

18 COMMITTEE REPORT BY: COMMITTEE ON RETIREMENT AND INSURANCE
19 February 24, 2020 - DO PASS AS AMENDED
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