STATE OF OKLAHOMA

2nd Session of the 57th Legislature (2020)

SENATE BILL 1868 By: David

AS INTRODUCED

An Act relating to health insurance; creating the Oklahoma Out-of-Network and Surprise Billing Act; defining terms; authorizing the Attorney General to bring a civil action against certain entities' for certain billing practices; requiring health benefit plan to ensure certain rates for emergency service from out-of-network provider and provide payment directly and in certain timeframe; requiring health benefit plan to ensure certain rates for emergency service at out-of-network facility and provide payment directly and in certain timeframe; requiring health benefit plan to ensure certain rates for non-emergency service by out-of-network provider at in-network facility and provide payment directly and in certain timeframe; requiring health benefit plan to ensure certain rates for non-emergency service by out-of-network provider at out-of-network facility and provide payment directly and in certain timeframe; construing provision; requiring insurer to provide written notice of explanation of benefits for an out-of-network provider or facility; requiring insurer to provide explanation of benefits on average amount paid for certain elective service upon request; providing definition for geozip; establishing terms for utilizing geozip in certain billing practices; authorizing out-of-network provider or facility to request arbitration with insurer or administrator for certain claims in certain circumstances; construing provision; requiring participation in arbitration; establishing timeline for arbitration on Insurance Department website in certain circumstances; requiring party requesting arbitration to provide certain notice; requiring parties in arbitration to participate in teleconference; requiring certain entity to arrange

teleconference; requiring Insurance Commissioner to promulgate certain rules; establishing issues arbitrator may address; prohibiting lawsuit until conclusion of arbitration; establishing that arbitration is not subject to Civil Procedure Code; establishing timeline and terms of selecting and terminating an arbitrator; establishing procedures for arbitration; requiring timeframe and establishing terms of arbitration decision; providing that the decision of the arbitrator is final; establishing terms for appeal of decision; requiring party losing appeal to pay certain fees; providing for confidentiality of certain information; establishing acts of bad faith participation in arbitration; authorizing certain penalty for bad faith act in arbitration; requiring Insurance Commissioner and Oklahoma Medical Board to establish rules related to investigation certain complaints; requiring Commissioner to maintain certain information in records; prohibiting use of personally identifiable information; requiring Department to conduct study on certain healthcare billing practices and arbitration; requiring Department to submit report to certain persons; 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 8000 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 Out-of-Network and Surprise Billing Act".

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

As used in this act,

1. "Arbitration" means a process in which an impartial arbitrator issues a binding determination in a dispute between an insurer or administrator and an out-of-network provider, facility, or both, or the provider or facility representative to settle a health benefit claim;

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

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

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

5. "Usual, customary and reasonable rate" means the eightieth percentile of all charges for the particular health care service performed by a healthcare provider in the same or similar specialty and provided in the same geographical area as reported in an independent benchmarking database maintained by a nonprofit

organization to be specified by the Insurance Commissioner. The nonprofit organization shall not be financially affiliated with an insurance carrier or health care provider. All health insurance benefit policies must reference the usual, customary and reasonable rate for the purpose of providing an enrollee with reimbursement transparency for out-of-network healthcare providers and facilities. The charges for services reflected by Current Procedural Terminology code, as reflected in the eightieth percentile of charge data supplied by an independent benchmarking database on the effective date of this act, shall constitute the baseline for provider charges. After the effective date of this act, provider charges may change anytime the charge data supplied by an independent benchmarking database changes but may not increase at a rate greater than that of the Consumer Price Index.

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

A. If a healthcare provider, as defined in paragraph 22 of Section 6902 of Title 36 of the Oklahoma Statutes, healthcare facility or administrator has billed an enrollee an amount greater than the applicable copayment, coinsurance and deductible amount required under this 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 amount. If the Attorney General prevails in an action brought against an insurer or administrator, the Attorney General may recover reasonable attorney's fees, costs and expenses, including court costs, and witness fees incurred in bringing the action.

B. If an insurer or administrator has restricted or prohibited a healthcare provider, healthcare facility or both from billing an insured, participant or enrollee the applicable copayment, coinsurance, and deductible amounts required under this act, the Attorney General may bring a civil action in the name of the state to ensure the healthcare provider, healthcare facility, or administrator may bill an enrollee the applicable copayment, coinsurance, and deductible amounts. If the Attorney General prevails in an action brought against an insurer or administrator, the Attorney General may recover reasonable attorney's 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 8003 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. When an enrollee in a health benefit plan that covers emergency services receives the services from an out-of-network provider or facility, the health benefit plan shall ensure that the enrollee is not charged greater out-of-pocket costs for the

emergency services than the enrollee would have incurred with an in-network provider or facility.

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

1. The Medicare rate;

2. The in-network rate; or

3. The usual, customary, and reasonable rate.

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

1. Thirty (30) days after the date the insurer receives an electronic clean claim for the covered 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 the covered 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 8004 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If an enrollee receives covered non-emergency services at an in-network facility from an out-of-network provider, the carrier shall pay the out-of-network provider directly and initial payment shall be at the usual, customary and reasonable rate or an agreed

upon rate, if applicable. The enrollee who receives care shall not be responsible for any amount greater than their applicable in-network copay, coinsurance and deductible amount

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

1. Thirty (30) days after the date the insurer receives and 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 insurers receives a nonelectronic clean claim for those services that includes all information necessary for the insurer to pay the claim.

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

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

1. Thirty (30) days after the date the insurer receives and 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 insurers receives a nonelectronic clean claim for those services that includes all information necessary for the insurer to pay the claim.

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

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

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

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

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

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

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

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

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

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

2. Have any other conflict of interest.

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

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

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

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

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8007 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 insurer or administrator may request arbitration of a settlement of an out-of-network health benefit claim through a portal to be located on the internet website of the Insurance Department if:

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

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

3. The health benefit claim is for:

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

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

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

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

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

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

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

3. The health benefit claim is for:

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

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

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

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

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

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

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

a. the total amount in controversy for multiple claims in one proceeding may not exceed Five Thousand Dollars ($5,000.00), and

b. the multiple claims in one proceeding must be limited to the same out-of-network provider, facility or both and the insurer.

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

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

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

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

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

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

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

1. The determination must consider:

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

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

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

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

e. the usual billed charge of the out-of-network provider, facilities or both for comparable services or supplies with regard to other enrollees for which the provider, facility or both is out-of-network,

f. the circumstances and complexity of the particular case of the enrollee, including the time and place of the provision of service or supply,

g. individual enrollee characteristics,

h. medical journals and peer reviewed articles pertaining to medical necessity,

i. percentiles of out-of-network billed charges for the same service or supply performed by a healthcare provider, facility or both in the same or similar specialty and provided in the same geozip as reported in a benchmarking database,

j. percentiles of rates for the service or supply paid to participating providers, facilities or both in the same or similar specialty and provided in the same geozip area as reported in a benchmarking database determined by the Commissioner,

k. the history of networking contracting between the parties,

l. historical data for percentiles, and

m. any offer made during the informal settlement teleconference

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

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

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

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

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

a. determines whether charge of the healthcare provider, facility or both is reasonable, or

b. the usual, customary and reasonable rate paid by an insurer is unreasonable, and

c. selects the amount determined to be the closest as the binding award; and

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

B. An arbitrator shall provide written notice, in the form and manner prescribed by the Insurance Commissioner, of the reasonable amount for the services or supplies and the binding award amount. If the parties settle before a decision, the parties shall provide written notice, in the form and manner prescribed by the Commissioner, of the amount of settlement. The Insurance Department shall maintain a record of the notices.

C. The decision of the arbitrator is binding.

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

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

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

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

A. The following constitutes bad faith participation in arbitration:

1. Failing to participate in the informal settlement teleconference;

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

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

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

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

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

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

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

2. Develop a form for filing a complaint; and

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

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

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

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

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

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

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

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

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

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

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

1. Trends and changes in billed amounts;

2. Trends and changes in paid amounts;

3. Trends and changes in-network participation;

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

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

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

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

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

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