HOUSE OF REPRESENTATIVES - FLOOR VERSION

STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 2872

By: Wallace and **Moore** of the House

and

Rosino of the Senate

COMMITTEE SUBSTITUTE

An Act relating to ambulances; creating the Out-of-Network Ambulance Provider Act; defining terms; setting minimum allowable rates; requiring certain payment to be payments in full; restricting billing to certain persons; setting certain limits on certain payments; requiring certain payments to certain entities; requiring certain timelines for certain payments; providing for certain processes for specific purposes; 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 6050.1 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 "Out-of-Network Ambulance Provider Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6050.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Out-of-Network Ambulance Provider Act:

1. "Ambulance service provider" means any ground ambulance service provider as defined by this act as any ground vehicle which is or should be approved by the Commissioner of Health, designed and equipped to transport a patient or patients on-scene and en route patient stabilization and care as required. Ground vehicles used as ambulances shall meet such standards as may be required by the Oklahoma State Board of Health for approval, and shall display evidence of such approval at all times;

2. "Covered services" means those ground ambulance services which an enrollee is entitled to receive under the terms of a health care benefit plan;

3. "Enrollee" means a person who is entitled to receive covered health care services under the terms of a health care benefit plan;

4. "Health care benefit plan" means a plan, policy, contract, certificate, agreement, or other evidence of coverage for health care services offered, issued, renewed, or extended in this state by a health care insurer;

5. "Health care insurer" means an entity that is subject to state insurance regulation and provides coverage for health benefits in this state and includes the following:

a. an insurance company,

b. health maintenance organization,

c. hospital and medical service corporation,

d. risk-based provider organization, or

e. sponsor or self-funded plan;

6. "Out-of-network" means a provider that does not contract with the health care insurer of the enrollee receiving the covered benefits; and

7. "Clean claim" means a claim that has no defect of impropriety, including any lack of required substantiating documentation or particular circumstances requiring special treatment that prevents timely payment from being made on the claim.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6050.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The minimum allowable reimbursement rate under any health care benefit plan issued by a health care insurer to an out-of-network ambulance service provider for providing ground services shall be at the rates set or approved, whether in contract or ordinance, by a local governmental entity in the jurisdiction in which the covered health care services originates.

B. In the absence of the rates as provided in subsection A of this section, the rate shall be the lesser of:

1. Three hundred twenty-five percent (325%) of the current published rate for ambulance services as established by the Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act for the same services provided in the same geographic area; or

2. The ambulance service provider's billed charges.

C. Payment made in compliance with this section shall be considered payment in full for the covered services provided, except for any copayment, coinsurance, deductible, and other cost-sharing feature amounts required to be paid by the enrollee. An ambulance service provider is prohibited from billing the enrollee for any additional amounts for the paid covered services in excess of what the health care insurer pays.

D. All copayments, coinsurance, deductible, and other cost-sharing feature amounts provided by subsection A of this section shall not exceed the in-network copayment, coinsurance, deductible, and other cost-sharing features for the covered health care services received by the enrollee.

E. A health care insurer shall, within thirty (30) days after of a clean claim for covered services, promptly remit payment for ambulance services directly to the ambulance service provider and shall not send payment to an enrollee.

F. If the claim is not a clean claim, the health care insurer shall, within thirty (30) days after receipt of the claim, send a

written notice acknowledging the date of the receipt of the claim and shall provide one of the following items:

1. That the insurer is declining to pay all or part of the claim and the specific reason or reasons for the denial; or

2. That additional information is necessary to determine if all or part of the claim is payable as well as the specific additional information that is required.

SECTION 4. This act shall become effective November 1, 2024.

COMMITTEE REPORT BY: COMMITTEE ON APPROPRIATIONS AND BUDGET, dated 02/26/2024 - DO PASS, As Amended and Coauthored.