STATE OF OKLAHOMA

2nd Session of the 56th Legislature (2018)

SENATE BILL 1478 By: Yen

AS INTRODUCED

An Act relating to health insurance; creating the Clinician Out-of-Network Act; defining terms; providing procedures for billing and reimbursement for certain services; prohibiting certain claims; requiring certain notice and consent for specified purposes; requiring notice and consent be obtained within specific time period; requiring notice to contain certain information; prohibiting reimbursement of certain amount; stating exception; authorizing mediation under certain circumstances; stating consequences when certain notice and contain is not obtained; providing procedures, permitted and prohibited acts for mediation; construing provisions; requiring Department of Insurance to promulgate certain rules; prohibiting certain statements and acts by specific entities; prohibiting entities from mediation under certain circumstances; providing for corrective action for certain prohibited acts; 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 6060.30 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 "Clinician Out-of-Network Act".

1 SECTION 2. NEW LAW A new section of law to be codified
2 in the Oklahoma Statutes as Section 6060.31 of Title 36 unless there
3 is created a duplication in numbering, reads as follows:
4 As used in the Clinician Out-of-Network Act:
5 1. "Clinician" means a physician or advance practice provider,
6 including but not limited to a physician assistant, nurse
7 practitioner, certified registered nurse anesthetist and certified
8 nurse midwife;
9 2. "Clinician's allowed charge" means the usual and customary
10 charge of a clinician after the discount applied under a contractual
11 arrangement, if entered into between a clinician and an insurance
12 carrier, or the amount of the allowed benefit if the clinician is out
13 of network. Where a contract has been entered into, the clinician's
14 allowed charge shall constitute the clinician's contractually adjusted
15 total expected payment for services;
16 3. "Clinicians' usual and customary charge" means the charges
17 routinely billed by clinicians for their professional services
18 notwithstanding the payer involved and before any discounts that are
19 applied pursuant to charity or indigent patient charge policies or
20 insurance carrier contracting discounts. The usual and customary
21 charge constitutes the clinician's total expected reimbursement for a
22 service;
23 4. "Guarantor" means the person who is financially responsible
24 for the professional services rendered to the patient by the

clinician. The guarantor may also be the patient. Provided, when the patient is a minor and the guarantor is the parent or guardian of the minor, for purposes of this act "patient" and "guarantor" shall be synonymous;

5. "Guarantor co-insurance" means the percentage of the charge by the clinician for professional services that the guarantor is financially responsible for reimbursing directly to the clinician who rendered the professional services pursuant to the terms of the contractual arrangement between the guarantor and the insurance carrier;

6. "Guarantor co-payments" means the amounts that are the guarantor's responsibility for professional services received from the clinicians, as required by the terms of the contractual arrangement between the guarantor and the insurance Carrier. Co-pay amounts may be stated as a percentage, as in the case of co-insurance, or may be stated as a flat rate for services on the patient's insurance card;

7. "Guarantor cost sharing" means the combination of the guarantor deductible amount, co-insurance percentage, and co-payment amount as used and described in the Affordable Care Act that are the responsibility of the guarantor for a clinician's professional services. Guarantor cost sharing for out-of-network services shall be limited to the amount and/or the percentage that the patient would have reimbursed the clinician for in-network services;

8. "Guarantor deductible" means the financial responsibility of the guarantor for the charges of the clinician that are applied to the clinician's usual and customary charges before applying either co-insurance or co-payments;

9. "Insurance carrier" means an insurance company, health care center, health services corporation, medical services corporation, fraternal benefit society or other entity that issues for delivery, renews and/or amends a health care plan in this state, including but not limited to preferred provider organization and/or third party administrators who provide administrative services to any of these entities;

10. "Insurance carrier out-of-network allowable" means the benefit amount that the insurance carrier assigns for the service rendered by a clinician that has not entered into a contractual arrangement with the insurance carrier that insures the patient.

11. "In-network services" means professional services provided to patients by clinicians who have contracted with the insurance carrier that insures the patient;

12. "Mediation" means the process to mediate claims disputes between insurance carriers and clinicians that are conducted outside of a formal court process. Mediation shall not be legally binding unless the parties have mutually agreed in writing to resolve their dispute per a settlement agreement. Nothing in this act shall be construed to bar any parties' right to pursue any legal remedy

otherwise authorized by law, except where parties have agreed not to proceed with legal action pursuant to a settlement agreement;

13. "Medicare physician fee schedule" means the fee schedule modified and published annually by the Centers for Medicare and Medicaid for professional services rendered by clinicians that are subject to federal statutes and regulations and budgetary constraints that have an impact on the changes in the fee schedule year to year;

14. "Minimum benefit standard" means an amount equal to the eightieth (80th) percentile of a geographically comparable database of clinician usual and customary charges maintained by an independent non-profit organization that is not affiliated, financially supported and/or otherwise supported by an insurance carrier. The minimum benefit standard shall not be linked to, defined in whole or in part as or otherwise referenced to the Medicare physician fee schedule;

15. "Opt-out-services" mean out-of-network clinician services in an inpatient hospital or outpatient hospital where the patient is provided written notice at least twenty-four (24) hours in advance, which includes disclosure of out-of-network charges and that the patient consents in writing to be treated by an out-of-network provider and will be financially responsible for the services. Opt-out-services shall not include emergency department services;

16. "Place-of-service inpatient hospital" means a facility, other than a psychiatric facility, which primarily provides diagnostic, therapeutic, surgical and nonsurgical, and rehabilitation services by,

or under, the supervision of physicians to patients admitted for medical conditions. Such facility shall be coded as place-of-service 21;

17. "Place-of-service outpatient hospital" means a portion of the main campus of a hospital which provides diagnostic, therapeutic, surgical and nonsurgical, and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. Such facility shall be coded as place-of-service 22;

18. "Place-of-service emergency department" means a portion of a hospital where emergency diagnosis and hospital treatment of illness or injury is provided. Such facility shall be coded as place-of-service 23;

19. "Out-of-network balance billing" means the amount of the clinician's usual and customary charge that remains after the insurance carrier determines the insurance carrier out-of-network benefit and guarantor cost-sharing amount;

20. "Out-of-network services" means a clinician's professional services provided to patients where the clinician does not have a contract with the insurance carrier of the patient; and

21. "Patient" means the recipient of the professional services of a clinician.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.32 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If out-of-network services are provided to a patient by a clinician, the clinician shall bill the patient's insurance carrier directly and the insurance carrier shall reimburse the clinician for the professional services as coded and billed by the clinician.

B. Insurance carriers shall not apply deductibles and co-insurance for non-elective services.

C. The insurance carrier shall adjudicate the guarantor's claim for out-of-network services at the guarantor's in-network benefits levels and the guarantor's cost sharing for out-of-network services shall be limited to the amount that the guarantor would have reimbursed the clinician for in-network services for elective and non-elective services.

D. The allowed out-of-network benefit shall be reimbursed at an amount that is not less than the minimum benefit standard for clinicians as defined in Section 2 of this act.

E. Clinicians shall be prohibited from submitting a claim and/or charges for out-of-network services or out-of-network balance bills to the guarantor if the clinician's place-of-service code is 21, 22, or 23, provided that the minimum benefit standard has been reimbursed to the clinician by the insurance carrier and provided that the guarantor

has not opted out of the protections for place-of-service 21 and 22 pursuant to these provisions.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.33 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except for clinician services provided in a place-of-service 23 emergency department, clinicians providing services shall not be prohibited from out-of-network balance billing provided the following guarantor notice provisions are provided and written guarantor consent is obtained as provided:

1. Clinicians shall be prohibited from out-of-network balance billing except where notice and consent is obtained from the guarantor pursuant to these provisions for place-of-service 21 and 22 and except as provided in subsection A of this section;

2. Notice and consent for opt-out-services shall be obtained at least twenty four (24) hours in advance of the provision of out-of-network services and the clinicians' notice shall be in advance of the guarantor's admission;

3. The clinician shall provide in the notice a disclosure of out-of-network charges that shall explain the guarantor's out-of-network benefit and cost sharing to the extent known to the clinician;

4. The clinician shall not be reimbursed for more than the total disclosed out-of-network charges in the notice unless there are unforeseen circumstances not anticipated at the time of services;

provided, time based charges for surgeries or procedures shall be reimbursed by the insurance carrier at rates based on the actual procedure time; however, the guarantor's cost sharing shall remain at the in-network rates for these out-of-network services;

5. If there are disputes regarding the out-of-network charges that arise out of unforeseen circumstances, either the clinician or guarantor may institute mediation pursuant to Section 5 of this act; and

6. If notice and consent is not obtained pursuant to these provisions for place-of-service 21 and 22, the clinician shall be prohibited from billing the guarantor pursuant to out-of-network balance billing, provided that the clinician is reimbursed pursuant to the minimum benefit standard.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.34 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Mediation may be initiated by the guarantor provided the amount in controversy meets the mediation threshold of One Thousand Dollars ($1,000.00) and the insurance carrier either did not reimburse at or above the minimum benefit standard or the guarantor opted-out pursuant to Section 4 of this act.

B. The clinician may initiate mediation if:

1. The insurance carrier does not reimburse the minimum benefit standard to the clinician; provided however, the clinician shall be

barred from requesting payment from the guarantor pursuant to out-of-network balance billing prior to the completion of the mediation process; or

2. The clinician believes that the minimum benefit standard does not properly recognize the clinician's training, qualifications and length of time in practice, the nature of the services provided, the clinician's usual and customary charges and for clinicians practicing in the same geographic area, and other aspects of the clinician's practice that may be relevant to the value of the clinician's out-of-network services.

C. Unless otherwise agreed to by the parties in a settlement agreement, the provisions of this act shall not be construed as a waiver of the right to sue.

D. The guarantor or clinician may initiate the mediation process by providing written notice of the dispute to the insurance carrier and the entity that will determine the mediation process.

E. Mediation resolution shall be within thirty (30) days of the date the mediation request is received by the insurance carrier from the patient.

F. Clinicians shall be permitted to bundle similar claims and/or claims presenting common issues of fact and/or law may be bundled together and adjudicated in one mediation process to promote speedy dispute resolutions.

G. The mediation official may select a reimbursement rate from either proposal of the parties, but shall not create his or her own reimbursement rate.

H. The Medicare Physician Fee Schedule shall not be used as a reference point for the mediation process.

I. The Oklahoma Department of Insurance shall promulgate rules to determine the mediation process.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.35 of Title 36, unless there is created a duplication in numbering, reads as follows:

Insurance carriers shall not state, communicate and/or include in written form any false, misleading or unclear information in their explanation of benefits to patients or guarantors regarding clinician usual and customary charges, out-of-network balance billing or mediation disputes between clinician and insurance carriers.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.36 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Clinicians shall be prohibited from submitting a claim or charges for out-of-network services or out-of-network balance bills to the guarantor except as provided for in Section 4 of this act.

B. Clinicians that engage in a pattern and practice of regularly sending or communicating out-of-network balance bills to

patients in violation of this act, except for cases of excusable neglect, shall lose the right to file mediation demands.

C. Insurance carriers that are in violation of these provisions may be subject to sanctions, penalties and other corrective actions by the Insurance Commissioner.

SECTION 8. This act shall become effective November 1, 2018.

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