

COMMITTEE AMENDMENT

HOUSE OF REPRESENTATIVES

State of Oklahoma

SPEAKER:

CHAIR:

I move to amend HB3483 _____
Of the printed Bill
Page _____ Section _____ Lines _____
Of the Engrossed Bill

By striking the Title, the Enacting Clause, the entire bill, and by
inserting in lieu thereof the following language:

AMEND TITLE TO CONFORM TO AMENDMENTS

Amendment submitted by: Marcus McEntire

Adopted: _____

Reading Clerk

STATE OF OKLAHOMA

2nd Session of the 57th Legislature (2020)

PROPOSED COMMITTEE
SUBSTITUTE
FOR
HOUSE BILL NO. 3483

By: McEntire

PROPOSED COMMITTEE SUBSTITUTE

An Act relating to insurance; creating the Oklahoma Surprise Billing Protection Act; defining terms; authorizing the Attorney General to bring civil action in certain cases; providing for reimbursement to a nonparticipating provider for emergency care; prohibiting prior authorization requirement; authorizing certain notice requirement; providing for payment time limits; providing for reimbursement for certain nonemergency care; requiring out-of-network service written disclosures; providing exception for surprise billing for nonemergency care; providing for payment time limits; requiring health carrier to establish a notification mechanism; providing for contractual provision; prohibiting collection of money from covered person; requiring health facility to post certain information; requiring disclosures in written communications; providing for notice by nonparticipating provider; prohibiting inducement; providing for persons who may request a mediation process; providing for a mediation process for dispute of medical necessity; requiring participation in mediation; requiring written notice; providing for multiple claims in mediation; providing for codification; and providing an effective date.

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

1 SECTION 1. NEW LAW A new section of law to be codified
2 in the Oklahoma Statutes as Section 6060.60 of Title 36, unless
3 there is created a duplication in numbering, reads as follows:

4 This act shall be known and may be cited as the "Oklahoma
5 Surprise Billing Protection Act".

6 SECTION 2. NEW LAW A new section of law to be codified
7 in the Oklahoma Statutes as Section 6060.61 of Title 36, unless
8 there is created a duplication in numbering, reads as follows:

9 As used in the Oklahoma Surprise Billing Protection Act:

10 1. "Allowed amount" means the maximum portion of a billed
11 charge that a health insurance carrier shall pay, including any
12 applicable covered person cost-sharing responsibility, for a covered
13 health care service or item rendered by a participating provider or
14 by a nonparticipating provider;

15 2. "Balance billing" means a nonparticipating provider's
16 practice of issuing a bill to a covered person for the difference
17 between the nonparticipating provider's billed charges on a claim
18 and any amount paid by the health insurance carrier as reimbursement
19 for that claim, excluding any cost-sharing amount due from the
20 covered person;

21 3. "Covered benefits" means those health care services to which
22 a covered person is entitled under the terms of a health benefits
23 plan;

24

1 4. "Health carrier" or "carrier" means an entity subject to the
2 insurance laws and regulations of this state, or subject to the
3 jurisdiction of the Insurance Commissioner, that contracts or offers
4 to contract, or enters into an agreement to provide, deliver,
5 arrange for, pay for or reimburse any of the costs of health care
6 services, including a health insurance company, a health maintenance
7 organization, a hospital and health service corporation, or any
8 other entity providing a plan of health insurance, health benefits
9 or health care services;

10 5. "Mediation" means a process in which an impartial entity
11 issues a binding determination in a dispute between a health benefit
12 plan issuer or administrator and an out-of-network provider or
13 facility or the provider or facilities representative to settle a
14 health benefit claim;

15 6. "Nonparticipating provider" means a provider who is not a
16 participating provider;

17 7. "Participating provider" means a provider or facility that,
18 under express contract with a health insurance carrier or with a
19 health insurance carrier's contractor or subcontractor, has agreed
20 to provide health care services to covered persons, with an
21 expectation of receiving payment directly or indirectly from the
22 health insurance carrier, subject to cost sharing; and

23 8. a. "Surprise bill" means a bill that a nonparticipating
24 provider issues to a covered person for health care

1 services rendered in the following circumstances, in
2 an amount that exceeds the covered person's cost-
3 sharing obligation that would apply for the same
4 health care services if these services had been
5 provided by a participating provider:

6 (1) emergency care provided by the nonparticipating
7 provider, or

8 (2) health care services, that are not emergency
9 care, rendered by a nonparticipating provider at
10 a participating facility where a participating
11 provider is unavailable, a nonparticipating
12 provider renders unforeseen services, or a
13 nonparticipating provider renders services for
14 which the covered person has not given specific
15 consent for that nonparticipating provider to
16 render.

17 b. "Surprise bill" does not mean a bill:

18 (1) for health care services received by a covered
19 person when a participating provider was
20 available to render the health care services and
21 the covered person knowingly elected to obtain
22 the services from a nonparticipating provider
23 without prior authorization, or
24

1 (2) received for health care services rendered by a
2 nonparticipating provider to a covered person
3 whose coverage is provided pursuant to a
4 preferred provider plan; provided, that the
5 health care services are not provided as
6 emergency care or for services rendered pursuant
7 to division (2) of subparagraph a of this
8 paragraph.

9 SECTION 3. NEW LAW A new section of law to be codified
10 in the Oklahoma Statutes as Section 6060.62 of Title 36, unless
11 there is created a duplication in numbering, reads as follows:

12 A. If a health benefit plan issuer or administrator has
13 restricted or prohibited a health care provider or health care
14 facility from billing an insured, participant or enrollee from
15 applicable copayment, coinsurance, and deductible amounts required
16 under the Oklahoma Surprise Billing Protection Act, the Attorney
17 General may bring a civil action in the name of the state to ensure
18 the health care provider, health care facility or administrator may
19 bill an enrollee the applicable copayment, coinsurance, and
20 deductible amounts. If the Attorney General prevails in an action
21 brought against a health benefit plan issuer or administrator, the
22 Attorney General may recover reasonable attorney fees, costs and
23 expenses, including court costs and witness fees incurred in
24 bringing the action.

1 B. If a health care provider, health care facility or
2 administrator has billed an enrollee an amount greater than the
3 applicable copayment, coinsurance, and deductible amount required
4 under the Oklahoma Surprise Billing Protection Act, the Attorney
5 General may bring a civil action in the name of the state to ensure
6 the enrollee is not responsible for an amount greater than the
7 applicable copayment, coinsurance, and deductible amounts. If the
8 Attorney General prevails in an action brought against a health
9 benefit plan issuer or administrator, the Attorney General may
10 recover reasonable attorney fees, costs and expenses, including
11 court costs and witness fees incurred in bringing the action.

12 SECTION 4. NEW LAW A new section of law to be codified
13 in the Oklahoma Statutes as Section 6060.63 of Title 36, unless
14 there is created a duplication in numbering, reads as follows:

15 A. A health insurance carrier shall reimburse a
16 nonparticipating provider for emergency care necessary to evaluate
17 and stabilize a covered person if a prudent layperson would
18 reasonably believe that emergency care is necessary, regardless of
19 eventual diagnosis.

20 B. A health insurance carrier shall not require that prior
21 authorization for emergency care be obtained by, or on behalf of, a
22 covered person prior to the point of stabilization of that covered
23 person if a prudent layperson would reasonably believe that the
24 covered person requires emergency care.

1 C. A health insurance carrier may require an emergency care
2 provider to notify a health insurance carrier of a covered person's
3 admission to the hospital within a reasonable time period after the
4 covered person has been stabilized.

5 D. The insurer shall make payment required by this section
6 directly to the provider no later than, as applicable:

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

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

13 SECTION 5. NEW LAW A new section of law to be codified
14 in the Oklahoma Statutes as Section 6060.64 of Title 36, unless
15 there is created a duplication in numbering, reads as follows:

16 A. Other than applicable cost sharing that would apply if a
17 participating provider had rendered the same services, a health
18 insurance carrier shall provide reimbursement for and a covered
19 person shall not be liable for charges and fees for covered
20 nonemergency care rendered by a nonparticipating provider that are
21 delivered when:

22 1. The covered person at an in-network facility does not have
23 the ability or opportunity to choose a participating provider who is
24 available to provide the covered services; or

1 2. Medically necessary care is unavailable within a health
2 benefits plan's network; provided, that "medical necessity" shall be
3 determined by a covered person's provider in conjunction with the
4 covered person's health benefits plan and health insurance carrier.

5 B. At the time a participating facility schedules a procedure
6 or seeks prior authorization from a health carrier for the provision
7 of nonemergency services to a covered person, the facility shall
8 provide the covered person with an out-of-network services written
9 disclosure that states the following:

10 1. That certain facility-based providers may be called upon to
11 render care to the covered person during the course of treatment;

12 2. That those facility-based providers may not have contracts
13 with the covered person's health care and are therefore considered
14 to be out-of-network;

15 3. That the services therefore will be provided on an out-of-
16 network basis;

17 4. A description of the range of the charges for the out-of-
18 network services for which the covered person may be responsible;

19 5. A notification that the covered person may either agree to
20 accept and pay the charges for the out-of-network services, contact
21 the covered person's health carrier for additional assistance or
22 rely on whatever other rights and remedies that may be available;
23 and
24

1 6. A statement indicating that the covered person may obtain a
2 list of facility-based providers from his or her health benefit plan
3 that are participating providers and that the covered person may
4 request those participating facility-based providers.

5 C. Except as set forth in subsection A of this section, nothing
6 in this section shall preclude a nonparticipating provider from
7 surprise billing for nonemergency care provided by a
8 nonparticipating provider to an individual who has knowingly chosen
9 to receive services from that nonparticipating provider.

10 D. The insurer shall make payment required by this section
11 directly to the provider no later than, as applicable:

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

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

18 SECTION 6. NEW LAW A new section of law to be codified
19 in the Oklahoma Statutes as Section 6060.65 of Title 36, unless
20 there is created a duplication in numbering, reads as follows:

21 A. Until November 1, 2023, surprise billing reimbursement shall
22 be:

23 1. At a rate of one hundred and thirty percent (130%) of the
24 Employees Group Insurance Division's (EGID) current contracted rates

1 as of November 1, 2020, or the future adjusted rates, whichever is
2 greater; or

3 2. At a rate established by a representative data set from a
4 statewide health information exchange (HIE) all-payer claims
5 database.

6 B. EGID shall post all current contracted rates on its website
7 in a publicly accessible manner.

8 SECTION 7. NEW LAW A new section of law to be codified
9 in the Oklahoma Statutes as Section 6060.66 of Title 36, unless
10 there is created a duplication in numbering, reads as follows:

11 A. A health carrier shall establish a mechanism by which the
12 participating provider will be notified on an ongoing basis of the
13 specific covered health care services for which the provider will be
14 responsible, including any limitations or conditions on services.

15 B. Every contract between a health carrier and a participating
16 provider shall set forth a hold harmless provision specifying
17 protection for covered persons. This requirement shall be met by
18 including a provision substantially similar to the following:

19 "Provider agrees that in no event, including, but not limited
20 to, nonpayment by the health carrier or intermediary, insolvency of
21 the health carrier or intermediary, or breach of this agreement,
22 shall the provider bill, charge, collect a deposit from, seek
23 compensation, remuneration or reimbursement from, or have any
24 recourse against a covered person or a person (other than the health

1 carrier or intermediary) acting on behalf of the covered person for
2 services provided pursuant to this agreement. This agreement does
3 not prohibit the provider from collecting coinsurance, deductibles
4 or copayments, as specifically provided in the evidence of coverage,
5 or fees for uncovered services delivered on a fee-for-service basis
6 to covered persons. Nor does this agreement prohibit a provider
7 (except for a health care professional who is employed full-time on
8 the staff of a health carrier and has agreed to provide services
9 exclusively to that health carrier's covered persons and no others)
10 and a covered person from agreeing to continue services solely at
11 the expense of the covered person, as long as the provider has
12 clearly informed the covered person that the health carrier may not
13 cover or continue to cover a specific service or services. Except
14 as provided herein, this agreement does not prohibit the provider
15 from pursuing any available legal remedy."

16 C. In no event shall a participating provider collect or
17 attempt to collect from a covered person any money owed to the
18 provider by the health carrier.

19 SECTION 8. NEW LAW A new section of law to be codified
20 in the Oklahoma Statutes as Section 6060.67 of Title 36, unless
21 there is created a duplication in numbering, reads as follows:

22 A. By July 1, 2021, the State Department of Health shall
23 require each health facility licensed in this state to post the
24

1 following in the health facility and on the health facility's
2 website in a publicly accessible manner:

3 1. The names and hyperlinks for direct access to the websites
4 of all health insurance carriers with which the hospital has a
5 contract for services;

6 2. A statement that sets forth the following:

7 a. services may be performed in the hospital by
8 participating providers as well as nonparticipating
9 providers who may separately bill the patient,

10 b. providers that perform health care services in the
11 hospital may or may not participate in the same health
12 benefits plans as the hospital, and

13 c. prospective patients should contact their health
14 insurance carriers in advance of receiving services at
15 that hospital to determine whether the scheduled
16 health care services provided in that hospital will be
17 covered at in-network rates; and

18 3. The rights covered under the Oklahoma Surprise Billing
19 Protection Act.

20 B. Any written communication, other than a receipt of payment
21 from a provider or health insurance carrier pertaining to a surprise
22 bill, shall clearly state that the covered person is responsible
23 only for payment of applicable in-network cost-sharing amounts under
24 the covered person's health benefits plan. A collection agency

1 collecting medical debt from Oklahoma residents shall post a notice
2 of consumer rights pursuant to the Oklahoma Surprise Billing
3 Protection Act on its website.

4 C. When a nonparticipating provider under nonemergency
5 circumstances has advance knowledge that the nonparticipating
6 provider is not contracted with the covered person's health
7 insurance carrier, the nonparticipating provider shall inform the
8 covered person of the nonparticipating provider's nonparticipating
9 status and advise the covered person to contact the covered person's
10 health insurance carrier to discuss the covered person's options.

11 SECTION 9. NEW LAW A new section of law to be codified
12 in the Oklahoma Statutes as Section 6060.68 of Title 36, unless
13 there is created a duplication in numbering, reads as follows:

14 A nonparticipating provider shall not, either directly or
15 indirectly, knowingly waive, rebate, give, pay or offer to waive,
16 rebate, give or pay all or part of a cost-sharing amount owed by a
17 covered person pursuant to the terms of the covered person's health
18 benefits plan as an inducement for the covered person to seek a
19 health care service from that nonparticipating provider.

20 SECTION 10. NEW LAW A new section of law to be codified
21 in the Oklahoma Statutes as Section 6060.69 of Title 36, unless
22 there is created a duplication in numbering, reads as follows:

23 A. An out-of-network provider, out-of-network facility, and
24 health benefit plan issuer or administrator may request mediation of

1 a settlement of an out-of-network health benefit claim utilizing a
2 fair and impartial mediation entity if:

3 1. The health benefit claim is for:

4 a. nonemergency care provided at an out-of-network
5 facility,

6 b. nonemergency care provided by an out-of-network
7 provider,

8 c. emergency care provided at an out-of-network facility,
9 or

10 d. emergency care provided by an out-of-network provider;
11 and

12 2. The calculated reimbursement rate is disputed.

13 B. If a person requests mediation under this section, the out-
14 of-network provider, out-of-network facility, or a representative of
15 the provider or facility, and the health benefit plan issuer or the
16 administrator, as appropriate, shall participate in mediation.

17 C. Nothing in this section shall prohibit a health care
18 provider or facility from utilizing mediation in cases where medical
19 necessity is disputed.

20 D. If a person requests mediation, the out-of-network provider,
21 out-of-network facility, or an appropriate representative, and the
22 health benefit plan issuer or administrator, as appropriate, shall
23 participate in mediation.

1 E. The party who requests mediation shall provide written
2 notice on the date mediation is requested to each party:

3 F. In an effort to settle the claim before mediation, all
4 parties shall participate in an informal settlement teleconference
5 no later than thirty (30) days after the date on which mediation is
6 requested. A health benefit plan issuer or administrator, as
7 applicable, shall make a reasonable effort to arrange the
8 teleconference.

9 G. For multiple claims in mediation:

10 1. The total amount in controversy for multiple claims in one
11 proceeding shall not exceed Five Thousand Dollars (\$5,000.00); and

12 2. The multiple claims in one proceeding shall be limited to
13 the same out-of-network provider or facility and health benefit plan
14 issuer.

15 H. After final determination of mediation proceedings, the
16 nonprevailing party shall be solely responsible for all costs
17 associated with mediation.

18 SECTION 11. This act shall become effective November 1, 2020.
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