

05/16/2019 04:10:13 PM

HOUSE OF REPRESENTATIVES
CONFERENCE COMMITTEE REPORT

Mr. President:
Mr. Speaker:

The Conference Committee, to which was referred

HB1053

By: McEntire of the House and Treat of the Senate

Title: Insurance; Small Employer Health Insurance Reform Act; providing not applicable to certain health plans; providing requirements for bona fide association health plans; effective date.

Together with Engrossed Senate Amendments thereto, beg leave to report that we have had the same under consideration and herewith return the same with the following recommendations:

1. That the Senate recede from its amendment; and
2. That the attached Conference Committee Substitute be adopted.

Respectfully submitted,

House Action _____ Date _____ Senate Action _____ Date _____

HB1053 CCR (A)
HOUSE CONFEREES

Bennett, Forrest

Marti, T.J.



McEntire, Marcus



Moore, Lewis

Sims, Lonnie



Sneed, Chris



Stone, Shane

Taylor, Zack



HB1053 CCR A

SENATE CONFEREES

Treat

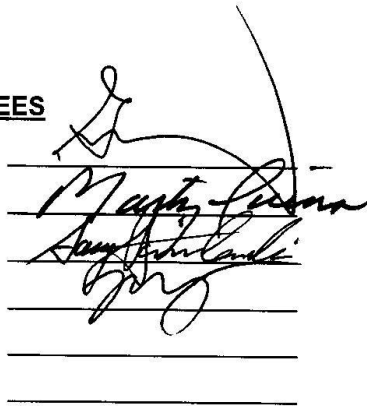
Quinn

Stanislawski

Montgomery

Brooks

Matthews

The image shows handwritten signatures of Senate conferees over horizontal lines. The signatures are written in black ink. The first signature is a simple 'L' shape. The second signature is 'Marty Quinn'. The third signature is 'Stanislawski'. The fourth signature is 'Montgomery'. The fifth signature is 'Brooks'. The sixth signature is 'Matthews'.

House Action _____ Date _____ Senate Action _____ Date _____

House Action _____ Date _____ Senate Action _____ Date _____

AUTHOR(s)/COAUTHOR(s)CURRENTLY IN THE QUEUE for HB1053

As of 5/16/2019 4:03:44 PM

Remove as author Senator Treat and substitute with Senator Quinn

Add as coauthor Senator Treat

STATE OF OKLAHOMA

1st Session of the 57th Legislature (2019)

CONFERENCE COMMITTEE
SUBSTITUTE
FOR ENGROSSED
HOUSE BILL NO. 1053

By: McEntire and McCall of the
House

and

Treat of the Senate

CONFERENCE COMMITTEE SUBSTITUTE

An Act relating to insurance; creating the Out-of-Network Surprise Billing Transparency Act; stating purpose; providing for applicability of act; defining terms; providing for qualifications of a surprise out-of-network bill; providing exceptions; providing for dispute resolution; requiring insurer to give notice to insured regarding coverage; requiring insurer to provide certain documents and information to insured about in-network and out-of-network coverage; requiring certain provision in contract between health carrier and provider; applying certain section to nonemergency services; requiring certain health care professionals to disclose health care plans and hospitals to which they belong; providing time limit for updating or disclosing certain information; providing exception; requiring health care facility to post certain information on website; providing for content in notification; requiring out-of-network services to provide written disclosures; providing elements of written disclosure; requiring in-network facility to provide written disclosures; providing elements of written disclosure; establishing a program of independent dispute resolution for disputed surprise out-of-network bills; instructing the Oklahoma Insurance Department to promulgate rules for implementation of program; authorizing Department to charge parties

1 participating in dispute resolution; requiring
2 Department to maintain list of reviewers; directing
3 Department to establish application process and fee
4 schedule; authorizing independent reviewer to
5 determine reasonableness of charges for certain
6 medical services; allowing parties to provide
7 information to independent reviewer to be considered
8 for dispute resolution; providing eligibility
9 qualification to serve as independent reviewer;
10 authorizing health carriers to initiate independent
11 dispute resolution proceedings; requiring Department
12 to arrange an informal settlement conference;
13 authorizing oral hearings in certain dispute
14 resolutions; assigning costs of dispute resolution;
15 authorizing court enforcement of independent
16 reviewer's decision; providing for confidentiality;
17 requiring out-of-network billing statement to contain
18 certain information; classifying out-of-network
19 referral denial; requiring certain information for
20 denials; providing for appeal of out-of-network
21 referral denial; providing procedure for external
22 appeal after internal appeal; requiring external
23 appeal agent to provide written statement; requiring
24 carriers to maintain an online and print directory;
requiring carrier to perform annual audit; providing
for required information for each network plan in
directory; providing requirements for maintaining
directory; requiring carrier to provide directory in
certain format; requiring carrier to provide certain
information upon request; 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 7500 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
Surprise Billing Transparency Act".

1 SECTION 2. NEW LAW A new section of law to be codified
2 in the Oklahoma Statutes as Section 7501 of Title 36, unless there
3 is created a duplication in numbering, reads as follows:

4 The purpose of the Out-of-Network Surprise Billing Transparency
5 Act is to protect consumers from surprise medical bills that result
6 from their receiving care from an out-of-network provider without
7 making an informed choice to receive care from the out-of-network
8 provider. Improved disclosures by health benefit plans, providers
9 and facilities, holding consumers harmless from surprise out-of-
10 network bills, and a procedure for appealing out-of-network referral
11 denials will help consumers better navigate the insurance processes
12 and reduce the incidence of costly, surprise out-of-network bills.

13 SECTION 3. NEW LAW A new section of law to be codified
14 in the Oklahoma Statutes as Section 7502 of Title 36, unless there
15 is created a duplication in numbering, reads as follows:

16 A. Except as provided in subsection B of this section, the Out-
17 of-Network Surprise Billing Transparency Act applies to any health
18 benefit plan, provider and health care facility as defined in Section
19 4 of this act.

20 B. The Out-of-Network Surprise Billing Transparency Act does
21 not apply to:

22 1. Any Medicaid programs operated in Oklahoma, including any
23 Medicaid managed care programs;

1 2. The Children's Health Insurance Program (CHIP) operated in
2 Oklahoma;

3 3. Medicare;

4 4. "Excepted benefit" products as defined in 42 U.S.C. 300gg-
5 91(c); or

6 5. Any Multiple Employer Welfare Arrangement (MEWA) or employer
7 self-insured plan that is exempt under the Employee Retirement
8 Income Security Act of 1974.

9 SECTION 4. NEW LAW A new section of law to be codified
10 in the Oklahoma Statutes as Section 7503 of Title 36, unless there
11 is created a duplication in numbering, reads as follows:

12 For the purposes of and as used in the Out-of-Network Surprise
13 Billing Transparency Act:

14 1. "Ambulance service" shall have the same meaning as set forth
15 in Section 1-2503 of Title 63 of the Oklahoma Statutes, except that
16 it shall not include any air ambulance that is exempt from state law
17 relating to price, route or service pursuant to the federal Airline
18 Deregulation Act, Public Law 95-504;

19 2. "Carrier" or "health carrier" means an entity subject to the
20 insurance laws and regulations of this state, or subject to the
21 jurisdiction of the Insurance Commissioner, that contracts or offers
22 to contract or enters into an agreement to provide, deliver, arrange
23 for, pay for or reimburse any of the costs of health care services.
24 Carriers include a health insurance company, health maintenance

1 organization, hospital and health service corporation or any other
2 entity providing a plan of health insurance, health benefits or
3 health care services;

4 3. "Commissioner" means the Insurance Commissioner of the State
5 of Oklahoma;

6 4. "Department" means the Oklahoma Insurance Department;

7 5. "Emergency services" includes any health care service
8 provided by an ambulance service or in a health care facility after
9 the sudden onset of a medical condition that manifests itself by
10 symptoms of sufficient severity, including severe pain, that the
11 absence of immediate medical attention could reasonably be expected
12 by a prudent layperson, who possesses an average knowledge of health
13 and medicine, to result in:

- 14 a. placing the health of the patient in serious jeopardy,
- 15 b. serious impairment to bodily functions, or
- 16 c. serious dysfunction of any bodily organ or part;

17 6. "Enrollee" means an individual who is eligible to receive
18 medical care through a health benefit plan;

19 7. "Facility-based provider" means an individual or group of
20 health care providers:

- 21 a. to whom the health care facility has granted clinical
22 privileges, and
- 23 b. who provide services to patients treated at the health
24 care facility under those clinical privileges;

1 8. "Health benefit plan" means a policy, contract, certificate
2 or agreement entered into, offered or issued by a health carrier to
3 provide, deliver, arrange for, pay for or reimburse any of the costs
4 of health care services, and includes the Oklahoma Employees Health
5 Insurance Plan as defined in Section 1303 of Title 74 of the
6 Oklahoma Statutes and coverage provided by a Multiple Employer
7 Welfare Arrangement (MEWA) or employer self-insured plan except as
8 exempt under the Employee Retirement Income Security Act of 1974;

9 9. "Health care facility" or "facility" means a hospital,
10 emergency clinic, outpatient clinic, birthing center, ambulatory
11 surgical center or other facility providing medical care, and which
12 is licensed by the Oklahoma State Department of Health;

13 10. "In-network facility" means a health care facility that has
14 contracted with a carrier to provide services to enrollees of a
15 health benefit plan;

16 11. "In-network provider" means a health care provider who has
17 contracted with a carrier to provide services to enrollees of a
18 health benefit plan;

19 12. "Network" means the providers and facilities that have
20 contracted to provide health care services to the enrollees of a
21 health benefit plan. This includes a network operated by, or
22 contracting with, a health maintenance organization, a preferred
23 provider organization or another entity, including an insurance
24 company that issues a health benefit plan;

1 13. "Network plan" means a health benefit plan that uses a
2 network to provide services to enrollees;

3 14. "Out-of-network facility" means a health care facility that
4 has not contracted with a carrier to provide services to enrollees
5 of a health benefit plan;

6 15. "Out-of-network provider" means a health care provider who
7 has not contracted with a carrier to provide services to enrollees of
8 a health benefit plan;

9 16. "Out-of-network referral denial" means a denial by a health
10 benefit plan of a request for an authorization or referral to an out-
11 of-network provider on the basis that the health benefit plan has an
12 in-network provider with appropriate training and experience to meet
13 the particular health care needs of the enrollee and who is able to
14 provide the requested health service;

15 17. "Preauthorization" shall have the same meaning as set forth
16 in Section 1250.2 of Title 36 of the Oklahoma Statutes;

17 18. "Provider" means an individual who is licensed to provide
18 and provides medical care; and

19 19. "Surprise out-of-network bill" means a bill submitted by an
20 out-of-network provider charging a health benefit plan the
21 difference between the provider's fee and what the enrollee is
22 required to pay in applicable deductibles, copayments, coinsurance
23 or other cost-sharing amounts required by the health benefit plan,
24

1 and that meets one of the requirements listed in subsection A of
2 Section 5 of this act.

3 SECTION 5. NEW LAW A new section of law to be codified
4 in the Oklahoma Statutes as Section 7504 of Title 36, unless there
5 is created a duplication in numbering, reads as follows:

6 A. A bill shall qualify as a surprise out-of-network bill if:

7 1. The bill was for emergency services or health care services
8 directly related to the emergency services;

9 2. The bill was for a health care service that was not provided
10 in the case of an emergency and the provider or the provider's
11 representative did not provide to the enrollee or the enrollee's
12 authorized representative, or did not provide to the enrollee or the
13 enrollee's representative within a reasonable amount of time before
14 the enrollee received the services, a written dated disclosure that
15 contained the following information:

16 a. notice that contains the name of the billing provider
17 and that states the provider is an out-of-network
18 provider,

19 b. the estimated total cost to be billed by the health
20 care provider or the provider's representative, and

21 c. notice that the enrollee or the enrollee's
22 representative is not required to sign the disclosure
23 to obtain medical care but, if the enrollee or the
24 enrollee's representative signs the disclosure, the

1 enrollee may be billed for any portion of the
2 provider's fee which is not covered by the enrollee's
3 health benefit plan.

4 For purposes of this subsection and as used in the Out-of-
5 Network Surprise Billing Transparency Act, an enrollee shall be
6 presumed to have been given the written dated disclosure required by
7 this subsection within a reasonable amount of time if it is provided
8 at least forty-eight (48) hours before the enrollee is scheduled to
9 receive services; or

10 3. The bill was for a health care service that was not provided
11 in the case of an emergency and the enrollee or the enrollee's
12 representative received the disclosure prescribed in paragraph 2 of
13 this subsection, but the enrollee or the enrollee's representative
14 chose not to sign the disclosure.

15 B. A surprise out-of-network bill shall be subject to the
16 following:

17 1. A health benefit plan enrollee shall not be liable for
18 payment of a surprise out-of-network bill, other than applicable
19 copayments, coinsurance and deductibles;

20 2. An out-of-network provider shall not bill, charge or seek
21 compensation from an enrollee for a surprise out-of-network bill
22 other than the amount the enrollee is required to pay in applicable
23 copayments, coinsurance and deductibles; and
24

1 3. A carrier shall be solely liable for payment of fees to an
2 out-of-network provider of covered services provided to an enrollee
3 in accordance with the coverage terms of the health benefit plan.

4 C. Surprise out-of-network bills submitted to a carrier
5 pursuant to subsection B of this section are subject to the
6 requirements of section 1219 of Title 36 of the Oklahoma Statutes.

7 D. Any dispute with regard to the reimbursement of a surprise
8 out-of-network bill as provided in this section may be resolved
9 through the independent dispute resolution process as set forth in
10 Section 10 of this act. A surprise out-of-network bill which is
11 less than Five Hundred Dollars (\$500.00) shall not be eligible for
12 the independent dispute resolution process.

13 SECTION 6. NEW LAW A new section of law to be codified
14 in the Oklahoma Statutes as Section 7505 of Title 36, unless there
15 is created a duplication in numbering, reads as follows:

16 A. Where applicable, and through its website, a health benefit
17 plan shall give to an enrollee:

18 1. Notice:

19 a. that the enrollee may obtain a referral or
20 preauthorization for services from an out-of-network
21 provider when the health benefit plan does not have in
22 its network a provider who is geographically
23 accessible to the enrollee and has the appropriate
24

- 1 training and experience to meet the particular health
2 care needs of the enrollee,
- 3 b. of the procedure for requesting and obtaining such
4 referral or preauthorization,
- 5 c. that the enrollee with a condition which requires
6 ongoing care from a specialist may request a standing
7 referral to such a specialist,
- 8 d. of the procedure for requesting and obtaining such a
9 standing referral,
- 10 e. that the enrollee with a life-threatening condition or
11 disease, or a degenerative and disabling condition or
12 disease, either of which requires specialized medical
13 care over a prolonged period of time, may request a
14 specialist responsible for providing or coordinating
15 the enrollee's medical care,
- 16 f. of the procedure for requesting and obtaining such a
17 specialist,
- 18 g. that the enrollee with a life-threatening condition or
19 disease, or a degenerative and disabling condition or
20 disease, either of which requires specialized medical
21 care over a prolonged period of time, may request
22 access to a specialty care center, and
- 23 h. of the procedure for requesting and obtaining such
24 access;

1 2. A listing of providers in the health plan network pursuant
2 to Section 13 of this act; and

3 3. With respect to out-of-network coverage:

- 4 a. a clear description of the methodology used by the
5 carrier to determine reimbursement for out-of-network
6 health care services,
- 7 b. a description of the amount that the carrier will
8 reimburse under the methodology for out-of-network
9 health care services set forth as a percentage of the
10 usual, customary and reasonable rate for out-of-network
11 health care services,
- 12 c. examples of anticipated out-of-pocket costs for
13 frequently billed out-of-network health care services,
- 14 d. information that reasonably permits an enrollee to
15 estimate the anticipated out-of-pocket cost for out-of-
16 network services in a geographical area or zip code
17 based upon the difference between what the health
18 benefit plan will reimburse for out-of-network
19 services and the usual, customary and reasonable rate
20 for out-of-network services, and
- 21 e. a statement that an enrollee is not responsible for
22 any charges for an out-of-network service in excess of
23 applicable copayment, coinsurance or deductible
24 amounts if the enrollee or the enrollee's

1 representative does not, within a reasonable amount of
2 time prior to receiving such services, agree in
3 writing to incur such additional charges.

4 B. A health benefit plan shall make a utilization review
5 determination involving health care services which require
6 preauthorization and provide notice of that determination to the
7 enrollee or representative of the enrollee and the health care
8 provider of the enrollee by telephone and in writing within three
9 (3) business days of receipt of the information necessary to make
10 the determination. To the extent practicable, such written
11 notification to the enrollee and the enrollee's health care provider
12 shall also be transmitted electronically in a manner and in a form
13 agreed upon by the parties. The notification shall identify:

14 1. Whether the services are considered in-network or out-of-
15 network;

16 2. Whether the services are covered by the health benefit plan;

17 3. Whether the enrollee will be responsible for any payment
18 other than any applicable copayment, coinsurance or deductible;

19 4. As applicable, the dollar amount the health benefit plan
20 will pay if the service is out-of-network;

21 5. As applicable, the estimated copayment, coinsurance and
22 deductible amounts the enrollee will owe for the services based upon
23 the provider's contracted rate, if the provider is in-network; and
24

1 6. As applicable, the estimated copayment, coinsurance and
2 deductible amounts the enrollee will owe for the services based upon
3 the difference between what the health benefit plan will reimburse
4 for out-of-network health care services and the usual, customary and
5 reasonable rate for out-of-network health care services, if the
6 provider is out-of-network.

7 C. A health benefit plan shall include with the notification
8 required by subsection B of this section a statement that an
9 enrollee is not responsible for any charges for an out-of-network
10 service in excess of applicable copayment, coinsurance or deductible
11 amounts if the enrollee or the enrollee's representative does not,
12 within a reasonable amount of time prior to receiving the services,
13 agree in writing to incur such additional charges.

14 D. Every contract between a carrier and an in-network provider
15 shall set forth a hold-harmless provision specifying protection for
16 enrollees. This requirement shall be met by including a provision
17 substantially similar to the following:

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

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

16 SECTION 7. NEW LAW A new section of law to be codified
17 in the Oklahoma Statutes as Section 7506 of Title 36, unless there
18 is created a duplication in numbering, reads as follows:

19 A. This section applies to the provision of nonemergency
20 services only.

21 B. A provider shall disclose in writing or through an Internet
22 website, or both, the health benefit plans with which the provider
23 is in-network. Upon request by an enrollee or an enrollee's
24 representative, a provider or the provider's representative shall

1 verbally disclose whether the provider is in-network with the health
2 benefit plan of the enrollee.

3 The information posted on the provider's website or included in
4 written materials pursuant to this subsection shall be updated
5 within three (3) business days after any change to such information.

6 C. If a provider is not in-network with the health benefit plan
7 of the enrollee, the provider shall, within forty-eight (48) hours
8 after an appointment is scheduled, provide the enrollee with a
9 written amount or estimated amount the provider anticipates billing
10 the enrollee for planned services absent unforeseen medical
11 circumstances that might arise when the services are provided. The
12 provider shall also provide a statement that the enrollee will not
13 be responsible for any charges from the out-of-network provider in
14 excess of any applicable copayment, coinsurance or deductible if the
15 enrollee or the enrollee's representative does not, within a
16 reasonable amount of time prior to receiving the service, agree in
17 writing to incur such charges.

18 Nothing in this subsection shall apply to emergent or unforeseen
19 conditions or circumstances discovered during a procedure.

20 D. When services rendered in an office of the provider require
21 referral to, or coordination with, another provider, the provider or
22 representative of the provider initiating the referral or
23 coordination shall give to the enrollee the following information in
24

1 writing about the aforementioned who will be providing services to
2 the enrollee:

3 1. Name, practice name, mailing address, telephone number; and

4 2. How to determine in which health benefit plan networks each
5 participates. The information shall be provided to the enrollee at
6 the time of the referral or commencement of the coordination of
7 services.

8 E. At the time a provider or the representative of the provider
9 is scheduling an enrollee to receive services at a health care
10 facility, that provider or representative shall give to the enrollee
11 the following information in writing about any other provider or
12 provider groups who will also be providing, or are reasonably
13 anticipated to provide, services to the enrollee:

14 1. Name, practice name, mailing address, telephone number; and

15 2. A notification that the enrollee should contact the provider
16 or provider group to determine in which health benefit plan networks
17 each participates.

18 SECTION 8. NEW LAW A new section of law to be codified
19 in the Oklahoma Statutes as Section 7507 of Title 36, unless there
20 is created a duplication in numbering, reads as follows:

21 A. This section applies to the provision of nonemergency
22 services only.

23 B. A health care facility shall establish, update and make
24 public through posting on its website, to the extent required by

1 federal guidelines, a list of the facility's standard charges for
2 items and services provided by the facility, including for
3 diagnosis-related groups established under Section 1886(d) (4) of the
4 federal Social Security Act.

5 C. A facility shall post on its website:

6 1. The networks in which the facility participates;

7 2. A statement that:

8 a. fees for provider services provided in the facility
9 are not included in the facility's charges,

10 b. providers who provide services in the facility may or
11 may not be in-network with the same health benefit
12 plans as the facility,

13 c. if an enrollee in a health benefit plan receives
14 services in the facility that is in the network of the
15 health benefit plan, but receives those services from a
16 provider who is not in that network, the enrollee may
17 be billed for the amount between what the provider
18 charges and what the health benefit plan of the
19 enrollee pays that provider, in addition to any
20 copayments, coinsurance, deductibles or combination
21 thereof that are the responsibility of the enrollee,

22 d. an enrollee will not be responsible for charges from
23 an out-of-network provider in excess of any applicable
24 copayment, coinsurance or deductible if the enrollee

1 or the enrollee's representative does not, within a
2 reasonable amount of time prior to receiving the
3 service, agree in writing to incur such additional
4 charges, and

5 e. the enrollee should check with the provider arranging
6 for the enrollee to receive services in the facility to
7 determine whether that provider participates in the
8 health benefit plans of the enrollee's network; and

9 3. As applicable, the name, mailing address and telephone number
10 of the facility-based providers and facility-based provider groups
11 that the facility has employed or contracted with to provide services
12 and instructions about how to determine in which health benefit plan
13 networks each participates.

14 The information posted on the facility website pursuant to this
15 section shall be updated within three (3) business days after any
16 change to such information.

17 D. At the time a participating health care facility schedules
18 services or seeks prior authorization from a health benefit plan for
19 the provision of nonemergency services to an enrollee, the facility
20 shall provide the enrollee an out-of-network services written
21 disclosure that states the following:

22 1. That certain facility-based providers may be called upon to
23 render care to the enrollee during the course of treatment;

1 2. That those facility-based providers may not have contracts
2 with the carrier of the enrollee and are therefore considered to be
3 out-of-network;

4 3. That the service or services therefore will be provided on an
5 out-of-network basis;

6 4. That the enrollee should check with the provider arranging
7 for the services to determine the name, practice name, mailing
8 address and telephone number of any other provider who is reasonably
9 anticipated to be providing services to the enrollee while in the
10 health care facility, including but not limited to providers
11 employed by or contracting with the health care facility;

12 5. That the enrollee may request from the facility a written
13 estimated amount that the facility anticipates billing the enrollee
14 for planned services absent unforeseen medical circumstances that
15 might arise when the services are provided;

16 6. A notification that if the enrollee incurs additional charges
17 from an out-of-network provider, the enrollee will not be responsible
18 for such charges in excess of any applicable copayment, coinsurance
19 or deductible if the enrollee or the enrollee's representative does
20 not, within a reasonable amount of time prior to receiving the
21 services, agree in writing to incur such additional charges; and

22 7. A statement indicating that the enrollee may obtain a list of
23 facility-based providers from his or her health benefit plan that are
24

1 in-network providers and that the enrollee may request those in-
2 network facility-based providers.

3 E. At the time of admission in the in-network facility where
4 the nonemergency services are to be performed on the enrollee, the
5 facility shall provide the enrollee with the written disclosure, as
6 outlined in subsection D of this section, and obtain the signature
7 of the enrollee or the representative of the enrollee on the
8 disclosure document acknowledging that the enrollee received the
9 disclosure document in advance prior to the time of admission.

10 F. Upon request, a facility shall provide the enrollee with a
11 written estimated amount that the facility anticipates billing the
12 enrollee for planned services absent unforeseen medical circumstances
13 that might arise when the services are provided, along with a
14 statement that fees for provider services provided in the facility
15 are not included in the facility's charges.

16 SECTION 9. NEW LAW A new section of law to be codified
17 in the Oklahoma Statutes as Section 7508 of Title 36, unless there
18 is created a duplication in numbering, reads as follows:

19 A. A program of independent dispute resolution for disputed
20 surprise out-of-network bills shall be established and administered
21 by the Oklahoma Insurance Department.

22 1. The Department shall promulgate rules, forms and procedures
23 for the implementation and administration of the independent dispute
24 resolution program.

1 2. The Department may charge the parties participating in the
2 independent dispute resolution program such fees as necessary to
3 cover its costs of implementation and administration.

4 3. The Department shall maintain a list of qualified reviewers.

5 4. The Department shall establish an application process and
6 fee schedule for independent reviewers.

7 B. The sole issue to be considered and determined in an
8 independent dispute resolution proceeding is the reasonableness of
9 the charge for the medical services provided to the individual. The
10 independent reviewer shall allow each party to provide information
11 the independent reviewer reasonably determines to be relevant in
12 evaluating the surprise out-of-network bill, including the following
13 information:

14 1. Average contracted amount that the health carrier pays for
15 the health care services at issue in the county where the health
16 care services were performed;

17 2. Average amount that the provider has contracted to accept
18 for the health care services at issue in the county where the
19 services were performed;

20 3. Amount that Medicare and Medicaid pay for the health care
21 services at issue; and

22 4. The eightieth percentile of allowed reimbursements for the
23 particular health care service performed by a provider in the same
24 or similar specialty and provided in the same geographical area as

1 reported in a bench marking database maintained by a nonprofit
2 organization specified by the commissioner. The nonprofit
3 organization shall not be financially affiliated with an insurance
4 carrier.

5 C. To be eligible to serve as an independent reviewer, an
6 individual must be knowledgeable and experienced in applicable
7 principles of contract and insurance law and the health care
8 industry generally.

9 1. In approving an individual as an independent reviewer, the
10 Department shall ensure that the individual does not have a conflict
11 of interest that would adversely impact the independence and
12 impartiality of the individual in rendering a decision in an
13 independent dispute resolution proceeding. A conflict of interest
14 includes but is not limited to current or recent ownership or
15 employment of either the individual or a close family member in a
16 health benefit plan, a carrier or a provider that may be involved in
17 an independent dispute resolution proceeding.

18 2. The Department shall immediately terminate the approval of
19 an independent reviewer who no longer meets the requirements to
20 serve as an independent reviewer.

21 SECTION 10. NEW LAW A new section of law to be codified
22 in the Oklahoma Statutes as Section 7509 of Title 36, unless there
23 is created a duplication in numbering, reads as follows:

1 A. A carrier or out-of-network provider may initiate an
2 independent dispute resolution proceeding to determine reimbursement
3 of a surprise out-of-network bill by submitting a request on a form
4 prescribed by the Insurance Department, which shall be made available
5 on the Department's website.

6 B. In an effort to settle the surprise out-of-network bill
7 before independent dispute resolution, the Department shall arrange
8 an informal settlement teleconference within thirty (30) calendar
9 days after the Department receives the request. The Department is
10 not a party to and may not participate in the informal settlement
11 teleconference except to the extent necessary to verify that parties
12 have joined in a scheduled teleconference. As part of the
13 settlement teleconference the health carrier shall provide to the
14 parties the enrollee's cost-sharing requirements under the
15 enrollee's health benefit plan based on the adjudicated claim. The
16 carrier shall notify the Department whether the informal settlement
17 teleconference resulted in settlement of the disputed surprise out-
18 of-network bill and, if settlement was reached, notify the
19 Department of the terms of the settlement within seven (7) calendar
20 days. If, after proper notice from the Department, either the
21 carrier or provider or the provider's representative fails to
22 participate in the teleconference, the other party may notify the
23 Department to immediately initiate the independent dispute
24

1 resolution proceeding and the nonparticipating party shall be
2 required to pay the total cost of the proceeding.

3 C. If the parties have not designated an independent reviewer by
4 mutual agreement within fifteen (15) days after the informal
5 settlement teleconference was conducted, or scheduled to be
6 conducted if it was not conducted, the Department shall select an
7 independent reviewer from the list of qualified reviewers.

8 D. An independent dispute resolution proceeding shall be
9 subject to the following:

10 1. Either party to an independent dispute resolution proceeding
11 may request an oral hearing;

12 2. If no oral hearing is requested, the independent reviewer
13 shall set a date for the submission of all information to be
14 considered by the independent reviewer;

15 3. Each party to the independent dispute resolution shall
16 submit a "binding award amount"; the independent reviewer must
17 choose the binding award amount of one party based on which amount
18 the independent reviewer determines to be closest to the reasonable
19 charge for services provided in accordance with subsection B of
20 Section 9 of this act, with no deviation;

21 4. If an oral hearing is requested, the independent reviewer may
22 make procedural rulings;

23 5. There shall be no discovery in independent dispute resolution
24 proceedings;

1 6. The independent reviewer shall issue his or her written
2 decision within ten (10) days of submission or hearing;

3 7. Unless otherwise agreed by the parties, each party shall:

4 a. bear its own attorney fees and costs, and

5 b. equally bear all fees and costs of the independent
6 reviewer and the Department, except as set forth in
7 subsection B of this section; and

8 8. Any oral hearing shall be conducted telephonically unless
9 otherwise agreed by all of the required participants.

10 E. The decision of the independent reviewer is final and shall
11 be binding on the parties. The prevailing party may seek
12 enforcement of the independent reviewer's decision in any court of
13 competent jurisdiction.

14 F. All pricing information provided by carriers and providers
15 in connection with the independent dispute resolution is confidential
16 and may not be disclosed by the reviewer or any other party
17 participating in the process or used by anyone, other than the
18 providing party, for any purpose other than to resolve the surprise
19 out-of-network bill. The Department may provide to the public any
20 information which is already public information.

21 G. All information received by the Department in connection
22 with an independent dispute resolution is confidential and may not be
23 disclosed by the Department to any person other than the reviewer.

1 SECTION 11. NEW LAW A new section of law to be codified
2 in the Oklahoma Statutes as Section 7510 of Title 36, unless there
3 is created a duplication in numbering, reads as follows:

4 A. If an out-of-network provider bills an enrollee for
5 nonemergency medical care, requesting payment on the balance of the
6 charge of the provider that is not related to copayments, coinsurance
7 or deductible payments and is not covered by the health benefit plan,
8 the billing statement from that provider must contain:

9 1. A Payment Responsibility Notice, which shall state the
10 following or substantially similar language:

11 "Payment Responsibility Notice - The services[s] outlined below
12 was [were] performed by a provider who is not in-network with
13 your health benefit plan. In addition to paying your applicable
14 cost-sharing obligation, such as a copayment, coinsurance or
15 deductible amount, you are also responsible for paying the
16 balance of the bill remaining after your health benefit plan's
17 payment of its out-of-network reimbursement amount. You are
18 receiving this bill for the balance of the charges because,
19 within a reasonable amount of time before the service[s] was
20 [were] rendered, you or your representative agreed to incur such
21 charges. A copy of the signed agreement is attached to this
22 notice.";

23 2. An itemized listing of the nonemergency medical care provided
24 along with the dates the services and supplies were provided;

1 3. A conspicuous, plain-language explanation that:

2 a. the provider is not in-network with the health benefit
3 plan, and

4 b. the health benefit plan has paid a rate, as determined
5 by the health benefit plan, which is below the
6 provider's billed amount;

7 4. A telephone number to call to discuss the statement, provide
8 an explanation of any acronyms, abbreviations and numbers used on
9 the statement, or discuss any payment issues;

10 5. A statement that the enrollee may call to discuss alternative
11 payment arrangements; and

12 6. A notice that if an enrollee agrees to a payment plan:

13 a. the provider will not furnish adverse information to a
14 consumer reporting agency if the enrollee
15 substantially complies with the terms of the payment
16 plan:

17 (1) within six (6) months of having received the
18 medical services, or

19 (2) within thirty (30) days of receiving the first
20 billing statement that reflects all insurance
21 payments and the final amount owed by the
22 enrollee, and

23 b. a patient may be considered by the provider to be out
24 of substantial compliance with the payment plan

1 agreement if payments in compliance with the agreement
2 have not been made for a period of forty-five (45)
3 days.

4 B. Out-of-network providers who do not provide an enrollee with
5 a Payment Responsibility Notice, as outlined in subsection A of this
6 section, or do not obtain, within a reasonable amount of time
7 before the enrollee receives the services, the signature of the
8 enrollee or the enrollee's representative on the disclosure required
9 by paragraph 2 of subsection A of Section 5 of this act may not bill
10 the enrollee for the difference between the provider's fee and the
11 sum of what the enrollee's health benefit plan pays and what the
12 enrollee is required to pay in applicable deductibles, copayments,
13 coinsurance or other cost-sharing amounts required by the health
14 benefit plan, but may initiate an independent dispute resolution
15 proceeding pursuant to Section 10 of this act.

16 SECTION 12. NEW LAW A new section of law to be codified
17 in the Oklahoma Statutes as Section 7511 of Title 36, unless there
18 is created a duplication in numbering, reads as follows:

19 A. An out-of-network referral denial under this section shall
20 not constitute an adverse determination.

21 B. The notice of an out-of-network referral denial provided to
22 an enrollee shall include information regarding how the enrollee can
23 appeal the denial, including but not limited to what information
24 must be submitted with the appeal.

1 C. 1. An enrollee or the representative of an enrollee may
2 appeal an out-of-network referral denial by submitting a written
3 statement from the attending physician of the enrollee, who must be
4 a licensed, board-certified or board-eligible physician qualified to
5 practice in the specialty appropriate to treat the enrollee for the
6 health service sought, provided that:

- 7 a. the in-network provider or providers recommended by the
8 health benefit plan do not have the appropriate
9 training and experience to meet the particular health
10 care needs of the enrollee for the health service, and
11 b. the attending physician recommends an out-of-network
12 provider with the appropriate training and experience
13 to meet the particular health care needs of the
14 enrollee and who is able to provide the requested
15 health service.

16 2. A health benefit plan shall provide a written decision on
17 any appeal of an out-of-network referral denial within twenty (20)
18 days after the date the enrollee or the enrollee's representative
19 files the appeal with the health benefit plan.

20 3. If an out-of-network referral denial has been upheld by the
21 internal appeals process of the health benefit plan and the enrollee
22 wishes to pursue an external appeal, the external appeal agent
23 shall:
24

- a. review the utilization review agent's health benefit plan's final adverse determination,
- b. make a determination as to whether the out-of-network referral shall be covered by the health benefit plan, provided that such determination shall be:
 - (1) conducted only by one or a greater odd number of clinical peer reviewers,
 - (2) based upon review of:
 - (a) the training and experience of the in-network health care provider or providers proposed by the plan,
 - (b) the training and experience of the requested out-of-network provider,
 - (c) the clinical standards of the plan,
 - (d) the information provided concerning the insured,
 - (e) the attending physician's recommendation,
 - (f) the insured's medical record, and
 - (g) any other pertinent information,
 - (3) subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan,
 - (4) binding on the plan and the insured, and
 - (5) admissible in any court proceeding, and

c. upon reaching its decision, submit to the enrollee and the health benefit plan, a written statement that:

(1) the out-of-network referral shall be covered by the health care plan either when the reviewer or a majority of the panel of reviewers determines that:

(a) the health plan does not have a provider with the appropriate training and experience to meet the particular health care needs of an insured who is able to provide the requested health service, and

(b) the out-of-network provider has the appropriate training and experience to meet the particular health care needs of an insured, is able to provide the requested health service and is likely to produce a more clinically beneficial outcome, or

(2) the external appeal agent is upholding the health plan's denial of coverage.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7512 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A carrier shall provide a provider directory on its website and in print format.

1 1. The carrier shall regularly, but at least annually, audit a
2 reasonable sample size of its provider directories for accuracy and
3 retain documentation of such an audit to be made available to the
4 Insurance Commissioner upon request.

5 2. The directory on the carrier website and in print format
6 shall contain the following general information in plain language for
7 each network plan:

- 8 a. a description of the criteria the carrier has used to
9 build its network,
- 10 b. if applicable, a description of the criteria the
11 carrier has used to tier providers,
- 12 c. if applicable, how the carrier designates the different
13 provider tiers or levels in the network and identifies
14 for each specific provider, hospital or other type of
15 facility in the network in which tier each is placed
16 (for example by name, symbols or grouping), in order
17 for a covered person or a prospective covered person to
18 be able to identify the provider tier,
- 19 d. if applicable, a statement that authorization or
20 referral may be required to access some providers,
- 21 e. what provider directory applies to which network plan,
22 such as including the specific name of the network plan
23 as marketed and issued in this state, and

f. a customer service email address and telephone number or electronic link that enrollees or the public may use to notify the carrier of inaccurate provider directory information.

B. Regarding the directory posted on the carrier website, the carrier shall:

1. Update the provider directory within three (3) business days after any change to the directory;

2. Ensure that the public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without the need to create or access an account or enter a policy or contract number;

3. Make available in a searchable format the following information for each network plan:

a. for health care professionals: name, gender, participating office locations, specialty if applicable, medical group affiliations if applicable, facility affiliations if applicable, participating facility affiliations if applicable, languages spoken other than English if applicable and whether the provider is accepting new patients,

b. for hospitals: hospital name, hospital type (i.e., acute, rehabilitation, children's, cancer),

1 participating hospital location and hospital
2 accreditation status, and

3 c. for facilities, other than hospitals, by type:
4 facility name, facility type, types of services
5 performed and participating facility locations; and

6 4. Make available the following information in addition to the
7 information available under paragraph 3 of this subsection:

8 a. for health care professionals: contact information,
9 board certifications and languages spoken other than
10 English by clinical staff, if applicable,

11 b. for hospitals: telephone number, and

12 c. for facilities other than hospitals: telephone number.

13 C. Regarding the provider directory in print format, the
14 carrier shall include a disclosure that the directory is accurate as
15 of the date of printing and that enrollees and prospective enrollees
16 should consult the carrier's electronic provider directory on its
17 website or call customer service to obtain current provider directory
18 information.

19 D. Upon request of an enrollee or a prospective enrollee, the
20 carrier shall make available in print format the following provider
21 directory information for the applicable network plan:

22 1. For health care professionals: name, contact information,
23 participating office locations, specialty if applicable, languages
24

1 spoken other than English if applicable and whether the provider is
2 accepting new patients;

3 2. For hospitals: hospital name, hospital type (i.e., acute,
4 rehabilitation, children's, cancer) and participating hospital
5 location and telephone number; and

6 3. For facilities, other than hospitals, by type: facility name,
7 facility type, types of services performed and participating
8 facility locations and telephone number.

9 SECTION 14. This act shall become effective November 1, 2019.

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