ENGROSSED HOUSE
BILL NO. 3388

By: Sneed, Townley, Boatman, Roe, Pae, Sterling, Davis, Marti, Cornwell, Moore, Frix, Olsen, Sims, Randleman, Sanders, Tadlock, McCall, Stark, Grego, Vancuren, Phillips, Johns, Humphrey, Hardin (David), West (Josh), Roberts (Dustin), Fincher, Gann, Roberts (Sean), May and Ortega of the House

and

David of the Senate

[insurance - creating the Oklahoma Out-of-Network Surprise Billing and Transparency Act - 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 6060.60 of Title 36, unless there is created a duplication in numbering, reads as follows:

Sections 1 through 21 of this act shall be known and may be cited as the "Oklahoma Out-of-Network Surprise Billing and Transparency Act".

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

The Oklahoma Out-of-Network Surprise Billing and Transparency Act shall apply to all state-regulated health benefit plans except:

1. HealthChoice health benefit plans administered by the Oklahoma Office of Management and Enterprise Services;

2. Medicaid;

3. Medicare; and

4. The Employee Retirement Income Security Act of 1974 health benefit plans.

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

As used in the Oklahoma Out-of-Network Surprise Billing and Transparency Act:

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

2. "Geozip" means an area that includes all zip codes with identical first three digits;

3. "Surprise billing" means the practice by a health care provider or facility who does not, or is unable to, participate in an enrollee's health benefit plan network, and charges an enrollee the difference between the provider's or facility's fee and the sum of what the enrollee's health benefit plan pays and what the enrollee is required to pay in applicable deductibles, copayments, coinsurance or other cost-sharing amounts required by the health benefit plan; and

4. "Usual, customary, and reasonable rate" or "UCR rate" means the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area as reported in an independent benchmarking database maintained by a nonprofit organization specified by the Insurance Commissioner; provided, the nonprofit organization shall not be financially affiliated with an insurance carrier or health care provider.

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

All health insurance benefit policies must reference the usual, customary, and reasonable rate for the purpose of providing an enrollee with reimbursement transparency for out-of-network health care providers and facilities. The charges for services reflected by the Current Procedural Terminology code as reflected in the

eighteenth percentile of charge data supplied by an independent benchmarking database on November 1, 2020, shall constitute the baseline for provider or facility charges. Beginning November 1, 2020, provider or facility charges may change anytime the charge data supplied by an independent benchmarking database changes, but may not increase at a rate greater than the Consumer Price Index.

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

If a health benefit plan issuer or administrator has restricted or prohibited a health care provider or health care facility from billing an insured, participant or enrollee for applicable copayment, coinsurance, and deductible amounts required under the Oklahoma Out-of-Network Surprise Billing and Transparency Act, the Attorney General may bring a civil action in the name of the state to ensure the health care provider, health care facility or administrator may bill an enrollee the applicable copayment, coinsurance, and deductible amounts. If the Attorney General prevails in an action brought against a health benefit plan issuer or administrator, the Attorney General may recover reasonable attorney fees, costs and expenses, including court costs and witness fees incurred in bringing the action.

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

If a health care provider, health care facility or administrator has billed an enrollee an amount greater than the applicable copayment, coinsurance, and deductible amounts required under the Oklahoma Out-of-Network Surprise Billing and Transparency Act, the Attorney General may bring a civil action in the name of the state to ensure the enrollee is not responsible for an amount greater than the applicable copayment, coinsurance, and deductible amounts. If the Attorney General prevails in an action brought against a health benefit plan issuer or administrator, the Attorney General may recover reasonable attorney fees, costs and expenses, including court costs and witness fees incurred in bringing the action.

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

A. When an enrollee in a health benefit plan that covers emergency services receives the services from an out-of-network provider or out-of-network facility, the health benefit plan shall ensure that the enrollee shall incur no greater out-of-pocket costs for the emergency services than the enrollee would have incurred with an in-network provider.

B. If a covered person receives covered emergency services by an out-of-network provider or out-of-network facility, the carrier shall pay the out-of-network provider directly and the initial payment shall be the greater of the:

1. Medicare rate;

2. In-network rate;

3. Usual, customary, and reasonable rate; or

4. Agreed upon rate.

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

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

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

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

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

B. The enrollee who receives care shall not be responsible for any amount greater than his or her applicable in-network copayment, coinsurance, and deductible amounts.

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

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

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

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

A. If a covered person with out-of-network health benefits elects to receive covered services at an out-of-network facility from an out-of-network provider, the carrier shall pay the out-of-network provider and facility directly and the initial payment shall be paid at the usual, customary, and reasonable rate or an agreed upon rate.

The enrollee who receives care shall not be responsible for any amount greater than his or her applicable out-of-network copayment, coinsurance, and deductible amounts.

B. The insurer shall make the payment required by this section directly to the provider and facility no later than, as applicable:

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

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

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

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

A. A health care or medical service or supply provided at a location that does not have a zip code is considered to be provided in the geozip area closest to the location at which the service or supply is provided.

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

1. Be affiliated with a health benefit plan issuer or administrator, a health care practitioner or other health care provider; or

2. Have any other conflict of interest.

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

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

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

D. Insurers shall be required to submit data necessary for the use of the benchmarking database as specified in this section.

E. The Commissioner may adopt rules governing the submission of information for the benchmarking database.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.70 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An out-of-network provider, out-of-network facility, and health benefit plan issuer or administrator may request arbitration of a settlement of an out-of-network health benefit claim through a portal on the Oklahoma Insurance Department's website if:

1. There is an amount billed by the out-of-network provider or out-of-network facility and unpaid by the issuer or administrator

after copayments, coinsurance, and deductibles for which an enrollee may not be billed; or

2. a. The required usual, customary, and reasonable rate paid by an insurer is deemed unreasonable, and

b. The health benefit claim is for:

(1) nonemergency care provided at an out-of-network facility,

(2) nonemergency care provided by an out-of-network provider,

(3) emergency care provided at an out-of-network facility,

(4) emergency care provided by an out-of-network provider, or

(5) an emergency claim denial is based on a review of the patient's diagnosis code.

B. If a person requests arbitration under this section, and depending on who initiates, the out-of-network provider, out-of-network facility, or a representative of the provider or facility, and the health benefit plan issuer or the administrator, as appropriate, shall participate in the arbitration.

C. Not later than ninety (90) days after the date an out-of-network provider or out-of-network facility receives the initial payment for a health care or medical service or supply, the out-of-network provider, health care facility, or representative of the

out-of-network health care provider or out-of-network facility, health benefit plan issuer or administrator may request arbitration of a settlement of an out-of-network health benefit claim through a portal on the Department's website if:

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

2. a. The required usual, customary, and reasonable rate paid by an insurer is deemed unreasonable, and

b. The health benefit claim is for:

(1) nonemergency care provided at an out-of-network facility,

(2) nonemergency care provided by an out-of-network provider,

(3) emergency care provided at an out-of-network facility,

(4) emergency care provided by an out-of-network provider, or

(5) an emergency claim denial is based on a review of the patient's diagnosis code.

D. Nothing in this section shall prohibit a health care provider or facility from utilizing arbitration in cases where medical necessity is disputed.

E. If a person requests arbitration, the out-of-network provider, out-of-network facility, or an appropriate representative, and the health benefit plan issuer or administrator, as appropriate, shall participate in the arbitration.

F. The party who requests arbitration shall provide written notice on the date the arbitration is requested in the form and manner prescribed by Insurance Commissioner rule to:

1. The Department; and

2. Each party.

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

H. The Commissioner shall promulgate rules providing requirements for submitting multiple claims to arbitration in one proceeding. The rules shall provide:

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

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

I. Nothing in this section shall be construed to limit the amount in controversy for an individual claim in one arbitration proceeding.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.71 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The only issue the arbitrator may determine is the reasonable amount for the health care or medical services or supplies provided to the enrollee by an out-of-network provider or out-of-network facility.

B. The determination shall take into account:

1. Whether there is a disparity between the fee billed by the out-of-network provider or out-of-network facility;

2. Fees paid to the out-of-network provider or out-of-network facility;

3. Level of training, education, and experience of the out-of-network provider;

4. The out-of-network provider's or facility's usual billed charge for comparable services or supplies with regard to other enrollees for which the provider or facility is out-of-network;

5. The circumstances and complexity of the enrollee's particular case, including the time and place of the provision of service or supply;

6. Individual enrollee characteristics;

7. Medical journals and peer-reviewed articles pertaining to medical necessity;

8. Percentiles of out-of-network billed charges for the same service or supply performed by a health care provider or facility in the same or similar specialty and provided in the same geozip as reported in a benchmarking database;

9. The usual, customary, and reasonable rate as defined in Section 3 of this act;

10. The history of networking contracting between the parties;

11. Historical data for percentiles; and

12. An offer made during the informal settlement teleconference.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.72 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An out-of-network provider, facility or health benefit plan issuer or administrator may not file suit for an out-of-network claim subject to the Oklahoma Out-of-Network Surprise Billing and Transparency Act until the conclusion of the arbitration on the issue of the amount to be paid in the out-of-network claim dispute.

B. The arbitration conducted under the Oklahoma Out-of-Network Surprise Billing and Transparency Act is not subject to the Uniform Arbitration Act.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.73 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If parties are unable to mutually agree on an arbitrator within thirty (30) days after the date the arbitration is requested, the party requesting arbitration shall notify the Insurance Commissioner, and the Commissioner shall select an arbitrator from the Commissioner's list of approved arbitrators.

B. In selecting an arbitrator, the Commissioner shall give preference to an arbitrator who is knowledgeable and experienced in applicable principles of contract and insurance law and the health care industry generally.

C. In approving an individual as an arbitrator, the Commissioner shall ensure that the individual does not have a conflict of interest that would adversely impact the arbitrator's independence and impartiality in rendering a decision in an arbitration. A conflict of interest includes current or recent ownership or employment of the individual or a close family member as a health benefit issuer or administrator, physician, health care practitioner, or other health care provider.

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

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.74 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The arbitrator shall set a date for submission of all information to be considered by the arbitrator.

B. A party shall not engage in discovery in connection with the arbitration.

C. On agreement of all parties, any deadline may be extended.

D. The party which is not awarded the amount submitted to arbitration shall pay all expenses and fees required by the arbitrator.

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

SECTION 16. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.75 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. No later than fifty-one (51) days after the date the arbitration is requested, an arbitrator shall provide the parties with a written decision in which the arbitrator:

1. Determines whether the health care provider or health care facility's charge is reasonable;

2. Determines whether the usual, customary, and reasonable rate paid by an insurer is unreasonable; and

3. Selects the amount determined to be the closest as the binding award.

B. An arbitrator shall not modify the binding award amount.

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

SECTION 17. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.76 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An arbitrator's decision shall be binding.

B. No later than forty-five (45) days after the date of an arbitrator's decision, a party not satisfied with the decision may file an action to determine the payment due.

C. In an action filed, the court shall determine whether the arbitrator's decision is proper based on a substantial evidence review.

D. No later than thirty (30) days after the date of an arbitrator's decision, a health benefit plan issuer or administrator shall pay the amount necessary to satisfy the binding award.

E. Based on the arbitrator's binding award amount, the losing party shall be required to pay the arbitrator's fees and expenses.

SECTION 18. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.77 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The following constitutes bad faith participation in arbitration:

1. Failing to participate in the informal settlement teleconference;

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

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

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

SECTION 19. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.78 of Title 36, unless there is created a duplication in numbering, reads as follows:

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

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

C. The Insurance Commissioner and the Oklahoma Board of Medical Licensure and Supervision or other regulatory agency, as appropriate, shall adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim.

1. The rules adopted shall distinguish between complaints for out-of-network coverage or payment and give priority to investigating allegations of delayed health care or medical care;

2. Develop a form for filing a complaint; and

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

D. The Oklahoma Insurance Department and State Board of Medical Licensure and Supervision or other appropriate regulatory agency shall maintain the following information on each complaint filed that concerns a claim and arbitration:

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

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

3. The county and metropolitan area in which the health care or medical service or supply was provided;

4. Whether the health care or medical service or supply was for emergency care;

5. Any other information about the health benefit plan issuer or administrator that the Commissioner by rule requires; or

6. The out-of-network provider or facility that the State Board of Medical Licensure and Supervision or other appropriate regulatory agency by rule requires.

E. All information collected is public information and may not include personally identifiable information.

SECTION 20. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.79 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma State Insurance Department shall, each biennium, conduct a study on the impacts of the Oklahoma Out-of-Network Surprise Billing and Transparency Act and shall include:

1. Trends and changes in billed amounts;

2. Trends and changes in paid amounts;

3. Trends and changes in network participation;

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

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

6. Number of complaints and results of claims that enter arbitration, including effectiveness of arbitration.

B. Beginning December 1, 2021, and no later than December 1 of every other year thereafter, the Department shall prepare and submit a written report on the results of the study to the Legislature and appropriate committees.

SECTION 21. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.80 of Title 36, unless there is created a duplication in numbering, reads as follows:

An insurer shall provide by written notice an explanation of benefits provided to the insured and the physician or health care provider in connection with a medical care or health care service or supply provided by an out-of-network provider or facility. The notice shall include a statement of the billing prohibition as applicable to the Oklahoma Out-of-Network Surprise Billing and Transparency Act that includes:

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

2. An explanation of benefits provided to the health care provider or facility with information required by rule advising the health care provider or facility of the availability of arbitration,

as applicable under the Oklahoma Out-of-Network Surprise Billing and Transparency Act; and

3. For elective services that are covered by an enrollee's health benefit plan, if requested by an enrollee before a scheduled service and explanation of benefits, the provider's average amounts paid to comparable in-network health care providers or facilities for covered services.

SECTION 22. AMENDATORY 12 O.S. 2011, Section 1854, is amended to read as follows:

Section 1854. A. The Uniform Arbitration Act governs an agreement to arbitrate made on or after January 1, 2006.

B. The Uniform Arbitration Act governs an agreement to arbitrate made before January 1, 2006, if all the parties to the agreement or to the arbitration proceeding so agree in a record.

C. Beginning January 1, 2006, the Uniform Arbitration Act governs an agreement to arbitrate whenever made.

D. The Uniform Arbitration Act shall not apply to the Oklahoma Out-of-Network Surprise Billing and Transparency Act.

SECTION 23. This act shall become effective November 1, 2020.

Passed the House of Representatives the 11th day of March, 2020.

_____
Presiding Officer of the House
of Representatives

Passed the Senate the ___ day of _____, 2020.

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Presiding Officer of the Senate