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

participating in dispute resolution; requiring Department to maintain list of reviewers; directing Department to establish application process and fee schedule; authorizing independent reviewer to determine reasonableness of charges for certain medical services; allowing parties to provide information to independent reviewer to be considered for dispute resolution; providing eligibility qualification to serve as independent reviewer; authorizing health carriers to initiate independent dispute resolution proceedings; requiring Department to arrange an informal settlement conference; authorizing oral hearings in certain dispute resolutions; assigning costs of dispute resolution; authorizing court enforcement of independent reviewer's decision; providing for confidentiality; requiring out-of-network billing statement to contain certain information; classifying out-of-network referral denial; requiring certain information for denials; providing for appeal of out-of-network referral denial; providing procedure for external appeal after internal appeal; requiring external appeal agent to provide written statement; requiring 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".

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

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

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

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

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

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

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

3. Medicare;

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

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

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

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

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

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

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

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

4. "Department" means the Oklahoma Insurance Department;

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

a. placing the health of the patient in serious jeopardy,

b. serious impairment to bodily functions, or

c. serious dysfunction of any bodily organ or part;

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

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

a. to whom the health care facility has granted clinical privileges, and

b. who provide services to patients treated at the health care facility under those clinical privileges;

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

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

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

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

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

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

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

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

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

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

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

19. "Surprise out-of-network bill" means a bill submitted by an out-of-network provider charging a health benefit plan the difference between the provider's fee 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 that meets one of the requirements listed in subsection A of Section 5 of this act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Notice:

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

training and experience to meet the particular health care needs of the enrollee,

b. of the procedure for requesting and obtaining such referral or preauthorization,

c. that the enrollee with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist,

d. of the procedure for requesting and obtaining such a standing referral,

e. that the enrollee with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request a specialist responsible for providing or coordinating the enrollee's medical care,

f. of the procedure for requesting and obtaining such a specialist,

g. that the enrollee with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center, and

h. of the procedure for requesting and obtaining such access;

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

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

a. a clear description of the methodology used by the carrier to determine reimbursement for out-of-network health care services,

b. a description of the amount that the carrier will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual, customary and reasonable rate for out-of-network health care services,

c. examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services,

d. information that reasonably permits an enrollee to estimate the anticipated out-of-pocket cost for out-of-network services in a geographical area or zip code based upon the difference between what the health benefit plan will reimburse for out-of-network services and the usual, customary and reasonable rate for out-of-network services, and

e. a statement that an enrollee is not responsible for any charges for an out-of-network service in excess of applicable copayment, coinsurance or deductible amounts if the enrollee or the enrollee's

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. A facility shall post on its website:

1. The networks in which the facility participates;

2. A statement that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. bear its own attorney fees and costs, and

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

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

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

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

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

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

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

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

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

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

3. A conspicuous, plain-language explanation that:

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

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

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

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

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

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

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

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

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

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

B. Out-of-network providers who do not provide an enrollee with a Payment Responsibility Notice, as outlined in subsection A of this section, or do not obtain, within a reasonable amount of time before the enrollee receives the services, the signature of the enrollee or the enrollee's representative on the disclosure required by paragraph 2 of subsection A of Section 5 of this act may not bill the enrollee for the difference between the provider'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, but may initiate an independent dispute resolution proceeding pursuant to Section 10 of this act.

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

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

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

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

a. the in-network provider or providers recommended by the health benefit plan do not have the appropriate training and experience to meet the particular health care needs of the enrollee for the health service, and

b. the attending physician recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the enrollee and who is able to provide the requested health service.

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

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

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

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

a. a description of the criteria the carrier has used to build its network,

b. if applicable, a description of the criteria the carrier has used to tier providers,

c. if applicable, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network in which tier each is placed (for example by name, symbols or grouping), in order for a covered person or a prospective covered person to be able to identify the provider tier,

d. if applicable, a statement that authorization or referral may be required to access some providers,

e. what provider directory applies to which network plan, such as including the specific name of the network plan 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),

participating hospital location and hospital accreditation status, and

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

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

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

b. for hospitals: telephone number, and

c. for facilities other than hospitals: telephone number.

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

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

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

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

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

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

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

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