STATE OF OKLAHOMA

1st Session of the 59th Legislature (2023)

SENATE BILL 881 By: Montgomery

AS INTRODUCED

An Act relating to health insurance; creating the Surprise Billing Protection Act of 2023; providing short title; defining terms; establishing provisions for reimbursement and certain cost-sharing requirements; requiring reimbursement under certain circumstances; construing provisions; prohibiting certain surprise billings; providing for certain appeals; requiring certain facilities to publish certain information by certain date; requiring refund to insured under certain circumstances; providing for interest to accrue for nonpayment; requiring Insurance Commissioner to annually review certain reimbursements by certain date; directing promulgation of rules; requiring provisions of act to apply to certain health coverage types; establishing certain reimbursement rate; prohibiting provider from submitting surprise bill; providing for adoption by certain exempted plans; allowing providers to recover certain fees and costs; requiring insurer to pay certain penalty for late payment; establishing penalty structure; providing for exemption from penalties; establishing payment process and means for payment; 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 4451 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 "Surprise Billing Protection Act of 2023".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4452 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in this section:

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

2. "Ambulance transportation service" means any government or private ground transportation service designated and used, or intended to be used, for the transportation of sick or injured persons;

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

4. "Claim" means a request from a provider for payment for health care services rendered;

5. “Co-insurance” means a cost-sharing method that requires a covered person to pay a stated percentage of medical expenses after any deductible amount is paid; provided, that co-insurance rates may differ for different types of services under the same health benefits plan;

6. “Copayment” means a cost-sharing method that requires a covered person to pay a fixed dollar amount when health care services are received, with the health insurance carrier paying the balance allowable amount; provided, that there may be different copayment requirements for different types of services under the same health benefits plan;

7. “Cost-sharing” means a copayment, co-insurance, deductible, or any other form of financial obligation of a covered person other than premium or share of premium, or any combination of any of these financial obligations as defined by the terms of a health benefits plan;

8. “Covered benefits” means those health care services to which a covered person is entitled under the terms of a health benefits plan;

9. “Covered person” means:

a. an enrollee, policyholder, or subscriber,

b. the enrolled dependent of an enrollee, policyholder, or subscriber, or

c. another individual participating in a health benefits plan;

10. "Deductible" means a fixed dollar amount that a covered person may be required to pay during the benefit period before the health insurance carrier begins payment for covered benefits; provided, that a health benefits plan may have both individual and family deductibles and separate deductibles for specific services;

11. "Emergency care" means a health care procedure, treatment, service, or ambulance transportation service delivered to a covered person after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention, regardless of eventual diagnosis, could be expected by a reasonable layperson to result in jeopardy to a person's physical or mental health or to the health or safety of a fetus or pregnant person, serious impairment of bodily function, serious dysfunction of a bodily organ or part, or disfigurement to a person;

12. "Facility" means an entity providing a health care service, including:

a. a general, special, psychiatric, or rehabilitation hospital,

b. an ambulatory surgical center,

c. a cancer treatment center,

d. a birth center,

e. an inpatient, outpatient, or residential drug and alcohol treatment center,

f. a laboratory, diagnostic, or other outpatient medical service or testing center,

g. a health care provider’s office or clinic,

h. an urgent care center,

i. a Hospital Outpatient Emergency Department emergency room, or

j. any other therapeutic health care setting;

13. “Hospital Outpatient Emergency Department emergency room” means a facility licensed by the State Department of Health that is physically separate from an acute care hospital and that provides twenty-four-hour emergency care to patients at the same level of care that a hospital-based emergency room delivers;

14. “Health benefit plan” means a policy or agreement entered into or offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services; provided, that “health benefits plan” does not include any of the following:

a. an accident-only policy,

b. a credit-only policy,

c. a long- or short-term care or disability,

d. a specified disease policy,

e. coverage provided pursuant to Title 18 of the federal Social Security Act, as amended,

f. a federal TRICARE policy, including a federal civilian health and medical program of the uniformed services supplement,

g. a fixed indemnity policy,

h. a dental-only policy,

i. a vision-only policy,

j. a workers' compensation policy,

k. an automobile medical payment policy, or

l. any other policy specified in rules by the Insurance Department;

15. "Health care services" means any service, supply, or procedure for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or other disease, including physical or behavioral health services, to the extent offered by a health benefits plan;

16. "Health insurance carrier" means an entity subject to state insurance laws, including a health insurance company, a health maintenance organization, a hospital and health service corporation, a provider service network, a nonprofit health care plan or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for, or reimburse any costs of health care services or that provides, offers, or

administers a health benefit policy or managed health care plan in the state;

17. “Hospital” means a facility offering inpatient health care services, nursing care and overnight care on a twenty-four-hours-per-day, seven-days-per-week basis for the diagnosis and treatment of physical, behavioral, or rehabilitative health conditions;

18. “Inducement” means the act or process of enticing or persuading another person to take a certain course of action;

19. “Network” means the group or groups of participating providers that have been contracted to provide health care services under a network plan;

20. “Network plan” means a health benefits plan that either requires a covered person to use or creates incentives, including financial incentives, for a covered person to use providers and facilities managed, owned, under contract with, or employed by the health insurance carrier offering the health benefits plan;

21. “Nonparticipating provider” means a provider who is not a participating provider;

22. “Participating provider” means a provider or facility that, under express contract with a health insurance carrier or with a health insurance carrier’s contractor or subcontractor, has agreed to provide health care services to covered persons, with an expectation of receiving payment directly or indirectly from the health insurance carrier, subject to cost-sharing;

23. “Prior authorization” means a pre-service determination made by a health insurance carrier regarding a covered person’s eligibility for services, medical necessity, benefit coverage, and the location or appropriateness of services, pursuant to the terms of a health benefits plan that the health insurance carrier offers;

24. “Provider” means a health care professional, hospital, or other facility licensed to furnish health care services;

25. “Stabilize” means to provide emergency care to a patient as may be necessary to ensure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient to a facility or, with respect to emergency labor, to deliver, including the delivery of a placenta; and

26. “Surprise bill” means a bill that a nonparticipating provider issues to a covered person for health care services in an amount that exceeds the covered person’s cost-sharing obligation that would apply for the same health care services if these services had been provided by a participating provider and are rendered in the following circumstances:

a. emergency care provided by the nonparticipating provider, or

b. health care services, that are not emergency care, rendered by a nonparticipating provider at a participating facility where:

(1) a participating provider is unavailable,

(2) a nonparticipating provider renders unforeseen services, or

(3) a nonparticipating provider renders services for which the covered person has not given specific consent for that nonparticipating provider to render the particular services rendered,

For the purposes of this act, "surprise bill" shall not mean a bill received for:

c. health care services received by a covered person when a participating provider was available to render the health care services and the covered person knowingly elected to obtain the services from a nonparticipating provider without prior authorization, or

d. health care services rendered by a nonparticipating provider to a covered person whose coverage is provided pursuant to a preferred provider plan, provided that the health care services are not provided as emergency care.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4453 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health insurance carrier shall directly reimburse a nonparticipating provider for emergency care necessary to evaluate

and stabilize a covered person if a prudent layperson would reasonably believe that emergency care is necessary, regardless of eventual diagnosis.

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

C. A health insurance carrier may impose a cost-sharing or limitation of benefits requirement for emergency care performed by a nonparticipating provider only to the same extent that the copayment, co-insurance or limitation of benefits requirement applies for participating providers and is documented in the policy.

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

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4454 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Other than applicable cost-sharing that would apply if a participating provider had rendered the same services, a health insurance carrier shall provide direct reimbursement for and a covered person shall not be liable for charges and fees for covered

non-emergency care rendered by a nonparticipating provider that are delivered when:

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

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

B. Except as set forth in subsection A of this section, nothing in this section shall preclude a nonparticipating provider from balance billing for non-emergency care provided by a nonparticipating provider to an individual who has knowingly chosen to receive services from that nonparticipating provider.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4455 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A nonparticipating provider shall not knowingly submit a surprise bill to a covered person.

B. In accordance with the hearing procedures established pursuant to this act, a covered person may appeal a health insurance carrier's determination made regarding a surprise bill.

C. By December 31, 2023, the State Department of Health shall require each health facility licensed pursuant to the Public Health

Act to post the following on the health facility's website in a publicly accessible manner:

1. The names and hyperlinks for direct access to the websites of all health benefits plans for which the hospital has a contract for services;

2. A statement that sets forth the following:

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

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

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

3. The rights of covered persons under this act; and

4. Instructions for contacting the Insurance Department.

D. Any communication from a provider, bill collector, or health insurance carrier pertaining to services provided under circumstances giving rise to a surprise bill shall clearly state that the covered person is responsible only for payment of

applicable in-network cost-sharing amounts under the covered person’s health benefits plan.

E. When a nonparticipating provider under nonemergency circumstances has advance knowledge that the nonparticipating provider is not contracted with the covered person’s health insurance carrier, the nonparticipating provider shall inform the covered person of the nonparticipating provider’s nonparticipating status and advise the covered person to contact the covered person’s health insurance carrier to discuss the covered person’s options.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4456 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If a covered person pays a nonparticipating provider more than the in-network cost-sharing amount for services provided under circumstances giving rise to a surprise bill, the nonparticipating provider shall refund to the covered person within forty-five calendar days of receipt any amount paid in excess of the in-network cost-sharing amount.

B. If a nonparticipating provider has not made a full refund to the covered person of any amount paid in excess of the in-network cost-sharing amount to the covered person within forty-five calendar days of receipt, interest shall accrue at the rate of ten percent (10%) per year beginning with the first calendar day following the forty-five-calendar-day period.

C. A covered person may seek recovery of the refund of the amount the covered person has paid in excess of the in-network cost-sharing amount that a nonparticipating provider owes, plus interest, pursuant to subsection B of this section by bringing an action in district court to recover that overpayment amount and interest owed and reasonable costs and attorney fees, if approved by the court.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4457 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Commissioner shall review the reimbursement rate for surprise bills by July 1, 2024, and every year thereafter to ensure fairness to providers and to evaluate the impact on health insurance premiums.

B. Calculation of the date of health insurance carrier receipt of a claim shall align with requirements for prompt payment.

C. A health insurance carrier shall make available to providers access to claims status information.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4458 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Insurance Commissioner shall promulgate rules as may be necessary to appropriately implement the provisions of the Surprise Billing Protection Act of 2023 and require by rule that health insurance carriers report the annual percentage of claims and

expenditures paid to nonparticipating providers for health care services.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4459 of Title 36, unless there is created a duplication in numbering, reads as follows:

The provisions of the Surprise Billing Protection Act of 2023 apply to the following types of health coverage delivered or issued for delivery in this state:

1. Group health coverage governed by the provisions of the Health Care Purchasing Act;

2. Individual health insurance policies, health benefits plans, and certificates of insurance governed by this title;

3. Multiple-employer welfare arrangements governed by this title;

4. Group and blanket health insurance policies, health benefits plans, and certificates of insurance governed by this title; and

5. Individual and group health maintenance organization contracts governed by the provisions of Section 6901 et seq. of Title 36 of the Oklahoma Statutes, including individual and group nonprofit health benefits plans governed by the provisions of Section 6952 et seq. of Title 36 of the Oklahoma Statutes.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4460 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Payment standard is defined as the greatest of the following with in-network coinsurance, copayments, and deductibles being excluded:

1. The median rate negotiated with in-network providers, facilities, emergency facilities, or ambulances for the service in question in that geographic region under that health benefits plan, which amount shall be disregarded when there is no per service amount, or when there is a capitation payment in place;

2. The usual, customary, and reasonable rate amount for out-of-network services which is defined by the seventy-fifth percentile of benchmarks for similar services in the community where services were provided published by an independent nonprofit that collects data for and manages the nation's largest database of privately billed health insurance claims and is entrusted with Medicare Parts A, B, and D claims data for 2013 to the present; or

3. 250% of the standard Medicare rate for similar services in the community where services were provided.

B. For services provided under circumstances giving rise to a surprise bill, a health insurance carrier shall directly reimburse a nonparticipating provider for care rendered at a rate defined below.

Where a payment standard applies for out-of-network services, the insurer must directly reimburse the out-of-network provider a minimum payment defined as:

1. The usual, customary and reasonable provider rate for out-of-network services in the same specialty in the same geographical area in the community where services were performed within forty-five (45) days of claim submittal as defined by the seventy-fifth percentile of benchmarks for similar services in the community where services were provided as published by an independent nonprofit that collects data for and manages the nation's largest database of privately billed health insurance claims and is entrusted with Medicare Parts A, B and D claims data for 2013 to the present for similar services performed by a provider; or

2. The charge mutually agreed to by the insurer and provider within sixty (60) days of submitting the claim.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4461 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A provider shall not knowingly submit to a covered person a surprise bill for health care services, which surprise bill demands payment for any amount in excess of the cost-sharing amounts that would have been imposed by the covered person's health benefits plan if the health care service from which the surprise bill arises had been rendered by a participating provider.

B. It shall be an unfair practice for a health care provider to submit a surprise bill to a collection agency.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4462 of Title 36, unless there is created a duplication in numbering, reads as follows:

A large group or self-insured health plan offered in accordance with the provisions of the federal Employee Retirement Income Security Act of 1974 that is exempt from regulation under the Oklahoma Insurance Code may adopt the provisions of the Surprise Billing Protection Act of 2023. The office of the Insurance Commissioner shall post on its website in a manner that is accessible to the public, information on which exempt large group and self-insurance health plans follow the provisions of the Surprise Billing Protection Act of 2023.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4463 of Title 36, unless there is created a duplication in numbering, reads as follows:

A provider may recover reasonable attorney fees and court costs in an action to recover payment under this act.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4464 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as provided by this section, if a clean claim submitted to an insurer is payable and the insurer does not determine that the claim is payable and pay the claim on or before the date the insurer is required to make a determination or

adjudication of the claim, the insurer shall pay the provider making the claim the contracted rate owed on the claim plus a penalty in the amount of the lesser of:

1. Fifty percent (50%) of the difference between the billed charges, as submitted on the claim, and the contracted rate; or

2. One Hundred Thousand Dollars ($100,000.00).

B. If the claim is paid on or after the forty-sixth day and before the ninety-first day after the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay a penalty in the amount of the lesser of:

1. One hundred percent (100%) of the difference between the billed charges, as submitted on the claim, and the contracted rate; or

2. Two Hundred Thousand Dollars ($200,000.00).

C. If the claim is paid on or after the ninety-first day after the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay a penalty computed under subsection B of this section plus eighteen percent (18%) annual interest on that amount. Interest under this subsection accrues beginning on the date the insurer was required to pay the claim and ending on the date the claim and the penalty are paid in full.

D. Except as provided by this section, an insurer that determines under subsection C of this section that a claim is

payable, pays only a portion of the amount of the claim on or before the date the insurer is required to make a determination or adjudication of the claim, and pays the balance of the contracted rate owed for the claim after that date shall pay to the provider, in addition to the contracted amount owed, a penalty on the amount not timely paid in the amount of the lesser of:

1. Fifty percent (50%) of the underpaid amount; or

2. One Hundred Thousand Dollars ($100,000.00).

E. If the balance of the claim is paid on or after the forty-sixth day and before the ninety-first day after the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay a penalty on the balance of the claim in the amount of the lesser of:

1. One hundred percent (100%) of the underpaid amount; or

2. Two Hundred Thousand Dollars ($200,000.00).

F. If the balance of the claim is paid on or after the ninety-first day after the date the insurer is required to make a determination or adjudication of the claim, the insurer shall pay a penalty on the balance of the claim computed under subsection E of this section plus eighteen percent (18%) annual interest on that amount. Interest under this subsection accrues beginning on the date the insurer was required to pay the claim and ending on the date the claim and the penalty are paid in full.

G. For the purposes of subsections D and E of this section, the underpaid amount is computed on the ratio of the amount underpaid on the contracted rate to the contracted rate as applied to an amount equal to the billed charges as submitted on the claim minus the contracted rate.

H. An insurer is not liable for a penalty under this section:

1. If the failure to pay the claim in accordance with subsection C of this section is a result of a catastrophic event that substantially interferes with the normal business operations of the insurer; or

2. If the claim was paid in accordance with subsection C, but for less than the contracted rate, and:

a. the provider notifies the insurer of the underpayment after the two-hundred-seventieth day after the date the underpayment was received, and

b. the insurer pays the balance of the claim on or before the thirtieth day after the date the insurer receives the notice.

The provisions of this subsection shall not be construed to relieve the insurer of the obligation to pay the remaining unpaid contracted rate owed the provider.

I. An insurer that pays a penalty under this section shall clearly indicate on the explanation of payment statement in the

manner prescribed by the Commissioner by rule the amount of the contracted rate paid and the amount paid as a penalty.

J. For a penalty under this section relating to a clean claim submitted by a provider other than an institutional provider, the insurer shall pay the entire penalty to the provider, except for any interest computed under subsection C of this section, which shall be paid to the Oklahoma Health Insurance High Risk Pool. For a penalty under this section relating to a clean claim submitted by an institutional provider, the insurer shall pay fifty percent (50%) of the penalty amount computed under this section, including interest, to the institutional provider and the remaining fifty percent (50%) of that amount to the Oklahoma Health Insurance High Risk Pool.

SECTION 15. This act shall become effective July 1, 2023.

SECTION 16. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

59-1-916 RD 1/19/2023 10:09:39 AM