Bill Summary
1st Session of the 57th Legislature

Bill No.:	**SB 677**
Version:	**INT**
Request No.:	**393**
Author:	**Sen. Bice**
Date:	**01/28/2019**

Bill Analysis

SB 677 creates the Network Adequacy and Use of Out-of-Network Oklahoma Health Care Providers Act. The measure requires the Insurance Commissioner to review networks in the state to ensure each network adequately meets the health needs of insureds and provides an appropriate choice of providers sufficient to render the services covered under the policy or contract.

The Commissioner must review health insurer networks at least every three years. Insurers that issue a comprehensive group or group remittance health insurance policy that covers out-of-network treatment are required to provide at least one option for coverage for at least 80% of the customary cost associated each out-of-network healthcare service. Insurers are further required by the measure to ensure that patients shall incur no greater out-of-pocket costs for emergency services than the insured or enrollee would have incurred with a health care provider that participates in the provider network. The Commissioner may require providers without the 80% out-of-network coverage to provide the service.

Insurers are further required to provide notice to an insured person that he or she may request for specialist referrals, obtain a referral for out-of-network care when the corporation does not have a health care provider who is geographically accessible, and request access to a specialty care center in life threatening situations. Enrollees must also have access to primary and preventive obstetric and gynecologic services. Insurers are also required to provide certain information to enrollees related to the network and out-of-network options. Insurers must make a utilization review determination involving health care services which require pre-authorization available to enrollees. Enrollees are authorized to appeal denials for out-of-network treatment.

A provider is required by the measure to disclose in writing or through a website the health care plans in which the provider is participating and must provide a patient with an estimate of costs associated with a treatment if the provider is not in the patient's network.

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