STATE OF OKLAHOMA

1st Session of the 57th Legislature (2019)

SENATE BILL NO. 677 By: Bice

AS INTRODUCED

An Act relating to health insurance; creating the Network Adequacy and Use of Out-of-Network Providers Act; stating purpose of act; requiring certain insurers to assess network adequacy; requiring Insurance Commissioner to review adequacy at certain times; requiring certain insurers to provide certain coverage options; authorizing Commissioner to require certain coverage options of insurers; authorizing Commissioner to waive certain coverage requirements in certain circumstances; defining terms; requiring Commission to specify certain nonprofit for specified duty; exempting certain medical services from act; providing construing provision; requiring health care plan to cover emergency services at certain cost; requiring insurer give certain notice to insured about coverage; requiring insurer provide certain documents and information to insured about covered facilities and coverage in-network and out-of-network; requiring utilization review agent of insurer to provide certain determination of coverage in certain amount of time; requiring determination be given to insured electronically; establishing terms of determination notification; providing procedure for appeal of determination in-network and out-of-network; requiring external appeal agent for reviews of out-of-network determination; requiring written statement for denial of certain coverage; providing terms of written statement for denial of coverage; requiring certain health care professionals to disclose health care plans and hospitals they belong to; requiring out-of-network health care professionals notify patients in certain circumstances; requiring physicians to provide information of certain health care professionals scheduled to treat patient; requiring hospitals to

post certain information on website; requiring hospitals to provide certain information in admission or registration materials; 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 7410 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 "Network Adequacy and Use of Out-of-Network Providers Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7411 of Title 36, unless there is created a duplication in numbering, reads as follows:

The purpose of this act is to protect consumers from unforeseen medical bills as a result of using out-of-network physicians. New network adequacy requirements, improved disclosures from insurers and providers to consumers and a procedure for appealing out-of-network referral denials will help consumers better navigate the insurance process and reduce the incidence of costly, unforeseen bills.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7412 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An insurer that issues a health insurance policy or contract with a network of healthcare providers shall ensure that the network is adequate to meet the health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract. The Insurance Commissioner shall review the network of health care providers for adequacy at the time of the initial approval of a health insurance policy or contract and at least every three (3) years thereafter, upon application for expansion of any service area associated with the policy or contract. To the extent that the network has been determined by the Commissioner to meet the standards set forth in this Act, such network shall be deemed adequate by the Commissioner.

B. An insurer that issues a comprehensive group or group remittance health insurance policy or contract that covers out-of-network health care services shall make available and, if requested by the policyholder or contract holder, provide at least one option for coverage for at least eighty percent (80%) of the usual and customary cost of each out-of-network healthcare service after imposition of a deductible or any permissible benefit maximum.

C. If there is no coverage available pursuant to subsection B of this section in a rating region, then the Commissioner may require an insurer issuing a comprehensive group or group remittance health insurance policy or contract in the rating region to make available and, if requested by the policyholder or contract holder,

provide at least one option for coverage of eighty percent (80%) of the usual and customary cost of each out-of-network health care service after imposition of any permissible deductible or benefit maximum. The Commissioner may permit an insurer to satisfy the requirements of this paragraph on behalf of another insurer, corporation or health maintenance organization within the same holding company system. The Commissioner may, upon written request, waive the requirement for coverage of out-of-network health care services to be made available pursuant to this subsection if the Commissioner determines that it would pose an undue hardship upon an insurer.

D. For the purposes of this subsection, "usual and customary cost" means the eightieth percentile of all charges 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 benchmarking database maintained by a nonprofit organization specified by the Commissioner. The nonprofit organization shall not be affiliated with an insurer.

E. This subsection shall not apply to emergency care services in hospital facilities or pre-hospital emergency medical services.

F. Nothing in this subsection shall limit the authority of the Commissioner to establish minimum standards for the form, content and sale of accident and health insurance policies and subscriber contracts, to require additional coverage options for out-of-network

services or to provide for standardization and simplification of coverage.

G. When an insured or enrollee under a contract or policy that provides coverage for emergency services receives the services from a health care provider that does not participate in the provider network of an insurer, the health care plan shall ensure that the insured or enrollee shall incur no greater out-of-pocket costs for the emergency services than the insured or enrollee would have incurred with a health care provider that participates in the provider network of the health care plan. For the purpose of this section, "emergency services" includes any healthcare services provided in a healthcare 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 placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7413 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Where applicable, an insurer shall give notice to an insured that:

1. An insured enrolled in a managed care product or in a comprehensive contract that utilizes a network of providers offered by the corporation may obtain a referral or preauthorization for a health care provider outside of the network or panel of the corporation when the corporation does not have a health care provider who is geographically accessible to the insured and who has the appropriate training and experience in the network or panel to meet the particular health care needs of the subscriber and the procedure by which the subscriber can obtain such referral or preauthorization;

2. An insured enrolled in a managed care product or a comprehensive contract that utilizes a network of providers offered by the corporation with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;

3. An insured enrolled in a managed care product or a comprehensive contract that utilizes a network of providers offered by the corporation 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 medical care of the subscriber and the procedure for requesting and obtaining such a specialist;

4. An insured enrolled in a managed care product or a comprehensive contract that utilizes a network of providers offered by the corporation 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 the procedure by which such access may be obtained; and

5. An enrollee shall have direct access to primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations and treatment of acute gynecologic conditions from a qualified provider of such services of her choice from within the plan or for any care related to a pregnancy.

B. Where applicable, an insurer must give to an insured:

1. A listing by specialty, which may be in a separate document that is updated annually, of the name, address and telephone number of all participating providers including facilities, and in addition, in the case of physicians, board certification, languages spoken and any affiliations with participating hospitals. The listing shall also be posted on the website of the insurer and the insurer shall update the website within fifteen (15) days of the addition or termination of a provider from the network of the insurer or a change in a hospital affiliation of a physician;

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

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

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

c. examples of unforeseen out-of-pocket costs for frequently billed out-of-network health care services; and

d. information in writing and through an internet website that reasonably permits an insured or prospective insured to estimate the unforeseen out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the insurer will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7414 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. "Out-of-network referral denial" means a denial under a managed care product of a request for an authorization or referral to an out-of-network provider on the basis that the health care plan has a health care provider in the in-network benefits portion of its network with appropriate training and experience to meet the particular health care needs of an insured, and who is able to provide the requested health service. The notice of an out-of-network referral denial provided to an insured shall include information explaining what information the insured must submit in order to appeal the out-of-network referral denial. An out-of-network referral denial under this subsection does not constitute an adverse determination.

B. A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or designee of the insured and the health care provider of the insured by telephone and in writing within three (3) business days of receipt of the necessary information. To the extent practicable, such written notification to the health care provider of the enrollee shall 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 insured will be held harmless for the services and not be responsible for any payment, other than any applicable co-payment, co-insurance or deductible;

3. As applicable, the dollar amount the health care plan will pay if the service is out-of-network; and

4. As applicable, information explaining how an insured may determine the unforeseen out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health care plan will reimburse for out-of-network health care services and the usual and customary cost for out-of-network health care services

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

1. The in-network health care provider or providers recommended by the health care plan do not have the appropriate training and experience to meet the particular health care needs of the insured for the health service; and

2. The attending physician recommends an out-of-network provider with the appropriate training and experience to meet the

particular health care needs of the insured, and who is able to provide the requested health service.

D. For external appeals requested relating to an out-of-network referral denial, the external appeal agent shall review the final adverse determination of the utilization review agent and, in accordance with the provisions of this act, shall make a determination as to whether the out-of-network referral shall be covered by the health plan; provided that such determination shall be conducted only by one or a greater odd number of clinical peer reviewers and be accompanied by a written statement:

1. Stating that 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, upon review of the training and experience of the in-network health care provider or providers proposed by the plan, the training and experience of the requested out-of-network provider, the clinical standards of the plan, the information provided concerning the insured, the recommendation of the attending physician, the medical record of the insured and any other pertinent information, that 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 that 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. Upholding the health plan's denial of coverage.

The determination shall also be subject to the terms and conditions generally applicable to benefits under the evidence of coverage of the health care plan, be binding on the plan and the insured and be admissible in any court proceeding.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7415 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health care professional, or a group practice of health care professionals, a diagnostic and treatment center or a health center on behalf of health care professionals rendering services at the group practice, diagnostic and treatment center or health center shall disclose to patients or prospective patients in writing or through an Internet website the health care plans in which the health care professional, group practice, diagnostic and treatment center or health center is a participating provider and the hospitals with which the health care professional is affiliated prior to the provision of non-emergency services and verbally at the time an appointment is scheduled.

B. If a health care professional, or a group practice of health care professionals, a diagnostic and treatment center or a health center on behalf of health care professionals rendering services at

the group practice, diagnostic and treatment center or health center does not participate in the network of a health care plan of a patient or prospective patient, the health care professional, group practice, diagnostic and treatment center or health center shall:

1. Prior to the provision of non-emergency services, inform a patient or prospective patient that the amount or estimated amount the health care professional will bill the patient for health care services is available upon request; and

2. Upon receipt of a request from a patient or prospective patient, disclose to the patient or prospective patient in writing the amount or estimated amount or, with respect to a health center, a schedule of fees that the health care professional, group practice, diagnostic and treatment center or health center will bill the patient or prospective patient for health care services provided or anticipated to be provided to the patient or prospective patient absent unforeseen medical circumstances that may arise when the health care services are provided.

C. A health care professional who is a physician shall provide a patient or prospective patient with the name, practice name, mailing address, and telephone number of any health care provider scheduled to perform anesthesiology, laboratory, pathology, radiology or assistant surgeon services in connection with care to be provided in the physician's office for the patient or coordinated

or referred by the physician for the patient at the time of referral to or coordination of services with such provider.

D. A health care professional who is a physician shall, for a scheduled hospital admission of a patient or scheduled outpatient hospital services, provide a patient and the hospital with the name, practice name, mailing address and telephone number of any other physician whose services will be arranged by the physician and are scheduled at the time of the pre-admission testing, registration or admission at the time non-emergency services are scheduled; and information as to how to determine the healthcare plans in which the physician participates.

E. A hospital shall establish, update and make public through posting on the website of the hospital, to the extent required by federal guidelines, a list of the standard charges for items and services provided by the hospital, including for diagnosis-related groups established under Section 1886(d)(4) of the federal Social Security Act.

F. A hospital shall post on the hospital's website:

1. The health care plans in which the hospital is a participating provider;

2. A statement that:

a. physician services provided in the hospital are not included in the charges of the hospital,

b. physicians who provide services in the hospital may or may not participate with the same health care plans as the hospital, and

c. the prospective patient should check with the physician arranging for the hospital services to determine the health care plans in which the physician participates;

2. As applicable, the name, mailing address and telephone number of the physician groups that the hospital has contracted with to provide services including anesthesiology, pathology or radiology, and instructions how to contact these groups to determine the health care plan participation of the physicians in these groups; and

3. As applicable, the name, mailing address and telephone number of physicians employed by the hospital and whose services may be provided at the hospital, and the health care plans in which they participate.

G. In registration or admission materials provided in advance of nonemergency hospital services, a hospital shall:

1. Advise the patient or prospective patient to check with the physician arranging the hospital services to determine:

a. the name, practice name, mailing address and telephone number of any other physician whose services will be arranged by the physician, and

b. whether the services of physicians who are employed or contracted by the hospital to provide services including anesthesiology, pathology or radiology is reasonably anticipated to be provided to the patient; and

2. Provide patients or prospective patients with information as to how to timely determine the health care plans participated in by physicians who are reasonably anticipated to provide services to the patient at the hospital, as determined by the physician arranging the patient's hospital services, and who are employees of the hospital or contracted by the hospital to provide services including anesthesiology, radiology or pathology.

SECTION 7. This act shall become effective November 1, 2019.

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