

1 STATE OF OKLAHOMA

2 1st Session of the 57th Legislature (2019)

3 SENATE BILL 677

By: Bice

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5
6 AS INTRODUCED

7 An Act relating to health insurance; creating the
8 Network Adequacy and Use of Out-of-Network Providers
9 Act; stating purpose of act; requiring certain
10 insurers to assess network adequacy; requiring
11 Insurance Commissioner to review adequacy at certain
12 times; requiring certain insurers to provide certain
13 coverage options; authorizing Commissioner to require
14 certain coverage options of insurers; authorizing
15 Commissioner to waive certain coverage requirements
16 in certain circumstances; defining terms; requiring
17 Commission to specify certain nonprofit for specified
18 duty; exempting certain medical services from act;
19 providing construing provision; requiring health care
20 plan to cover emergency services at certain cost;
21 requiring insurer give certain notice to insured
22 about coverage; requiring insurer provide certain
23 documents and information to insured about covered
24 facilities and coverage in-network and out-of-
25 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

1 post certain information on website; requiring
2 hospitals to provide certain information in admission
3 or registration materials; providing for
4 codification; and providing an effective date.

5 BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

6 SECTION 1. NEW LAW A new section of law to be codified
7 in the Oklahoma Statutes as Section 7410 of Title 36, unless there
8 is created a duplication in numbering, reads as follows:

9 This act shall be known and may be cited as the "Network
10 Adequacy and Use of Out-of-Network Providers Act".

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

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

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

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

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

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

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

12 D. For the purposes of this subsection, "usual and customary
13 cost" means the eightieth percentile of all charges for the
14 particular health care service performed by a provider in the same
15 or similar specialty and provided in the same geographical area as
16 reported in a benchmarking database maintained by a nonprofit
17 organization specified by the Commissioner. The nonprofit
18 organization shall not be affiliated with an insurer.

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

21 F. Nothing in this subsection shall limit the authority of the
22 Commissioner to establish minimum standards for the form, content
23 and sale of accident and health insurance policies and subscriber
24 contracts, to require additional coverage options for out-of-network
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1 services or to provide for standardization and simplification of
2 coverage.

3 G. When an insured or enrollee under a contract or policy that
4 provides coverage for emergency services receives the services from
5 a health care provider that does not participate in the provider
6 network of an insurer, the health care plan shall ensure that the
7 insured or enrollee shall incur no greater out-of-pocket costs for
8 the emergency services than the insured or enrollee would have
9 incurred with a health care provider that participates in the
10 provider network of the health care plan. For the purpose of this
11 section, "emergency services" includes any healthcare services
12 provided in a healthcare facility after the sudden onset of a
13 medical condition that manifests itself by symptoms of sufficient
14 severity including severe pain, that the absence of immediate
15 medical attention could reasonably be expected by a prudent
16 layperson, who possesses an average knowledge of health and
17 medicine, to result in placing the patient's health in serious
18 jeopardy, serious impairment to bodily functions or serious
19 dysfunction of any bodily organ or part.

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

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

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

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

17 3. An insured enrolled in a managed care product or a
18 comprehensive contract that utilizes a network of providers offered
19 by the corporation with a life-threatening condition or disease or a
20 degenerative and disabling condition or disease, either of which
21 requires specialized medical care over a prolonged period of time
22 may request a specialist responsible for providing or coordinating
23 the medical care of the subscriber and the procedure for requesting
24 and obtaining such a specialist;

1 4. An insured enrolled in a managed care product or a
2 comprehensive contract that utilizes a network of providers offered
3 by the corporation with a life-threatening condition or disease or a
4 degenerative and disabling condition or disease, either of which
5 requires specialized medical care over a prolonged period of time
6 may request access to a specialty care center and the procedure by
7 which such access may be obtained; and

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

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

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

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

- 1 a. a clear description of the methodology used by the
2 insurer to determine reimbursement for out-of-network
3 health care services,
4 b. a description of the amount that the insurer will
5 reimburse under the methodology for out-of-network
6 health care services set forth as a percentage of the
7 usual and customary cost for out-of-network health
8 care services,
9 c. examples of unforeseen out-of-pocket costs for
10 frequently billed out-of-network health care services;
11 and
12 d. information in writing and through an internet website
13 that reasonably permits an insured or prospective
14 insured to estimate the unforeseen out-of-pocket cost
15 for out-of-network health care services in a
16 geographical area or zip code based upon the
17 difference between what the insurer will reimburse for
18 out-of-network health care services and the usual and
19 customary cost for out-of-network health care
20 services.

21 SECTION 5. NEW LAW A new section of law to be codified
22 in the Oklahoma Statutes as Section 7414 of Title 36, unless there
23 is created a duplication in numbering, reads as follows:
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1 A. "Out-of-network referral denial" means a denial under a
2 managed care product of a request for an authorization or referral
3 to an out-of-network provider on the basis that the health care plan
4 has a health care provider in the in-network benefits portion of its
5 network with appropriate training and experience to meet the
6 particular health care needs of an insured, and who is able to
7 provide the requested health service. The notice of an out-of-
8 network referral denial provided to an insured shall include
9 information explaining what information the insured must submit in
10 order to appeal the out-of-network referral denial. An out-of-
11 network referral denial under this subsection does not constitute an
12 adverse determination.

13 B. A utilization review agent shall make a utilization review
14 determination involving health care services which require pre-
15 authorization and provide notice of a determination to the insured
16 or designee of the insured and the health care provider of the
17 insured by telephone and in writing within three (3) business days
18 of receipt of the necessary information. To the extent practicable,
19 such written notification to the health care provider of the
20 enrollee shall be transmitted electronically, in a manner and in a
21 form agreed upon by the parties. The notification shall identify:

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

1 2. Whether the insured will be held harmless for the services
2 and not be responsible for any payment, other than any applicable
3 co-payment, co-insurance or deductible;

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

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

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

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

22 2. The attending physician recommends an out-of-network
23 provider with the appropriate training and experience to meet the
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1 particular health care needs of the insured, and who is able to
2 provide the requested health service.

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

11 1. Stating that the out-of-network referral shall be covered by
12 the health care plan either when the reviewer or a majority of the
13 panel of reviewers determines, upon review of the training and
14 experience of the in-network health care provider or providers
15 proposed by the plan, the training and experience of the requested
16 out-of-network provider, the clinical standards of the plan, the
17 information provided concerning the insured, the recommendation of
18 the attending physician, the medical record of the insured and any
19 other pertinent information, that the health plan does not have a
20 provider with the appropriate training and experience to meet the
21 particular health care needs of an insured, who is able to provide
22 the requested health service and that the out-of-network provider
23 has the appropriate training and experience to meet the particular
24 health care needs of an insured, is able to provide the requested

1 health service and is likely to produce a more clinically beneficial
2 outcome; or

3 2. Upholding the health plan's denial of coverage.

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

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

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

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

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

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

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

18 C. A health care professional who is a physician shall provide
19 a patient or prospective patient with the name, practice name,
20 mailing address, and telephone number of any health care provider
21 scheduled to perform anesthesiology, laboratory, pathology,
22 radiology or assistant surgeon services in connection with care to
23 be provided in the physician's office for the patient or coordinated
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1 or referred by the physician for the patient at the time of referral
2 to or coordination of services with such provider.

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

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

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

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

21 2. A statement that:

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

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

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

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

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

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

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

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

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

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

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

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