STATE OF OKLAHOMA

2nd Session of the 56th Legislature (2018)

SENATE BILL 1546 By: David

AS INTRODUCED

An Act relating to insurance; creating the Oklahoma Right to Shop Act; providing short title; defining terms; requiring certain carriers to develop certain types of health plans; providing requirements to be used by plans; specifying eligibility guidelines; providing for availability; construing certain provision as not an expense; requiring enrollees to make certain filing; requiring carriers to file certain evidence of incentive payments; specifying information to be submitted; authorizing adopting of rules; requiring carriers to comply with certain requirements by certain date; specifying requirements; authorizing certain enrollees to obtain services out-of-network under certain conditions; providing payment method; allowing non-emergency admission under certain circumstances; providing requirements of non-emergency admissions; requiring certain notification procedure; requiring certain agency to perform certain analysis; requiring communications with certain legislative committees; providing for noncodification; 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 not to be codified in the Oklahoma Statutes reads as follows:

This act shall be known and may be cited as the "Oklahoma Right to Shop Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.40 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Oklahoma Right to Shop Act, the following definitions apply:

1. "Health Care Entity" means a physician, hospital, pharmaceutical company, pharmacy, pharmacist, laboratory or other state-licensed or state-recognized provider of health care services;

2. "Insurance carrier" means an insurance company that issues policies of accident and health insurance and is or should be licensed to sell insurance in this state;

3. " Allowed amount" means the contractually agreed upon amount paid by a carrier to a health care entity participating in the carrier's network;

4. "Program" means the comparable health care service incentive program established by a carrier pursuant to this section;

5. "Comparable health care service" means any covered non-emergency health care service or bundle of services. The Commissioner of the Insurance Department may limit what is considered a comparable health care service if a carrier can demonstrate allowed amount variation among network providers in less than Fifty Dollars ($50.00); and

6. "Average" means mean, median or mode.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.41 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Beginning January 1, 2019, a carrier offering a health plan in this state shall develop and implement a program that provides incentives for enrollees in a health plan who elect to receive a comparable health care service that is covered by the plan from providers that charge less than the average allowed amount paid by that carrier to network providers for that comparable health care service.

1. Incentives may be calculated as a percentage of the difference in allowed amounts to the average, as a flat dollar amount, or by some other reasonable methodology approved by the Insurance Commissioner of the Department Insurance. The carrier shall provide the incentive as a cash payment to the enrollee or credit toward the enrollee's annual in-network deductible and out-of-pocket limit. Carriers may let enrollees decide which method they prefer to receive the incentive.

2. The incentive program must provide enrollees with at least fifty percent (50%) of the carrier's saved costs for each service or category of comparable health care service resulting from shopping by enrollees. A carrier is not required to provide a payment or credit to an enrollee when the carrier's saved cost is Twenty-five Dollars ($25.00) or less.

3. A carrier will base the average amount on the average allowed amount paid to a network providers for the procedure or service under the enrollee's health plan within a reasonable timeframe not to exceed one (1) year. A carrier may determine an alternate methodology for calculating the average allowed amount if approved by the Commissioner. A carrier shall inform enrollees of their ability to request the average allowed amount for a procedure or service and the process, both on their website and in benefit plan material.

4. Eligibility for an incentive payment may require an enrollee to demonstrate, through reasonable documentation such as a quote from the provider, that the enrollee compared offers prior to receiving care from the provider who charges less for the comparable health care service than the average allowed amount paid by that carrier. Carriers shall provide additional mechanisms for the enrollee to satisfy this requirement by utilizing the carrier's cost transparency website or toll-free number, established under this act.

B. An insurance carrier shall make the incentive program available as a component of all health plans offered by the carrier in this state. Annually at enrollment or renewal, a carrier shall provide notice to earn such incentives to any enrollee who is enrolled in a health plan eligible for the program about the

availability of the program, a description of the incentives available to an enrollee and how.

C. A comparable health care service incentive payment made by a carrier in accordance with this section is not an administrative expense of the carrier for rate development or rate filing purposes.

D. Prior to offering the program to any enrollee, a carrier shall file a description of the program established by the carrier pursuant to this section with the Insurance Commissioner using a form provided by the Insurance Department. The Commissioner may review the filing made by the carrier to determine if the carrier's program complies with the requirements of this section. Filings and any supporting documentation made pursuant to this subsection are confidential until the filing has been approved or denied by the Commissioner.

E. A carrier shall file annually with the Insurance Department, for the most recent calendar year, the total number of comparable health care service incentive payments made pursuant to this section, the use of comparable health care services by category of service for which comparable health care service incentives are made, the total payments made to enrollees, the average amount of incentive payments made by service for such transactions, the total savings achieved below the average allowed amount by service for such transactions, and the total number and percentage of a carrier's enrollees that participated in such transactions.

Beginning no later than eighteen (18) months after implementation of comparable health care service incentive programs under this section, and annually by April 1 of each year thereafter, the Commissioner shall submit an aggregate report for all carriers filing the information required by this subsection to the Retirement and Insurance Committee of the Oklahoma State Senate and the Insurance Committee of the Oklahoma House of Representatives. The Commissioner may set reasonable limits on the annual reporting requirements on carriers to focus on the more popular comparable health care services.

F. The Insurance Department may adopt any rules necessary to implement the Oklahoma Right to Shop Act.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.42 of Title 36, unless there is created a duplication in numbering, reads as follows:

Beginning upon approval of the next health insurance rate filing after enactment, a carrier offering a health plan in this state shall comply with the following requirements:

1. A carrier shall establish an interactive mechanism on its publicly accessible website that enables an enrollee to request and obtain from the carrier information on the payments made by the carrier to network entities or providers for comparable health care services, as well as quality data for those providers, to the extent the data is available. The interactive mechanism must allow an

enrollee seeking information about the cost of a particular health care service to compare allowed amounts among network providers, estimate out-of-pocket costs applicable to that enrollees health plan and the average paid to a network provider for the procedure or service under the enrollee's health plan within a reasonable timeframe, not to exceed one (1) year. The out-of-pocket estimate must provide a good faith estimate of the amount the enrollee will be responsible to pay out-of-pocket for a proposed non-emergency procedure or service that is a medically necessary covered benefit from a carrier's network provider, including any copayment, deductible, coinsurance or other out-of-pocket amount for any covered benefit, based on the information available to the carrier at the time the request is made. A carrier may contract with a third-party vendor to satisfy the requirements of this paragraph;

2. Nothing in this section shall prohibit a carrier from imposing cost-sharing requirements disclosed in the enrollee's certificate of coverage for unforeseen health care services that arise out of the non-emergency procedure or service or for a procedure or service provided to an enrollee that was not included in the original estimate; and

3. A carrier shall notify an enrollee that these are estimated costs, and that the actual amount the enrollee will be responsible to pay may vary due to unforeseen services that arise out of the proposed non-emergency procedure or service.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.43 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If an enrollee elects to receive a covered health care service from an out-of-network provider at a price that is the same or less than the average that an enrollee's insurance carrier pays for that service to health care providers within its provider network within a reasonable timeframe, not to exceed one (1) year, the carrier shall allow the enrollee to obtain the service from the out-of-network provider at the provider's price and, upon request by the enrollee, shall apply the payments made by the enrollee for that health care service toward the enrollee's deductible and out-of-pocket maximum, as specified in the enrollee's health plan, as if the health care services had been provided by a network provider. The carrier shall provide a downloadable or interactive online form to the enrollee for the purpose of submitting proof of payment to an out-of-network provider for purposes of administering this section.

B. A carrier may base the average paid to a network provider on what that carrier pays to providers within the network, applicable to the enrollee's specific health plan, or across all of their plans offered in the state. A carrier shall, at minimum, inform enrollees of their ability, and the process to request the average allowed amount paid for a procedure or service, both on their website and in benefit plan material.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.44 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If a patient or prospective patient is covered by insurance, a health care entity that participates in a carrier's network shall, upon request of a patient or prospective patient, provide within 2 (two) working days, based on the information available to the health care entity at the time of the request, sufficient information regarding the proposed non-emergency admission, procedure or service for the patient or prospective patient to receive a cost estimate from their insurance carrier to identify out-of-pocket costs which could be through a developed toll-free telephone number or website. A health care entity may assist a patient or prospective patient in using a carrier's toll-free number and website.

B. If a health care entity is unable to quote a specific amount under subsection A of this section or this subsection, in advance due to the health care entity's inability to predict the specific treatment or diagnostic code, the health care entity shall disclose what is known for the estimated amount for a proposed non-emergency admission, procedure or service, including the amount for any facility fees required. A health care entity shall disclose the incomplete nature of the estimate and inform the patient or prospective patient of their ability to obtain an updated estimate once additional information is determined.

C. Prior to a non-emergency admission, procedure or service and upon request by a patient or prospective patient, a health care entity outside of the patient or prospective patient insurer network shall, within two (2) working days, disclose the price that will be charged for the non-emergency admission, procedure or service, including the amount for any facility fees required.

D. Health care entities shall post, in a visible area, notification of the patient's ability, for those with individual or small group health insurance, to obtain a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association sufficient to allow an insurance carrier to assist the patient in comparing out-of-pocket and contracted amounts paid for their care to different providers for similar services. This notification shall inform patients of their right to obtain services from different providers regardless of a referral or recommendation from the provider at the health care entity, and that seeing a high-value provider, either their currently referred provider or a different provider, may result in an incentive to the patient if they follow the steps outlined by their insurance carrier. The notification shall give an outline of the parameters of potential incentives approved in this act. It should also notify the patient that their carrier is required to provide enrollees an estimate of out-of-pocket costs and contracted amounts paid for their care to different

providers for similar services via a toll-free telephone number and health care price transparency tool. A health care entity may provide additional information in any form to patient's that inform them of carrier specific price transparency tools or toll-free phone numbers.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.45 of Title 36, unless there is created a duplication in numbering, reads as follows:

The administrators of the state health plan shall conduct an analysis no later than one (1) year from the effective date of this act of the cost effectiveness of implementing an incentive-based program for current enrollees and retirees. Any program found to be cost effective shall be implemented as part of the next open enrollment. The administrators of the state health plan shall communicate the rationale for its decision in writing to the legislative committees dealing with insurance matters.

SECTION 8. This act shall become effective November 1, 2018.

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