STATE OF OKLAHOMA

2nd Session of the 57th Legislature (2020)

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 3489 By: Sneed of the House

and

David of the Senate

COMMITTEE SUBSTITUTE

An Act relating to health insurance; creating the Oklahoma Right to Shop Act; defining terms; requiring insurance carriers to create certain program; establishing requirements of program; construing certain provision as not an expense; requiring certain filing with Insurance Department; requiring carriers to establish certain online program; establishing requirements of program; authorizing exemption to requirements of act; requiring certain notification; requiring certain enrollees to receive out-of-network treatment under certain conditions; requiring certain payment method; authorizing certain average rates paid to certain providers; 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 6060.40 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 "Oklahoma Right to Shop Act".

SECTION 2. 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:

As used in the Oklahoma Right to Shop Act:

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

2. "Comparable health care service" shall mean any covered nonemergency health care service or bundle of services. The Insurance Commissioner may limit what is considered a comparable health care service if an insurance carrier can demonstrate allowed amount variation among network providers of less than Fifty Dollars ($50.00);

3. "Health care entity" shall mean a physician, hospital, pharmaceutical company, pharmacist, laboratory or other state-licensed or state-recognized provider of health care services;

4. "Insurance carrier" or "carrier" shall mean an insurance company that issues policies of accident and health insurance and is licensed to sell insurance in this state; and

5. "Program" shall mean the comparable health care service incentive program established by a carrier pursuant to this act.

SECTION 3. 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 in 2020, a carrier offering a health benefit plan as defined in Section 6060.4 of this title in this state in the individual or small group insurance market, except plans where enrollees receive a premium subsidy under the federal Patient Protection and Affordable Care Act, or are under sole jurisdiction of the federal Department of Labor, shall comply with the following requirements:

1. A carrier shall establish for all health benefit plans a program in which enrollees can be incentivized to shop, before and after their out-of-pocket limit has been met, for lower cost by a nonparticipating health care provider or facility for comparable health care services. Incentives may include a reduction of premiums, copayments, coinsurance or deductible. Incentives shall be calculated as the difference of the average allowed amount and the nonparticipating health care provider or facilities agreed-upon rate, so long as the amount is less than the average allowed amount. The carrier shall provide the incentive as a credit toward the enrollee's annual in-network deductible, copayment or coinsurance amount. Carriers shall let the enrollee decide whether the enrollee's incentive is credited toward deductible, copayment or coinsurance amount. The incentive program shall provide the enrollee with at least fifty percent (50%) of the carriers saved costs for each service or comparable health care service. The

remaining fifty percent ($50%) of savings shall be provided by the enrollee's insurer;

2. Annually at enrollment or renewal, a carrier shall provide notice to enrollees of the availability of the program with a description of the incentives available to an enrollee and how they are earned;

3. 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; and

4. Prior to offering the program to any enrollee, a carrier shall file with the Insurance Commissioner a description of the program established by the carrier pursuant to this section, using a form provided by the Insurance Department.

SECTION 4. 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:

Beginning upon approval of the next health insurance rate filing in 2020, a carrier offering a health benefit plan in this state in the individual or small group insurance market 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 enrollee's health benefit plan and the average paid to the network provider and facility for the procedure or service under the enrollee's health benefit plan. 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 nonemergency procedure or service that is a medically necessary covered benefit from a network provider of the carrier, 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 section;

2. Nothing in this section shall prohibit a carrier from imposing cost-sharing requirements disclosed in the certificate of coverage of the enrollee for unforeseen health care services that arise out of the nonemergency 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 nonemergency procedure or service.

SECTION 5. 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 an enrollee elects to receive a covered health care service from a United-States-based out-of-network provider or facility and the out-of-network provider or facility agrees to accept a price that is the same or less than the average that the insurance carrier of the enrollee currently pays to health care providers or facilities within the enrollee's network, the carrier shall allow the enrollee to obtain the service from the out-of-network provider or facility and, upon request by the enrollee, shall apply the payments made by the enrollee for that health care service toward the deductible and out-of-pocket maximum specified in the enrollee's health benefit plan, as if the health care services had been provided by a network provider or facility. Payment made by a carrier in regard to this section shall not be construed to limit an out-of-network provider or facility from being reimbursed any additional payment by an enrollee, provided that an enrollee has received sufficient disclosure in a timely manner and has agreed to subsequent payment responsibility. Any additional payment agreed to by an enrollee for out-of-network care shall be deemed payment in full. Nothing in this section shall be construed to require an

insurer to reimburse an out-of-network provider or facility more than the average contracted rate. A carrier shall provide a downloadable or interactive online form to the enrollee for the purpose of providing proof of payment responsibility to an out-of-network provider or facility for the purpose of administering this section.

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

SECTION 6. This act shall become effective November 1, 2020.

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