STATE OF OKLAHOMA

2nd Session of the 57th Legislature (2020)

COMMITTEE SUBSTITUTE
FOR
SENATE BILL 1575

By: David, Bullard, and Pemberton

COMMITTEE SUBSTITUTE

An Act relating to health insurance; creating the Oklahoma Right to Shop Act; defining terms; requiring certain health benefit plan insurers to establish certain incentivization program; establishing terms of program; requiring notice of program; classifying certain payment as nonadministrative for certain purposes; requiring certain filing with Insurance Commissioner; exempting certain health benefit plans from act; requiring certain health insurers to establish mechanism on website for program information; establishing terms and information provided by mechanism; authorizing insurers to contract with third-party vendors; allowing for services exempted from program requirements; requiring certain notification to insured; requiring insurer to allow and apply payment for out-of-network providers or facilities in certain conditions; establishing terms of certain out-of-network care and payment; requiring insurer to provide certain online form; establishing payment rates; requiring notification of certain payment information to insured; 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 7500 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 7501 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this act, the following definitions apply:

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

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

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

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

5. "Program" means 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 7502 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Upon approval of the next health insurance rate filing in 2021, a carrier offering a health benefit plan, as defined in Section 6060.4 of Title 36 of the Oklahoma Statutes, in the individual or small group insurance market in this state shall comply with the following requirements:

1. A carrier shall establish for all health benefit plans a program in which enrollees are incentivized to shop, before and after their out-of-pocket limit has been met, for lower-cost health care services by a nonparticipating health care provider or facility that are comparable to participating health care provider services. Incentives shall include but are not limited to a reduction of premiums, copayments, coinsurance or deductibles. Incentives shall be calculated as the difference between average allowed amount and the agreed upon rate of the non-participating health care provider or facility, so long as the amount is less than the average allowed amount. The carrier shall provide the incentive as a credit towards the annual in-network deductible, copayment or coinsurance amount of the enrollee and shall allow the enrollee to decide which is credited. The incentive program shall provide the enrollee with at

least fifty percent (50%) of the saved costs of the carrier for each service or comparable healthcare service. The remaining percentage of savings shall be provided to the insurer of the enrollee;

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 the enrollee and how the incentives are earned;

3. 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.

B. The provisions of this section shall not apply to health benefit plans in which enrollees receive a premium subsidy under the Patient Protection and Affordable Care Act or are under sole jurisdiction of the federal Department of Labor.

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

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7503 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Upon approval of the next health insurance rate filing in 2021, a carrier offering a health benefit plan in the individual or

small group insurance market in this state shall comply with the following requirements:

1. A carrier shall establish an interactive mechanism on its publicly accessible website enabling 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 the health benefit plan of the enrollee and the average paid to a network provider and facility for the procedure or service under that 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; and

2. A carrier may contract with a third-party vendor to satisfy the requirements of this subsection.

B. 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.

C. 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 7504 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, or both, and that provider or facility agrees to accept a price that is the same or less than the average the insurance carrier of the enrollee currently pays to health care providers or facilities within its 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 health benefit plan of the enrollee as if the health care services had been provided in network.

1. Payment made by a carrier regarding 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 relevant disclosure in a timely manner and has agreed to subsequent payment responsibility.

2. Any additional payment agreed to by an enrollee for out of-network care shall be deemed payment in full.

3. 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.

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

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

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