

1 SECTION 3. NEW LAW A new section of law to be codified
2 in the Oklahoma Statutes as Section 7502 of Title 36, unless there
3 is created a duplication in numbering, reads as follows:

4 A. Except as provided in subsection B of this section, this act
5 applies to any health benefit plan, provider, and health care
6 facility as defined in Section 4 of this act.

7 B. This act does not apply to:

- 8 1. Any Medicaid programs operated in Oklahoma, including any
9 Medicaid managed care programs;
- 10 2. The Children's Health Insurance Program (CHIP) operated in
11 Oklahoma;
- 12 3. Medicare; or
- 13 4. "Excepted benefit" products as defined in 42 U.S.C. 300gg-
14 91(c).

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

18 For the purposes of and as used in this act:

- 19 1. "Balance billing" means the practice by a provider, who does
20 not participate in an health benefit plan network of the enrollee, of
21 charging the enrollee the difference between the provider's fee and
22 the sum of what the enrollee's health benefit plan pays and what the
23 enrollee is required to pay in applicable deductibles, co-payments,

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1 coinsurance or other cost-sharing amounts required by the health
2 benefit plan;

3 2. "Carrier" or "health carrier" means an entity subject to the
4 insurance laws and regulations of this state, or subject to the
5 jurisdiction of the Insurance Commissioner, that contracts or offers
6 to contract or enters into an agreement to provide, deliver, arrange
7 for, pay for or reimburse any of the costs of health care services.
8 Carriers include a health insurance company, HMO, a hospital and
9 health service corporation or any other entity providing a plan of
10 health insurance, health benefits or health care services;

11 3. "Commissioner" means the Insurance Commissioner of the State
12 of Oklahoma;

13 4. "Department" means the Oklahoma Insurance Department;

14 5. "Emergency services" includes any health care service
15 provided in a health care facility after the sudden onset of a
16 medical condition that manifests itself by symptoms of sufficient
17 severity, including severe pain, that the absence of immediate
18 medical attention could reasonably be expected by a prudent
19 layperson, who possesses an average knowledge of health and
20 medicine, to result in:

- 21 a. placing the health of the patient in serious jeopardy,
- 22 b. serious impairment to bodily functions, or
- 23 c. serious dysfunction of any bodily organ or part;

1 6. "Enrollee" means an individual who is eligible to receive
2 medical care through a health benefit plan;

3 7. "Facility-based provider" means an individual or group of
4 health care providers:

5 a. to whom the health care facility has granted clinical
6 privileges, and

7 b. who provides services to patients treated at the
8 health care facility under those clinical privileges;

9 8. "Health benefit plan" means a policy, contract, certificate
10 or agreement entered into, offered or issued by a health carrier to
11 provide, deliver, arrange for, pay for or reimburse any of the costs
12 of health care services, and includes the Oklahoma Employees Health
13 Insurance Plan as defined in Section 1303 of Title 74 of the
14 Oklahoma Statutes and coverage provided by a Multiple Employer
15 Welfare Arrangement (MEWA) or employer self-insured plan except as
16 exempt under the Employee Retirement Income Security Act of 1974;

17 9. "Health care facility" means a hospital, emergency clinic,
18 outpatient clinic, birthing center, ambulatory surgical center or
19 other facility providing medical care, and which is licensed by the
20 Oklahoma State Department of Health;

21 10. "Network" means the providers and health care facilities
22 that have contracted to provide health care services to the enrollees
23 of a health benefit plan. This includes a network operated by, or
24 contracts with, a health maintenance organization, a preferred

1 provider organization or another entity, including an insurance
2 company that issues a health benefit plan;

3 11. "Network plan" means a health benefit plan that uses a
4 network to provide services to enrollees;

5 12. "Out-of-network facility" means a health care facility that
6 has not contracted with a carrier to provide services to enrollees
7 of a health benefit plan;

8 13. "Out-of-network provider" means a health care provider who
9 has not contracted with a carrier to provide services to enrollees of
10 a health benefit plan;

11 14. "Out-of-network referral denial" means a denial by a health
12 benefit plan of a request for an authorization or referral to an out-
13 of-network provider on the basis that the health benefit plan has an
14 in-network provider with appropriate training and experience to meet
15 the particular health care needs of the enrollee and who is able to
16 provide the requested health service;

17 15. "Provider" means an individual who is licensed to provide
18 and provides medical care; and

19 16. "Usual, customary and reasonable rate" means the eightieth
20 percentile of all charges for the particular health care service
21 performed by a provider in the same or similar specialty and
22 provided in the same geographical area as reported in a benchmarking
23 database maintained by a nonprofit organization specified by the
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1 Commissioner. The nonprofit organization shall not be financially
2 affiliated with an insurance carrier.

3 SECTION 5. NEW LAW A new section of law to be codified
4 in the Oklahoma Statutes as Section 7504 of Title 36, unless there
5 is created a duplication in numbering, reads as follows:

6 A. A carrier that issues a comprehensive group health benefit
7 plan that covers services provided by out-of-network providers shall
8 make available and, if requested by the policyholder or contract
9 holder, provide at least one option for coverage for at least eighty
10 percent (80%) of the usual, customary and reasonable rate of each
11 service provided by an out-of-network provider after imposition of a
12 deductible or any permissible benefit maximum.

13 B. If there is no coverage available pursuant to subsection A
14 of this section in a rating region, then the Commissioner may require
15 a carrier issuing a comprehensive group health benefit plan in the
16 rating region, to make available and, if requested by the
17 policyholder or contract holder, provide at least one option for
18 coverage of eighty percent (80%) of the usual, customary and
19 reasonable rate of each service provided by an out-of-network
20 provider after imposition of any permissible deductible or benefit
21 maximum. The Commissioner may, after considering the public
22 interest, permit a carrier to satisfy the requirements of this
23 subsection on behalf of another carrier, corporation, or health
24 maintenance organization within the same holding company system. The

1 Commissioner may, upon written request, waive the requirement for
2 coverage of services provided by out-of-network providers to be made
3 available pursuant to this subsection if the Commissioner determines
4 that it would pose an undue hardship upon a carrier.

5 C. This section shall not apply to emergency services.

6 D. Nothing in this section shall limit the Commissioner's
7 authority to establish minimum standards for the form, content, and
8 sale of health benefit plans and subscriber contracts, to require
9 additional coverage options for services provided by out-of-network
10 providers, or to provide for standardization and simplification of
11 coverage.

12 SECTION 6. NEW LAW A new section of law to be codified
13 in the Oklahoma Statutes as Section 7505 of Title 36, unless there
14 is created a duplication in numbering, reads as follows:

15 When an enrollee in a health benefit plan that covers emergency
16 services receives the services from an out-of-network provider, the
17 health benefit plan shall ensure that the enrollee shall incur no
18 greater out-of-pocket costs for the emergency services than the
19 enrollee would have incurred with an in-network provider.

20 SECTION 7. NEW LAW A new section of law to be codified
21 in the Oklahoma Statutes as Section 7506 of Title 36, unless there
22 is created a duplication in numbering, reads as follows:

23 A. Where applicable, and through its website, a health benefit
24 plan shall give to an enrollee:

1 1. Notice:

- 2 a. that the enrollee may obtain a referral or
3 preauthorization for services from an out-of-network
4 provider when the health benefit plan does not have in
5 its network a provider who is geographically
6 accessible to the enrollee and has the appropriate
7 training and experience to meet the particular health
8 care needs of the enrollee,
- 9 b. of the procedure for requesting and obtaining such
10 referral or preauthorization,
- 11 c. that the enrollee with a condition which requires
12 ongoing care from a specialist may request a standing
13 referral to such a specialist,
- 14 d. of the procedure for requesting and obtaining such a
15 standing referral,
- 16 e. that the enrollee with a life-threatening condition or
17 disease, or a degenerative and disabling condition or
18 disease, either of which requires specialized medical
19 care over a prolonged period of time may request a
20 specialist responsible for providing or coordinating
21 the enrollee's medical care,
- 22 f. of the procedure for requesting and obtaining such a
23 specialist,
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- 1 g. that the enrollee with a life-threatening condition or
2 disease, or a degenerative and disabling condition or
3 disease, either of which requires specialized medical
4 care over a prolonged period of time may request access
5 to a specialty care center,
- 6 h. of the procedure for requesting and obtaining such
7 access may be obtained, and
- 8 i. that an enrollee shall have direct access to primary
9 and preventive obstetric and gynecologic services,
10 including annual examinations, care resulting from
11 such annual examinations, and treatment of acute
12 gynecologic conditions, from a qualified provider of
13 such services of her choice from within the plan or for
14 any care related to a pregnancy;

15 2. A listing of providers in the health plan network; and

16 3. With respect to out-of-network coverage:

- 17 a. a clear description of the methodology used by the
18 carrier to determine reimbursement for out-of-network
19 health care services,
- 20 b. a description of the amount that the carrier will
21 reimburse under the methodology for out-of-network
22 health care services set forth as a percentage of the
23 usual, customary and reasonable rate for out-of-network
24 health care services,

- 1 c. examples of anticipated out-of-pocket costs for
2 frequently billed out-of-network health care services,
3 d. information that reasonably permits an enrollee to
4 estimate the anticipated out-of-pocket cost for out-of-
5 network health care services in a geographical area or
6 zip code based upon the difference between what the
7 health benefit plan will reimburse for out-of-network
8 health care services and the usual, customary and
9 reasonable rate for out-of-network health care
10 services.

11 B. No later than forty-eight (48) hours after the enrollee has
12 been pre-certified to receive nonemergency services at a facility, a
13 health benefit plan shall provide to the enrollee by electronic and
14 written correspondence, information on:

15 1. Whether the provider and the facility of the enrollee
16 participate in the health benefit plan network;

17 2. Whether proposed nonemergency medical care is covered by the
18 health benefit plan;

19 3. What the personal responsibility of the insured will be for
20 payment of applicable copayment or deductible amounts; and

21 4. If applicable, coinsurance amounts owed by the enrollee based
22 on the provider's contracted rate for in-network services or the
23 insurer's usual, customary and reasonable rate for out-of-network
24 services.

1 C. Every contract between a health carrier and a participating
2 provider shall set forth a hold harmless provision specifying
3 protection for enrollees. This requirement shall be met by
4 including a provision substantially similar to the following:

5 "Provider agrees that in no event, including but not limited to
6 nonpayment by the health carrier or intermediary, insolvency of
7 the health carrier or intermediary, or breach of this agreement,
8 shall the provider bill, charge, collect a deposit from, seek
9 compensation, remuneration or reimbursement from or have any
10 recourse against an enrollee or a person (other than the health
11 carrier or intermediary) acting on behalf of the enrollee for
12 services provided pursuant to this agreement. This agreement
13 does not prohibit the provider from collecting coinsurance,
14 deductibles or copayments, as specifically provided in the
15 evidence of coverage, or fees for uncovered services delivered
16 on a fee-for-service basis to enrollees. Nor does this
17 agreement prohibit a provider (except for a health care
18 professional who is employed full-time on the staff of a health
19 carrier and has agreed to provide services exclusively to that
20 health carrier's enrollees and no others) and an enrollee from
21 agreeing to continue services solely at the expense of the
22 enrollee, as long as the provider has clearly informed the
23 enrollee that the health carrier may not cover or continue to
24 cover a specific service or services. Except as provided

1 herein, this agreement does not prohibit the provider from
2 pursuing any available legal remedy."

3 SECTION 8. NEW LAW A new section of law to be codified
4 in the Oklahoma Statutes as Section 7507 of Title 36, unless there
5 is created a duplication in numbering, reads as follows:

6 A. This section applies to the provision of nonemergency
7 services only.

8 B. Verbally at the time an appointment is scheduled and in
9 writing or through a website prior to providing services, a health
10 care provider or the representative of the provider shall disclose to
11 the enrollee in writing or through an Internet website or both, the
12 health benefit plans in which the provider participates and the
13 hospitals with which the provider is affiliated.

14 C. If a provider does not participate in the health benefit
15 plan network of the enrollee, the provider shall, within forty-eight
16 (48) hours after an appointment is scheduled, provide the enrollee
17 with a written amount or estimated amount the provider anticipates
18 billing the enrollee for planned services absent unforeseen medical
19 circumstances that might arise when the services are provided;

20 Nothing in this subsection shall apply to emergent or unforeseen
21 conditions or circumstances discovered during a procedure.

22 D. When services rendered in an office of the provider require
23 referral to, or coordination with, an anesthesiologist, laboratory,
24 pathologist, radiologist or assistant surgeon, the provider or

1 representative of the provider initiating the referral or
2 coordination shall give to the enrollee, the following information in
3 writing about the aforementioned who will be providing services to
4 the enrollee: (1) name, practice name, mailing address, telephone
5 number and (2) how to determine in which health benefit plan networks
6 each participates. The information shall be provided to the enrollee
7 at the time of the referral or commencement of the coordination of
8 services.

9 E. At the time a provider or the representative of the provider
10 is scheduling an enrollee to receive services at a health care
11 facility, that provider or representative shall give to the enrollee
12 the following information in writing about any anesthesiologist,
13 laboratory, pathologist, radiologist or assistant surgeon who will
14 also be providing services to the enrollee: (1) name, practice name,
15 mailing address, telephone number and (2) how to determine in which
16 health benefit plan networks each participates.

17 SECTION 9. NEW LAW A new section of law to be codified
18 in the Oklahoma Statutes as Section 7508 of Title 36, unless there
19 is created a duplication in numbering, reads as follows:

20 A. This section applies to the provision of nonemergency
21 services only.

22 B. A health care facility shall establish, update and make
23 public through posting on its website, to the extent required by
24 federal guidelines, a list of the facility's standard charges for

1 items and services provided by the facility, including for
2 diagnosis-related groups established under section 1886(d)(4) of the
3 federal Social Security Act.

4 C. A health care facility shall post on its website:

5 1. The networks in which the health care facility is a
6 participating provider;

7 2. A statement that:

8 a. provider services provided in the health care facility
9 are not included in the facility's charges,

10 b. providers who provide services in the facility may or
11 may not participate with the same health benefit plans
12 as the facility,

13 c. if an enrollee in a health benefit plan receives
14 services in the facility that is in the network of the
15 health benefit plan, but receives those services from a
16 provider who is not in that network, the enrollee may
17 be billed for the amount between what the provider
18 charges and what the health benefit plan of the
19 enrollee pays that provider, including any co-pays,
20 co-insurance and/or deductibles that are the
21 responsibility of the enrollee, and

22 d. the enrollee should check with the provider arranging
23 for the enrollee to receive services in the facility to
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1 determine whether that provider participates in the
2 health benefit plans of the enrollee network; and

3 3. As applicable, the name, mailing address and telephone number
4 of the facility-based providers and facility-based provider groups
5 that the facility has employed or contracted with to provide services
6 including anesthesiology, pathology, and/or radiology, and
7 instructions about how to determine in which health benefit plan
8 networks each participates.

9 The information posted on the facility website pursuant to this
10 section shall be updated within three (3) business days after any
11 change to such information.

12 D. At the time a participating health care facility schedules
13 services or seeks prior authorization from a health benefit plan for
14 the provision of nonemergency services to an enrollee, the facility
15 shall provide the enrollee an out-of-network services written
16 disclosure that states the following:

17 1. That certain facility-based providers may be called upon to
18 render care to the enrollee during the course of treatment;

19 2. That those facility-based providers may not have contracts
20 with the carrier of the enrollee and are therefore considered to be
21 out-of-network;

22 3. That the service or services therefore will be provided on an
23 out-of-network basis;

1 4. That the enrollee should check with the provider arranging
2 for the services to determine the name, practice name, mailing
3 address and telephone number of any other provider who is reasonably
4 anticipated to be providing services to the enrollee while in the
5 health care facility, including but not limited to providers
6 employed by or contracting with the health care facility;

7 5. A description of the range of the charges for the out-of-
8 network service(s) for which the enrollee may be responsible;

9 6. A notification that if the enrollee incurs additional charges
10 for out-of-network service or services, the enrollee may either agree
11 to accept and pay the charges for the out-of-network service or
12 services, contact the enrollee's carrier for additional assistance,
13 initiate an independent dispute resolution process with the Oklahoma
14 Insurance Department, or rely on whatever other rights and remedies
15 that may be available under state or federal law; and

16 7. A statement indicating that the enrollee may obtain a list of
17 facility-based providers from his or her health benefit plan that are
18 participating providers and that the enrollee may request those
19 participating facility-based providers.

20 E. At the time of admission in the participating facility where
21 the nonemergency services are to be performed on the enrollee, the
22 facility shall provide the enrollee with the written disclosure, as
23 outlined in subsection D of this section, and obtain the signature
24 of the enrollee or the representative of the enrollee on the

1 disclosure document acknowledging that the enrollee received the
2 disclosure document in advance prior to the time of admission.

3 F. Upon request, a facility shall provide the enrollee with a
4 written amount or estimated amount that the facility anticipates
5 billing the enrollee for planned services absent unforeseen medical
6 circumstances that might arise when the services are provided.

7 SECTION 10. NEW LAW A new section of law to be codified
8 in the Oklahoma Statutes as Section 7509 of Title 36, unless there
9 is created a duplication in numbering, reads as follows:

10 A. A program of Independent Dispute Resolution for disputed
11 out-of-network charges, including balance bills, shall be
12 established and administered by the Oklahoma Insurance Department.

13 1. The Department shall promulgate rules, forms and procedures
14 for the implementation and administration of the Independent Dispute
15 Resolution program.

16 2. The Department may charge the parties participating in the
17 Independent Dispute Resolution program such fees as necessary to
18 cover its costs of implementation and administration.

19 3. The Department shall maintain a list of qualified reviewers.

20 B. The independent reviewer shall determine the amount the
21 health care provider is entitled to receive as payment for the
22 health care services. The independent reviewer shall allow each
23 party to provide information the independent reviewer reasonably
24

determines to be relevant in evaluating the **surprise**, out-of-network bill, including the following information:

1. Average contracted amount that the health insurer pays for the health care services at issue in the county where the health care services were performed;

2. Average amount that the health care provider has contracted to accept for the health care services at issue in the county where the services were performed;

3. Amount that Medicare and Medicaid pay for the health care services at issue;

4. Level of training, education and experience of the provider;

5. Circumstances and complexity of the particular case, including time and place of the service;

6. Individual patient characteristics; and

7. The usual, customary and reasonable rate of the service.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7510 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health carrier or out-of-network provider may initiate an independent dispute resolution process to determine reimbursement for health care services provided by an out-of-network provider. Failure to respond within fifteen (15) calendar days to the initiation of the independent dispute resolution process shall constitute acceptance of the submission of the initiating party.

1 B. The Insurance Commissioner shall establish an application
2 process and fee schedule for independent reviewers.

3 C. If the parties have not designated an independent reviewer
4 by mutual agreement within thirty (30) days of the request for
5 Independent Dispute Resolution, the Commissioner shall select an
6 independent reviewer from the list of qualified reviewers.

7 D. To be eligible to serve as an independent reviewer, an
8 individual must be knowledgeable and experienced in applicable
9 principles of contract and insurance law and the healthcare industry
10 generally.

11 1. In approving an individual as an independent reviewer, the
12 Commissioner shall ensure that the individual does not have a
13 conflict of interest that would adversely impact the independence and
14 impartiality of the individual in rendering a decision in an
15 independent dispute resolution procedure. A conflict of interest
16 includes, but is not limited to, current or recent ownership or
17 employment of either the individual or a close family member in a
18 health plan or a health care provider that may be involved in an
19 independent dispute resolution procedure.

20 2. The Commissioner shall immediately terminate the approval of
21 an independent reviewer who no longer meets the requirements to
22 serve as an independent reviewer.

23 E. Either party to an Independent Dispute Resolution proceeding
24 may request an oral hearing.

1 1. If no oral hearing is requested, the independent reviewer
2 shall set a date for the submission of all information to be
3 considered by the independent reviewer.

4 2. If an oral hearing is requested, the independent reviewer may
5 make procedural rulings.

6 3. There shall be no discovery in Independent Dispute Resolution
7 proceedings.

8 4. The independent reviewer shall issue his or her written
9 decision within ten (10) days of submission or hearing.

10 5. Unless otherwise agreed by the parties, each party shall:

11 a. bear its own attorney fees and costs, and

12 b. equally bear all fees and costs of the independent
13 reviewer.

14 F. The decision of the independent reviewer is final and shall
15 be binding on the parties. The prevailing party may seek
16 enforcement of the independent reviewer's decision in any court of
17 competent jurisdiction.

18 G. All pricing information provided by carriers and providers
19 in connection with the Independent Dispute Resolution is confidential
20 and may not be disclosed by the reviewer or any other party
21 participating in the process or used by anyone, other than the
22 providing party, for any purpose other than to resolve the **surprise**
23 out-of-network bill.

1 H. All information received by the Department in connection
2 with an Independent Dispute Resolution is confidential and may not be
3 disclosed by the Department to any person other than the reviewer.

4 SECTION 12. NEW LAW A new section of law to be codified
5 in the Oklahoma Statutes as Section 7511 of Title 36, unless there
6 is created a duplication in numbering, reads as follows:

7 A. If an out-of-network provider bills an enrollee for
8 nonemergency medical care, requesting payment on the balance of the
9 charge of the provider that is not related to co-pays, coinsurance
10 payments or deductible payments and is not covered by the health
11 benefits plan, the billing statement from that provider must contain:

12 1. A Payment Responsibility Notice, which shall state the
13 following or substantially similar language:

14 "Payment Responsibility Notice - The services[s] outlined below
15 was [were] performed by a facility-based provider who is a
16 nonparticipating provider with your health benefit plan. At this
17 time, you are responsible for paying your applicable cost-sharing
18 obligation - copayment, coinsurance or deductible amount - just
19 as you would be if the provider is within your plan's network.
20 With regard to the remaining balance, you have four choices: 1)
21 you may choose to pay the balance of the bill; OR 2) if the
22 difference between the billed charge and the plan's allowable
23 amount is more than \$500, you may send the bill to your health
24 carrier for processing pursuant to the carrier's nonparticipating

1 facility-based provider billing process; OR 3) you may initiate
2 an independent dispute resolution process with the Oklahoma
3 Insurance Department; OR 4) you may rely on other rights and
4 remedies that may be available in your state.";

5 2. An itemized listing of the nonemergency medical care provided
6 along with the dates the services and supplies were provided;

7 3. A conspicuous, plain-language explanation that:

8 a. the provider is not within the health plan network,
9 and

10 b. the health benefit plan has paid a rate, as determined
11 by the health benefit plan, which is below the
12 facility-based provider's billed amount;

13 4. A telephone number to call to discuss the statement, provide
14 an explanation of any acronyms, abbreviations and numbers used on
15 the statement, or discuss any payment issues;

16 5. A statement that the enrollee may call to discuss alternative
17 payment arrangements;

18 6. A notice that:

19 a. the enrollee may file complaints with the Oklahoma
20 Board of Medical Licensure and Supervision and includes
21 the Oklahoma Board of Medical Licensure and
22 Supervision web address, mailing address and complaint
23 telephone number, or
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1 b. the enrollee may initiate an Independent Dispute
2 Resolution proceeding to dispute the billing statement
3 in the same manner as a health carrier or
4 nonparticipating provider pursuant to Section 11 of
5 this act. The notice shall include the contact
6 information at the Department for such initiation,
7 including the web address, mailing address and
8 telephone number; and

9 7. A notice that if an enrollee agrees to a payment plan:

10 a. the provider will not furnish adverse information to a
11 consumer reporting agency if the enrollee
12 substantially complies with the terms of the payment
13 plan:

14 (1) within six (6) months of having received the
15 medical services, or

16 (2) within thirty (30) days of receiving the first
17 billing statement that reflects all insurance
18 payments and the final amount owed by the
19 enrollee, and

20 b. a patient may be considered by the provider to be out
21 of substantial compliance with the payment plan
22 agreement if payments in compliance with the agreement
23 have not been made for a period of forty-five (45)
24 days.

1 B. Health carriers shall develop a program for payment of out-
2 of-network, facility-based provider bills submitted pursuant to this
3 section, subject to the following requirements:

4 1. Health carriers may elect to pay out-of-network, facility-
5 based provider bills as submitted or the health carrier may pay the
6 usual, customary and reasonable rate for the services provided;

7 2. Nonparticipating facility-based providers who object to the
8 payments made in paragraph 1 of this subsection may elect the
9 independent dispute resolution process described in Section 11 of
10 this act; and

11 3. Nothing in this section shall preclude a health carrier and
12 an out-of-network facility-based provider from agreeing to a
13 separate payment arrangement.

14 C. Out-of-network facility-based providers who do not provide
15 an enrollee with a Payment Responsibility Notice, as outlined in of
16 subsection A of this section, may not balance bill the enrollee.

17 SECTION 13. NEW LAW A new section of law to be codified
18 in the Oklahoma Statutes as Section 7512 of Title 36, unless there
19 is created a duplication in numbering, reads as follows:

20 A. An out-of-network referral denial under this section does not
21 constitute an adverse determination.

22 B. The notice of an out-of-network referral denial provided to
23 an enrollee shall include information regarding how the enrollee can
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1 appeal the denial, including but not limited to what information
2 must be submitted with the appeal.

3 C. 1. An enrollee or designee of an enrollee may appeal an
4 out-of-network referral denial by submitting a written statement from
5 the attending physician of the enrollee, who must be a licensed,
6 board certified or board eligible physician qualified to practice in
7 the specialty appropriate to treat the enrollee for the health
8 service sought, provided that:

- 9 a. the in-network provider or providers recommended by the
10 health benefit plan do not have the appropriate
11 training and experience to meet the particular health
12 care needs of the enrollee for the health service, and
13 b. the attending physician recommends an out-of-network
14 provider with the appropriate training and experience
15 to meet the particular health care needs of the
16 enrollee, and who is able to provide the requested
17 health service.

18 2. If an out-of-network referral denial has been upheld by the
19 internal appeals process of the health benefit plan and the enrollee
20 wishes to pursue an external appeal, the external appeal agent
21 shall:

- 22 a. review the utilization review agent's health benefit
23 plan's final adverse determination,
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1 b. make a determination as to whether the out-of-network
2 referral shall be covered by the health benefit plan,
3 provided that such determination shall be:

4 (1) conducted only by one or a greater odd number of
5 clinical peer reviewers,

6 (2) based upon review of the:

7 (a) training and experience of the in-network
8 health care provider or providers proposed
9 by the plan,

10 (b) the training and experience of the requested
11 out-of-network provider,

12 (c) the clinical standards of the plan,

13 (d) the information provided concerning the
14 insured,

15 (e) the attending physician's recommendation,

16 (f) the insured's medical record, and

17 (g) any other pertinent information, and

18 (3) subject to the terms and conditions generally
19 applicable to benefits under the evidence of
20 coverage under the health care plan,

21 (4) binding on the plan and the insured, and

22 (5) admissible in any court proceeding, and
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1 c. Upon reaching its decision, the external appeals agent
2 shall submit to the enrollee and the health benefit
3 plan, a written statement that:

4 (1) the out-of-network referral shall be covered by
5 the health care plan either when the reviewer or a
6 majority of the panel of reviewers determines
7 that:

8 (a) the health plan does not have a provider
9 with the appropriate training and experience
10 to meet the particular health care needs of
11 an insured who is able to provide the
12 requested health service, and

13 (b) that the out-of-network provider has the
14 appropriate training and experience to meet
15 the particular health care needs of an
16 insured, is able to provide the requested
17 health service and is likely to produce a
18 more clinically beneficial outcome, or

19 (2) the external appeal agent is upholding the health
20 plan's denial of coverage.

21 SECTION 14. NEW LAW A new section of law to be codified
22 in the Oklahoma Statutes as Section 7513 of Title 36, unless there
23 is created a duplication in numbering, reads as follows:
24

1 A health benefit plan shall make a utilization review
2 determination involving health care services which require pre-
3 authorization and provide notice of that determination to the
4 enrollee or designee of the enrollee and the health care provider of
5 the enrollee by telephone and in writing within three (3) business
6 days of receipt of the information necessary to make the
7 determination. To the extent practicable, such written notification
8 to the enrollee and the enrollee's health care provider shall also
9 be transmitted electronically, in a manner and in a form agreed upon
10 by the parties. The notification shall identify:

11 1. Whether the services are considered in-network or out-of-
12 network;

13 2. Whether the enrollee will be responsible for any payment,
14 other than any applicable copayment, coinsurance or deductible;

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

17 4. As applicable, information explaining how an enrollee can
18 determine the anticipated out-of-pocket cost for out-of-network
19 health care services in a geographical area or zip code based upon
20 the difference between what the health benefit plan will reimburse
21 for out-of-network health care services and the usual, customary and
22 reasonable rate for out-of-network health care services.

23

24

1 SECTION 15. NEW LAW A new section of law to be codified

2 in the Oklahoma Statutes as Section 7514 of Title 36, unless there
3 is created a duplication in numbering, reads as follows:

4 A. A carrier shall provide a provider directory on both the
5 carrier website and in print format.

6 1. The carrier shall annually audit a reasonable sample size of
7 its provider directories for accuracy and retain documentation of
8 such an audit to be made available to the insurance commissioner upon
9 request.

10 2. The directory on the carrier website and in print format
11 shall contain the following general information in plain language for
12 each network plan:

- 13 a. a description of the criteria the carrier has used to
14 build its network,
- 15 b. if applicable, a description of the criteria the
16 carrier has used to tier providers,
- 17 c. if applicable, how the carrier designates the different
18 provider tiers or levels in the network and identifies
19 for each specific provider, hospital or other type of
20 facility in the network which tier each is placed, for
21 example by name, symbols or grouping, in order for a
22 covered person or a prospective covered person to be
23 able to identify the provider tier,

- d. if applicable, a statement that authorization or referral may be required to access some providers,
- e. what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state, and
- f. a customer service email address and telephone number or electronic link that enrollees or the public may use to notify the carrier of inaccurate provider directory information.

B. Regarding the directory posted online, the carrier shall:

1. Update the provider directory at least monthly;

2. Ensure that the public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number;

3. Make available in a searchable format the following information for each network plan:

- a. for health care professionals: name, gender, participating office locations, specialty, if applicable, medical group affiliations, if applicable, facility affiliations, if applicable; participating facility affiliations, if applicable, languages spoken other than English, if applicable and whether the provider is accepting new patients,

- 1 b. for hospitals: hospital name, hospital type (i.e.,
2 acute, rehabilitation, children's, cancer),
3 participating hospital location and hospital
4 accreditation status, and
- 5 c. for facilities, other than hospitals, by type:
6 facility name, facility type, types of services
7 performed and participating facility locations;

8 4. Make available the following information in addition to the
9 information available under paragraph 3 of subsection B of this
10 section:

- 11 a. for health care professionals: contact information,
12 board certifications and languages spoken other than
13 English by clinical staff, if applicable,
- 14 b. for hospitals: telephone number, and
- 15 c. for facilities other than hospitals: telephone number.

16 C. Regarding the provider directory in print format, the
17 carrier shall include a disclosure that the directory is accurate as
18 of the date of printing and that enrollees and prospective enrollees
19 should consult the carrier's electronic provider directory on its
20 website or call customer service to obtain current provider directory
21 information.

22 D. Upon request of an enrollee or a prospective enrollee, the
23 carrier shall make available in print format, the following provider
24 directory information for the applicable network plan:

1 1. For health care professionals: name; contact information;
2 participating office locations; specialty, if applicable; languages
3 spoken other than English, if applicable; and whether the provider is
4 accepting new patients;

5 2. For hospitals: hospital name, hospital type (i.e., acute
6 rehabilitation, children's, cancer) and participating hospital
7 location and telephone number; and

8 3. For facilities, other than hospitals, by type: facility name,
9 facility type, types of services performed and participating
10 facility locations and telephone number.

11 SECTION 16. This act shall become effective November 1, 2019.

12 COMMITTEE REPORT BY: COMMITTEE ON RETIREMENT AND INSURANCE
13 February 18, 2019 - DO PASS AS AMENDED
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