STATE OF OKLAHOMA

1st Session of the 57th Legislature (2019)

SENATE BILL 218 By: Pemberton

AS INTRODUCED

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 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 this act, the following definitions apply:

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

2. "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;

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

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

5. "Comparable health care service" shall mean any covered non-emergency 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 in less than Fifty Dollars ($50.00).

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:

Beginning upon approval of the next health insurance rate filing in 2020, a carrier offering a health plan 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, shall comply with the following requirements:

1. A carrier shall establish for all health care plans a program in which enrollees are directly incentivized to shop, before and after their out-of-pocket limit has been met, for lower-cost participating health care providers or health care entities for comparable health care services. Incentives may include cash payments, gift cards or credits or reductions of premiums, copayments, cost-sharing or deductibles;

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 6060.42 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 plan in this state in the individual or small group insurance market shall comply with the following requirements:

A. 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 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 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.

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

2. A carrier may submit to the Insurance Commissioner a request for exemption from the requirements of this subsection and shall list the reasons for the need for exemption in the request. The Commissioner may approve any request for exemption with reasonably sufficient evidence. This information shall be public upon action by the Commissioner.

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 non-emergency 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 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 a United States based out-of-network provider at a

price that is the same or less than the average that the insurance carrier of the enrollee pays to health care providers within its network within a reasonable timeframe, not to exceed one (1) year, for that service, the carrier shall allow the enrollee to obtain the service from the out-of-network provider 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 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 upon what that carrier pays to providers within the network, applicable to the specific health plan of the enrollee, or across all of their plans offered in this state. A carrier shall, at minimum, inform enrollees of their ability and the process to request the average allowed amount paid for a procedure both on their website and in benefit plan materials.

SECTION 6. This act shall become effective November 1, 2019.

57-1-562 CB 4/1/2019 8:19:13 AM