BILL SUMMARY
1st Session of the 57th Legislature

Bill No.:	**SB 1011**
Version:	**Engrossed**
Request Number:	**941**
Author:	**Quinn (S). McEntire (H)**
Date:	**3/27/2019**
Impact:	**Please see previous summary of this measure**

Research Analysis

SB 1011 creates the Out-of-Network Surprise Billing Transparency Act and defines terms used. The measure requires health benefit plans that cover out-of-network non-emergency services to provide at least one option for coverage for at least 80% of the customary rate associated with each out-of-network service. The Insurance Commissioner may require health benefit plans without available coverage in a rating region to make available one option for at least 80% of the customary rate for out-of-network non-emergency services. This requirement may also be waived by the Commissioner. An insurer covering emergency services must ensure that the enrollee will not incur greater out-of-pocket costs for out-of-network providers than would have been incurred by an in-network provider.

The measure requires insurers to provide enrollees with notice that an enrollee may request specialist referrals for out-of-network providers and for ongoing or life-threatening conditions, and will have access to obstetric and gynecologic services. The insurer must also provide the enrollee with a list of in-network providers, methodology for determining out-of-network coverage, anticipated out-of-pocket costs, and information to allow an enrollee to estimate costs. An insurer must make available on its website a directory of providers. Within 48 hours of receiving pre-authorization for non-emergency services, an insurer will provide an enrollee with information about coverage of the provider/service, personal responsibility of deductible or copayment, and applicable coinsurance amounts. The measure requires contracts between providers and insurers to contain a statement that providers will not bill enrollees for nonpayment of insurers.

The measure requires providers to provide patients with information regarding which plans the provider is a participant, estimated amount if the provider does not participate in the plan of the patient, and information regarding referrals. The measure requires health care facilities to make available on its website a list of standard charges for non-emergency services, networks in which the facility is a participant, and statements regarding the participation of a facility's providers in the networks. The health care facility must provide a disclosure statement to the patient at the time of scheduling services or seeking prior authorization from a health benefit plan for potential out-of-network services.

The measure creates a program of Independent Dispute Resolution under the Oklahoma Insurance Department for resolving dispute out-of-network charges and establishes procedures. The measure requires certain information to be included on an out-of-network provider's bill to an enrollee for non-emergency services, including a Payment Responsibility Notice. Insurers must make a utilization review determination involving services which require pre-authorization available to enrollees. Enrollees may appeal denials for out-of-network treatment.

Prepared By: Anna Rouw

Fiscal Analysis

The measure is currently under review and impact information will be completed.

Prepared By: Mark Tygret

Other Considerations

None.