STATE OF OKLAHOMA

2nd Session of the 57th Legislature (2020)

HOUSE BILL 3290 By: Taylor

AS INTRODUCED

An Act relating to 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 filing with Insurance Department; requiring carriers to establish online program; establishing requirements of program; authorizing exemption to requirements of act; requiring certain notification to enrollees; allowing enrollees to receive out-of-network treatment; requiring health care providers to provide certain cost estimates; directing the Insurance Department to promulgate rules; requiring the Insurance Department to conduct yearly analysis; 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" means the contractually agreed-upon amount paid by a carrier to a health care entity participating in the carrier's network;

2. "Average" means mean, median or mode;

3. "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 an insurance carrier can demonstrate allowed amount variation among network providers is less than Fifty Dollars ($50.00);

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

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

6. "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 6060.42 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Beginning upon approval of the next health insurance rate filing in 2021, a carrier offering a health plan in this state shall develop and implement a program that provides incentives for enrollees in a health plan who elect to receive a comparable health care service that is covered by the plan from providers that charge less than the average allowed amount paid by that carrier to network providers for that comparable health care service.

1. Incentives may be calculated as a percentage of the difference in allowed amounts to the average, as a flat dollar amount, or by some other reasonable methodology approved by the Insurance Department. The carrier shall provide the incentive as a cash payment to the enrollee or credit toward the enrollee's annual in-network deductible and out-of-pocket limit. Carriers may let enrollees decide which method the enrollee prefers to receive the incentive.

2. The incentive program shall provide enrollees with at least fifty percent (50%) of the carrier's saved costs for each service or category of comparable health care service resulting from shopping by enrollees. A carrier is not required to provide a payment or credit to an enrollee when the carrier's saved cost is Twenty-five Dollars ($25.00) or less.

3. A carrier shall base the average amount on the average allowed amount paid to a network provider for the procedure or service under the enrollee's health plan within a reasonable time frame not to exceed one (1) year. A carrier may determine an alternate methodology for calculating the average allowed amount if approved by the Insurance Department. A carrier shall, at minimum, inform enrollees of the enrollee's ability, and the process to request the average allowed amount for a procedure or service, both on the carrier's website but also in benefit plan material.

4. Eligibility for an incentive payment may require an enrollee to demonstrate, through reasonable documentation, such as a quote from the provider, that the enrollee shopped prior to receiving care from the provider who charges less for the comparable health care service than the average allowed amount paid by that carrier. Carriers shall provide additional mechanisms for the enrollee to satisfy this requirement by utilizing the carrier's cost transparency website or toll-free number established under the Oklahoma Right to Shop Act.

B. An insurance carrier shall make the incentive program available as a component of all health plans offered by the carrier in this state. Annually at enrollment or renewal, a carrier shall provide notice about the availability of the program, a description of the incentives available to an enrollee and how to earn such

incentives to any enrollee who is enrolled in a health plan eligible for the program.

C. 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.

D. Prior to offering the program to any enrollee, a carrier shall file a description of the program established by the carrier pursuant to this section with the Insurance Department in a manner determined by the Department. The Department may review the filing made by the carrier to determine if the carrier's program complies with the requirements of this section. Filings and any supporting documentation made pursuant to this subsection are confidential until the filing has been approved or denied by the Department.

E. Annually a carrier shall file with the Department, for the most recent calendar year, the total number of comparable health care service incentive payments made pursuant to this section, the use of comparable health care services by category of service for which comparable health care service incentives are made, the total payments made to enrollees, the average amount of incentive payments made by service for such transactions, and the total savings achieved below the average allowed amount by service for such transactions. Beginning no later than eighteen (18) months after implementation of a comparable health care service incentive program under this section and annually by April 1 of each year thereafter,

the Department shall submit an aggregate report for all carriers filing the information required by this subsection to the legislative committee having jurisdiction over health insurance matters. The Department may set reasonable limits on the annual reporting requirements on carriers to focus on the more popular comparable health care services.

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:

A. Beginning upon approval of the next health insurance rate filings, a carrier offering a health plan in this state 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; and

2. The interactive mechanism shall 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 time frame, 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 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 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 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 an 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 time frame, 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. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.45 of Title 36, unless there is created a duplication in numbering, reads as follows:

All health care providers as defined in Section 1-116 of Title 63 of the Oklahoma Statutes shall provide an estimate of charges prior to an admission, procedure or service.

1. If a patient or prospective patient is covered by insurance, a health care entity that participates in a carrier's network shall, upon request of a patient or prospective patient, provide within two (2) working days, based on the information available to the health care entity at the time of the request, sufficient information regarding the proposed nonemergency admission, procedure or service for the patient or prospective patient to receive a cost estimate from their insurance carrier to identify out-of-pocket costs which could be through an applicable toll-free telephone number of website. A health care entity may assist a patient or prospective patient in using a carrier's toll-free number and website.

2. If a health care entity is unable to quote a specific amount in advance due to the health care entity's inability to predict the specific treatment or diagnostic code, the health care entity shall disclose what is known for the estimated amount for a proposed nonemergency admission, procedure or service, including the amount for any facility fees required. A health care entity shall disclose the incomplete nature of the estimate and inform the patient or prospective patient of their ability to obtain an updated estimate once additional information is determined.

3. Prior to a nonemergency admission, procedure or service, and upon request by a patient or prospective patient, a health care entity outside the patient's or prospective patient's insurer network shall, within two (2) working days, disclose the price that

will be charged for the nonemergency admission, procedure or service, including the amount for any facility fees required.

4. Health care entities shall post in a visible area notification of the patient's ability, for those with individual or small group health insurance, to obtain a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association sufficient to allow an insurance carrier to assist the patient in comparing out-of-pocket and contracted amounts paid for their care to different providers for similar services. The notification shall inform patients of their right to obtain services from different providers regardless of a referral or recommendation from the provider at the health care entity, and that seeing a high-value provider, either their currently referred provider or a different provider, may result in an incentive to the patient if they follow the steps set by their insurance carrier. The notification shall give an outline of the parameters of potential incentives approved in accordance with the Oklahoma Right to Shop Act. It shall also notify the patient that his or her carrier is required to provide enrollees an estimate of out-of-pocket costs and contracted amounts paid for the enrollee's care to different providers for similar services via a toll-free telephone number and health care price transparency tool. A health care entity may provide additional

information in any form to patients that inform them of carrier-specific price transparency tools or toll-free phone numbers.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.46 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Insurance Department shall promulgate necessary rules for the implementation of the Oklahoma Right to Shop Act.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.47 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Insurance Department shall conduct an analysis no later than November 1, 2021, of the cost-effectiveness of implementing an incentive-based program for current enrollees. Any program found to be cost-effective shall be implemented as part of the next open enrollment. The Department shall communicate the rationale for its decision to relevant legislative committees in writing.

SECTION 9. This act shall become effective November 1, 2020.

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