STATE OF OKLAHOMA

1st Session of the 57th Legislature (2019)

SENATE BILL NO. 1011 By: Quinn

AS INTRODUCED

An Act relating to insurance; creating the Out-of-Network Unforeseen Billing Transparency Act; stating purpose of act; providing for applicability of act; defining terms; requiring certain insurers to assess network adequacy; requiring Insurance Commissioner to review adequacy at certain times; requiring certain insurers to provide certain coverage options; authorizing Commissioner to require certain coverage options of insurers; authorizing Commissioner to waive certain coverage requirements in certain circumstances; exempting certain medical services from act; providing construing provision; requiring health care plan to cover emergency services at certain cost; requiring insurer give certain notice to insured about coverage; requiring insurer provide certain documents and information to insured about covered facilities and coverage in-network and out-of-network; requiring certain provision in contract between health carrier and provider; applying certain section to nonemergency services; requiring certain health care professionals to disclose health care plans and hospitals they belong to; requiring out-of-network health care professionals provide certain information within two days; requiring physicians to provide information of certain health care professionals scheduled to treat patient; requiring hospitals to post certain information on website; requiring out-of-network services written disclosure in certain circumstances; providing elements of written disclosure; requiring hospitals to provide certain information in admission or registration materials; establishing a program of Independent Dispute Resolution for certain disputed charges; instructing Insurance Department to promulgate rules; authorizing Department to charge parties

participating in dispute resolution; requiring Department to maintain list of reviewers; authorizing independent reviewer to determine certain amount health care provider is entitled to; providing information to be considered for dispute resolution; authorizing health carriers to initiate dispute resolution; establishing procedure for dispute resolution process; providing eligibility requirements for independent reviewers; authorizing oral hearings in certain dispute resolutions; assigning costs of dispute resolution; authorizing court enforcement of decision of dispute resolution; establishing certain pricing and dispute resolution information as confidential; requiring out-of-network billing statement to contain certain information and notice; requiring health carriers to develop program for payment of certain out-of-network, facility-based provider bills; establishing requirements of program; prohibiting balanced billing in certain circumstances; classifying out-of-network referral denial; requiring certain information for denials; authorizing appeal of denial in certain circumstances; providing procedures for external appeals after internal appeal upholds denial; requiring external appeal agent provide certain written statement; requiring health benefit plan provider utilization review determination in certain timeframe; establishing procedures for notification; requiring carriers to maintain certain directory; requiring carrier perform certain annual audit; providing required elements of directory; providing requirements for maintaining directory; requiring certain disclosure for directory; requiring carrier to provide directory in certain format; requiring carrier provide certain information in directory; 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 "Out-of-Network Unforeseen Billing Transparency 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:

The purpose of this act is to protect consumers from unexpected medical bills that result from their receiving care from out-of-network providers. Improved disclosures by health benefit plans, providers, and facilities, and a procedure for appealing out-of-network referral denials will help consumers better navigate the insurance processes and reduce the incidence of costly, unforeseen bills.

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

B. This act does not apply to:

1. Any Medicaid programs operated in Oklahoma, including any Medicaid managed care programs;

2. The Children's Health Insurance Program (CHIP) operated in Oklahoma;

3. Medicare; or

4. "Excepted benefit" products as defined in 42 U.S.C. 300gg-91(c).

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:

For the purposes of and as used in this act:

1. "Balance billing" means the practice by a provider, who does not participate in an health benefit plan network of the enrollee, of charging the enrollee the difference between the provider's fee and the sum of what the enrollee's health benefit plan pays and what the enrollee is required to pay in applicable deductibles, co-payments, coinsurance or other cost-sharing amounts required by the health benefit plan;

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

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

4. "Department" means the Oklahoma Insurance Department;

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

a. placing the health of the patient in serious jeopardy,

b. serious impairment to bodily functions, or

c. serious dysfunction of any bodily organ or part;

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

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

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

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

8. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs

of health care services, and includes the Oklahoma Employees Health Insurance Plan as defined in Section 1303 of Title 74 of the Oklahoma Statutes and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employer self-insured plan except as exempt under the Employee Retirement Income Security Act of 1974;

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

10. "Network" means the providers and health care facilities that have contracted to provide health care services to the enrollees of a health benefit plan. This includes a network operated by, or contracts with, a health maintenance organization, a preferred provider organization or another entity, including an insurance company that issues a health benefit plan;

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

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

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

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

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

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

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. A carrier that issues a comprehensive group health benefit plan that covers services provided by out-of-network providers shall make available and, if requested by the policyholder or contract holder, provide at least one option for coverage for at least eighty percent (80%) of the usual, customary and reasonable rate of each

service provided by an out-of-network provider after imposition of a deductible or any permissible benefit maximum.

B. If there is no coverage available pursuant to subsection A of this section in a rating region, then the Commissioner may require a carrier issuing a comprehensive group health benefit plan in the rating region, to make available and, if requested by the policyholder or contract holder, provide at least one option for coverage of eighty percent (80%) of the usual, customary and reasonable rate of each service provided by an out-of-network provider after imposition of any permissible deductible or benefit maximum. The Commissioner may, after considering the public interest, permit a carrier to satisfy the requirements of this subsection on behalf of another carrier, corporation, or health maintenance organization within the same holding company system. The Commissioner may, upon written request, waive the requirement for coverage of services provided by out-of-network providers to be made available pursuant to this subsection if the Commissioner determines that it would pose an undue hardship upon a carrier.

C. This section shall not apply to emergency services.

D. Nothing in this section shall limit the Commissioner's authority to establish minimum standards for the form, content, and sale of health benefit plans and subscriber contracts, to require additional coverage options for services provided by out-of-network

providers, or to provide for standardization and simplification of coverage.

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

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

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

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

1. Notice:

a. that the enrollee may obtain a referral or preauthorization for services from an out-of-network provider when the health benefit plan does not have in its network a provider who is geographically accessible to the enrollee and has the appropriate training and experience to meet the particular health care needs of the enrollee,

b. of the procedure for requesting and obtaining such referral or preauthorization,

c. that the enrollee with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist,

d. of the procedure for requesting and obtaining such a standing referral,

e. that the enrollee with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the enrollee's medical care,

f. of the procedure for requesting and obtaining such a specialist,

g. that the enrollee with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request access to a specialty care center,

h. of the procedure for requesting and obtaining such access may be obtained, and

i. that an enrollee shall have direct access to primary and preventive obstetric and gynecologic services,

including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions, from a qualified provider of such services of her choice from within the plan or for any care related to a pregnancy;

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

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

a. a clear description of the methodology used by the carrier to determine reimbursement for out-of-network health care services,

b. a description of the amount that the carrier will reimburse under the methodology for out-of-network health care services set forth as a percentage of the usual, customary and reasonable rate for out-of-network health care services,

c. examples of anticipated out-of-pocket costs for frequently billed out-of- network health care services,

d. information that reasonably permits an enrollee to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health benefit plan will reimburse for out-of-network health care services and the usual, customary and

reasonable rate for out-of-network health care services.

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

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

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

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

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

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

"Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek

compensation, remuneration or reimbursement from or have any recourse against an enrollee or a person (other than the health carrier or intermediary) acting on behalf of the enrollee for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to enrollees. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's enrollees and no others) and an enrollee from agreeing to continue services solely at the expense of the enrollee, as long as the provider has clearly informed the enrollee that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

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

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

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

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

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

D. When services rendered in an office of the provider require referral to, or coordination with, an anesthesiologist, laboratory, pathologist, radiologist or assistant surgeon, the provider or representative of the provider initiating the referral or coordination shall give to the enrollee, the following information in writing about the aforementioned who will be providing services to the enrollee: (1) name, practice name, mailing address, telephone number and (2) how to determine in which health benefit plan networks each participates. The information shall be provided to the enrollee

at the time of the referral or commencement of the coordination of services.

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

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

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

B. A health care facility shall establish, update and make public through posting on its website, to the extent required by federal guidelines, a list of the facility's standard charges for items and services provided by the facility, including for diagnosis-related groups established under section 1886(d)(4) of the federal Social Security Act.

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

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

2. A statement that:

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

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

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

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

3. As applicable, the name, mailing address and telephone number of the facility-based providers and facility-based provider groups that the facility has employed or contracted with to provide services including anesthesiology, pathology, and/or radiology, and

instructions about how to determine in which health benefit plan networks each participates.

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

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

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

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

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

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

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

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

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

E. At the time of admission in the participating facility where the nonemergency services are to be performed on the enrollee, the facility shall provide the enrollee with the written disclosure, as outlined in subsection D of this section, and obtain the signature of the enrollee or the representative of the enrollee on the disclosure document acknowledging that the enrollee received the disclosure document in advance prior to the time of admission.

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

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

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

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

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

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

B. The independent reviewer shall determine the amount the health care provider is entitled to receive as payment for the health care services. The independent reviewer shall allow each party to provide information the independent reviewer reasonably determines to be relevant in evaluating the unforeseen, 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.

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

C. If the parties have not designated an independent reviewer by mutual agreement within thirty (30) days of the request for

Independent Dispute Resolution, the Commissioner shall select an independent reviewer from the list of qualified reviewers.

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

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

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

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

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

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

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

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

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

a. bear its own attorney fees and costs, and

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

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

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

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

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

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

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

"Payment Responsibility Notice – The services[s] outlined below was [were] performed by a facility-based provider who is a nonparticipating provider with your health benefit plan. At this time, you are responsible for paying your applicable cost-sharing obligation – copayment, coinsurance or deductible amount – just as you would be if the provider is within your plan's network. With regard to the remaining balance, you have four choices: 1) you may choose to pay the balance of the bill; OR 2) if the difference between the billed charge and the plan's allowable amount is more than $500, you may send the bill to your health carrier for processing pursuant to the carrier's nonparticipating facility-based provider billing process; OR 3) you may initiate an independent dispute resolution process with the Oklahoma

Insurance Department; OR 4) you may rely on other rights and remedies that may be available in your state.";

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

3. A conspicuous, plain-language explanation that:

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

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

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

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

6. A notice that:

a. the enrollee may file complaints with the Oklahoma Board of Medical Licensure and Supervision and includes the Oklahoma Board of Medical Licensure and Supervision web address, mailing address and complaint telephone number, or

b. the enrollee may initiate an Independent Dispute Resolution proceeding to dispute the billing statement in the same manner as a health carrier or

nonparticipating provider pursuant to Section 11 of this act. The notice shall include the contact information at the Department for such initiation, including the web address, mailing address and telephone number; and

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

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

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

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

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

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

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

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

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

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

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

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

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

C. 1. An enrollee or designee of an enrollee may appeal an out-of-network referral denial by submitting a written statement from

the attending physician of the enrollee, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty appropriate to treat the enrollee for the health service sought, provided that:

a. the in-network provider or providers recommended by the health benefit plan do not have the appropriate training and experience to meet the particular health care needs of the enrollee for the health service, and

b. the attending physician recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the enrollee, and who is able to provide the requested health service.

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

a. review the utilization review agent's health benefit plan's final adverse determination,

b. make a determination as to whether the out-of-network referral shall be covered by the health benefit plan, provided that such determination shall be:

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

(2) based upon review of the:

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

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

(c) the clinical standards of the plan,

(d) the information provided concerning the insured,

(e) the attending physician's recommendation,

(f) the insured's medical record, and

(g) any other pertinent information, and

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

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

(5) admissible in any court proceeding, and

c. Upon reaching its decision, the external appeals agent shall submit to the enrollee and the health benefit plan, a written statement that:

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

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

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

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

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

A health benefit plan shall make a utilization review determination involving health care services which require pre-authorization and provide notice of that determination to the enrollee or designee of the enrollee and the health care provider of the enrollee by telephone and in writing within three (3) business days of receipt of the information necessary to make the determination. To the extent practicable, such written notification to the enrollee and the enrollee's health care provider shall also

be transmitted electronically, in a manner and in a form agreed upon by the parties. The notification shall identify:

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

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

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

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

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7514 of Title 36, unless there is created a duplication in numbering, reads as follows:

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

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

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

a. a description of the criteria the carrier has used to build its network,

b. if applicable, a description of the criteria the carrier has used to tier providers,

c. if applicable, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, in order for a covered person or a prospective covered person to be 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,

b. for hospitals: hospital name, hospital type (i.e., acute, rehabilitation, children's, cancer), participating hospital location and hospital accreditation status, and

c. for facilities, other than hospitals, by type: facility name, facility type, types of services performed and participating facility locations;

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

a. for health care professionals: contact information, board certifications and languages spoken other than English by clinical staff, if applicable,

b. for hospitals: telephone number, and

c. for facilities other than hospitals: telephone number.

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

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

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

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

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

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

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