

1 **SENATE FLOOR VERSION**

2 February 21, 2023

3 COMMITTEE SUBSTITUTE
4 FOR

5 SENATE BILL NO. 442

6 By: Montgomery of the Senate

7 and

8 Sneed of the House

9 An Act relating to health benefit plan directories;
10 defining terms; directing plans to publish certain
11 provider directories on certain website; describing
12 information to be included in directory; requiring
13 directory to be publicly accessible; directing plan
14 to publish certain criteria; providing for
15 accessibility of certain directories; requiring
16 certain disclosure; providing for reporting
17 procedure; requiring plan response to report by
18 certain date; requiring annual audit of certain
19 information; requiring notice to be provided to
20 certain providers by plan; directing plan to remove
21 certain providers after certain time period;
22 directing plan to submit certain information to
23 Insurance Commissioner; establishing procedure for
24 certain use of inaccurate information by insured;
requiring reimbursement by plan under certain
circumstances for care provided by out-of-network
provider; authorizing Commissioner to promulgate
rules; providing for codification; and providing an
effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

1 SECTION 1. NEW LAW A new section of law to be codified
2 in the Oklahoma Statutes as Section 6971 of Title 36, unless there
3 is created a duplication in numbering, reads as follows:

4 A. As used in this section:

5 1. "Health benefit plan" means a plan as defined pursuant to
6 Section 6060.4 of Title 36 of the Oklahoma Statutes;

7 2. "Health care facility" means a facility as defined pursuant
8 to Section 1-725.2 of Title 63 of the Oklahoma Statutes;

9 3. "Health care professional" means a professional as defined
10 pursuant to Section 6802 of Title 36 of the Oklahoma Statutes;

11 4. "Hospital" means a hospital as defined pursuant to Section
12 1-701 of Title 63 of the Oklahoma Statutes; and

13 5. "Provider" means a health care provider as defined pursuant
14 to Section 6571 of Title 36 of the Oklahoma Statutes.

15 B. Any insurer of a health benefit plan that is offered,
16 issued, or renewed in this state on or after the effective date of
17 this act shall publish an electronic provider directory for each of
18 its network plans, to be updated every sixty (60) days. The insurer
19 shall make clear the provider directory that applies to each network
20 plan as marketed and issued in this state. The electronic directory
21 shall be published on an easily accessible website in a
22 standardized, downloadable, and searchable format. The electronic
23 directory shall include the following information:

24 1. For health care professionals:

- a. name,
- b. contact information, including a website address, physical address, and phone number, and
- c. specialty, if applicable;

2. For hospitals:

- a. hospital name,
- b. hospital type, including, but not limited to, acute, rehabilitation, children's, or cancer,
- c. participating hospital location,
- d. hospital accreditation status,
- e. customer service telephone number, and
- f. website address; and

3. For health care facilities other than hospitals:

- a. facility name,
- b. facility type,
- c. types of services performed,
- d. participating facility location or locations,
- e. customer service telephone number, and
- f. website address.

C. Any insurer of a health benefit plan that publishes a provider directory pursuant to this section shall ensure that the general public is able to view all of the current providers for a network plan, through a clearly identifiable hyperlink or website

1 tab, without requiring any person to create or sign into an account
2 or submit a policy or contract number.

3 D. For each network plan published, an insurer of a health
4 benefit plan shall include in plain language the following
5 information:

6 1. A description of the criteria used to build its provider
7 network; and

8 2. If applicable:

9 a. a description of the criteria used to tier providers,

10 b. how the plan designates the different provider tiers
11 or levels, including, but not limited to, by name,
12 symbols, or grouping, in the network and for each
13 specific provider in the network, which tier each is
14 placed for an insured or a prospective insured to be
15 able to identify the provider tier, and

16 c. a notice that authorization or referral may be
17 required to access some providers.

18 E. 1. Provider directories, whether in electronic or, if
19 offered, print format, shall be accessible to individuals with
20 disabilities and individuals with limited English proficiency as
21 defined in 45 C.F.R. Sections 92.201 and 155.205.

22 2. The plan shall include a disclosure in any print directory
23 issued under this subsection that the information in the directory
24 is accurate as of the date of printing and that an insured or

1 prospective insured should consult the electronic provider directory
2 on the website of the plan or call the listed customer service
3 telephone number to obtain current provider directory information.

4 F. 1. The health benefit plan shall include in both its online
5 and print directories, if offered, a clearly identifiable telephone
6 number, email address, or link to a webpage which an insured or the
7 general public may use to report to the plan inaccurate information
8 listed in the provider directory. Whenever a plan receives a
9 report, it shall promptly investigate the report and, not later than
10 two (2) days following the receipt of such report, either verify the
11 accuracy of the information or update the information.

12 2. A plan shall take appropriate steps to ensure the accuracy
13 of the information concerning each provider listed in the provider
14 directory. The plan shall contact providers as necessary to ensure
15 that the information provided in the directory is up to date.

16 3. The plan shall, at least annually, audit its provider
17 directories for accuracy. The audit should be focused on the top
18 four utilized specialties to include at least one specialty related
19 to mental health. Alternatively, plans may audit based on a
20 reasonable sample size of providers, as long as the sample size
21 includes behavioral health providers. The plan shall retain
22 documentation of any audit conducted under this paragraph to be made
23 available to the Insurance Commissioner. Based on the results of a
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1 given audit, the plan shall verify and attest to the accuracy of the
2 information or update the information.

3 G. An insurer of a health benefit plan shall, by certified
4 mail, return receipt requested, or by electronic mail, read receipt
5 requested, notify any provider of its removal from the network if
6 the provider has not submitted claims to the plan or otherwise
7 communicated intent to continue participation in the plan network
8 within a twelve-month period. If the provisions of the contract
9 entered between the plan and the provider provides notice terms, the
10 notice shall be provided in accordance with such terms. If the plan
11 does not receive a response from the provider within thirty (30)
12 days of such notification, the plan shall remove the provider from
13 the network.

14 H. In accordance with any timeframes and requirements that may
15 be established by the Commissioner, an insurer of a health benefit
16 plan shall report to the Commissioner the following:

17 1. The number of reports received pursuant to subsection F of
18 this section, the timeliness of the response from the plan, and the
19 corrective action or actions taken; and

20 2. All auditing reports conducted by the plan pursuant to
21 subsection F of this section.

22 I. If an insured reasonably relies upon materially inaccurate
23 information contained in a provider directory of a plan, the
24 Commissioner may require the plan to provide coverage for all

1 covered health care services provided to the insured and to
2 reimburse the insured for any amount that he or she would have to
3 pay if the services would have been delivered by an in-network
4 provider under the network plan. Provided, the Commissioner shall
5 take into consideration that health benefit plan insurers are
6 relying on health care providers to report changes to their
7 information prior to requiring any reimbursement to an insured. In
8 the event that the Commissioner finds that the provider has not
9 provided updated information for the network directory of the
10 insurer of a health benefit plan, the Commissioner may require that
11 the provider be reimbursed at the assignment of benefits rate for
12 the service if it were conducted in-network. Prior to requiring
13 reimbursement under this subsection, the Commissioner shall conclude
14 that the services received by the plan were covered services under
15 the insured's network plan. If the services satisfy requirements of
16 this subsection, a plan shall not deny reimbursement to an insured
17 based on the provider of the services being out-of-network.

18 J. The Commissioner may promulgate rules to effectuate the
19 provisions of this section.

20 SECTION 2. This act shall become effective November 1, 2023.

21 COMMITTEE REPORT BY: COMMITTEE ON RETIREMENT AND INSURANCE
22 February 21, 2023 - DO PASS AS AMENDED BY CS
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