STATE OF OKLAHOMA

1st Session of the 59th Legislature (2023)

COMMITTEE SUBSTITUTE
FOR
SENATE BILL 442 By: Montgomery of the Senate

and

Sneed of the House

COMMITTEE SUBSTITUTE

An Act relating to health benefit plan directories; defining terms; directing plans to publish certain provider directories on certain website; describing information to be included in directory; requiring directory to be publicly accessible; directing plan to publish certain criteria; providing for accessibility of certain directories; requiring certain disclosure; providing for reporting procedure; requiring plan response to report by certain date; requiring annual audit of certain information; requiring notice to be provided to certain providers by plan; directing plan to remove certain providers after certain time period; directing plan to submit certain information to Insurance Commissioner; establishing procedure for 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:

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

A. As used in this section:

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

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

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

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

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

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

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

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

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

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

2. If applicable:

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

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

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

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

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

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

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

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

3. The plan shall, at least annually, audit its provider directories for accuracy. The audit should be focused on the top four utilized specialties to include at least one specialty related to mental health. Alternatively, plans may audit based on a reasonable sample size of providers, as long as the sample size includes behavioral health providers. The plan shall retain documentation of any audit conducted under this paragraph to be made available to the Insurance Commissioner. Based on the results of a

given audit, the plan shall verify and attest to the accuracy of the information or update the information.

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

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

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

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

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

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

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

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

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