SENATE BILL 228:
Allow Employers to Offer Exclusive Provider Option Benefit Plans.

2021-2022 General Assembly

Committee:		**Date:**	December 8, 2021
Introduced by:		**Prepared by:**	Jason Moran-Bates
Analysis of:	S.L. 2021-151		Staff Attorney

OVERVIEW: S.L. 2021-151 allows insurers to offer exclusive provider benefit health plans and establishes continuity of care provisions for those plans.

This act became effective October 1, 2021, and applies to contracts entered into, renewed, or amended on or after that date.

BILL ANALYSIS:

The act allows insurers to offer exclusive provider benefit plans where out-of-network services are not covered unless they were emergency services or medically necessary services provided when an in-network provider was not reasonably available.

The act creates definitions for "exclusive provider benefit plan," "exclusive provider organization," "insurer," and "participating provider."

Providers who were members of one insurer's exclusive network are permitted to participate in networks with other insurers. Insurers offering exclusive provider benefit plans must make annual reports to the Department of Insurance on the terms of their agreements with providers in the exclusive network. The existing insurance rules for preferred provider organizations also apply to exclusive provider organizations.

The act establishes continuity of care provisions for exclusive provider organizations (EPO). This transitional coverage must be available to individuals who are newly insured by the EPO and to individuals whose healthcare providers left the EPO's network.

- In general, the insurer must continue paying the provider for treatment received within 90 days of the provider leaving the network.
- If the care is related to surgery, organ transplantation, or inpatient care, coverage must be continued for 90 days after discharge.
- If the care is related to pregnancy, and the insured was in her second trimester when the provider left the network, coverage must continue through 60 days of postpartum care.
- Coverage for terminal illness must be extended for the duration of the insured's life.

Insurers may condition coverage for continuing care on the following:

- The provider agreeing to accept reimbursement from the insurer and not charge the patient a greater cost-share.
- The provider agreeing to comply with the insurer's quality assurance programs and policies for in-network providers.

- The provider agreeing to discontinue providing services to the insured at the end of the transition period and assist the insured in finding an in-network provider.

Insurers are not required to:

- Cover benefits during the transition period that would not have been covered previously.
- Provide continuing coverage when the provider is removed from the network for reasons of fraud.
- Provide transition coverage when the insurer determines the provider's continuing services would result in serious danger to the health or safety of the insured.

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