

ENGROSSED SENATE
BILL NO. 1166

By: Long (Ed) of the Senate

and

Voskuhl of the House

[health insurance - choice and compensation of
practitioners - copayments based on discounted or
nondiscounted charges - effective
date]

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

SECTION 1. AMENDATORY 36 O.S. 1991, Section 6055, as last amended by Section 1, Chapter 356, O.S.L. 1995 (36 O.S. Supp. 1995, Section 6055), is amended to read as follows:

Section 6055. A. For any individual, group, blanket or franchise policy, insurance trust, nonprofit contract or agreement whatever, providing accident or health benefits hereafter renewed or issued for delivery from out of Oklahoma or in Oklahoma by any insurer, whether a stock or mutual insurance company, medical service corporation or association, nonprofit hospital service and medical indemnity corporation, self-insured trust, nonprofit group, or any other type of insurer whatever, and covering an Oklahoma risk, the services and procedures may be performed by any practitioner selected by the insured, or the insured's parent or guardian if the insured is a minor, provided that the practitioner is duly licensed under the laws of this state to perform such services or procedures approved by the appropriate board of examiners.

B. A policy, contract or agreement, as described in subsection A of this section, may exclude or limit coverage for a particular illness, disease, injury or condition; but, except for such exclusions or limits, shall not exclude or limit particular services or procedures that can be provided for the diagnosis and treatment of a covered illness, disease, injury or condition, if such exclusion or limitation has the effect of discriminating against a particular class of practitioner. However, such services and procedures, in order to be a covered medical expense, must be medically necessary, must be of proven efficacy, and must fall within the licensed scope of practice of the practitioner providing same.

C. A practitioner or hospital, as defined in Section 1-701 of Title 63 of the Oklahoma Statutes, shall be compensated directly by an insurer when benefits are assigned and on file and claims are processed on a uniform health insurance claim form prescribed by the Insurance Commissioner pursuant to Section 6581 of this title and a duplicate copy of the bill has been sent to the insured. The provisions of this subsection shall not apply to:

1. Any PPO contract, as defined by generally accepted industry standards; or
2. Any statewide provider network which:
 - a. provides that a practitioner or hospital who joins the provider network shall be compensated directly by the insurer,
 - b. does not have any terms or conditions which have the effect of discriminating against a particular class of practitioner, and
 - c. allows any hospital or practitioner, except a practitioner who has a prior felony conviction, to become a network provider if said hospital or

practitioner is willing to comply with the terms and conditions of a standard network provider contract.

D. A practitioner shall be equally compensated for such services and procedures on the basis of charges prevailing in the same community for similar services and procedures to similarly ill or injured persons regardless of the branch of the healing arts to which the practitioner may belong, provided such profession or practitioner does not permit false and fraudulent advertising or such profession or practitioner does not aid or abet the insured to violate the terms of the contract or agreement.

E. Nothing in this section shall prohibit a practitioner from contracting with a payor, payors or insurers for alternative levels or methods of payment.

F. A policy, contract or agreement, as described in subsection A of this section or issued for any preferred provider or other provider arrangement or managed care plan, which requires the insured or enrollee to make a copayment when benefits are provided, shall disclose to the insured or enrollee the calculation for the copayment. In no case shall the payment for services under the policy, contract or agreement and the copayment made by the insured or enrollee be more than the actual amount which has been or will be paid to the practitioner, hospital or other provider of health care services; provided, however, in no case shall the copayment be based on a higher figure than either the amount billed or the amount paid, whichever is less.

SECTION 2. This act shall become effective November 1, 1996.

Passed the Senate the 27th day of February, 1996.

President of the Senate

Passed the House of Representatives the ____ day of
_____, 1996.

Speaker of the House of
Representatives