

ENROLLED HOUSE  
BILL NO. 1318

By: Stanley, Beutler, Matlock  
and Lindley of the House

and

Henry and Crutchfield of  
the Senate

An Act relating to insurance and health care; amending Section 18, Chapter 342, O.S.L. 1994, 36 O.S. 1991, Section 6054, as last amended by Section 1, Chapter 76, O.S.L. 1996, 6055, as last amended by Section 2, Chapter 76, O.S.L. 1996, 6056, as amended by Section 3, Chapter 76, O.S.L. 1996, and 6057, as amended by Section 4, Chapter 76, O.S.L. 1996 (36 O.S. Supp. 1998, Sections 6053, 6054, 6055, 6056 and 6057), which relate to the Health Care Freedom of Choice Act; modifying short title; exempting certain contracts; adding and modifying definitions; providing for construction of section; adding home care agencies and ambulatory surgical centers to application of act; modifying construction of certain provisions; providing certain limitations; specifying and limiting certain deductibles, percentage amounts, points and disclosures; authorizing certain contracts requiring certain disclosures; providing for terms and conditions; restricting certain terms and conditions; prohibiting certain discrimination and constructions; expanding participation benefits and assignments by certain providers; expanding application of Health Care Freedom of Choice Act to include additional providers; authorizing the Insurance Commissioner to issue certain orders; providing enforcement authority; providing for certain assistance by the Attorney General; providing for award of attorney fees; providing for deposits; providing and authorizing administrative penalties; specifying amounts; providing for enforcement; providing for deposits; providing for judicial review; providing for promulgation of rules; amending 36 O.S. 1991, Section 3624, as amended by Section 1, Chapter 370, O.S.L. 1992 (36 O.S. Supp. 1998, Section 3624), which relates to assignment of certain insurance policies; updating certain cites; providing for codification; and providing an effective date.

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

SECTION 1. AMENDATORY Section 18, Chapter 342, O.S.L. 1994 (36 O.S. Supp. 1998, Section 6053), is amended to read as follows:

Section 6053. A. Sections 6053 through 6057 of Title 36 of the Oklahoma Statutes this title and Sections 6 through 9 of this act shall be known and may be cited as the "Health Care Freedom of Choice Act".

B. The provisions of the Health Care Freedom of Choice Act shall not apply to contracts executed with a preferred provider organization to provide health care services for employer-sponsored self-funded plans covered by the federal Employee Retirement Income Security Act (ERISA).

SECTION 2. AMENDATORY 36 O.S. 1991, Section 6054, as last amended by Section 1, Chapter 76, O.S.L. 1996 (36 O.S. Supp. 1998, Section 6054), is amended to read as follows:

Section 6054. As used in the Health Care Freedom of Choice Act:

1. "Accident and health insurance policy" or "policy" means any policy, certificate, contract, agreement or other instrument that provides accident and health insurance, as defined in Section 703 of this title, to any person in this state;

2. "Ambulatory surgical center" means any ambulatory surgery facility licensed by the State Department of Health as defined in Section 2657 of Title 63 of the Oklahoma Statutes;

3. "Home care agency" means any sole proprietorship, partnership, association, corporation, or other organization which administers, offers, or provides home care services, for a fee or pursuant to a contract for such services, to clients in their place of residence. The term "home care agency" shall not include an individual who contracts with the Department of Human Services to provide personal care services; provided, such individual shall not be exempt from certification as a home health aide;

4. "Hospital" means any facility as defined in Section 1-701 of Title 63 of the Oklahoma Statutes;

~~3.~~ 5. "Insured" means any person entitled to reimbursement for expenses of health care services and procedures under an accident and health insurance policy issued by an insurer;

~~4.~~ 6. "Insurer" means any entity that provides an accident and health insurance policy in this state, including but not limited to a licensed insurance company, a not-for-profit hospital service ~~and/or~~ and medical indemnity corporation, a fraternal benefit society, a multiple employer welfare arrangement, or any other entity subject to regulation by the Insurance Commissioner; ~~and~~

~~5.~~ 7. "Practitioner" means any person holding a valid license to practice medicine and surgery, osteopathic medicine, chiropractic, podiatric medicine, optometry or dentistry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes; and

8. "Preferred provider organization (PPO)" means a network of practitioners, hospitals, home care agencies or ambulatory surgical centers, which have entered into a contract with an insurer to provide health care services under the terms and conditions established in the contract.

SECTION 3. AMENDATORY 36 O.S. 1991, Section 6055, as last amended by Section 2, Chapter 76, O.S.L. 1996 (36 O.S. Supp. 1998, Section 6055), is amended to read as follows:

Section 6055. A. Under any accident and health insurance policy, hereafter renewed or issued for delivery from out of Oklahoma or in Oklahoma by any insurer 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 ~~and~~, if the services and procedures fall within the licensed scope of practice of the practitioner providing the ~~service~~ same.

B. An accident and health insurance policy may:

1. 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:

- a. be medically necessary,
- b. be of proven efficacy, and
- c. fall within the licensed scope of practice of the practitioner providing same; and

2. Provide for the application of deductibles and copayment provisions, when equally applied to all covered charges for services and procedures that can be provided by any practitioner for the diagnosis and treatment of a covered illness, disease, injury or condition. This provision shall not be construed to prohibit differences in deductibles and copayment provisions between practitioners, hospitals and ambulatory surgical centers who are participating ~~network practitioners~~ preferred provider organization providers and ~~nonparticipating network practitioners, hospitals and ambulatory surgical centers who are not participating in the~~ preferred provider organization, subject to the following limitations:

- a. the amount of any annual deductible per covered person or per family for treatment in a hospital or ambulatory surgical center that is not a preferred provider shall not exceed three times the amount of a corresponding annual deductible for treatment in a hospital or ambulatory surgical center that is a preferred provider,
- b. if the policy has no deductible for treatment in a preferred provider hospital or ambulatory surgical center, the deductible for treatment in a hospital or ambulatory surgical center that is not a preferred provider shall not exceed One Thousand Dollars (\$1,000.00) per covered-person visit,

- c. the amount of any annual deductible per covered person or per family treatment, other than inpatient treatment, by a practitioner that is not a preferred practitioner shall not exceed three times the amount of a corresponding annual deductible for treatment, other than inpatient treatment, by a preferred practitioner,
- d. if the policy has no deductible for treatment by a preferred practitioner, the annual deductible for treatment received from a practitioner that is not a preferred practitioner shall not exceed Five Hundred Dollars (\$500.00) per covered person,
- e. the percentage amount of any coinsurance to be paid by an insured to a practitioner, hospital or ambulatory surgical center that is not a preferred provider shall not exceed by more than thirty (30) percentage points the percentage amount of any coinsurance payment to be paid to a preferred provider,
- f. a practitioner, hospital or ambulatory surgical center that is not a preferred provider shall disclose to the insured, in writing, that the insured may be responsible for:
  - (1) higher coinsurance and deductibles, and
  - (2) practitioner, hospital or ambulatory surgical center charges which exceed the allowable charges of a preferred provider, and
- g. when a referral is made to a nonparticipating hospital or ambulatory surgical center, the referring practitioner must disclose in writing to the insured, any ownership interest in the nonparticipating hospital or ambulatory surgical center.

C. Benefits available under an accident and health insurance policy, at the option of the insured, shall be assignable to a practitioner ~~or~~, hospital, home care agency or ambulatory surgical center who has provided services and procedures which are covered under the policy. A practitioner ~~or~~, hospital, home care agency or ambulatory surgical center shall be compensated directly by an insurer for services and procedures which have been provided when the following conditions are met:

1. Benefits available under a policy have been assigned in writing by an insured to the practitioner ~~or~~, hospital, home care agency or ambulatory surgical center;

2. A copy of the assignment has been provided by the practitioner ~~or~~, hospital, home care agency or ambulatory surgical center to the insurer;

3. A claim has been submitted by the practitioner ~~or~~, hospital, home care agency or ambulatory surgical center to the insurer on a uniform health insurance claim form ~~prescribed~~ adopted by the Insurance Commissioner pursuant to Section 6581 of this title; and

4. A copy of the claim has been provided by the practitioner ~~or~~, hospital, home care agency or ambulatory surgical center to the insured.

D. The provisions of subsection C of this section shall not apply to:

1. Any preferred provider organization (PPO) contract, as defined by generally accepted industry standards; or

2. Any statewide provider network which:

- a. provides that a practitioner ~~or~~, hospital, home care agency or ambulatory surgical center 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 practitioner, hospital or practitioner, home care agency or ambulatory surgical center, 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.

E. A nonparticipating practitioner, hospital or ambulatory surgical center may request from an insurer and the insurer shall supply a good-faith estimate of the allowable fee for a procedure to be performed upon an insured based upon information regarding the anticipated medical needs of the insured provided to the insurer by the nonparticipating practitioner.

F. A practitioner shall be equally compensated for covered services and procedures provided to an insured on the basis of charges prevailing in the same geographical area or in similar sized communities for similar services and procedures provided to similarly ill or injured persons regardless of the branch of the healing arts to which the practitioner may belong, if:

1. The practitioner does not authorize or permit false and fraudulent advertising regarding the services and procedures provided by the practitioner; and

2. The practitioner does not aid or abet the insured to violate the terms of the policy.

~~F. G.~~ Nothing in the Health Care Freedom of Choice Act shall prohibit a practitioner from contracting with an insurer for from establishing a preferred provider organization and a standard participating provider contract therefor, specifying the terms and conditions, including, but not limited to, provider qualifications, and alternative levels or methods of payment that must be met by a practitioner selected by the insurer as a participating preferred provider organization provider.

H. A preferred provider organization, in executing a contract, shall not, by the terms and conditions of the contract or internal

protocol, discriminate within its network of practitioners with respect to participation and reimbursement as it relates to any practitioner who is acting within the scope of the practitioner's license under the law solely on the basis of such license.

I. Nothing in this act shall be construed as prohibiting an insurer, preferred provider organization or other network from determining the adequacy of the size of its network.

SECTION 4. AMENDATORY 36 O.S. 1991, Section 6056, as amended by Section 3, Chapter 76, O.S.L. 1996 (36 O.S. Supp. 1998, Section 6056), is amended to read as follows:

Section 6056. Services and procedures covered under an accident and health insurance policy may be performed at any hospital, home care agency or ambulatory surgical center where a practitioner is authorized to practice, doctor's office or clinic, at the choice of the insured, or the insured's parent or guardian if the insured is a minor, and the practitioner who is providing the services and procedures.

SECTION 5. AMENDATORY 36 O.S. 1991, Section 6057, as amended by Section 4, Chapter 76, O.S.L. 1996 (36 O.S. Supp. 1998, Section 6057), is amended to read as follows:

Section 6057. A. Any provision, exclusion or limitation in an accident and health insurance policy which:

1. Denies an insured, or the insured's parent or guardian if the insured is a minor, the free choice of any practitioner or the use of any hospital, home care agency or ambulatory surgical center where the practitioner is authorized to practice, doctor's office or clinic; or

2. Otherwise conflicts with any provision of the Health Care Freedom of Choice Act~~+~~L

shall, to the extent of the denial or conflict, be void, but such avoidance shall not affect the validity of the other provisions of the policy.

B. Any policy form presently approved for use containing any provision, exclusion or limitation determined by the Insurance Commissioner to be in conflict with any provision of the Health Care Freedom of Choice Act shall be brought into compliance with the act by the filing of a rider, an endorsement, or a new or revised policy form approved by the Commissioner.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6057.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner, upon finding an insurer in violation of any provision of the Health Care Freedom of Choice Act, may issue a cease and desist order to the insurer directing the insurer to stop such unlawful practices. If the insurer refuses or fails to comply with the order, the Commissioner shall have the authority to revoke or suspend the insurer's certificate of authority. The Commissioner shall use the authority specified in this subsection to the extent deemed necessary to obtain the

insurer's compliance with the order. The Attorney General shall offer assistance if requested by the Commissioner to enforce the Commissioner's orders.

B. Reasonable attorney fees shall be awarded to the Commissioner if judicial action is necessary for the enforcement of the orders. Such fees shall be based upon those prevailing in the community. Fees collected by the Commissioner without the assistance of the Attorney General shall be credited to the Insurance Commissioner's Revolving Fund. Fees collected by the Attorney General shall be credited to the Attorney General's Revolving Fund.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6057.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

For any violation of the Health Care Freedom of Choice Act, the Insurance Commissioner may, after notice and opportunity hearing, subject an insurer or practitioner to an administrative penalty of not less than One Hundred Dollars (\$100.00) nor more than Five Thousand Dollars (\$5,000.00) for each occurrence. Such administrative penalty may be enforced in the same manner in which civil judgments may be enforced. The penalties collected shall be placed in the Insurance Commissioner's Revolving Fund.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6057.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

Any insurer or practitioner affected by an order of the Insurance Commissioner issued pursuant to the Health Care Freedom of Choice Act may seek judicial review of such order pursuant to Article II of the Administrative Procedures Act.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6057.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Insurance Commissioner shall promulgate rules for the implementation and administration of the Health Care Freedom of Choice Act.

SECTION 10. AMENDATORY 36 O.S. 1991, Section 3624, as amended by Section 1, Chapter 370, O.S.L. 1992 (36 O.S. Supp. 1998, Section 3624), is amended to read as follows:

Section 3624. Except as provided in subsection B C of Section 6055 of this title, a policy may be assignable or not assignable, as provided by its terms. Subject to its terms relating to assignability, any life or accident and health policy, whether heretofore or hereafter issued, under the terms of which the beneficiary may be changed upon the sole request of the insured, may be assigned either by pledge or transfer of title, by an assignment executed by the insured alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer. Any such assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment, until the insurer has received at its home office written notice of termination of the assignment or pledge, or

written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment.

SECTION 11. This act shall become effective November 1, 1999.

Passed the House of Representatives the 20th day of May, 1999.

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Speaker of the House of  
Representatives

Passed the Senate the 24th day of May, 1999.

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President of the Senate