

STATE OF OKLAHOMA

2nd Session of the 47th Legislature (2000)

HOUSE BILL HB2385

By: Frame

AS INTRODUCED

An Act relating to insurance; amending 36 O.S. 1991, Sections 1219, as last amended by Section 50, Chapter 418, O.S.L. 1997, 6054, as last amended by Section 2, Chapter 331, O.S.L. 1999, and 6055, as last amended by Section 3, Chapter 331, O.S.L. 1999 (36 O.S. Supp. 1999, Sections 1219, 6054 and 6055), and Section 2, Chapter 250, O.S.L. 1995, as last amended by Section 5, Chapter 180, O.S.L. 1997 (36 O.S. Supp. 1999, Section 6532), which relate to payment of claims, prohibited acts, definitions, performance of services and procedures, and the Health Insurance High Risk Pool; requiring payment of interest if claim is not paid within certain time period; providing for accrual of interest; requiring payment of clean claims within certain time frame and providing exceptions; providing for penalty for nonpayment; modifying definitions; construing act; modifying application of provision of law; removing certain entity from definition of insurer; clarifying references; providing for codification; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 1991, Section 1219, as last amended by Section 50, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 1999, Section 1219), is amended to read as follows:

Section 1219. A. In the administration, servicing, or processing of any accident and health insurance policy, it shall be an unfair claim settlement practice for any insurer to fail to notify a policyholder or assignee of record in writing of the cause for delay in payment of any claim where the claim is not paid within thirty (30) days after receipt of proof of loss. Failure of an insurer to provide a policyholder or assignee of record with such notification shall constitute prima facie evidence that the claim will be paid in accordance with the terms of the policy.

B. 1. If a claim is not paid within sixty (60) days after receipt of proof of loss, the insurer shall pay interest which shall be the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year as certified to the Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two (2) percentage points, which shall accrue from the sixty-first day after receipt of proof of loss until the claim is paid.

2. If a claim is not paid within six (6) months after receipt of proof of loss, the insurer shall pay interest at a rate which shall be the same as the average United States Treasury Bill rate of the preceding calendar year, as certified to the Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus four (4) percentage points. Such interest shall accrue from the sixty-first day after receipt of proof of loss until the claim is paid.

C. As used in this section:

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; and

2. "Proof of loss" means written documents such as claim forms, medical bills, or other reasonable evidence of a claim, but shall not include information not necessary for determination of proof of loss and not pertinent to filed claims, such as any medical reports that the insurer wants to secure merely for completion of business records or files.

D. In the event litigation should ensue based upon such a claim, the prevailing party shall be entitled to recover a reasonable attorney's fee to be set by the court and taxed as costs against the party or parties who do not prevail.

E. The provisions of this section shall not apply to the Oklahoma Life and Health Insurance Guaranty Association or to the Oklahoma Property and Casualty Insurance Guaranty Association.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1219.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Any health insurer, excluding the State of Oklahoma, the Oklahoma State and Education Employees Group Insurance Board, the Oklahoma Health Care Authority, and federal Medicare carriers, to which a health care provider submits a clean claim shall pay the clean claim within thirty (30) calendar days of receipt of the claim.

B. Failure for any reason on the part of a health insurer to pay a clean claim within the allotted time frame shall result in payment of a penalty by the health insurer that is equal to the Bank of Oklahoma Prime plus, two (2) percentage points per month or fraction of a month until the claim is paid.

C. As used in this section, "clean claim" means a claim for medical services submitted by a health care provider for payment for services, and that is filed on an industry standard claim form which contains correct information and which accurately reflects those items necessary to pay the claim, including, but not limited to:

1. The patient's name;
2. The patient's address;
3. The patient's identifying numbers;
4. Appropriate Current Procedural Terminology (CPT);
5. ICD-9 codes; and
6. Provider information, including the provider's name, address, the dates of service, and the appropriate tax identification numbers.

D. Nothing in this section shall be construed as adding any additional responsibilities for the insured or the health care

provider beyond those that already exist either by implication or by contract between the parties.

SECTION 3. AMENDATORY 36 O.S. 1991, Section 6054, as last amended by Section 2, Chapter 331, O.S.L. 1999 (36 O.S. Supp. 1999, 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;

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;

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 medical indemnity corporation, a fraternal benefit society, a multiple employer welfare arrangement, or any other entity subject to regulation by the Insurance Commissioner;

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, medical groups and other health care providers, 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 4. AMENDATORY 36 O.S. 1991, Section 6055, as last amended by Section 3, Chapter 331, O.S.L. 1999 (36 O.S. Supp. 1999, 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, if the services and procedures fall within the licensed scope of practice of the practitioner providing the 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 preferred provider organization providers and 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, hospital, home care agency or ambulatory surgical center who has provided services and procedures which are covered under the policy. A practitioner, 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, hospital, home care agency or ambulatory surgical center;

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

3. A claim has been submitted by the practitioner, hospital, home care agency or ambulatory surgical center to the insurer on a uniform health insurance claim form 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, 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, 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, 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.

G. Nothing in the Health Care Freedom of Choice Act shall prohibit an insurer 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 5. AMENDATORY Section 2, Chapter 250, O.S.L. 1995, as last amended by Section 5, Chapter 180, O.S.L. 1997 (36 O.S. Supp. 1999, Section 6532), is amended to read as follows:

Section 6532. As used in the Health Insurance High Risk Pool Act:

1. "Agent" means any person who is licensed to sell health insurance in this state;

2. "Board" means the Board of Directors of the Health Insurance High Risk Pool;

3. "Church plan" has the meaning given such term under Section 3(33) of the Employee Retirement Income Security Act of 1974;

4. "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

- a. a group health plan,
- b. health insurance coverage,
- c. Part A or B of Title XVIII of the Social Security Act,
- d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 of such act,
- e. Chapter 55 of Title 10, U.S. Code,
- f. a medical care program of the Indian Health Service or of a tribal organization,
- g. a state health benefits risk pool,
- h. a health plan offered under Chapter 89 of Title 5, U.S. Code,
- i. a public health plan as defined in federal regulations, or

j. a health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);

5. "Federally defined eligible individual" means an individual:

- a. for whom, as of the date on which the individual seeks coverage under the Health Insurance High Risk Pool Act, the aggregate of the periods of creditable coverage, as defined in Section 1D of the Employee Retirement Income Security Act of 1974, is eighteen (18) or more months,
- b. whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in conjunction with any such plan,
- c. who is not eligible for coverage under a group health plan, part A or B of Title XVIII of the Social Security Act, or a state plan under Title XIX of such Act or any successor program and who does not have other health insurance coverage,
- d. with respect to whom the most recent coverage under a COBRA continuation provision or under a similar state program, elected such coverage, and
- e. who has exhausted such continuation coverage under such provision or program, if the individual elected the continuation coverage described in ~~paragraph 5 of this section~~ subparagraphs a, b and d of this paragraph;

6. "Governmental plan" has the same meaning given such term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan;

7. "Group health benefit plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides

medical care as defined in Section 3N of the Employee Retirement Income Security Act of 1974 and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise;

8. "Health insurance" means any individual or group hospital or medical expense-incurred policy or health care benefits plan or contract. The term does not include any policy governing short-term accidents only, a fixed-indemnity policy, a limited benefit policy, a specified accident policy, a specified disease policy, a Medicare supplement policy, a long-term care policy, medical payment or personal injury coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance, a disability policy, or workers' compensation;

9. "Insurer" means any individual, corporation, association, partnership, fraternal benefit society, or any other entity engaged in the health insurance business, except insurance agents and brokers. This term shall also include not-for-profit hospital service and medical indemnity plans, health maintenance organizations, preferred provider organizations, prepaid health plans, ~~the State and Education Employees Group Health Insurance Plan,~~ and any reinsurer reinsuring health insurance in this state, which shall be designated as engaged in the business of insurance for the purposes of Section 6531 et seq. of this title;

10. "Medical care" means amounts paid for:

- a. the diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,
- b. transportation primarily for and essential to medical care referred to in ~~paragraph 1 of this section~~ subparagraph a of this paragraph, and

c. insurance covering medical care referred to in ~~paragraphs 1 and 2 of this section~~ subparagraphs a and b of this paragraph;

11. "Medicare" means coverage under Parts A and B of Title XVIII of the Social Security Act (Public Law 74-271, 42 U.S.C., Section 1395 et seq., as amended);

12. "Pool" means the Health Insurance High Risk Pool;

13. "Physician" means a doctor of medicine and surgery, doctor of osteopathic medicine, doctor of chiropractic, doctor of podiatric medicine, doctor of optometry, and, for purposes of oral and maxillofacial surgery only, a doctor of dentistry, each duly licensed by this state;

14. "Plan" means the comprehensive health insurance benefit plan as adopted by the Board of Directors of the Health Insurance High Risk Pool, or by rule; and

15. "Reinsurer" means any insurer as defined in Section 103 of this title from whom any person providing health insurance to Oklahoma insureds procures insurance for itself as the insurer, with respect to all or part of the health insurance risk of the person.

SECTION 6. This act shall become effective November 1, 2000.

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