

STATE OF OKLAHOMA

2nd Session of the 48th Legislature (2002)

COMMITTEE SUBSTITUTE
FOR
SENATE BILL 990

By: Rozell

COMMITTEE SUBSTITUTE

[Insurance - Health Care Consumer Protection Act -
codification -

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 3650.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Health Care Consumer Protection Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 3650.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Health Care Consumer Protection Act:

1. "Balance billing" means willfully collecting or attempting to collect an amount from a person, while knowing, or having constructive knowledge, that such collection or attempt violates an agreement, arrangement or contract between the provider and a health care payor. Balance billing shall not include billing a patient for payments the patient is obligated to make under the health plan provisions such as copayments, coinsurance and deductibles;
2. "Commissioner" means the Insurance Commissioner;
3. "Department" means the Insurance Department;

4. "Health plan" means a health maintenance organization or a prepaid health plan as defined in Section 2503 of Title 63 of the Oklahoma Statutes or a preferred provider organization as defined in Section 6054 of Title 36 of the Oklahoma Statutes;

5. "Participating provider" means a physician, as defined in Section 725.2 of Title 59 of the Oklahoma Statutes, hospital, pharmacy, laboratory, or other appropriately state-licensed or otherwise state-recognized provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a managed care plan;

6. "Provider" means a physician, as defined in Section 725.2 of Title 59 of the Oklahoma Statutes, hospital, pharmacy, laboratory, or other appropriately state-licensed or otherwise state-recognized provider of health care services or supplies; and

7. "Significant abnormal result" means:

- a. a diagnostic test result that is twice the value of the normal range typically provided, or
- b. any abnormality on a diagnostic or routine test that a physician reviewer has indicated needs further study or advises clinical correlation with the patient's condition.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 3650.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. It shall be unlawful for any participating provider to willfully collect or attempt to collect an amount from a person through means including, but not limited to, balance billing, knowing that such collection or attempt violates an agreement, arrangement or contract between the provider and a health care payor. It shall not be unlawful to bill a patient for payments the

patient is obligated to make under the health plan provisions, such as copayments, coinsurance and deductibles.

B. Any out-of-network provider who determines that a health plan's fee schedule for the treatment provided will be accepted as payment in full and so notifies the patient shall do so in writing in order to protect the patient from subsequent balance billing.

C. 1. A provider who is not a participating provider shall disclose to the patient in writing, on a standardized form approved by the Insurance Commissioner, that the patient may be responsible for:

- a. higher coinsurance and deductibles, or
- b. provider charges which exceed the allowable charges of a participating provider for the same services.

2. The Insurance Department shall, by rule, develop the standardized form to be used by providers for the disclosures required by this section.

D. When a provider makes a referral to a nonparticipating hospital or ambulatory surgical center, the referring provider shall disclose, in writing, any ownership interest in the nonparticipating hospital or ambulatory surgical center.

E. No provider shall falsely advise a patient that a referral required by Section 2505 of Title 63 of the Oklahoma statutes has been denied by the health plan.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 3650.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

It shall be the responsibility of the provider who orders diagnostic testing to ensure that the patient is directly notified, in writing or verbally, of any significant abnormal diagnostic or routine results within three calendar days of their availability to the ordering physician, as well as the proposed course of action the patient should take.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 3650.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

A health plan holding a full-risk bearing contract with a medical group, Independent Practice Association (IPA), or Management Services Organization (MSO) may request two independent audits anytime during a fiscal year.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 3650.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Any provider who is determined by the Insurance Commissioner to have violated any provision of the Health Care Consumer Protection Act shall be subject to the following penalties:

1. Imposition of an administrative fine not to exceed One Thousand Dollars (\$1,000.00), payable to the Anti-Fraud Unit of the Insurance Department, for each count or separate offense; and, if applicable,

2. Payment of a full and complete refund of all inappropriately billed fees and charges to the patient or third party payor, along with interest in the amount of fifteen percent (15%), to be calculated from the date of inappropriate billing.

B. 1. Within ten (10) days of an inspection documenting a violation of the provisions of the Health Care Consumer Protection Act, a physician or facility may appeal such decision pursuant to the provisions of Article II of the Administrative Procedures Act.

2. The amount of the penalty shall be assessed by the Insurance Commissioner pursuant to the provisions of subsection A of this section, after notice and hearing. In determining the amount of the penalty, the Commissioner shall include, but not be limited to:

- a. consideration of the nature, circumstances and gravity of the violation,
- b. the repetitive nature of the violation,

- c. the previous degree of difficulty in obtaining compliance with the rules, and
- d. with respect to the person who has committed the violation, the degree of culpability, the effect on the ability of the person to continue to do business, and any show of good faith in attempting to achieve compliance with the provisions of the Health Care Consumer Protection Act.

C. 1. In the event a provider has inappropriately placed a patient account with a collection agency or an attorney for collection, reported the patient to be credit reporting agency, or placed a physician's lien on the patient in violation of the provisions of this act, it shall be the responsibility of the provider to:

- a. refund all inappropriately billed fees and charges to the patient or third party payor,
- b. reimburse all applicable court costs and fees,
- c. eradicate any incorrect entry or notation reported on the patient's credit report, and
- d. release any physician's liens and file a notice of discharge.

2. The provider shall notify the credit reporting agency, in writing, of the incorrect entry to be eradicated and shall mail a copy of the written notification to the patient at the patient's last known address.

SECTION 7. This act shall become effective November 1, 2002.

48-2-3004

CJ

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