

CS for SB 990

1 THE STATE SENATE
2 Tuesday, February 26, 2002

3 Committee Substitute for
4 Senate Bill No. 990

5 COMMITTEE SUBSTITUTE FOR SENATE BILL NO. 990 - By: ROZELL of the
6 Senate and McCARTER of the House.

7 [Insurance - Health Care Consumer Protection Act -
8 codification -
9 effective date]

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

11 SECTION 1. NEW LAW A new section of law to be codified
12 in the Oklahoma Statutes as Section 3650.1 of Title 36, unless there
13 is created a duplication in numbering, reads as follows:

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

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

19 As used in the Health Care Consumer Protection Act:

20 1. "Balance billing" means willfully collecting or attempting
21 to collect an amount from a person, while knowing, or having
22 constructive knowledge, that such collection or attempt violates an
23 agreement, arrangement or contract between the provider and a health
24 care payor. Balance billing shall not include billing a patient for

1 payments the patient is obligated to make under the health plan
2 provisions such as copayments, coinsurance and deductibles;

3 2. "Commissioner" means the Insurance Commissioner;

4 3. "Department" means the Insurance Department;

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

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

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

20 7. "Significant abnormal result" means:

21 a. a diagnostic test result that is twice the value of
22 the normal range typically provided, or

1 b. any abnormality on a diagnostic or routine test that a
2 physician reviewer has indicated needs further study
3 or advises clinical correlation with the patient's
4 condition.

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

8 A. It shall be unlawful for any participating provider to
9 willfully collect or attempt to collect an amount from a person
10 through means including, but not limited to, balance billing,
11 knowing that such collection or attempt violates an agreement,
12 arrangement or contract between the provider and a health care
13 payor. It shall not be unlawful to bill a patient for payments the
14 patient is obligated to make under the health plan provisions, such
15 as copayments, coinsurance and deductibles.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 B. 1. Within ten (10) days of an inspection documenting a
23 violation of the provisions of the Health Care Consumer Protection

1 Act, a physician or facility may appeal such decision pursuant to
2 the provisions of Article II of the Administrative Procedures Act.

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

- 7 a. consideration of the nature, circumstances and gravity
8 of the violation,
- 9 b. the repetitive nature of the violation,
- 10 c. the previous degree of difficulty in obtaining
11 compliance with the rules, and
- 12 d. with respect to the person who has committed the
13 violation, the degree of culpability, the effect on
14 the ability of the person to continue to do business,
15 and any show of good faith in attempting to achieve
16 compliance with the provisions of the Health Care
17 Consumer Protection Act.

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

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

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

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

13 COMMITTEE REPORT BY: COMMITTEE ON HUMAN RESOURCES, dated 2-21-02 -
14 DO PASS, As Amended and Coauthored.