

STATE OF OKLAHOMA

1st Session of the 50th Legislature (2005)

HOUSE BILL 1626

By: Wilt

AS INTRODUCED

An Act relating to insurance; amending 36 O.S. 2001, Sections 6053, 6054, 6055, as amended by Section 2, Chapter 288, O.S.L. 2003, 6057, 6057.1, 6057.2, 6057.3 and 6057.4 (36 O.S. Supp. 2004, Section 6055), which relate to Health Care Freedom of Choice Act; modifying title of act; updating language; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2001, Section 6053, is amended to read as follows:

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

B. The provisions of the Oklahoma 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. 2001, Section 6054, is amended to read as follows:

Section 6054. As used in the Oklahoma 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, 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. 2001, Section 6055, as amended by Section 2, Chapter 288, O.S.L. 2003 (36 O.S. Supp. 2004, 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 parent or guardian of the insured 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. Upon submission of a claim by a practitioner, hospital, home care agency, or ambulatory surgical center to an insurer on a uniform health care claim form adopted by the Insurance Commissioner pursuant to Section 6581 of this title, the insurer shall provide a timely explanation of benefits to the practitioner, hospital, home care agency, or ambulatory surgical center regardless of the network participation status of such person or entity.

D. 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.

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

1. Any preferred provider organization (PPO) as defined by generally accepted industry standards, that contracts with practitioners that agree to accept the reimbursement available under the PPO agreement as payment in full and agree not to balance bill the insured; 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,
- 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, and

- d. contracts with practitioners that agree to accept the reimbursement available under the network agreement as payment in full and agree not to balance bill the insured.

F. 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.

G. 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.

H. Nothing in the Oklahoma 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.

I. 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.

J. Decisions by an insurer or a preferred provider organization (PPO) to authorize or deny coverage for an emergency service shall be based on the patient presenting symptoms arising from any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in serious:

1. Jeopardy to the health of the patient;
2. Impairment of bodily function; or
3. Dysfunction of any bodily organ or part.

K. An insurer or preferred provider organization (PPO) shall not deny an otherwise covered emergency service based solely upon lack of notification to the insurer or PPO.

L. An insurer or a preferred provider organization (PPO) shall compensate a provider for patient screening, evaluation, and examination services that are reasonably calculated to assist the provider in determining whether the condition of the patient requires emergency service. If the provider determines that the patient does not require emergency service, coverage for services rendered subsequent to that determination shall be governed by the policy or PPO contract.

M. 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. 2001, 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 Oklahoma Health Care Freedom of Choice Act, 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 Oklahoma 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 5. AMENDATORY 36 O.S. 2001, Section 6057.1, is amended to read as follows:

Section 6057.1 A. In order to enforce the provisions of the Oklahoma Health Care Freedom of Choice Act, the Insurance Commissioner may conduct an examination of insurers' and preferred provider organizations' claims files pursuant to the procedure set forth in Section 1250.4 of this title.

B. The Commissioner, upon finding an insurer in violation of any provision of the Oklahoma 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.

C. 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 6. AMENDATORY 36 O.S. 2001, Section 6057.2, is amended to read as follows:

Section 6057.2 For any violation of the Oklahoma 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~~ The 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 7. AMENDATORY 36 O.S. 2001, Section 6057.3, is amended to read as follows:

Section 6057.3 Any insurer or practitioner affected by an order of the Insurance Commissioner issued pursuant to the Oklahoma Health Care Freedom of Choice Act may seek judicial review of such order pursuant to Article II of the Administrative Procedures Act.

SECTION 8. AMENDATORY 36 O.S. 2001, Section 6057.4, is amended to read as follows:

Section 6057.4 The Insurance Commissioner shall promulgate rules for the implementation and administration of the Oklahoma Health Care Freedom of Choice Act.

SECTION 9. This act shall become effective November 1, 2005.

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