

THE HOUSE OF REPRESENTATIVES
Monday, February 23, 2009

Committee Substitute for
House Bill No. 1028

COMMITTEE SUBSTITUTE FOR HOUSE BILL NO. 1028 - By: COX AND SHELTON
of the House and CRAIN of the Senate.

An Act relating to insurance; amending 36 O.S. 2001, Section 1219, as last amended by Section 2, Chapter 338, O.S.L. 2007 (36 O.S. Supp. 2008, Section 1219), which relates to time for processing claims; eliminating certain time for reimbursement of clean claims covered by other laws; providing certain time period for notification of certain defects or improprieties; eliminating certain modification requirements; modifying entities to whom certain forms are provided; providing that certain claims are clean claims; providing for adoption of rules; prohibiting the requirement of certain data elements; authorizing modification of number of data elements by contract; providing effect of inclusion of additional information; prohibiting waiver, voidance, or nullification; providing time limit for payment of claim; providing for payment of entire claim; providing payment requirements when entire claim is not determined payable; providing for payment of claim under audit; providing time limit of payment of claim; providing requirements for requests for additional information; providing limitation of request for additional information; providing remedy for noncompliance with request for information; providing for recovery of overpayment of claim; providing for appeal of overpayment of claim; authorizing establishment of process for appeals; providing time limit for determination of appeal; defining term; providing for specifications contained in verification; requiring toll-free telephone number; providing hours of operation; requiring answering and recording services for after hours; allowing declination of eligibility; providing time period for valid verification; requiring reason for declination of verification; prohibiting waiver, voidance, or nullification; providing for preauthorization; providing time limit for submission of list of services requiring preauthorization; providing for determination of necessary services; requiring review and determination of preauthorized services; providing for issuance of length of stay in facility if preauthorization required; requiring toll-free telephone number; providing hours of operation; requiring answering and recording services for after hours;

prohibiting denial of services if preauthorization occurs; allowing denial of service if certain conditions occur; applying provisions to agents or other persons; prohibiting waiver, avoidance, or nullification; providing for payment and amount if insurer fails to timely pay claim; providing penalty for late payment; providing for accrual of interest on late payment; prohibiting liability under certain circumstances; requiring disclosure of payment of penalty; providing for additional administrative penalties; amending 36 O.S. 2001, Section 6055, as amended by Section 2, Chapter 288, O.S.L. 2003 (36 O.S. Supp. 2008, Section 6055), which relates to selection of health care provider by the insured; requiring insurer to list provider as a payee on any check or negotiable instrument sent to the insured for payment of services if the provider is outside of the preferred provider organization; providing for codification; and providing an effective date.

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

1 SECTION 1. AMENDATORY 36 O.S. 2001, Section 1219, as last amended by
2 Section 2, Chapter 338, O.S.L. 2007 (36 O.S. Supp. 2008, Section 1219), is amended to
3 read as follows:

4 Section 1219. A. ~~In the administration, servicing, or processing of any accident and~~
5 ~~health insurance policy, every insurer shall reimburse all clean claims of an insured, an~~
6 ~~assignee of the insured, or a health care provider within forty-five (45) calendar days~~
7 ~~after receipt of the claim by the insurer.~~

8 ~~B.~~ As used in this section:

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

1 certificate or any evidence of coverage issued by a health maintenance organization to
2 any person in this state;

3 2. "Clean claim" means a claim that has no defect or impropriety, including a lack
4 of any required substantiating documentation, or particular circumstance requiring
5 special treatment that impedes prompt payment; and

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

11 ~~C. B.~~ If a claim or any portion of a claim is determined to have defects or
12 improprieties, including a lack of any required substantiating documentation, or
13 particular circumstance requiring special treatment, the insured, enrollee or subscriber,
14 assignee of the insured, enrollee or subscriber, and health care provider shall be notified
15 in writing within forty-five (45) calendar days after receipt of a claim by the insurer from
16 a health care provider in a nonelectronic format or thirty (30) calendar days after receipt
17 of the claim by the insurer from a health care provider in an electronic format. The
18 written notice shall specify the portion of the claim that is causing a delay in processing
19 and explain any additional information or corrections needed. Failure of an insurer to
20 provide the insured, enrollee or subscriber, assignee of the insured, enrollee or
21 subscriber, and health care provider with the notice shall constitute prima facie evidence
22 that the claim will be paid in accordance with the terms of the policy. Provided, if a

1 claim is not submitted into the system due to a failure to meet basic Electronic Data
2 Interchange (EDI) and/or Health Insurance Portability and Accountability Act (HIPAA)
3 edits, electronic notification of the failure to the submitter shall be deemed compliance
4 with this subsection. ~~Provided further, health maintenance organizations shall not be~~
5 ~~required to notify the insured, enrollee or subscriber, or assignee of the insured, enrollee~~
6 ~~or subscriber of any claim defect or impropriety.~~

7 ~~D. C.~~ Upon receipt of the additional information or corrections which led to the
8 claim's being delayed and a determination that the information is accurate, an insurer
9 shall either pay or deny the claim or a portion of the claim within forty-five (45) calendar
10 days.

11 ~~E. D.~~ Payment shall be considered made on:

12 1. The date a draft or other valid instrument which is equivalent to the amount of
13 the payment is placed in the United States mail in a properly addressed, postpaid
14 envelope; or

15 2. If not so posted, the date of delivery.

16 ~~F. E.~~ An overdue payment shall bear simple interest at the rate of ten percent
17 (10%) per year.

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

21 ~~H. G.~~ The Insurance Commissioner shall develop a standardized prompt pay form
22 for use by providers in reporting violations of prompt pay requirements. The form shall

1 include a requirement that documentation of the reason for the delay in payment or
2 documentation of proof of payment must be provided within ten (10) days of the filing of
3 the form. The Commissioner shall provide the form to ~~health maintenance organizations~~
4 all insurers and providers.

5 I. H. The provisions of this section shall not apply to the Oklahoma Life and Health
6 Insurance Guaranty Association or to the Oklahoma Property and Casualty Insurance
7 Guaranty Association.

8 SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma
9 Statutes as Section 1219A of Title 36, unless there is created a duplication in numbering,
10 reads as follows:

11 A. As used in this act, a nonelectronic claim by a physician or health care provider,
12 other than an institutional provider, is a clean claim, as defined by Section 1219 of Title
13 36 of the Oklahoma Statutes, if the claim is submitted using the Centers for Medicare
14 and Medicaid Services Form 1500 or, if adopted by the Insurance Commissioner by rule,
15 a successor to that form developed by the National Uniform Claim Committee or the
16 successor of the committee. An electronic claim by a physician or provider, other than an
17 institutional provider, is a clean claim if the claim is submitted using the Professional
18 837 (ASC X12N 837) format or, if adopted by the Insurance Commissioner by rule, a
19 successor to that format adopted by the Centers for Medicare and Medicaid Services or
20 the successor of the centers.

21 B. A nonelectronic claim by an institutional provider is a
22 clean claim if the claim is submitted using the Centers for

UNDERLINED language denotes Amendments to present Statutes.
BOLD FACE CAPITALIZED language denotes Committee Amendments.
~~Strike thru~~ language denotes deletion from present Statutes.

1 Medicare and Medicaid Services Form UB-04 or, if adopted by the
2 Insurance Commissioner by rule, a successor to that form developed by the National
3 Uniform Billing Committee or the successor of the committee. An electronic claim by an
4 institutional provider is a clean claim if the claim is submitted using the Institutional
5 837 (ASC X12N 837) format or, if adopted by the Insurance Commissioner by rule, a
6 successor to that format adopted by the Centers for Medicare and Medicaid Services or
7 the successor of the centers.

8 C. The Insurance Commissioner may adopt rules that specify the information that
9 shall be entered into the appropriate fields on the applicable claim form for a claim to be
10 a clean claim.

11 D. The Insurance Commissioner shall not require any data element for an
12 electronic claim that is not required in an electronic transaction set needed to comply
13 with federal law.

14 E. An insurer and a health care provider may agree by contract to use fewer data
15 elements than are required in an electronic transaction set needed to comply with federal
16 law.

17 F. An otherwise clean claim submitted by a physician or health care provider that
18 includes additional fields, data elements, attachments, or other information not required
19 pursuant to this section is considered to be a clean claim for the purposes of this act.

20 G. Except as provided by subsection E of this section, the provisions of this section
21 shall not be waived, voided, or nullified by contract.

1 SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma
2 Statutes as Section 1219B of Title 36, unless there is created a duplication in numbering,
3 reads as follows:

4 Unless an insurer has requested additional information from a treating health care
5 provider to determine payment, the insurer, not later than forty-five (45) days after the
6 date an insurer receives a clean claim from a health care provider in a nonelectronic
7 format or thirty (30) days after the date an insurer receives a clean claim from a health
8 care provider that is electronically submitted, the insurer shall make a determination of
9 whether the claim is payable and:

- 10 1. If the insurer determines the entire claim is payable, pay the total amount of the
11 claim in accordance with the contract between the health care provider and the insurer;
- 12 2. If the insurer determines a portion of the claim is payable, pay the portion of the
13 claim that is not in dispute and notify the health care provider in writing why the
14 remaining portion of the claim will not be paid; or
- 15 3. If the insurer determines that the claim is not payable, notify the health care
16 provider in writing why the claim will not be paid.

17 SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma
18 Statutes as Section 1219C of Title 36, unless there is created a duplication in numbering,
19 reads as follows:

20 A. Unless an insurer has requested additional information from a treating health
21 care provider to determine payment, an insurer that intends to audit a claim submitted

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~~Strike thru~~ language denotes deletion from present Statutes.

1 by a health care provider shall pay the charges submitted at one hundred percent (100%)
2 of the contracted rate on the claim not later than:

3 1. Thirty (30) days after the date the insurer receives the clean claim from the
4 health care provider if the claim is submitted electronically; or

5 2. Forty-five (45) days after the date the insurer receives the clean claim from the
6 health care provider if the claim is submitted nonelectronically.

7 B. The insurer shall clearly indicate on the explanation of payment statement in
8 the manner prescribed by the Insurance Commissioner by rule that the clean claim is
9 being paid at one hundred percent (100%) of the contracted rate, subject to completion of
10 the audit.

11 C. If the insurer requests additional information to complete the audit, the request
12 shall describe with specificity the clinical information requested and relate only the
13 information the insurer in good faith can demonstrate is specific to the claim or episode
14 of care. The insurer shall not request as a part of the audit information that is not
15 contained, or is not in the process of being incorporated into, the medical or billing record
16 of the patient maintained by the health care provider.

17 D. If the health care provider does not supply information reasonably requested by
18 the insurer in connection with the audit, the insurer may:

19 1. Notify the provider in writing that the provider must provide the information not
20 later than forty-five (45) days after the date of the notice or forfeit the amount of the
21 claim; and

1 2. If the provider does not provide the information required by this section, recover
2 the amount of the claim.

3 SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma
4 Statutes as Section 1219D of Title 36, unless there is created a duplication in numbering,
5 reads as follows:

6 A. An insurer may recover an overpayment to a physician or health care provider if:

7 1. Not later than one hundred eighty (180) days after the date the physician or
8 provider receives the payment, the insurer provides written notice of the overpayment to
9 the physician or provider that includes the basis and specific reasons for the request for
10 recovery of funds; and

11 2. The physician or provider does not make arrangements for repayment of the
12 requested funds on or before forty-five (45) days after the date the physician or provider
13 receives the notice.

14 B. 1. If a physician or health care provider disagrees with a request for recovery of
15 an overpayment, the insurer shall provide the physician or provider with an opportunity
16 to appeal, and the insurer shall not attempt to recover the overpayment until all appeal
17 rights are exhausted.

18 2. The Insurance Commissioner shall establish a process for appeals and shall
19 promulgate any necessary rules to effectuate a process for appeals. Each appeal shall be
20 considered and determined within thirty (30) days of its commencement.

1 SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma
2 Statutes as Section 1219E of Title 36, unless there is created a duplication in numbering,
3 reads as follows:

4 A. As used in this section, “verification” includes preauthorization only if
5 preauthorization is a condition for the verification.

6 B. On the request of a health care provider for verification of a particular medical
7 care or health care service the health care provider proposes to provide to a particular
8 patient, the insurer shall inform the health care provider without delay whether the
9 service, if provided to that patient, will be paid by the insurer and shall specify any
10 deductibles, copayments, or coinsurance for which the insured is responsible.

11 C. An insurer shall have appropriate personnel reasonably available at a toll-free
12 telephone number to provide a verification under this section between 6 a.m. and 6 p.m.
13 central time Monday through Friday on each day that is not a legal holiday and between
14 9 a.m. and 12 noon central time on Saturday, Sunday and legal holidays. An insurer
15 shall have a telephone system capable of accepting or recording incoming phone calls for
16 verifications after 6 p.m. central time Monday through Friday and after 12 noon central
17 time on Saturday, Sunday and legal holidays and responding to each of those calls on or
18 before the second calendar day after the date the call is received.

19 D. An insurer may decline to determine eligibility for payment if the insurer
20 notifies the physician or health care provider that requested the verification of the
21 specific reason the determination was not made.

1 E. An insurer may establish a specific period during which the verification is valid
2 of not less than thirty (30) days.

3 F. An insurer that declines to provide a verification shall notify the physician or
4 provider that requested the verification of the specific reason the verification was not
5 provided.

6 G. If an insurer has provided a verification for proposed medical care or health care
7 services, the insurer shall not deny or reduce payment to the physician or provider for
8 those medical care or health care services if provided to the insured on or before thirty
9 (30) days after the date the verification was provided unless the physician or provider
10 has materially misrepresented the proposed medical care or health care services or has
11 substantially failed to perform the proposed medical care or health care services.

12 H. The provisions of this section shall not be waived, voided or nullified by contract.

13 SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma
14 Statutes as Section 1219F of Title 36, unless there is created a duplication in numbering,
15 reads as follows:

16 A. An insurer that uses a preauthorization process for medical care and health care
17 services shall provide to each health care provider, not later than twenty-four (24) hours
18 after the first business day after the date a request is made, a list of medical care and
19 health care services that require preauthorization and information concerning the
20 preauthorization process.

21 B. If proposed medical care or health care services require preauthorization as a
22 condition of the payment by the insurer to a health care provider under a health

1 insurance policy, the insurer shall determine whether the medical care or health care
2 services proposed to be provided to the insured are medically necessary and appropriate.

3 C. On receipt of a request from a health care provider for preauthorization, the
4 insurer shall review and issue a determination indicating whether the proposed medical
5 care or health care services are preauthorized. The determination shall be issued and
6 transmitted not later than the third calendar day after the date the request is received
7 by the insurer.

8 D. If the proposed medical care or health care services involve inpatient care and
9 the insurer requires preauthorization as a condition of payment, the insurer shall review
10 the request and issue a length of stay for the admission into a health care facility based
11 on the recommendation of the physician of the patient or health care provider and the
12 written medically accepted screening criteria and review procedures of the insurer. If
13 the proposed medical or health care services are to be provided to a patient who is an
14 inpatient in a health care facility at the time the services are proposed, the insurer shall
15 review the request and issue a determination indicating whether proposed services are
16 preauthorized within twenty-four (24) hours of the request by the physician or provider.

17 E. An insurer shall have appropriate personnel reasonably available at a toll-free
18 telephone number to respond to requests for a preauthorization between 6 a.m. and 6
19 p.m. central time Monday through Friday on each day that is not a legal holiday and
20 between 9 a.m. and 12 noon central time on Saturday, Sunday and legal holidays. An
21 insurer shall have a telephone system capable of accepting or recording incoming phone
22 calls for preauthorizations after 6 p.m. central time Monday through Friday and after 12

1 noon central time on Saturday, Sunday and legal holidays and responding to each of
2 those calls not later than twenty-four (24) hours after the call is received.

3 F. If an insurer has preauthorized medical care or health care services, the insurer
4 shall not deny or reduce payment to the physician or health care provider for those
5 services based on medical necessity or appropriateness of care unless the physician or
6 provider has materially misrepresented the proposed medical or health care services or
7 has substantially failed to perform the proposed medical or health care services.

8 G. This section applies to an agent or other person with whom an insurer contracts
9 to perform, or to whom the insurer delegates the performance of, preauthorization of
10 proposed medical or health care services.

11 H. The provisions of this section shall not be waived, voided or nullified by contract.

12 SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma
13 Statutes as Section 1219G of Title 36, unless there is created a duplication in numbering,
14 reads as follows:

15 A. Except as provided by this section, if a clean claim submitted to an insurer is
16 payable and the insurer does not determine that the claim is payable and pay the claim
17 on or before the date the insurer is required to make determination or adjudication of the
18 claim, the insurer shall pay the health care provider making the claim the contracted
19 rate owed on the claim plus a penalty in the amount of the lesser of:

20 1. Fifty percent (50%) of the difference between the billed charges, as submitted on
21 the claim, and the contracted rate; or

22 2. One Hundred Thousand Dollars (\$100,000.00).

1 B. If the claim is paid on or after the forty-sixth day and before the ninety-first day
2 after the date the insurer is required to make a determination or adjudication of the
3 claim, the insurer shall pay a penalty in the amount of the lesser of:

4 1. One hundred percent (100%) of the difference between the billed charges, as
5 submitted on the claim, and the contracted rate; or

6 2. Two Hundred Thousand Dollars (\$200,000.00).

7 C. If the claim is paid on or after the ninety-first day after the date the insurer is
8 required to make a determination or adjudication of the claim, the insurer shall pay a
9 penalty computed under subsection B of this section plus eighteen percent (18%) annual
10 interest on that amount. Interest pursuant to this subsection accrues beginning on the
11 date the insurer was required to pay the claim and ending on the date the claim and the
12 penalty are paid in full.

13 D. Except as provided by this section, an insurer that determines that a claim is
14 payable, that pays only a portion of the amount of the claim on or before the date the
15 insurer is required to make a determination or adjudication of the claim, and pays the
16 balance of the contracted rate owed for the claim after that date, shall pay to the health
17 care provider, in addition to the contracted amount owed, a penalty on the amount not
18 timely paid in the amount of the lesser of:

19 1. Fifty percent (50%) of the underpaid amount; or

20 2. One Hundred Thousand Dollars (\$100,000.00).

21 E. If the balance of the claim is paid on or after the forty-sixth day and before the
22 ninety-first day after the date the insurer is required to make a determination or

1 adjudication of the claim, the insurer shall pay a penalty on the balance of the claim in
2 the amount of the lesser of:

- 3 1. One hundred percent (100%) of the underpaid amount; or
- 4 2. Two Hundred Thousand Dollars (\$200,000.00).

5 F. If the balance of the claim is paid on or after the ninety-first day after the date
6 the insurer is required to make a determination or adjudication of the claim, the insurer
7 shall pay a penalty on the balance of the claim computed under subsection E of this
8 section plus eighteen percent (18%) annual interest on that amount. Interest pursuant
9 to this subsection accrues beginning on the date the insurer was required to pay the
10 claim and ending on the date the claim and the penalty are paid in full.

11 G. For the purposes of subsections D and E of this section, the underpaid amount
12 shall be computed on the ratio of the amount underpaid on the contracted rate to the
13 contracted rate as applied to the billed charges as submitted on the claim.

14 H. An insurer is not liable for a penalty under this section if:

- 15 1. The failure to pay the claim is a result of a catastrophic event that substantially
16 interferes with the normal business operations of the insurer; or
- 17 2. The claim was paid, but for less than the contracted rate, and:
 - 18 a. the health care provider notifies the insurer of the underpayment after
19 the one-hundred-eightieth day after the date the underpayment was
20 received, and
 - 21 b. the insurer pays the balance of the claim on or before the forty-fifth
22 day after the date the insurer receives the notice.

1 I. Subsection H of this section does not relieve the insurer of the obligation to pay
2 the remaining unpaid contracted rate owed the health care provider.

3 J. An insurer that pays a penalty pursuant to this section shall clearly indicate on
4 the explanation of payment statement in the manner prescribed by the Insurance
5 Commissioner by rule the amount of the contracted rate paid and the amount paid as a
6 penalty.

7 K. In addition to any other penalty or remedy authorized by law, an insurer that
8 violates Section 2 or 3 of this act in processing more than two percent (2%) of clean
9 claims submitted to the insurer may be subject to available administrative penalties as
10 provided for by the administrative rules of the Oklahoma Insurance Department. The
11 Insurance Commissioner shall have authority to impose any administrative penalty
12 provided for by the administrative rules of the Oklahoma Insurance Department. For
13 each day an administrative penalty is imposed under this subsection, the penalty shall
14 not exceed One Thousand Dollars (\$1,000.00) for each claim that remains unpaid in
15 violation of Section 2 or 3 of this act. In determining whether an insurer has processed
16 health care provider claims in compliance with Section 2 or 3 of this act, the Insurance
17 Commissioner shall consider paid claims, other than claims that have been paid under
18 Section 3 of this act, and shall compute a compliance percentage for physician and
19 provider claims, other than institutional provider claims, and a compliance percentage
20 for institutional provider claims.

1 SECTION 9. AMENDATORY 36 O.S. 2001, Section 6055, as amended by
2 Section 2, Chapter 288, O.S.L. 2003 (36 O.S. Supp. 2008, Section 6055), is amended to
3 read as follows:

4 Section 6055. A. Under any accident and health insurance policy, hereafter
5 renewed or issued for delivery from out of Oklahoma or in Oklahoma by any insurer and
6 covering an Oklahoma risk, the services and procedures may be performed by any
7 practitioner selected by the insured, or the parent or guardian of the insured if the
8 insured is a minor, if the services and procedures fall within the licensed scope of
9 practice of the practitioner providing the same.

10 B. An accident and health insurance policy may:

11 1. Exclude or limit coverage for a particular illness, disease, injury or condition;
12 but, except for such exclusions or limits, shall not exclude or limit particular services or
13 procedures that can be provided for the diagnosis and treatment of a covered illness,
14 disease, injury or condition, if such exclusion or limitation has the effect of
15 discriminating against a particular class of practitioner. However, such services and
16 procedures, in order to be a covered medical expense, must:

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

21 2. Provide for the application of deductibles and copayment provisions, when
22 equally applied to all covered charges for services and procedures that can be provided by

1 any practitioner for the diagnosis and treatment of a covered illness, disease, injury or
2 condition. This provision shall not be construed to prohibit differences in deductibles and
3 copayment provisions between practitioners, hospitals and ambulatory surgical centers
4 who are participating preferred provider organization providers and practitioners,
5 hospitals and ambulatory surgical centers who are not participating in the preferred
6 provider organization, subject to the following limitations:

- 7 a. the amount of any annual deductible per covered person or per family
8 for treatment in a hospital or ambulatory surgical center that is not a
9 preferred provider shall not exceed three times the amount of a
10 corresponding annual deductible for treatment in a hospital or
11 ambulatory surgical center that is a preferred provider,
12 b. if the policy has no deductible for treatment in a preferred provider
13 hospital or ambulatory surgical center, the deductible for treatment in
14 a hospital or ambulatory surgical center that is not a preferred
15 provider shall not exceed One Thousand Dollars (\$1,000.00) per
16 covered-person visit,
17 c. the amount of any annual deductible per covered person or per family
18 treatment, other than inpatient treatment, by a practitioner that is not
19 a preferred practitioner shall not exceed three times the amount of a
20 corresponding annual deductible for treatment, other than inpatient
21 treatment, by a preferred practitioner,

- 1 d. if the policy has no deductible for treatment by a preferred
2 practitioner, the annual deductible for treatment received from a
3 practitioner that is not a preferred practitioner shall not exceed Five
4 Hundred Dollars (\$500.00) per covered person,
- 5 e. the percentage amount of any coinsurance to be paid by an insured to a
6 practitioner, hospital or ambulatory surgical center that is not a
7 preferred provider shall not exceed by more than thirty (30) percentage
8 points the percentage amount of any coinsurance payment to be paid to
9 a preferred provider,
- 10 f. a practitioner, hospital or ambulatory surgical center that is not a
11 preferred provider shall disclose to the insured, in writing, that the
12 insured may be responsible for:
- 13 (1) higher coinsurance and deductibles, and
14 (2) practitioner, hospital or ambulatory surgical center charges
15 which exceed the allowable charges of a preferred provider, and
- 16 g. when a referral is made to a nonparticipating hospital or ambulatory
17 surgical center, the referring practitioner must disclose in writing to
18 the insured, any ownership interest in the nonparticipating hospital or
19 ambulatory surgical center.

20 C. Upon submission of a claim by a practitioner, hospital, home care agency, or
21 ambulatory surgical center to an insurer on a uniform health care claim form adopted by
22 the Insurance Commissioner pursuant to Section 6581 of this title, the insurer shall

1 provide a timely explanation of benefits to the practitioner, hospital, home care agency,
2 or ambulatory surgical center regardless of the network participation status of such
3 person or entity.

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

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

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

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

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

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

20 1. Any preferred provider organization (PPO) as defined by generally accepted
21 industry standards, that contracts with practitioners that agree to accept the

1 reimbursement available under the PPO agreement as payment in full and agree not to
2 balance bill the insured; or

3 2. Any statewide provider network which:

- 4 a. provides that a practitioner, hospital, home care agency or ambulatory
5 surgical center who joins the provider network shall be compensated
6 directly by the insurer,
- 7 b. does not have any terms or conditions which have the effect of
8 discriminating against a particular class of practitioner,
- 9 c. allows any practitioner, hospital, home care agency or ambulatory
10 surgical center, except a practitioner who has a prior felony conviction,
11 to become a network provider if said hospital or practitioner is willing
12 to comply with the terms and conditions of a standard network
13 provider contract, and
- 14 d. contracts with practitioners that agree to accept the reimbursement
15 available under the network agreement as payment in full and agree
16 not to balance bill the insured.

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

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

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

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

10 H. Notwithstanding any other provisions of this section, if an insured elects to
11 receive medical treatment from a provider outside of a preferred provider organization
12 (PPO) network and if the medical treatment is provided, upon proper submission of a
13 claim by the provider, the insurer shall list the provider as a payee on any check or
14 negotiable instrument sent to the insured for payment of the services provided so long as
15 the provider accepts such check or negotiable instrument as payment in full and
16 guarantees that the patient will not be balance-billed for any amount over what the
17 insurer pays.

18 I. Nothing in the Health Care Freedom of Choice Act shall prohibit an insurer from
19 establishing a preferred provider organization and a standard participating provider
20 contract therefor, specifying the terms and conditions, including, but not limited to,
21 provider qualifications, and alternative levels or methods of payment that must be met

1 by a practitioner selected by the insurer as a participating preferred provider
2 organization provider.

3 ~~I.~~ J. A preferred provider organization, in executing a contract, shall not, by the
4 terms and conditions of the contract or internal protocol, discriminate within its network
5 of practitioners with respect to participation and reimbursement as it relates to any
6 practitioner who is acting within the scope of the practitioner's license under the law
7 solely on the basis of such license.

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

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

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

19 ~~L.~~ M. An insurer or a preferred provider organization (PPO) shall compensate a
20 provider for patient screening, evaluation, and examination services that are reasonably
21 calculated to assist the provider in determining whether the condition of the patient
22 requires emergency service. If the provider determines that the patient does not require

1 emergency service, coverage for services rendered subsequent to that determination shall
2 be governed by the policy or PPO contract.

3 ~~M. N.~~ Nothing in this act shall be construed as prohibiting an insurer, preferred
4 provider organization or other network from determining the adequacy of the size of its
5 network.

6 SECTION 10. This act shall become effective November 1, 2009.

7 COMMITTEE REPORT BY: COMMITTEE ON ECONOMIC DEVELOPMENT AND
8 FINANCIAL SERVICES, dated 02-19-09 - DO PASS, As Amended and Coauthored.