

1 STATE OF OKLAHOMA

2 1st Session of the 52nd Legislature (2009)

3 SENATE BILL 917

By: Reynolds

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6 AS INTRODUCED

7 An Act relating to insurance; creating the Patient's
8 Bill of Rights Act; providing short title; defining
9 terms; making certain practices relating to health
10 care claims unlawful; requiring certain providers to
11 make certain notice and disclosures; prohibiting
12 false representation regarding certain denial;
13 providing for penalties; specifying requirements
14 pursuant to inappropriate placement of a patient
15 account; requiring certain contract to be in writing
16 and to contain certain provision regarding balance
17 billing; requiring a health plan to establish certain
18 procedures relating to notification of termination of
19 participating providers; requiring a participating
20 provider to furnish certain written notice upon
21 termination of certain contract; prohibiting a health
22 plan from denying an application based on certain
23 stated criteria; specifying conditions when certain
24 health care services may be rendered to certain
health plan's enrollees; requiring a health plan to
provide enrollees a certain list; specifying
requirements of certain contract; allowing purchaser
of health benefits to choose from certain policies;
providing for codification; and providing an
effective date.

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

22 SECTION 1. NEW LAW A new section of law to be codified
23 in the Oklahoma Statutes as Section 6065 of Title 36, unless there
24 is created a duplication in numbering, reads as follows:

1 This act shall be known and my be cited at the "Patient's Bill
2 of Rights Act".

3 SECTION 2. NEW LAW A new section of law to be codified
4 in the Oklahoma Statutes as Section 6065.1 of Title 36, unless there
5 is created a duplication in numbering, reads as follows:

6 As used in the Patients' Bill of Rights Act:

7 1. "Balance billing" means willfully collecting or attempting
8 to collect an amount from a person, while knowing, or having
9 constructive knowledge, that such collection or attempt violates an
10 agreement, arrangement or contract between the health care provider
11 and a health care payor. Balance billing does not include billing a
12 patient for payments he or she is obligated to make under the health
13 plan provisions such as copayments, coinsurance or deductibles;

14 2. "Commissioner" means the Oklahoma Insurance Commissioner;

15 3. "Department" means the Oklahoma Insurance Department;

16 4. "Enrollee" means any person entitled to health care services
17 from a health plan;

18 5. "Health plan" means a health maintenance organization or a
19 prepaid health plan as defined in Section 6902 of Title 36 of the
20 Oklahoma Statutes or a preferred provider organization as defined in
21 Section 6054 of Title 36 of the Oklahoma Statutes;

22 6. "Non participating provider" includes any class of provider
23 licensed under Title 59 of the Oklahoma Statutes, hospital,
24 pharmacy, laboratory, or other appropriately state-licensed or

1 otherwise state-recognized provider of health care services or
2 supplies, that has not entered into an agreement with a health plan
3 to provide such services or supplies to a patient;

4 7. "Participating provider" includes any class of provider
5 licensed under Title 59 of the Oklahoma Statutes, hospital,
6 pharmacy, laboratory, or other appropriately state-licensed or
7 otherwise state-recognized provider of health care services or
8 supplies, that has entered into an agreement with a health plan to
9 provide such services or supplies to a patient enrolled in a health
10 plan;

11 8. "Primary care provider" includes physicians or other health
12 care providers specializing in general practice, family practice,
13 general internal medicine and pediatrics who are selected as the
14 primary care provider of record by the enrollee, when required, as
15 part of the health plan enrollment process; and

16 9. "Provider" includes any class of provider licensed under
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.

20 SECTION 3. NEW LAW A new section of law to be codified
21 in the Oklahoma Statutes as Section 6065.2 of Title 36, unless there
22 is created a duplication in numbering, reads as follows:

23 A. It shall be unlawful for any participating provider to
24 willfully collect or attempt to collect an amount from a person

1 through means including, but not limited to balance billing, knowing
2 that such collection or attempt violates an agreement, arrangement
3 or contract between the provider and a health care payor. It shall
4 not be unlawful to bill a patient for payments he or she is
5 obligated to make under the health plan provisions, such as
6 copayments, coinsurance, or deductibles.

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

11 C. 1. A nonparticipating provider shall disclose to the
12 patient in writing prior to non-emergent health care services being
13 rendered, on a standardized form approved by the Insurance
14 Commissioner, that the patient may be responsible for:

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

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

21 D. When a participating or nonparticipating provider makes a
22 referral to a nonparticipating provider, laboratory, hospital or
23 ambulatory surgical center or any other medical service provider to
24 which a proposed referral is to be made, the referring provider

1 shall disclose, in writing to the patient and health plan, any
2 ownership interest in the nonparticipating hospital or ambulatory
3 surgical center.

4 E. No provider shall falsely advise a patient that a referral
5 required by Section 6933 of Title 36 of the Oklahoma Statutes has
6 been denied by the health plan.

7 SECTION 4. NEW LAW A new section of law to be codified
8 in the Oklahoma Statutes as Section 6065.3 of Title 36, unless there
9 is created a duplication in numbering, reads as follows:

10 A. Any health care provider who is determined by the Insurance
11 Commissioner to have violated any provision of the Patient's Bill of
12 Rights Act shall be subject to the following penalties:

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

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

22 B. 1. In the event a provider has placed a patient account
23 with a collection agency or an attorney for collection, reported the
24 patient to a credit reporting agency or placed a physician's lien on

1 the patient in violation of the Patient's Bill of Rights Act, it
2 shall be the responsibility of the provider to:

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

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

14 SECTION 5. NEW LAW A new section of law to be codified
15 in the Oklahoma Statutes as Section 6065.4 of Title 36, unless there
16 is created a duplication in numbering, reads as follows:

17 A. Every contract between a health plan and a participating
18 provider shall be in writing and shall set forth, in addition to any
19 other provisions required by Title 36 of the Oklahoma Statutes, a
20 provision which prohibits the participating provider from balance
21 billing an enrollee for contracted health care services for which
22 the health plan is obligated to pay.

23 B. In the event that the contract has not been reduced to
24 writing pursuant to subsection A of this section, or if the contract

1 fails to contain the required prohibition against balance billing
2 for contracted health care services, the participating provider
3 shall not collect or attempt to collect from the enrollee any amount
4 for which the health plan is obligated to pay.

5 SECTION 6. NEW LAW A new section of law to be codified
6 in the Oklahoma Statutes as Section 6065.5 of Title 36, unless there
7 is created a duplication in numbering, reads as follows:

8 A. A health plan that requires the selection of a primary care
9 provider shall establish procedures for:

10 1. Notifying enrollee of termination from the health plan's
11 network of participating providers of the enrollee's primary care
12 provider; and

13 2. Notifying participating primary care providers of
14 termination from the network of participating providers at least
15 ninety (90) days prior to the termination date, except when a
16 participating provider is terminated for cause.

17 B. Whenever a participating provider voluntarily terminates his
18 or her contract with a health plan to provide health care services
19 to the health plan's enrollees under a health plan, he or she shall
20 furnish written notice of such termination to his or her patients
21 who are enrollees under such health plan at the patient's last known
22 mailing address.

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1 C. A health plan may not deny an application for participation
2 or terminate participation in its network on the basis of gender,
3 race, age, religion or national origin.

4 D. 1. For a period of at least ninety (90) days from the date
5 of the notice of a participating provider's termination from the
6 health plan's network, except when a participating provider is
7 terminated for cause, the participating provider shall be permitted
8 by the health plan to render health care services to any of the
9 health plan's enrollees who:

10 a. were in an active course of treatment from the
11 participating provider prior to the notice of
12 termination, and

13 b. request to continue receiving health care services from
14 the participating provider.

15 2. Notwithstanding the provisions of paragraph 1 of this
16 subsection, any participating provider shall be permitted by the
17 health plan to continue rendering health services to any enrollee
18 who has entered the second trimester of pregnancy at the time of a
19 participating provider's termination of participation, except when a
20 participating provider is terminated for cause. Such treatment
21 shall, at the enrollee's option, continue through the provision of
22 postpartum care directly related to the delivery.

23 3. Notwithstanding the provisions of paragraph 1 of this
24 subsection, any participating provider shall be permitted by the

1 health plan to continue rendering health services to any enrollee
2 who is determined to be terminally ill as defined under Section 1861
3 (dd) (3) (A) of the Social Security Act at the time of a participating
4 provider's termination of participation, except when a participating
5 provider is terminated for cause. Such treatment shall, at the
6 enrollee's option, continue for the remainder of the enrollee's life
7 for care directly related to the treatment of the terminal illness.

8 4. A health plan shall reimburse a provider under this
9 subsection in accordance with the health plan's agreement with such
10 provider existing immediately before the provider's termination of
11 participation.

12 E. 1. A health plan shall provide to an enrollee upon
13 enrollment and make available to existing enrollees at least once a
14 year a list of primary care physician participating providers, which
15 list shall also indicate those participating providers who are not
16 currently accepting new patients. Such list may be made available in
17 a form other than a printed document, provided the enrollee is given
18 the means to request and receive a printed copy of such list.

19 2. The information provided under paragraph 1 of this
20 subsection shall be updated at least once a year if in paper form,
21 and monthly if in electronic form.

22 F. No contract between a health plan and a participating
23 provider may require that the participating provider indemnify the
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1 health plan for the health plan's negligence, willful misconduct, or
2 breach of contract, if any.

3 G. No contract between a health plan and a participating
4 provider shall require a provider, as a condition of participation
5 in the network, to waive any right to seek legal redress against the
6 health plan. This does not prohibit a health plan and a
7 participating provider from agreeing to arbitration or other
8 alternative dispute resolution provisions in a contract.

9 H. No contract between a health plan and a participating
10 provider shall prohibit, impede or interfere in the discussion of
11 medical treatment options between a patient and a provider.

12 I. A contract between a health plan and a participating
13 provider shall permit and require the provider to discuss medical
14 treatment options with the patient.

15 J. Any health plan requiring preauthorization for medical
16 treatment shall have personnel available to accept incoming requests
17 for preauthorization during normal business hours.

18 K. No contract between a participating provider and a health
19 plan shall include provisions that require a participating provider
20 or participating provider group to deny covered services that such
21 provider or group knows to be medically necessary, appropriate and
22 consistent with generally accepted medical practices in the state of
23 Oklahoma, that are provided with respect to a specific enrollee or
24 group of enrollees with similar medical conditions.

1 SECTION 7. NEW LAW A new section of law to be codified
2 in the Oklahoma Statutes as Section 6065.6 of Title 36, unless there
3 is created a duplication in numbering, reads as follows:

4 An individual purchasing health benefits or an employer
5 purchasing such benefits for its employees may select the coverage
6 they choose to purchase from the policies that have been filed and
7 approved by the Insurance Commissioner. In no event will such
8 purchaser be required to purchase specific coverage, other than that
9 which is required by law to be included in the policy.

10 SECTION 8. This act shall become effective November 1, 2009.

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