STATE OF OKLAHOMA

2nd Session of the 53rd Legislature (2012)

COMMITTEE SUBSTITUTE
FOR ENGROSSED
HOUSE BILL 2447 By: Quinn of the House

and

Brinkley of the Senate

COMMITTEE SUBSTITUTE

[insurance - Health Care Freedom of Choice Act - Health Insurance High Risk Pool - Hospital and Medical Services Utilization Review Act - effective date]

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

SECTION 1. AMENDATORY 36 O.S. 2011, Section 6054, is amended to read as follows:

Section 6054. As used in the 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. "Exclusive provider benefit plan" (also known as an "EPO plan") means a benefit plan in which an insurer excludes benefits to an insured provided by a non-network provider, other than emergency care services, except as provided in Section 6055 of this title;

4. "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.~~ 5. "Hospital" means any facility as defined in Section 1-701 of Title 63 of the Oklahoma Statutes;

~~5.~~ 6. "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.~~ 7. "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.~~ 8. "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.~~ 9. "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 2. AMENDATORY 36 O.S. 2011, 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.

C. 1. Paragraph 2 of subsection B of this section shall not be construed to prohibit differences in cost-sharing provisions such as 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 or an exclusive provider benefit plan, 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, and

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.

Subparagraphs a through e of this paragraph shall not apply to an exclusive provider benefit plan.

2. The Commissioner has discretion to approve a cost-sharing arrangement which does not satisfy the limitations imposed by this subsection if the Commissioner finds that such cost-sharing arrangement will provide a reduction in premium costs.

3. If a covered service is medically necessary and is not available through a preferred provider, the issuer of an exclusive provider benefit plan, on the request of a preferred provider, shall:

a. approve the referral of an insured to a non-preferred provider within a reasonable period, and

b. reimburse the non-preferred provider at a rate agreed to by the issuer and the non-preferred provider.

4. An exclusive provider benefit plan shall provide for a review by a health care provider with expertise in the same specialty as or a specialty similar to the type of health care

provider to whom a referral is requested under paragraph 3 of this subsection.

D. 1. 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:

a. higher coinsurance and deductibles, and

b. practitioner, hospital or ambulatory surgical center charges which exceed the allowable charges of a preferred provider.

2. 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.

E. 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.

F. 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.

G. The provisions of subsection F of this section shall not apply to:

1. Any preferred provider organization (PPO) as defined by generally accepted industry standards or any exclusive provider benefit plan, that contracts with practitioners that agree to accept the reimbursement available under the PPO or exclusive provider

benefit plan 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~~ the 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.

H. 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.

I. 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.

J. Nothing in the Health Care Freedom of Choice Act shall prohibit an insurer from establishing a preferred provider organization or an exclusive provider benefit plan 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.

K. A preferred provider organization or exclusive provider benefit plan, 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.

L. Decisions by an insurer ~~or~~, a preferred provider organization (PPO) or exclusive provider benefit plan 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.

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

N. An insurer or a preferred provider organization (PPO) or exclusive provider benefit plan 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 or EPO contract. If a non-preferred provider provides emergency care, as defined by subsection L of this section, to an enrollee in an exclusive provider benefit plan, the issuer of the plan shall reimburse the non-preferred provider at one of the following:

1. The amount negotiated with in-network providers for the emergency service furnished;

2. The amount for the emergency service calculated using the same method the plan or issuer generally uses to determine payments for out-of-network services, but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing provisions; or

3. The amount that would be paid under Medicare for the emergency service.

Each of these amounts is calculated without the application of any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee; however, the in-network copayment and coinsurance may be applied to the final claim.

O. An insurer that offers an exclusive provider benefit plan shall provide to a current or prospective group contract holder or current or prospective insured notice that the benefit plan includes limited or no coverage for services provided by a physician or

1 health care provider that is not a preferred provider. An
2 identification card or similar document issued by an insurer to an
3 insured in an exclusive provider benefit pan shall display:
4 1. a. the first date on which the insured became insured
5 under the plan, or
6 b. a toll-free number or website that a physician or
7 health care provider may use to obtain the date on
8 which the insured became insured under the plan; and
9 2. The acronym "EPO" or the phrase "Exclusive Provider Plan" on
10 the card.
11 P. Nothing in ~~this act~~ the Health Care Freedom of Choice Act
12 shall be construed as prohibiting an insurer, preferred provider
13 organization, exclusive provider benefit plan or other network from
14 determining the adequacy of the size of its network.
15 Q. Nothing in the Health Care Freedom of Choice Act shall be
16 construed as prohibiting an exclusive provider benefit plan from
17 excluding or limiting benefits for services provided by a non-
18 network provider; however, nothing in the Health Care Freedom of
19 Choice Act shall allow discrimination among classes of providers.
20 R. An insurer who offers an EPO plan to an employer shall also
21 offer the employer a plan that includes an out-of-network benefit.
22 SECTION 3. AMENDATORY 36 O.S. 2011, Section 6057.1, is
23 amended to read as follows:
24

Section 6057.1 A. In order to enforce the provisions of the Health Care Freedom of Choice Act, the Insurance Commissioner may conduct an examination of ~~insurers' and~~ the claim files of insurers, preferred provider ~~organizations' claims files~~ organizations, and exclusive provider benefit plans, 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 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 4. AMENDATORY 36 O.S. 2011, Section 6532, is amended to read as follows:

Section 6532. As used in the Health Insurance High Risk Pool Act:

1. "Agent" means any person who is licensed to sell health insurance in this state;

2. "Primary plan" means the comprehensive health insurance benefit plan adopted by the Board of Directors of the Health Insurance High Risk Pool which meets all requirements of federal law as a plan required to be offered by the Pool;

3. "Board" means the Board of Directors of the Health Insurance High Risk Pool;

4. "Church plan" has the meaning given such term under Section 3(33) of the Employee Retirement Income Security Act of 1974;

5. "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

a. a group health plan,

b. health insurance coverage,

c. Part A or B of Title XVIII of the Social Security Act,

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 of such act,

e. Chapter 55 of Title 10, U.S. Code,

f. a medical care program of the Indian Health Service or of a tribal organization,

g. a state health benefits risk pool,

h. a health plan offered under Chapter 89 of Title 5, U.S. Code,

i. a public health plan as defined in federal regulations,

j. a health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e), or

k. a temporary high risk pool referred to as the Pre-Existing Condition Insurance Plan or PCIP program, offered pursuant to Section 1101(b) of the Patient Protection and Affordable Care Act ("Affordable Care Act", Public Law 111-148);

6. "Federally defined eligible individual" means an individual:

a. for whom, as of the date on which the individual seeks coverage under the Health Insurance High Risk Pool Act, the aggregate of the periods of creditable coverage, as defined in Section 1D of the Employee Retirement Income Security Act of 1974, is eighteen (18) or more months. The eighteen-month period required in this ~~paragraph~~ subparagraph shall not apply to an individual whose most recent creditable coverage was under a plan defined in ~~paragraph~~

1 subparagraph k of ~~subsection~~ paragraph 5 of this
2 section,
3 b. whose most recent prior creditable coverage was under
4 a group health plan, governmental plan, church plan, a
5 temporary high risk health insurance pool referred to
6 as the Pre-Existing Condition Insurance Plan or PCIP
7 program, offered pursuant to Section 1101(b) of the
8 Patient Protection and Affordable Care Act
9 ("Affordable Care Act", Public Law 111-148) which has
10 ceased to be available or health insurance coverage
11 offered in conjunction with any such plan, and
12 c. who is not eligible for coverage under a group health
13 plan, part A or B of Title XVIII of the Social
14 Security Act, or a state plan under Title XIX of such
15 Act or any successor program and who does not have
16 other health insurance coverage, except that a person
17 who has exhausted COBRA coverage shall be, for the
18 purposes of the Health Insurance High Risk Pool Act, a
19 federally defined individual;
20 7. "Governmental plan" has the same meaning given such term
21 under Section 3(32) of the Employee Retirement Income Security Act
22 of 1974 and any federal governmental plan;
23 8. "Group health benefit plan" means an employee welfare
24 benefit plan as defined in section 3(1) of the Employee Retirement

Income Security Act of 1974 to the extent that the plan provides medical care as defined in Section 3N of the Employee Retirement Income Security Act of 1974 and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise;

9. "Health insurance" means any individual or group hospital or medical expense-incurred policy or health care benefits plan or contract. The term does not include any policy governing short-term accidents only, a fixed-indemnity policy, a limited benefit policy, a specified accident policy, a specified disease policy, a Medicare supplement policy, a long-term care policy, medical payment or personal injury coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance, a disability policy, or workers' compensation;

10. "Insurer" means any individual, corporation, association, partnership, fraternal benefit society, or any other entity engaged in the health insurance business, except insurance agents and brokers. This term shall also include not-for-profit hospital service and medical indemnity plans, health maintenance organizations, preferred provider organizations, exclusive provider benefit plans, prepaid health plans, the State and Education Employees Group Health Insurance Plan, and any reinsurer reinsuring health insurance in this state, which shall be designated as engaged

in the business of insurance for the purposes of the Health Insurance High Risk Pool Act;

11. "Medical care" means amounts paid for:

a. the diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

b. transportation primarily for and essential to medical care referred to in subparagraph a of this paragraph, and

c. insurance covering medical care referred to in subparagraphs a and b of this paragraph;

12. "Medicare" means coverage under Parts A and B of Title XVIII of the Social Security Act (Public Law 74-271, 42 U.S.C., Section 1395 et seq., as amended);

13. "Pool" means the Health Insurance High Risk Pool;

14. "Physician" means a doctor of medicine and surgery, doctor of osteopathic medicine, doctor of chiropractic, doctor of podiatric medicine, doctor of optometry, and, for purposes of oral and maxillofacial surgery only, a doctor of dentistry, each duly licensed by this state;

15. "Plan" means any of the comprehensive health insurance benefit plans as adopted by the Board of Directors of the Health Insurance High Risk Pool, or by rule;

16. "Alternative plan" means any of the comprehensive health insurance benefit plans adopted by the Board of Directors of the Health Insurance High Risk Pool other than the primary plan; and

17. "Reinsurer" means any insurer as defined in Section 103 of this title from whom any person providing health insurance to Oklahoma insureds procures insurance for itself as the insurer, with respect to all or part of the health insurance risk of the person.

SECTION 5. AMENDATORY 36 O.S. 2011, Section 6552, is amended to read as follows:

Section 6552. As used in the Hospital and Medical Services Utilization Review Act:

1. "Utilization review" means a system for prospectively, concurrently and retrospectively reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients. It does not include an insurer's normal claim review process to determine compliance with the specific terms and conditions of the insurance policy;

2. "Private review agent" means a person or entity who performs utilization review on behalf of:

a. an employer in this state, or

b. a third party that provides or administers hospital and medical benefits to citizens of this state, including, but not limited to:

(1) a health maintenance organization issued a license pursuant to ~~Section 2501 et seq.~~ the requirements of Title 63 of the Oklahoma Statutes, unless the health maintenance organization is federally regulated and licensed and has on file with the Commissioner of Health a plan of utilization review carried out by health care professionals and providing for complaint and appellate procedures for claims, or

(2) a health insurer, not-for-profit hospital service or medical plan, health insurance service organization, ~~or~~ preferred provider organization, exclusive provider benefit plan or other entity offering health insurance policies, contracts or benefits in this state;

3. "Utilization review plan" means a description of utilization review procedures;

4. "Commissioner" means the Insurance Commissioner;

5. "Certificate" means a certificate of registration granted by the Insurance Commissioner to a private review agent; and

6. "Health care provider" means any person, firm, corporation or other legal entity that is licensed, certified, or otherwise authorized by the laws of this state to provide health care

services, procedures or supplies in the ordinary course of business or practice of a profession.

SECTION 6. AMENDATORY 36 O.S. 2011, Section 6554, is amended to read as follows:

Section 6554. A. The Insurance Commissioner shall waive the requirements of the Hospital and Medical Services Utilization Review Act for the activities of a private review agent in connection with a contract with the federal or state government for utilization review of patients eligible for hospital and medical services under the Social Security Act.

B. No certificate is required for those private review agents conducting general in-house utilization review for hospitals, home health agencies, preferred provider organizations, exclusive provider benefit plans, or other managed care entities, clinics, private offices or any other health facility or entity, so long as the review does not result in the approval or denial of payment for hospital or medical services for a particular case. Such general in-house utilization review shall be exempt from all provisions of the Hospital and Medical Services Utilization Review Act.

SECTION 7. AMENDATORY 36 O.S. 2011, Section 6571, is amended to read as follows:

Section 6571. A. As used in this section:

1. "Health care provider" means any person, firm, corporation or other legal entity that is licensed, certified or otherwise

authorized by the laws of this state to provide health care services, procedures or supplies in the ordinary course of business or practice of a profession; and

2. "Insurer" means any insurance company, not-for-profit hospital service and medical indemnity plan, health insurance service organization, preferred provider organization, exclusive provider benefit plan or other entity offering health insurance policies, contracts or benefits in this state.

B. Any insurer which:

1. Makes a determination or contracts with a third party who makes the determination of average area charges or customary and reasonable charges for health care services, procedures or supplies; and

2. Based on such determination, authorizes payment in an amount which is less than the amount charged by the health care provider for such services, procedures or supplies;

shall, upon the request of a health care provider, furnish the name, mailing address and telephone number of the party making the determination to the health care provider.

C. Upon the request of the health care provider, the party shall furnish, for a reasonable charge, information used to determine the average area charges or customary and reasonable charges for the services, procedures or supplies provided by the health care provider and authorized for payment pursuant to

paragraph 2 of subsection B of this section. The information shall include the rationale and documentation of sources used in the determination of the average area charges or customary and reasonable charges for the services, procedures or supplies in question, including names, mailing addresses and telephone numbers of sources if available. Such information shall be furnished to the health care provider no later than ten (10) working days after the request for information by the health care provider.

D. 1. No insurer shall use the services of a party for the determination of average area charges or customary and reasonable charges which is not in compliance with the provisions of this section.

2. Noncompliance shall be reported to the Insurance Commissioner who, upon investigation of the complaint and determination that the party is in noncompliance and that no resolution of the complaint will be made within a reasonable time, shall compile and maintain a list of parties which are not in compliance with the provisions of this section.

SECTION 8. This act shall become effective November 1, 2012.

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