HOUSE OF REPRESENTATIVES - FLOOR VERSION

STATE OF OKLAHOMA

2nd Session of the 53rd Legislature (2012)

HOUSE BILL 2447 By: Quinn of the House

and

Brinkley of the Senate

AS INTRODUCED

An Act relating to insurance; amending 36 O.S. 2011, Section 1219.3, which relates to discounted fee reimbursement limitations; adding exclusive provider benefit plans to exceptions; amending 36 O.S. 2011, Sections 6054, 6055 and 6057.1, which relate to the Health Care Freedom of Choice Act; adding definition; authorizing certain differences in cost-sharing provisions; specifying certain exception; authorizing insurers to create certain exclusive provider benefit plans; prohibiting certain benefit plans from discriminating within a network; specifying certain treatment decisions may be made by exclusive provider benefit plans; prohibiting the denial of certain emergency treatment by exclusive provider benefit plans; requiring exclusive provider benefit plans to compensate providers for certain treatment; authorizing exclusive provider benefit plans to determine the adequacy of network; authorizing Insurance Commissioner to conduct examinations of exclusive provider benefit plans; amending 36 O.S. 2011, Section 6532, which relates to Health Insurance High Risk Pool definitions; modifying definition; amending 36 O.S. 2011, Sections 6552 and 6554, which relate to the Hospital and Medical Services Utilization Review Act; modifying definition; specifying certificate shall not be required for certain reviews of exclusive provider benefit plans; amending 36 O.S. 2011, Section 6571, which relates to

health care provider and insurer definitions and determinations; modifying definition; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2011, Section 1219.3, is amended to read as follows:

Section 1219.3 A. An insurer or third-party administrator shall not reimburse a health care provider on a discounted fee basis for covered services that are provided to an insured unless:

1. The insurer or third-party administrator has contracted with either:

a. the health care provider, or

b. a preferred provider organization or exclusive provider benefit plan which has contracted with the health care provider;

2. The health care provider has agreed to provide health care services under the terms of the contract; and

3. The insurer or third-party administrator has agreed to provide coverage for those health care services under an accident and health insurance policy.

B. A party to a preferred provider contract, including a contract with a preferred provider organization or exclusive

provider benefit plan, may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority and prior adequate notification of the other contracting parties.

SECTION 2. 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" means a benefit plan in which an insurer excludes benefits to an insured for some or all services, other than emergency care services, provided by a physician or health care provider who is not a preferred provider;

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 3. 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.

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 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 contract.

O. Nothing in this act shall be construed as prohibiting an insurer, preferred provider organization, exclusive provider benefit plan or other network from determining the adequacy of the size of its network.

SECTION 4. AMENDATORY 36 O.S. 2011, Section 6057.1, is amended to read as follows:

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 5. 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~~ subparagraph k of ~~subsection~~ paragraph 5 of this section,

b. whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, a temporary high risk health insurance 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) which has ceased to be available or health insurance coverage offered in conjunction with any such plan, and

c. who is not eligible for coverage under a group health plan, part A or B of Title XVIII of the Social Security Act, or a state plan under Title XIX of such Act or any successor program and who does not have other health insurance coverage, except that a person who has exhausted COBRA coverage shall be, for the purposes of the Health Insurance High Risk Pool Act, a federally defined individual;

7. "Governmental plan" has the same meaning given such term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan;

8. "Group health benefit plan" means an employee welfare 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 6. 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 7. 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 8. 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 9. This act shall become effective November 1, 2012.

COMMITTEE REPORT BY: COMMITTEE ON INSURANCE, dated 02/27/2012 - DO PASS, As Coauthored.