

1                   **HOUSE OF REPRESENTATIVES - FLOOR VERSION**

2                                   STATE OF OKLAHOMA

3                                   2nd Session of the 53rd Legislature (2012)

4   HOUSE BILL 2864

                                  By: Shelton

7                                   AS INTRODUCED

8                   An Act relating to insurance; amending 36 O.S. 2011,  
9                   Section 6055, which relates to accident and health  
10                  insurance policy requirements and exclusions;  
                          requiring certain notice by diagnostic service  
                          providers; and providing an effective date.

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

14           SECTION 1.        AMENDATORY        36 O.S. 2011, Section 6055, is  
15   amended to read as follows:

16           Section 6055. A. Under any accident and health insurance  
17   policy, hereafter renewed or issued for delivery from out of  
18   Oklahoma or in Oklahoma by any insurer and covering an Oklahoma  
19   risk, the services and procedures may be performed by any  
20   practitioner selected by the insured, or the parent or guardian of  
21   the insured if the insured is a minor, if the services and  
22   procedures fall within the licensed scope of practice of the  
23   practitioner providing the same.

1 B. An accident and health insurance policy may:

2 1. Exclude or limit coverage for a particular illness, disease,  
3 injury or condition; but, except for such exclusions or limits,  
4 shall not exclude or limit particular services or procedures that  
5 can be provided for the diagnosis and treatment of a covered  
6 illness, disease, injury or condition, if such exclusion or  
7 limitation has the effect of discriminating against a particular  
8 class of practitioner. However, such services and procedures, in  
9 order to be a covered medical expense, must:

- 10 a. be medically necessary,  
11 b. be of proven efficacy, and  
12 c. fall within the licensed scope of practice of the  
13 practitioner providing same; and

14 2. Provide for the application of deductibles and copayment  
15 provisions, when equally applied to all covered charges for services  
16 and procedures that can be provided by any practitioner for the  
17 diagnosis and treatment of a covered illness, disease, injury or  
18 condition.

19 C. 1. Paragraph 2 of subsection B of this section shall not be  
20 construed to prohibit differences in cost-sharing provisions such as  
21 deductibles and copayment provisions between practitioners,  
22 hospitals and ambulatory surgical centers who are participating  
23 preferred provider organization providers and practitioners,  
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1 hospitals and ambulatory surgical centers who are not participating  
2 in the preferred provider organization, subject to the following  
3 limitations:

4 a. the amount of any annual deductible per covered person  
5 or per family for treatment in a hospital or  
6 ambulatory surgical center that is not a preferred  
7 provider shall not exceed three times the amount of a  
8 corresponding annual deductible for treatment in a  
9 hospital or ambulatory surgical center that is a  
10 preferred provider,

11 b. if the policy has no deductible for treatment in a  
12 preferred provider hospital or ambulatory surgical  
13 center, the deductible for treatment in a hospital or  
14 ambulatory surgical center that is not a preferred  
15 provider shall not exceed One Thousand Dollars  
16 (\$1,000.00) per covered-person visit,

17 c. the amount of any annual deductible per covered person  
18 or per family treatment, other than inpatient  
19 treatment, by a practitioner that is not a preferred  
20 practitioner shall not exceed three times the amount  
21 of a corresponding annual deductible for treatment,  
22 other than inpatient treatment, by a preferred  
23 practitioner,

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

1           d.    if the policy has no deductible for treatment by a  
2                preferred practitioner, the annual deductible for  
3                treatment received from a practitioner that is not a  
4                preferred practitioner shall not exceed Five Hundred  
5                Dollars (\$500.00) per covered person, and

6           e.    the percentage amount of any coinsurance to be paid by  
7                an insured to a practitioner, hospital or ambulatory  
8                surgical center that is not a preferred provider shall  
9                not exceed by more than thirty (30) percentage points  
10              the percentage amount of any coinsurance payment to be  
11              paid to a preferred provider.

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

16           D.  1.  A practitioner, hospital or ambulatory surgical center  
17                that is not a preferred provider shall disclose to the insured, in  
18                writing, that the insured may be responsible for:

- 19                a.    higher coinsurance and deductibles, and  
20                b.    practitioner, hospital or ambulatory surgical center  
21                charges which exceed the allowable charges of a  
22                preferred provider.

1           2. When a referral is made to a nonparticipating hospital or  
2 ambulatory surgical center, the referring practitioner must disclose  
3 in writing to the insured, any ownership interest in the  
4 nonparticipating hospital or ambulatory surgical center.

5           3. A diagnostic laboratory or diagnostic and therapeutic  
6 radiological service provider shall disclose to the insured, in  
7 writing, if the laboratory or provider is not a preferred provider  
8 and that the insured may be responsible for all or a portion of the  
9 service charges.

10           E. Upon submission of a claim by a practitioner, hospital, home  
11 care agency, or ambulatory surgical center to an insurer on a  
12 uniform health care claim form adopted by the Insurance Commissioner  
13 pursuant to Section 6581 of this title, the insurer shall provide a  
14 timely explanation of benefits to the practitioner, hospital, home  
15 care agency, or ambulatory surgical center regardless of the network  
16 participation status of such person or entity.

17           F. Benefits available under an accident and health insurance  
18 policy, at the option of the insured, shall be assignable to a  
19 practitioner, hospital, home care agency or ambulatory surgical  
20 center who has provided services and procedures which are covered  
21 under the policy. A practitioner, hospital, home care agency or  
22 ambulatory surgical center shall be compensated directly by an  
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1 insurer for services and procedures which have been provided when  
2 the following conditions are met:

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

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

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

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

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

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

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

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

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

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

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

12 J. Nothing in the Health Care Freedom of Choice Act shall  
13 prohibit an insurer from establishing a preferred provider  
14 organization and a standard participating provider contract  
15 therefor, specifying the terms and conditions, including, but not  
16 limited to, provider qualifications, and alternative levels or  
17 methods of payment that must be met by a practitioner selected by  
18 the insurer as a participating preferred provider organization  
19 provider.

20 K. A preferred provider organization, in executing a contract,  
21 shall not, by the terms and conditions of the contract or internal  
22 protocol, discriminate within its network of practitioners with  
23 respect to participation and reimbursement as it relates to any  
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1 practitioner who is acting within the scope of the practitioner's  
2 license under the law solely on the basis of such license.

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

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

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

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

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1       0. Nothing in this act shall be construed as prohibiting an  
2 insurer, preferred provider organization or other network from  
3 determining the adequacy of the size of its network.

4       SECTION 2. This act shall become effective November 1, 2012.

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

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