HOUSE OF REPRESENTATIVES - FLOOR VERSION

STATE OF OKLAHOMA

2nd Session of the 56th Legislature (2018)

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 3228 By: Moore of the House

and

Standridge of the Senate

COMMITTEE SUBSTITUTE

An Act relating to insurance; creating the Patient Protection Act; prohibiting the health care insurer from imposing advantages or penalties when certain nonnetwork providers agree to accept certain reimbursement rates; prohibiting balance billing in certain circumstances; requiring insurers provide timely payment to providers; specifying certain actions of an insurer shall not be prohibited or required; defining terms; prohibiting insurer from terminating, refusing to issue or renew a physician contract under certain circumstances; providing for codification; providing for noncodification; and providing an effective date.

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

SECTION 1. NEW LAW A new section of law not to be codified in the Oklahoma Statutes reads as follows:

This act shall be known and may be cited as the "Patient Protection Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6057.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. When a health care provider not participating in a preferred provider organization network agrees to accept the highest contract reimbursement rate available under the preferred provider organization agreement for professional and facility fees provided on behalf of an insured, the health care insurer shall not impose a monetary advantage or penalty under a health benefit plan that would affect the choice of the insured to select among those health care providers participating and not participating in the health benefit plan. "Monetary advantage" or "penalty" includes:

1. Higher cost-sharing provisions, such as deductibles and copayment;

2. A reduction in reimbursement for services; or

3. Promotion of one health care provider over another by these methods.

B. Health care providers not participating in the preferred provider organization that agree to accept the highest contract reimbursement and perform services and procedures in any facility that provides similar services available under the preferred provider organization agreement shall accept the reimbursement as payment in full and shall not balance bill the insured. Insurers

shall provide timely payment to the health care provider in accordance with a contract provider agreement.

C. Nothing in this section shall be construed to:

1. Prohibit or require an insurer from contracting with any health care provider;

2. Prohibit or require the same reimbursement to different types of health care providers whose licensed scope of practice differs;

3. Prohibit or require coverage of services from any particular type of health care provider;

4. Prevent a health benefit plan from instituting measures designed to maintain quality and to control costs, including, but not limited to, the utilization of a gatekeeper system, as long as such measures are imposed equally on all providers in the same class; or

5. Allow an insurer to discriminate against a facility that offers the same service or procedures.

D. As used in this section:

1. "Balance bill" means charging the difference between a nonpreferred provider's bill for a health care service and the insurer's allowed amount;

2. "Gatekeeper system" means a system of administration used by any health benefit plan in which a primary care provider furnishes basic patient care and coordinates diagnostic testing, indicated

treatment and specialty referral for persons covered by the health benefit plan;

3. "Health care provider" means a physician, hospital, ambulatory surgical center, pharmaceutical company, pharmacy, pharmacist, laboratory or other state-licensed or state-recognized provider of health care services; and

4. "Preferred provider organization" means a network of health care providers which has entered into a contract with an insurer or entity contracting with providers to provide health care services under the terms and conditions established in the contract.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6057.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

An insurer issuing health benefit plans in this state shall not terminate, refuse to issue or renew a contract with a physician participating in a preferred provider organization network for the reason that the physician provided the person insured under the health benefit plan a referral or name of another physician that is not participating in a preferred provider organization network.

SECTION 4. This act shall become effective November 1, 2018.

COMMITTEE REPORT BY: COMMITTEE ON INSURANCE, dated 02/28/2018 - DO PASS, As Amended and Coauthored.