

1 STATE OF OKLAHOMA

2 2nd Session of the 57th Legislature (2020)

3 COMMITTEE SUBSTITUTE
4 FOR

5 HOUSE BILL NO. 3368

By: Frix

6 COMMITTEE SUBSTITUTE

7 An Act relating to health insurance; amending 36 O.S.
8 2011, Section 6055, which relates to compensation of
9 practitioners; requiring insurer failing to pay
10 assigned benefits claim to pay certain costs;
11 authorizing Insurance Commissioner to impose civil
fine for certain violation; requiring fine be
deposited in State Insurance Commissioner Revolving
Fund; construing provision; and providing an
effective date.

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

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

17 Section 6055. A. Under any accident and health insurance
18 policy, hereafter renewed or issued for delivery from out of
19 Oklahoma or in Oklahoma by any insurer and covering an Oklahoma
20 risk, the services and procedures may be performed by any
21 practitioner selected by the insured, or the parent or guardian of
22 the insured if the insured is a minor, if the services and
23 procedures fall within the licensed scope of practice of the
24 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,
24 hospitals and ambulatory surgical centers who are not participating

1 in the preferred provider organization, subject to the following
2 limitations:

- 3 a. the amount of any annual deductible per covered person
4 or per family for treatment in a hospital or
5 ambulatory surgical center that is not a preferred
6 provider shall not exceed three times the amount of a
7 corresponding annual deductible for treatment in a
8 hospital or ambulatory surgical center that is a
9 preferred provider,
- 10 b. if the policy has no deductible for treatment in a
11 preferred provider hospital or ambulatory surgical
12 center, the deductible for treatment in a hospital or
13 ambulatory surgical center that is not a preferred
14 provider shall not exceed One Thousand Dollars
15 (\$1,000.00) per covered-person visit,
- 16 c. the amount of any annual deductible per covered person
17 or per family treatment, other than inpatient
18 treatment, by a practitioner that is not a preferred
19 practitioner shall not exceed three times the amount
20 of a corresponding annual deductible for treatment,
21 other than inpatient treatment, by a preferred
22 practitioner,
- 23 d. if the policy has no deductible for treatment by a
24 preferred practitioner, the annual deductible for

1 treatment received from a practitioner that is not a
2 preferred practitioner shall not exceed Five Hundred
3 Dollars (\$500.00) per covered person,

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

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

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

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

21 2. When a referral is made to a nonparticipating hospital or
22 ambulatory surgical center, the referring practitioner must disclose
23 in writing to the insured, any ownership interest in the
24 nonparticipating hospital or ambulatory surgical center.

1 E. Upon submission of a claim by a practitioner, hospital, home
2 care agency, or ambulatory surgical center to an insurer on a
3 uniform health care claim form adopted by the Insurance Commissioner
4 pursuant to Section 6581 of this title, the insurer shall provide a
5 timely explanation of benefits to the practitioner, hospital, home
6 care agency, or ambulatory surgical center regardless of the network
7 participation status of such person or entity.

8 F. Benefits available under an accident and health insurance
9 policy, at the option of the insured, shall be assignable to a
10 practitioner, hospital, home care agency or ambulatory surgical
11 center who has provided services and procedures which are covered
12 under the policy. A practitioner, hospital, home care agency or
13 ambulatory surgical center shall be compensated directly by an
14 insurer for services and procedures which have been provided when
15 the following conditions are met:

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

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

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

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

6 G. When any covered health care benefits are assigned to an
7 out-of-network practitioner, hospital, home care agency or
8 ambulatory surgical center and have met all conditions for
9 compensation required by subsection F of this section:

10 1. An insurer shall directly compensate the practitioner,
11 hospital, home care agency or ambulatory surgical center according
12 to the benefits provided by the insured's policy; and

13 2. Such out-of-network practitioner, hospital, home care agency
14 or ambulatory surgical center shall accept the compensation as
15 payment in full and not balance bill the insured.

16 An insurer that fails to compensate the practitioner, hospital,
17 home care agency or ambulatory surgical center under this subsection
18 or an out-of-network practitioner, hospital, home care agency or
19 ambulatory surgical center that balance bills the insured shall be
20 liable for compensatory damages of one hundred fifty percent (150%)
21 of the charged amount, any interest charges, court costs and other
22 legal fees, if applicable. For any violation of this paragraph, the
23 Insurance Commissioner may, after notice and a hearing, subject an
24 insurer or out-of-network practitioner, hospital, home care agency

1 or ambulatory surgical center that balance bills the insured to an
2 additional civil fine in an amount to be determined by the
3 Commissioner within fifteen (15) days of a hearing in which a
4 violation is found. The fine will be placed in the State Insurance
5 Commissioner Revolving Fund.

6 H. The provisions of subsection F and G of this section shall
7 not apply to:

8 1. Any preferred provider organization (PPO) as defined by
9 generally accepted industry standards, that contracts with
10 practitioners that agree to accept the reimbursement available under
11 the PPO agreement as payment in full and agree not to balance bill
12 the insured; or

13 2. Any statewide provider network which:

- 14 a. provides that a practitioner, hospital, home care
15 agency or ambulatory surgical center who joins the
16 provider network shall be compensated directly by the
17 insurer,
- 18 b. does not have any terms or conditions which have the
19 effect of discriminating against a particular class of
20 practitioner,
- 21 c. allows any practitioner, hospital, home care agency or
22 ambulatory surgical center, except a practitioner who
23 has a prior felony conviction, to become a network
24 provider if ~~said~~ the hospital or practitioner is

1 willing to comply with the terms and conditions of a
2 standard network provider contract, and

3 d. contracts with practitioners that agree to accept the
4 reimbursement available under the network agreement as
5 payment in full and agree not to balance bill the
6 insured.

7 Nothing in this subsection shall be construed to prohibit a
8 preferred provider organization with out-of-network provisions from
9 assigning benefits available under an accident and health insurance
10 policy to an out-of-network practitioner, hospital, home care agency
11 or ambulatory surgical center.

12 ~~H.~~ I. A nonparticipating practitioner, hospital or ambulatory
13 surgical center may request from an insurer and the insurer shall
14 supply a good-faith estimate of the allowable fee for a procedure to
15 be performed upon an insured based upon information regarding the
16 anticipated medical needs of the insured provided to the insurer by
17 the nonparticipating practitioner.

18 ~~I.~~ J. A practitioner shall be equally compensated for covered
19 services and procedures provided to an insured on the basis of
20 charges prevailing in the same geographical area or in similar sized
21 communities for similar services and procedures provided to
22 similarly ill or injured persons regardless of the branch of the
23 healing arts to which the practitioner may belong, if:
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1 1. The practitioner does not authorize or permit false and
2 fraudulent advertising regarding the services and procedures
3 provided by the practitioner; and

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

6 ~~J.~~ K. Nothing in the Health Care Freedom of Choice Act shall
7 prohibit an insurer from establishing a preferred provider
8 organization and a standard participating provider contract
9 therefor, specifying the terms and conditions, including, but not
10 limited to, provider qualifications, and alternative levels or
11 methods of payment that must be met by a practitioner selected by
12 the insurer as a participating preferred provider organization
13 provider.

14 ~~K.~~ L. A preferred provider organization, in executing a
15 contract, shall not, by the terms and conditions of the contract or
16 internal protocol, discriminate within its network of practitioners
17 with respect to participation and reimbursement as it relates to any
18 practitioner who is acting within the scope of the practitioner's
19 license under the law solely on the basis of such license.

20 ~~L.~~ M. Decisions by an insurer or a preferred provider
21 organization (PPO) to authorize or deny coverage for an emergency
22 service shall be based on the patient presenting symptoms arising
23 from any injury, illness, or condition manifesting itself by acute
24 symptoms of sufficient severity, including severe pain, such that a

1 reasonable and prudent layperson could expect the absence of medical
2 attention to result in serious:

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

6 ~~M.~~ N. An insurer or preferred provider organization (PPO) shall
7 not deny an otherwise covered emergency service based solely upon
8 lack of notification to the insurer or PPO.

9 ~~N.~~ O. An insurer or a preferred provider organization (PPO)
10 shall compensate a provider for patient screening, evaluation, and
11 examination services that are reasonably calculated to assist the
12 provider in determining whether the condition of the patient
13 requires emergency service. If the provider determines that the
14 patient does not require emergency service, coverage for services
15 rendered subsequent to that determination shall be governed by the
16 policy or PPO contract.

17 ~~O.~~ P. Nothing in ~~this act~~ the Health Care Freedom of Choice Act
18 shall be construed as prohibiting an insurer, preferred provider
19 organization or other network from determining the adequacy of the
20 size of its network.

21 SECTION 2. This act shall become effective November 1, 2020.

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