

1 ENGROSSED SENATE AMENDMENT
TO
2 ENGROSSED HOUSE
BILL NO. 2322 By: Frix and Sims of the House
3
and
4 Bullard of the Senate
5
6

7 [health insurance - requiring insurer failing to pay
8 assigned benefits claim to pay certain costs -
9 effective date]
10
11

12 AUTHOR: Add the following House Coauthors: Sneed and Roberts
(Eric)
13

14 AUTHOR: Add the following Senate Coauthor: Pemberton
15

16 AMENDMENT NO. 1. Page 1, strike the stricken title, enacting clause
and entire bill and insert
17

18 "[health insurance - requiring insurer failing to
19 pay assigned benefits claim to pay certain costs -
effective date]
20

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

22 SECTION 1. AMENDATORY 36 O.S. 2021, Section 3624, is
amended to read as follows:
23

24 Section 3624. Except as provided in ~~subsection D~~ of Section
6055 of this title, a policy may be assignable or not assignable, as

1 provided by its terms. Subject to its terms relating to
2 assignability, any life or accident and health policy, whether
3 heretofore or hereafter issued, under the terms of which the
4 beneficiary may be changed upon the sole request of the insured, may
5 be assigned either by pledge or transfer of title, by an assignment
6 executed by the insured alone and delivered to the insurer, whether
7 or not the pledgee or assignee is the insurer. Any such assignment
8 shall entitle the insurer to deal with the assignee as the owner or
9 pledgee of the policy in accordance with the terms of the
10 assignment, until the insurer has received at its home office
11 written notice of termination of the assignment or pledge, or
12 written notice by or on behalf of some other person claiming some
13 interest in the policy in conflict with the assignment.

14 SECTION 2. AMENDATORY 36 O.S. 2021, 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.

24 B. An accident and health insurance policy may:

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

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

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

18 C. 1. Paragraph 2 of subsection B of this section shall not be
19 construed to prohibit differences in cost-sharing provisions such as
20 deductibles and copayment provisions between practitioners,
21 hospitals, ~~and~~ ambulatory surgical centers, home care agencies, or
22 other health care providers or facilities that are licensed or
23 certified by the state who are participating preferred provider
24 organization providers and practitioners, hospitals, ~~and~~ ambulatory

1 surgical centers, home care agencies, or other health care providers
2 or facilities that are licensed or certified by the state who are
3 not participating in the preferred provider organization, subject to
4 the following limitations:

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

12 b. if the policy has no deductible for treatment in a
13 preferred provider hospital or ambulatory surgical
14 center, the deductible for treatment in a hospital or
15 ambulatory surgical center that is not a preferred
16 provider shall not exceed One Thousand Dollars
17 (\$1,000.00) per covered-person visit,

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

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 home care agency, or other health care providers or facilities that
18 are licensed or certified by the state that is not a preferred
19 provider shall disclose to the insured, in writing, that the insured
20 may be responsible for:

- 21 a. higher coinsurance and deductibles, and
22 b. practitioner, hospital or ambulatory surgical center
23 charges which exceed the allowable charges of a
24 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 E. Upon submission of a claim by a practitioner, hospital, home
6 care agency, ~~or~~ ambulatory surgical center, or other health care
7 provider or facility that is licensed or certified by the state to
8 an insurer on a uniform health care claim form adopted by the
9 Insurance Commissioner pursuant to Section 6581 of this title, the
10 insurer shall provide a timely explanation of benefits to the
11 practitioner, hospital, home care agency, ~~or~~ ambulatory surgical
12 center, or other health care provider or facility that is licensed
13 or certified by the state regardless of the network participation
14 status of such person or entity.

15 F. Benefits available under an accident and health insurance
16 policy, at the option of the insured, shall be assignable to a
17 practitioner, hospital, home care agency, ~~or~~ ambulatory surgical
18 center, or other health care provider or facility that is licensed
19 or certified by the state who has provided services and procedures
20 which are covered under the policy. A practitioner, hospital, home
21 care agency, ~~or~~ ambulatory surgical center, or other health care
22 provider or facility that is licensed or certified by the state
23 shall be compensated directly by an insurer for services and
24

1 procedures which have been provided when the following conditions
2 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, or other health care provider
6 or facility that is licensed or certified by the state;

7 2. A copy of the assignment has been provided by the
8 practitioner, hospital, home care agency, ~~or~~ ambulatory surgical
9 center, or other health care provider or facility that is licensed
10 or certified by the state to the insurer;

11 3. A claim has been submitted by the practitioner, hospital,
12 home care agency, ~~or~~ ambulatory surgical center, or other health
13 care provider or facility that is licensed or certified by the state
14 to the insurer on a uniform health insurance claim form adopted by
15 the Insurance Commissioner pursuant to Section 6581 of this title;
16 and

17 4. A copy of the claim has been provided by the practitioner,
18 hospital, home care agency, ~~or~~ ambulatory surgical center, or other
19 health care provider or facility that is licensed or certified by
20 the state to the insured.

21 G. When any covered health care benefits are assigned to an
22 out-of-network practitioner, hospital, home care agency, ambulatory
23 surgical center, or other health care provider or facility that is
24 licensed or certified by the state, and have met all conditions for

1 compensation required by subsection F of this section, an insurer
2 that fails to compensate the practitioner, hospital, home care
3 agency, ambulatory surgical center, or other health care provider or
4 facility that is licensed or certified by the state shall be liable
5 for actual damages, any interest charges, court costs, or other
6 legal fees, if applicable. For any violation of this paragraph, the
7 Insurance Commissioner may, after notice and a hearing, subject an
8 insurer to an additional civil fine in an amount to be determined by
9 the Commissioner within fifteen (15) days of a hearing in which a
10 violation is found. The fine will be placed in the State Insurance
11 Commissioner Revolving Fund.

12 H. The provisions of subsection F of this section shall not
13 apply to:

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

19 2. Any statewide provider network which:

20 a. provides that a practitioner, hospital, home care
21 agency, ~~or~~ ambulatory surgical center, or other health
22 care provider or facility that is licensed or
23 certified by the state who joins the provider network
24 shall be compensated directly by the insurer,

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

16 The provisions of this section shall not be deemed to prohibit a
17 policyholder from assigning benefits available pursuant to an
18 accident and health insurance policy provided that the benefits of
19 such policy include out-of-network provisions and are being assigned
20 to an out-of-network practitioner, hospital, home care agency,
21 ambulatory surgical center, or other health care provider or
22 facility that is licensed or certified by the state. The
23 assignability of an accident and health insurance policy related to
24

1 out-of-network care shall only be subject to the terms and
2 conditions specified in subsection F of this section.

3 ~~H.~~ I. A nonparticipating practitioner, hospital or ambulatory
4 surgical center may request from an insurer and the insurer shall
5 supply a good-faith estimate of the allowable fee for a procedure to
6 be performed upon an insured based upon information regarding the
7 anticipated medical needs of the insured provided to the insurer by
8 the nonparticipating practitioner.

9 ~~I.~~ J. A practitioner shall be equally compensated for covered
10 services and procedures provided to an insured on the basis of
11 charges prevailing in the same geographical area or in similar sized
12 communities for similar services and procedures provided to
13 similarly ill or injured persons regardless of the branch of the
14 healing arts to which the practitioner may belong, if:

15 1. The practitioner does not authorize or permit false and
16 fraudulent advertising regarding the services and procedures
17 provided by the practitioner; and

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

20 ~~J.~~ K. Nothing in the Health Care Freedom of Choice Act shall
21 prohibit an insurer from establishing a preferred provider
22 organization and a standard participating provider contract
23 therefor, specifying the terms and conditions, including, but not
24 limited to, provider qualifications, and alternative levels or

1 methods of payment that must be met by a practitioner selected by
2 the insurer as a participating preferred provider organization
3 provider.

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

10 ~~L.~~ M. Decisions by an insurer or a preferred provider
11 organization (PPO) to authorize or deny coverage for an emergency
12 service shall be based on the patient presenting symptoms arising
13 from any injury, illness, or condition manifesting itself by acute
14 symptoms of sufficient severity, including severe pain, such that a
15 reasonable and prudent layperson could expect the absence of medical
16 attention to result in serious:

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

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

23 ~~N.~~ O. An insurer or a preferred provider organization (PPO)
24 shall compensate a provider for patient screening, evaluation, and

1 examination services that are reasonably calculated to assist the
2 provider in determining whether the condition of the patient
3 requires emergency service. If the provider determines that the
4 patient does not require emergency service, coverage for services
5 rendered subsequent to that determination shall be governed by the
6 policy or PPO contract.

7 ~~Θ. P.~~ P. Nothing in ~~this act~~ the Health Care Freedom of Choice Act
8 shall be construed as prohibiting an insurer, preferred provider
9 organization or other network from determining the adequacy of the
10 size of its network.

11 ~~P. Q.~~ Q. An insurer or a preferred provider organization shall not
12 unilaterally remove a provider from the network solely because the
13 provider informs an enrollee of the full range of physicians and
14 providers available to the enrollee, including out-of-network
15 providers. Nothing in ~~this act~~ the Health Care Freedom of Choice
16 Act prohibits any insurer from allowing a contract to expire by its
17 own terms or negotiating a new contract with the provider at the end
18 of the contract term. A provider agreement shall not, as a
19 condition of the agreement, prohibit, penalize, terminate, or
20 otherwise restrict a preferred provider from referring to an out-of-
21 network provider; provided, the insured signs an acknowledgment of
22 referral that the insured may be responsible for:

- 23 1. Higher coinsurance and deductibles; and

2. Charges which exceed the allowable charges of a preferred provider.

SECTION 3. This act shall become effective November 1, 2022."

Passed the Senate the 27th day of April, 2022.

Presiding Officer of the Senate

Passed the House of Representatives the ____ day of _____,
2022.

Presiding Officer of the House
of Representatives

1 ENGROSSED HOUSE
2 BILL NO. 2322

By: Frix and Sims of the House

3 and

4 Bullard of the Senate

5
6
7 [health insurance - requiring insurer failing to
8 pay assigned benefits claim to pay certain costs -
9 effective date]
10
11

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

13 SECTION 4. AMENDATORY 36 O.S. 2011, Section 3624, is
14 amended to read as follows:

15 Section 3624. Except as provided in ~~subsection D of~~ Section
16 6055 of this title, a policy may be assignable or not assignable, as
17 provided by its terms. Subject to its terms relating to
18 assignability, any life or accident and health policy, whether
19 heretofore or hereafter issued, under the terms of which the
20 beneficiary may be changed upon the sole request of the insured, may
21 be assigned either by pledge or transfer of title, by an assignment
22 executed by the insured alone and delivered to the insurer, whether
23 or not the pledgee or assignee is the insurer. Any such assignment
24 shall entitle the insurer to deal with the assignee as the owner or

pledgee of the policy in accordance with the terms of the assignment, until the insurer has received at its home office written notice of termination of the assignment or pledge, or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment.

SECTION 5. 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, 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,

- 1 b. if the policy has no deductible for treatment in a
2 preferred provider hospital or ambulatory surgical
3 center, the deductible for treatment in a hospital or
4 ambulatory surgical center that is not a preferred
5 provider shall not exceed One Thousand Dollars
6 (\$1,000.00) per covered-person visit,
- 7 c. the amount of any annual deductible per covered person
8 or per family treatment, other than inpatient
9 treatment, by a practitioner that is not a preferred
10 practitioner shall not exceed three times the amount
11 of a corresponding annual deductible for treatment,
12 other than inpatient treatment, by a preferred
13 practitioner,
- 14 d. if the policy has no deductible for treatment by a
15 preferred practitioner, the annual deductible for
16 treatment received from a practitioner that is not a
17 preferred practitioner shall not exceed Five Hundred
18 Dollars (\$500.00) per covered person,
- 19 e. the percentage amount of any coinsurance to be paid by
20 an insured to a practitioner, hospital or ambulatory
21 surgical center that is not a preferred provider shall
22 not exceed by more than thirty (30) percentage points
23 the percentage amount of any coinsurance payment to be
24 paid to a preferred provider.

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

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

8 a. higher coinsurance and deductibles, and

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

12 2. When a referral is made to a nonparticipating hospital or
13 ambulatory surgical center, the referring practitioner must disclose
14 in writing to the insured, any ownership interest in the
15 nonparticipating hospital or ambulatory surgical center.

16 E. Upon submission of a claim by a practitioner, hospital, home
17 care agency, or ambulatory surgical center to an insurer on a
18 uniform health care claim form adopted by the Insurance Commissioner
19 pursuant to Section 6581 of this title, the insurer shall provide a
20 timely explanation of benefits to the practitioner, hospital, home
21 care agency, or ambulatory surgical center regardless of the network
22 participation status of such person or entity.

23 F. Benefits available under an accident and health insurance
24 policy, at the option of the insured, shall be assignable to a

1 practitioner, hospital, home care agency or ambulatory surgical
2 center who has provided services and procedures which are covered
3 under the policy. A practitioner, hospital, home care agency or
4 ambulatory surgical center shall be compensated directly by an
5 insurer for services and procedures which have been provided when
6 the following conditions are met:

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

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

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

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

20 G. When any covered health care benefits are assigned to an
21 out-of-network practitioner, hospital, home care agency or
22 ambulatory surgical center and have met all conditions for
23 compensation required by subsection F of this section, an insurer
24 that fails to compensate the practitioner, hospital, home care

1 agency or ambulatory surgical center shall be liable for actual
2 damages, any interest charges, court costs or other legal fees, if
3 applicable. For any violation of this paragraph, the Insurance
4 Commissioner may, after notice and a hearing, subject an insurer to
5 an additional civil fine in an amount to be determined by the
6 Commissioner within fifteen (15) days of a hearing in which a
7 violation is found. The fine will be placed in the State Insurance
8 Commissioner Revolving Fund.

9 H. The provisions of subsection F of this section shall not
10 apply to:

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

16 2. Any statewide provider network which:

- 17 a. provides that a practitioner, hospital, home care
18 agency or ambulatory surgical center who joins the
19 provider network shall be compensated directly by the
20 insurer,
- 21 b. does not have any terms or conditions which have the
22 effect of discriminating against a particular class of
23 practitioner,

1 c. allows any practitioner, hospital, home care agency or
2 ambulatory surgical center, except a practitioner who
3 has a prior felony conviction, to become a network
4 provider if ~~said~~ the hospital or practitioner is
5 willing to comply with the terms and conditions of a
6 standard network provider contract, and

7 d. contracts with practitioners that agree to accept the
8 reimbursement available under the network agreement as
9 payment in full and agree not to balance bill the
10 insured.

11 ~~H.~~ The provisions of this section shall not be deemed to
12 prohibit a policyholder from assigning benefits available pursuant
13 to an accident and health insurance policy provided that the
14 benefits of such policy include out-of-network provisions and are
15 being assigned to an out-of-network practitioner, hospital, home
16 care agency or ambulatory surgical center. The assignability of an
17 accident and health insurance policy related to out-of-network care
18 shall only be subject to the terms and conditions specified in
19 subsection F of this section.

20 I. A nonparticipating practitioner, hospital or ambulatory
21 surgical center may request from an insurer and the insurer shall
22 supply a good-faith estimate of the allowable fee for a procedure to
23 be performed upon an insured based upon information regarding the
24

1 anticipated medical needs of the insured provided to the insurer by
2 the nonparticipating practitioner.

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

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

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

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

22 ~~K.~~ L. A preferred provider organization, in executing a
23 contract, shall not, by the terms and conditions of the contract or
24 internal protocol, discriminate within its network of practitioners

1 with respect to participation and reimbursement as it relates to any
2 practitioner who is acting within the scope of the practitioner's
3 license under the law solely on the basis of such license.

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

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

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

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

1 ~~Θ. P.~~ P. Nothing in ~~this act~~ the Health Care Freedom of Choice Act

2 shall be construed as prohibiting an insurer, preferred provider
3 organization or other network from determining the adequacy of the
4 size of its network.

5 ~~P. Q.~~ Q. An insurer or a preferred provider organization shall not
6 unilaterally remove a provider from the network solely because the
7 provider informs an enrollee of the full range of physicians and
8 providers available to the enrollee, including out-of-network
9 providers. Nothing in this act prohibits any insurer from allowing
10 a contract to expire by its own terms or negotiating a new contract
11 with the provider at the end of the contract term. A provider
12 agreement shall not, as a condition of the agreement, prohibit,
13 penalize, terminate, or otherwise restrict a preferred provider from
14 referring to an out-of-network provider; provided, the insured signs
15 an acknowledgment of referral that the insured may be responsible
16 for:

17 1. Higher coinsurance and deductibles; and

18 2. Charges which exceed the allowable charges of a preferred
19 provider.

20 SECTION 6. This act shall become effective November 1, 2022.

1 Passed the House of Representatives the 22nd day of March, 2022.

2
3 _____
4 Presiding Officer of the House
of Representatives

5 Passed the Senate the ____ day of _____, 2022.

6
7 _____
8 Presiding Officer of the Senate