

STATE OF OKLAHOMA

1st Session of the 58th Legislature (2021)

COMMITTEE SUBSTITUTE
FOR

HOUSE BILL NO. 2323

By: Frix

COMMITTEE SUBSTITUTE

An Act relating to insurance; amending 36 O.S. 2011, Section 6055, which relates to health insurance; prohibiting certain health insurers from removing provider from a network for certain reasons; providing prohibition shall not apply to certain contract expirations; prohibiting restrictions on out-of-network referrals; requiring certain signed acknowledgement; and providing an effective date.

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

SECTION 1. 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

1 procedures fall within the licensed scope of practice of the
2 practitioner providing the same.

3 B. An accident and health insurance policy may:

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

12 a. be medically necessary,

13 b. be of proven efficacy, and

14 c. fall within the licensed scope of practice of the
15 practitioner providing same; and

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

21 C. 1. Paragraph 2 of subsection B of this section shall not be
22 construed to prohibit differences in cost-sharing provisions such as
23 deductibles and copayment provisions between practitioners,
24 hospitals and ambulatory surgical centers who are participating

1 preferred provider organization providers and practitioners,
2 hospitals and ambulatory surgical centers who are not participating
3 in the preferred provider organization, subject to the following
4 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,

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.

23 2. When a referral is made to a nonparticipating hospital or
24 ambulatory surgical center, the referring practitioner must disclose

1 in writing to the insured, any ownership interest in the
2 nonparticipating hospital or ambulatory surgical center.

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

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

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

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

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

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

8 G. The provisions of subsection F of this section shall not
9 apply to:

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

15 2. Any statewide provider network which:

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

1 has a prior felony conviction, to become a network
2 provider if said hospital or practitioner is willing
3 to comply with the terms and conditions of a standard
4 network provider contract, and

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

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

15 I. A practitioner shall be equally compensated for covered
16 services and procedures provided to an insured on the basis of
17 charges prevailing in the same geographical area or in similar sized
18 communities for similar services and procedures provided to
19 similarly ill or injured persons regardless of the branch of the
20 healing arts to which the practitioner may belong, if:

21 1. The practitioner does not authorize or permit false and
22 fraudulent advertising regarding the services and procedures
23 provided by the practitioner; and
24

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

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

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

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

24 1. Jeopardy to the health of the patient;

1 2. Impairment of bodily function; or

2 3. Dysfunction of any bodily organ or part.

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

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

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

17 P. An insurer or a preferred provider organization shall not
18 unilaterally remove a provider from the network, solely because the
19 provider informs an enrollee of the full range of physicians and
20 providers available to the enrollee, including out-of-network
21 providers. Nothing in this Act prohibits any insurer from allowing
22 a contract to expire by its own terms or negotiating a new contract
23 with the provider at the end of the contract term. A provider
24 agreement shall not, as a condition of the agreement, prohibit,

1 penalize, terminate, or otherwise restrict a preferred provider from
2 referring to an out-of-network provider, provided the insured signs
3 an acknowledgment of referral that the insured may be responsible
4 for:

- 5 1. higher coinsurance and deductibles, and
- 6 2. charges which exceed the allowable charges of a preferred
7 provider.

8 SECTION 2. This act shall become effective November 1, 2021.

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