

STATE OF OKLAHOMA

2nd Session of the 58th Legislature (2022)

COMMITTEE SUBSTITUTE
FOR ENGROSSED
HOUSE BILL 2322

By: Frix and Sims of the House

and

Bullard of the Senate

COMMITTEE SUBSTITUTE

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

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

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

Section 3624. Except as provided in ~~subsection D of~~ Section
6055 of this title, a policy may be assignable or not assignable, as
provided by its terms. Subject to its terms relating to
assignability, any life or accident and health policy, whether
heretofore or hereafter issued, under the terms of which the
beneficiary may be changed upon the sole request of the insured, may
be assigned either by pledge or transfer of title, by an assignment
executed by the insured alone and delivered to the insurer, whether
or not the pledgee or assignee is the insurer. Any such assignment
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 2. AMENDATORY 36 O.S. 2021, 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, home care agencies, or other health care providers or facilities that are licensed or certified by the state who are participating preferred provider organization providers and practitioners, hospitals, ~~and~~ ambulatory surgical centers, home care agencies, or other health care providers or facilities that are licensed or certified by the state 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

1 corresponding annual deductible for treatment in a
2 hospital or ambulatory surgical center that is a
3 preferred provider,

4 b. if the policy has no deductible for treatment in a
5 preferred provider hospital or ambulatory surgical
6 center, the deductible for treatment in a hospital or
7 ambulatory surgical center that is not a preferred
8 provider shall not exceed One Thousand Dollars
9 (\$1,000.00) per covered-person visit,

10 c. the amount of any annual deductible per covered person
11 or per family treatment, other than inpatient
12 treatment, by a practitioner that is not a preferred
13 practitioner shall not exceed three times the amount
14 of a corresponding annual deductible for treatment,
15 other than inpatient treatment, by a preferred
16 practitioner,

17 d. if the policy has no deductible for treatment by a
18 preferred practitioner, the annual deductible for
19 treatment received from a practitioner that is not a
20 preferred practitioner shall not exceed Five Hundred
21 Dollars (\$500.00) per covered person, and

22 e. the percentage amount of any coinsurance to be paid by
23 an insured to a practitioner, hospital or ambulatory
24 surgical center that is not a preferred provider shall

1 not exceed by more than thirty (30) percentage points
2 the percentage amount of any coinsurance payment to be
3 paid to a preferred provider.

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

8 D. 1. A practitioner, hospital, ~~or~~ ambulatory surgical center,
9 home care agency, or other health care providers or facilities that
10 are licensed or certified by the state that is not a preferred
11 provider shall disclose to the insured, in writing, that the insured
12 may be responsible for:

- 13 a. higher coinsurance and deductibles, and
- 14 b. practitioner, hospital or ambulatory surgical center
15 charges which exceed the allowable charges of a
16 preferred provider.

17 2. When a referral is made to a nonparticipating hospital or
18 ambulatory surgical center, the referring practitioner must disclose
19 in writing to the insured, any ownership interest in the
20 nonparticipating hospital or ambulatory surgical center.

21 E. Upon submission of a claim by a practitioner, hospital, home
22 care agency, ~~or~~ ambulatory surgical center, or other health care
23 provider or facility that is licensed or certified by the state to
24 an insurer on a uniform health care claim form adopted by the

1 Insurance Commissioner pursuant to Section 6581 of this title, the
2 insurer shall provide a timely explanation of benefits to the
3 practitioner, hospital, home care agency, ~~or~~ ambulatory surgical
4 center, or other health care provider or facility that is licensed
5 or certified by the state regardless of the network participation
6 status of such person or entity.

7 F. Benefits available under an accident and health insurance
8 policy, at the option of the insured, shall be assignable to a
9 practitioner, hospital, home care agency, ~~or~~ ambulatory surgical
10 center, or other health care provider or facility that is licensed
11 or certified by the state who has provided services and procedures
12 which are covered under the policy. A practitioner, hospital, home
13 care agency, ~~or~~ ambulatory surgical center, or other health care
14 provider or facility that is licensed or certified by the state
15 shall be compensated directly by an insurer for services and
16 procedures which have been provided when the following conditions
17 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, or other health care provider
21 or facility that is licensed or certified by the state;

22 2. A copy of the assignment has been provided by the
23 practitioner, hospital, home care agency, ~~or~~ ambulatory surgical
24

1 center, or other health care provider or facility that is licensed
2 or certified by the state to the insurer;

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

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

13 G. When any covered health care benefits are assigned to an
14 out-of-network practitioner, hospital, home care agency, ambulatory
15 surgical center, or other health care provider or facility that is
16 licensed or certified by the state, and have met all conditions for
17 compensation required by subsection F of this section, an insurer
18 that fails to compensate the practitioner, hospital, home care
19 agency, ambulatory surgical center, or other health care provider or
20 facility that is licensed or certified by the state shall be liable
21 for actual damages, any interest charges, court costs, or 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 to an additional civil fine in an amount to be determined by

1 the Commissioner within fifteen (15) days of a hearing in which a
2 violation is found. The fine will be placed in the State Insurance
3 Commissioner Revolving Fund.

4 H. The provisions of subsection F of this section shall not
5 apply to:

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

11 2. Any statewide provider network which:

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

1 ~~said~~ the hospital or practitioner is willing to comply
2 with the terms and conditions of a standard network
3 provider contract, and

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

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

18 ~~H.~~ I. 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.~~ J. 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.~~ K. 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.~~ L. A preferred provider organization, in executing a
21 contract, shall not, by the terms and conditions of the contract or
22 internal protocol, discriminate within its network of practitioners
23 with 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.~~ M. Decisions by an insurer or a preferred provider
4 organization (PPO) to authorize or deny coverage for an emergency
5 service shall be based on the patient presenting symptoms arising
6 from any injury, illness, or condition manifesting itself by acute
7 symptoms of sufficient severity, including severe pain, such that a
8 reasonable and prudent layperson could expect the absence of medical
9 attention 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.~~ N. 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.~~ O. An insurer or a preferred provider organization (PPO)
17 shall 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.

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~~ the Health Care Freedom of Choice

10 Act prohibits any insurer from allowing a contract to expire by its
11 own terms or negotiating a new contract with the provider at the end
12 of the contract term. A provider agreement shall not, as a
13 condition of the agreement, prohibit, penalize, terminate, or
14 otherwise restrict a preferred provider from referring to an out-of-
15 network provider; provided, the insured signs an acknowledgment of
16 referral that the insured may be responsible for:

17 1. Higher coinsurance and deductibles; and

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

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

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