

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

13 SECTION 1. 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 2. 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 3. This act shall become effective November 1, 2022.  
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1 Passed the House of Representatives the 22nd day of March, 2022.

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4 Presiding Officer of the House  
of Representatives

5 Passed the Senate the \_\_\_\_ day of \_\_\_\_\_, 2022.

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8 Presiding Officer of the Senate