

1 **SENATE FLOOR VERSION**

February 14, 2023

2 **AS AMENDED**

3 SENATE BILL NO. 438

By: Montgomery

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6 **[Health Care Freedom of Choice Act - policies -
effective date]**

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

10 SECTION 1. AMENDATORY 36 O.S. 2021, Section 6055, is
11 amended to read as follows:

12 Section 6055. A. Under any accident and health insurance
13 policy, hereafter renewed or issued for delivery from out of
14 Oklahoma or in Oklahoma by any insurer and covering an Oklahoma
15 risk, the services and procedures may be performed by any
16 practitioner selected by the insured, or the parent or guardian of
17 the insured if the insured is a minor, if the services and
18 procedures fall within the licensed scope of practice of the
19 practitioner providing the same.

20 B. An accident and health insurance policy may:

21 1. Exclude or limit coverage for a particular illness, disease,
22 injury or condition; but, except for such exclusions or limits,
23 shall not exclude or limit particular services or procedures that
24 can be provided for the diagnosis and treatment of a covered

1 illness, disease, injury or condition, if such exclusion or
2 limitation has the effect of discriminating against a particular
3 class of practitioner. Any copay or reimbursement for services,
4 treatments, or procedures under this subsection shall not
5 discriminate against a particular class of practitioner. However,
6 such services and procedures, in order to be a covered medical
7 expense, must:

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

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

17 C. 1. Paragraph 2 of subsection B of this section shall not be
18 construed to prohibit differences in cost-sharing provisions such as
19 deductibles and copayment provisions between practitioners,
20 hospitals and ambulatory surgical centers who are participating
21 preferred provider organization providers and practitioners,
22 hospitals and ambulatory surgical centers who are not participating
23 in the preferred provider organization, subject to the following
24 limitations:

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

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

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

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

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

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

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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. The provisions of subsection F of this section shall not
7 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 hospital or practitioner is willing

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

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

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

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

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

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

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

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

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

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

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

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

1 an acknowledgment of referral that the insured may be responsible
2 for:

- 3 1. Higher coinsurance and deductibles; and
- 4 2. Charges which exceed the allowable charges of a preferred
5 provider.

6 SECTION 2. This act shall become effective November 1, 2023.

7 COMMITTEE REPORT BY: COMMITTEE ON RETIREMENT AND INSURANCE
8 February 14, 2023 - DO PASS AS AMENDED
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