SHORT TITLE: Public health; relating to regulation of certain health care plans; requiring certain rules for geographic service variation and point of service plans; prohibiting operation as a preferred provider organization unless licensed by State Department of Health; codification; effective date.

STATE OF OKLAHOMA

2nd Session of the 44th Legislature (1994)

SENATE BILL NO. 1178 By: Monson

AS INTRODUCED

An Act relating to public health; amending 63 O.S. 1991, Sections 2503 and 2507, as amended by Sections 3 and 7, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1993, Sections 2503 and 2507), which relate to regulation of certain health care plans; modifying and adding definitions; requiring rule for geographic service variation provide for certain referrals; requiring State Board of Health provide by rule requirements for point of service plans to achieve certain purposes with certain limitations and requiring rule address certain issues; defining terms; prohibiting operation as a preferred provider organization unless licensed by State Department of Health; providing for application for license and renewal and related procedures; requiring notification of certain changes; authorizing State Commissioner of Health make certain examination or investigation and requiring certain visit; requiring issuance of license if certain conditions are met; authorizing PPOs to contract on certain bases and with certain entities; authorizing enrollees to obtain services from nonparticipating providers and providing for payment; authorizing participation of nonparticipating providers with certain restrictions; allowing PPO to use primary care

gatekeeper without being licensed as a health maintenance organization if certain requirements and standards are met; requiring certain disclosure and approval; prohibiting certain acts; providing for suspension and revocation of PPO license for certain findings; prohibiting certain acts if license is suspended or revoked; requiring promulgation of certain rules; making actions subject to Administrative Procedures Act; providing for deposit of fees; providing administrative penalties and requiring consideration of certain factors in determining amount of penalty; providing for codification; and providing an effective date.

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

SECTION 1. AMENDATORY 63 O.S. 1991, Section 2503, as amended by Section 3, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1993, Section 2503), is amended to read as follows:

Section 2503. As used in Section 2501 et seq. of this title:

1. "Health maintenance organization" means any organization, subject to the provisions of Section 2501 et seq. of this title, organized pursuant to the laws of this state, or the laws of another state or the District of Columbia, which provides, either directly or through arrangements with others, comprehensive health services to members enrolled with the organization on a fixed prepayment basis;

2. "Enrollee" means a person who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into, with a health maintenance organization or prepaid health plan for comprehensive health services;

3. "Person" includes but is not limited to individuals, partnerships, associations, corporations, or other public or private legal entities;

4. "Agent" means a person associated with a health maintenance organization and who engages in solicitation;

5. "Department" means the ~~Oklahoma~~ State Department of Health;

6. "Comprehensive health services" includes but is not limited to allopathic, osteopathic, chiropractic, podiatric, optometric, psychological, outpatient diagnostic and treatment, inpatient hospital, short-term rehabilitation and physical therapy, medically necessary emergency, short-term outpatient mental health, substance abuse diagnostic and medical treatment, home health, and preventive health services; ~~and~~

7. a. "Prepaid health plan" means any organization, subject to the provisions of Section 2501 et seq. of this title, organized pursuant to the laws of this state, or the laws of another state or the District of Columbia, which provides, either directly, or through arrangements with others, or through reimbursement of claims, comprehensive health services to members enrolled with the plan on a fixed prepayment basis.

b. As used in this paragraph, "reimbursement of claims" means that a prepaid health plan may make provisions for ~~reimbursements to members who receive covered services through noncontracting providers and may make provisions for~~ payments to noncontracting providers for covered services rendered to members~~. A prepaid health plan may impose supplementary deductibles and copayments for covered services rendered through noncontracting providers in order to cover the costs of such services and to encourage members to use contracting providers~~; and

8. "Point of service plan" means a product of a health maintenance organization which includes an option for the use of out-of-network providers.

SECTION 2. AMENDATORY 63 O.S. 1991, Section 2507, as amended by Section 7, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1993, Section 2507), is amended to read as follows:

Section 2507. A. Comprehensive health services as herein provided may be furnished to enrollees of health maintenance organizations outside this state only in accordance with the laws of the state or of the United States which govern the provisions of such services in the state or place concerned; provided, that an enrollee may be reimbursed directly for emergency health care expenses incurred by him while temporarily outside the state, when such expenses would have been provided under the enrollee's program had he been within the state. Such reimbursement made by a health maintenance organization shall not be construed as an indemnity and no health maintenance organization shall be an insurer or make any contract of insurance of any kind whatsoever.

B. 1. The State Board of Health shall provide by rule the requirements for claims reimbursements by a prepaid health plan for health care services rendered by professionals or facilities not covered under an agreement with the managed care organization, whether those providers are located inside or outside the state.

2. The State Board of Health also shall provide by rule for geographic service area variations which ~~remit~~ permit prepaid health plans to enroll persons who ~~desire to become members but who do not~~ reside in an area where contracting primary and emergency care providers are available and accessible ~~within~~ with reasonable promptness, but where the unavailability of providers will necessitate referral of the person outside the service area to obtain the balance of comprehensive health services.

3. Prepaid health plans may reimburse out-of-state providers for services received by Title XIX enrollees at the medicaid fee-for-service rates in effect in this state or the rates in effect in the state in which care was rendered, whichever are lower.

C. 1. The State Board of Health shall provide by rule the requirements for point of service plans to be offered by duly licensed health maintenance organizations in order to expand the availability of comprehensive health services to employer groups who are interested in the health maintenance organization product but who do not want to restrict their employees' freedom of choice of provider to the extent required by a traditional health maintenance organization. The rules shall address member usage of noncontracting providers, the increased financial risk associated with a point of service plan, protection of the continuity of care, assurance of adequate disclosure of limitations and conditions, and such other requirements as the Board deems necessary to ensure the protection of health maintenance organization members and the financial solvency of the health maintenance organization.

2. These rules also shall require the health maintenance organization to design the point of service plan so that the member's selection of an out-of-network provider results in out-of-pocket expenses to the member for copayments, deductibles or coinsurance, or results in other limitations which give the member reasonable incentive to use the health maintenance organization's contracting providers. The point of service plan incentives and the health maintenance organization's marketing and enrolling practices must be structured to ensure that the primary business of the health maintenance organization shall remain one of providing and financing comprehensive health services through the health maintenance organization's own organized health service delivery system and primary care physician network.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2531 of Title 63, unless there is created a duplication in numbering, reads as follows:

As used in Sections 3 through 6 of this act:

1. "Capitation" means the practice of prepaying a participating provider or a group of participating providers for the health care services of a defined population on a per capita basis;

2. "Department" means the State Department of Health;

3. "Enrollee" means an individual who is covered by a PPO;

4. "Exclusive provider organization" means a managed care plan organized as an insurer that provides access to nonemergency covered health care services only through a contracted panel of participating providers, whose reimbursement includes prepayment, withholds, capitation, or other risk-sharing arrangements;

5. "Gatekeeper" means a primary care physician selected by an enrollee from among a list of participating primary care physicians from whom the enrollee receives, as a condition for receipt of a higher level of benefits or reimbursement level, or both, referrals for nonemergency specialty, hospital and other services;

6. "Health maintenance organization" or "HMO" means an organization licensed by the State Department of Health pursuant to Section 2501 et seq. of Title 63 of the Oklahoma Statutes;

7. "Insurer" means an entity licensed or subject to licensure under Title 36 of the Oklahoma Statutes, and includes any nonprofit hospital service and medical indemnity corporation;

8. "Participating provider" or "network provider" means a physician or other health care provider, or a group of physicians or health care providers, or a medical facility, program, or agency that has a contractual arrangement with a PPO to provide specified covered health care services to enrollees;

9. "Passive gatekeeper product" means a product offered by a plan which does not require an enrollee to preselect a particular

primary care physician but requires, as a condition for receipt of a higher level of benefits or reimbursement level, or both, that an enrollee receive care from, or a referral from, a participating preferred primary care physician;

10. "Person" includes associations, trusts, partnerships or corporations;

11. "Preferred provider organization" or "PPO" means a preferred provider contract, organization, plan, or arrangement, or a type of health plan that is offered by an insurer or any other person, in which:

a. there is no transfer of insurance risk to health care providers through capitated payment arrangements, fee withholds, bonuses, or other risk-sharing arrangements,

b. health care services are provided by a network of contract health care providers who are paid on negotiated or discounted fee-for-service bases, and

c. either or both of the following features are present:

(1) utilization management and quality management programs are employed to manage the providing of health care services, or

(2) covered individuals are given incentives to limit their use of health care services to network providers;

12. "Primary care physician" means a physician duly licensed to practice medicine in the fields of general and family practice, general internal medicine, pediatrics, or obstetrics and gynecology;

13. "Quality assurance" means a program of reviews, studies, evaluations, and other activities used by an HMO for the purpose of monitoring and enhancing quality of health care and services provided to enrollees;

14. "Utilization management" means those methodologies used by PPOs in conjunction with utilization review organizations to improve the quality and maximize the efficiency of the health care delivery system; and

15. "Withholds" as a noun, means the contractual practice of withholding a portion of a provider's claim reimbursement, or the setting aside of a predetermined percentage of premium income that eventually may be payable to a provider based upon a predetermined set of utilization review performance standards or claims dollar volumes.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2532 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. No person shall act as, offer to act as, or hold itself out as a preferred provider organization, hereinafter PPO, without holding a valid PPO license issued by the State Department of Health.

B. 1. Each application for the issuance or renewal of a PPO license shall be made on a form prescribed by the Department, and shall include such information as the Department requires to determine the applicant's compliance with this act.

2. A duly licensed PPO shall file a notice with the Department in a timely manner describing any significant modification of information previously filed with the Department, and shall promptly notify the Department of any significant changes in the provider arrangement that would impair the PPO's ability to arrange for the delivery of health care services.

3. A PPO license must be renewed annually. The request for renewal shall be made on a form approved by the Department. The Department shall renew the license upon determining that the PPO continues to be in compliance with the applicable statutes and rules of this state.

C. 1. Before issuing any license, the State Commissioner of Health may make such examinations or investigations as deemed necessary. Provided, a site visit shall be conducted before the approval of a PPO license and scheduled within forty-five (45) days after the receipt of the license application.

2. The Commissioner shall issue a PPO license upon receiving sufficient information that the PPO will operate in compliance with the applicable statutes and rules of this state and upon being satisfied that the PPO will meet the minimum solvency requirements established by rule by the State Board of Health.

D. PPOs may contract with providers on fee-for-service or discounted fee-for-service bases for the provision of health care services, and may also contract with:

1. Any person or any licensed insurer for the provision of health care benefits; or

2. A self-insured single employer, or an employee benefit plan preempted from state insurance regulation by the Employee Retirement Income Security Act of 1974, as amended, for the provision of health care benefits to its employees and dependents; or

3. Any person for the performance, on the PPO's behalf, of functions such as marketing, management information systems, quality assurance and utilization review, and other similar services. However, if a PPO subcontracts any element of its business to a third party, the PPO is responsible for regular monitoring of the delegated responsibilities and the regulatory compliance of its total operations.

E. 1. An individual enrolled in a preferred provider plan may obtain covered health care services from a provider not participating in the plan.

2. Preferred provider policies or contracts offered pursuant to this section shall provide for payment for services rendered by nonparticipating providers. Except as provided in this act or by

rule promulgated pursuant thereto, such payment may differ from that provided to participating providers in the discretion of the PPO.

3. Nonparticipating providers may participate in other arrangements with the preferred provider, but will be subject to the provider's approved reimbursement mechanisms including, but not limited to, direct payment of health insurance benefits to the subscriber without right of assignment to the provider of health care services.

F. The use of a primary care gatekeeper is a feature associated with health maintenance organizations. A PPO using a primary care gatekeeper feature, otherwise meeting the requirements of this section, will not be considered an HMO by the Department or be required to obtain an HMO license prior to commencement of operations if it meets the following standards:

1. Preferred primary care physicians are reimbursed solely on a fee-for-service basis;

2. Preferred primary care physicians are not placed at financial risk for the level or volume of health services used by enrollees through use of withholds or other means of financial reward for utilization control; and

3. The PPO is not an exclusive provider organization.

G. A PPO will be permitted to utilize primary care gatekeepers which are capitated or at financial risk, or both, if the primary care gatekeeper services are being offered under a subcontract between the PPO and an affiliated licensed HMO, if:

1. The provisions of the contract are reviewed and accepted by the Department; and

2. The HMO's quality assurance systems and similar consumer protection measures are extended to the PPO enrollees in a manner found acceptable by the Department.

H. Passive gatekeeper products are permissible if their restrictions are adequately disclosed to enrollees. The PPO must

obtain Department approval of the passive gatekeeper products prior to their marketing or use.

I. 1. No PPO or its representatives shall cause or knowingly permit the use of advertising that is untrue or misleading or any solicitation that is untrue or misleading. For the purposes of this section, a statement or item of information is untrue if it does not conform to fact in any respect that is or may be significant to an individual considering contracting with the PPO.

2. No PPO may use in its name, contract, or literature any of the words "health maintenance organization", "HMO", "HMO-like", "capitation", "withholds", "prepaid", or any other of the words descriptive of a health maintenance organization or prepaid health plan or deceptively similar to the name or business of a health maintenance organization or prepaid health plan.

3. No PPO may hold itself out or represent itself as being an insurer.

J. 1. The Department may suspend or revoke a PPO license if the Commissioner finds that a PPO:

a. is being operated by an insolvent insurer,

b. is using such methods and practices in the conduct of its business as to render its further transaction of business in this state hazardous or injurious to its participants or to the public,

c. is operating in violation of any applicable statutes or rules of this state, or has violated any lawful order of the Department, or

d. has refused to produce materials or files for examination by the Department under the provisions of this act.

2. After a license is suspended or revoked, the PPO shall not contract to cover or serve any additional groups or individuals, except newborn children or other newly acquired dependents of

existing covered employees or spouses of participating employee groups, and shall not engage in any sales, marketing or soliciting activities for a PPO.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2533 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The State Board of Health shall promulgate rules as necessary to effectuate the purposes of this act, to protect the public and to ensure the sound, proper and efficient operation of PPOs in this state; and shall fix by rule and collect license fees for the operation of PPOs. All actions of the Board and the State Department of Health shall be subject to the provisions of the Administrative Procedures Act. License fees collected shall be deposited in the Public Health Special Fund, created by Section 1-107 of Title 63 of the Oklahoma Statutes.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2534 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Any person who has been determined by the State Department of Health to have violated any provision of this act, or any rule or order issued pursuant to the provisions of this act, may be liable for an administrative penalty of not less than One Hundred Dollars ($100.00) nor more than One Thousand Dollars ($1,000.00), per occurrence of the violation. Willful violations, after notice and hearing, may subject the person to an administrative penalty of not less than One Hundred Dollars ($100.00) nor more than Five Thousand Dollars ($5,000.00).

B. The amount of any penalty shall be assessed by the Department only after notice and hearing and subject to appeal pursuant to Article II of the Administrative Procedures Act. In determining the amount of the penalty, the Department shall include, but not be limited to, consideration of:

1. The nature, circumstances and gravity of the violation;

2. The repetitive nature of the violation;

3. The previous degree of difficulty in obtaining compliance with the rules; and

4. With respect to the person found to have committed the violation:

a. the degree of culpability,

b. the effect on ability of the person to continue to do business, and

c. any show of good faith in attempting to achieve compliance with this act.

SECTION 7. This act shall become effective September 1, 1994.

44-2-1677 JY