ENGROSSED HOUSE
BILL NO. 1940

By: Crocker and Glover of the House

and

Stipe of the Senate

(public health - Managed Health Care Standards and Patient Protection Act - amending 12 sections in Title 63 - health maintenance organizations - effective date)

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

SECTION 1. AMENDATORY 63 O.S. 1991, Section 2501, as amended by Section 1, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1994, Section 2501), is amended to read as follows:

Section 2501. A. Sections 2501 through 2512 of this title shall be known and may be cited as the "Managed Health Care Standards and Patient Protection Act".

B. It is the purpose and intent of the Legislature to promote and protect the public health, to promote a wider distribution of health care services, and to maintain the standards and promote the progress of providing alternative delivery systems of managed health care, such as prepaid health care, including comprehensive medically necessary managed care services ~~and~~, comprehensive health maintenance services and other managed health care arrangements in this state.

1. While it is the intent of this act to provide an opportunity for the development of prepaid health plans and health maintenance organizations, there is no intention to impair the present system of delivery of health services. It shall be the policy of this state to eliminate unnecessary legal barriers to the organization, promoting and expansion of alternative delivery systems of comprehensive prepaid health care.

2. Managed health care plans utilizing a variety of managed care techniques that include and affect decisions regarding coverage, appropriateness and quality of health care have become a significant and growing part of Oklahoma's health care delivery system. It is therefore incumbent upon the state to establish and enforce standards for managed health care plans that provide for patient protection and physician, provider and health plan fairness and for quality assurance, and the utilization review of services provided by managed health care plans.

SECTION 2. AMENDATORY 63 O.S. 1991, Section 2502, as amended by Section 2, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1994, Section 2502), is amended to read as follows:

Section 2502. Notwithstanding any law to the contrary, in accordance with the provisions of the Managed Health Care Standards and Patient Protection Act, any person may organize and operate a managed health care plan, including but not limited to a health maintenance organization or a prepaid health plan which provides comprehensive health services to enrollees who have become subscribers to said health maintenance organization or prepaid health plan pursuant to a contract entitling each enrollee to comprehensive health services on a prepaid, capitated basis.

SECTION 3. AMENDATORY 63 O.S. 1991, Section 2503, as amended by Section 3, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1994, Section 2503), is amended to read as follows:

Section 2503. As used in ~~Section 2501 et seq. of this title~~ the Managed Health Care Standards and Patient Protection Act:

1. "Managed health care plan" means any organization or entity, including but not limited to health maintenance organizations and prepaid health plans, that offers or provides health care services or contracts with health care providers to provide health care services to covered or enrolled individuals through a system of care that:

a. integrates the financing and delivery of appropriate health care services to said individuals through contracts or other arrangements with selected health care providers to furnish a specified set of health services, which may be comprehensive health services, to said individuals,

b. has explicit standards for the selection of health care providers, formal programs for ongoing quality assurance and utilization review, and

c. establishes significant financial incentives for covered or enrolled individuals to use health care providers and procedures associated with the managed health care plan;

2. "Health maintenance organization" means any organization, subject to the provisions of ~~Section 2501 et seq. of this title~~ the Managed Health Care Standards and Patient Protection Act, 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.~~ 3. "Enrollee" means a person who has entered into a contractual arrangement, or on whose behalf a contractual arrangement has been entered into, with a managed health care plan,

a health maintenance organization or prepaid health plan for comprehensive health services;

~~3.~~ 4. "Person" includes but is not limited to individuals, partnerships, associations, corporations, or other public or private legal entities;

~~4.~~ 5. "Agent" means a person associated with a managed health ~~maintenance organization~~ care plan and who engages in solicitation;

~~5.~~ 6. "Department" means the Oklahoma State Department of Health;

~~6.~~ 7. "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.~~ 8. 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

9. "Behavioral health care services" means screening, evaluation, diagnostic and treatment services for mental or emotional illness or for drug or alcohol abuse or addiction.

SECTION 4. AMENDATORY 63 O.S. 1991, Section 2504, as amended by Section 4, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1994, Section 2504), is amended to read as follows:

Section 2504. A. Upon compliance with the provisions of ~~Section 2501 et seq. of this title~~ the Managed Health Care Standards and Patient Protection Act, any organization, association, or corporation, public or private, ~~may~~ shall be licensed by the State Department of Health to organize, operate and maintain a ~~health maintenance organization or a prepaid~~ managed health care plan for its duly enrolled members and their dependents in this state.

B. Prior to the issuing of any license to a health maintenance organization or a prepaid health plan, the State Department of Health shall forward one copy of the application to the Insurance Commissioner, who shall be required within thirty (30) days to review said application with regard to the provisions in the application for fiscal responsibility and fiducial integrity, and make recommendations to the Department. If a response is not received from the Insurance Commissioner within thirty (30) days, the Department may proceed to make a determination upon the application as submitted. The Insurance Commissioner, after notice and hearing, may promulgate such reasonable rules as are necessary to provide for the licensing of agents.

C. The Department shall annually determine if each ~~health maintenance organization or prepaid~~ managed health care plan has complied with all requirements set forth in this section and in any

rules promulgated pursuant to ~~Section 2501 et seq. of this title~~ the Managed Health Care Standards and Patient Protection Act. Every ~~health maintenance organization and prepaid~~ managed health care plan may be relicensed, annually, upon compliance with the provisions of ~~Section 2501 et seq. of this title~~ the Managed Health Care Standards and Patient Protection Act and any regulations promulgated pursuant to the provisions of ~~Section 2501 et seq. of this title~~ the Managed Health Care Standards and Patient Protection Act. ~~Enrollment~~ Except as provided by the Oklahoma Medicaid Healthcare Options Act, enrollment in any such organization or plan shall be voluntary only.

~~B. A license from the Department shall not be required for any prepaid health plan duly licensed as an insurer by the Insurance Commissioner pursuant to Title 36 of the Oklahoma Statutes~~

D. The Commissioner of Health shall consult and coordinate with the Insurance Commissioner for the purpose of ensuring that, to the extent reasonable and practical, there is no contradiction or conflict between the rules promulgated by the State Board of Health for the implementation of the Managed Health Care Standards and Patient Protection Act and the rules of the Insurance Department that apply to health insurers required to be licensed by the Insurance Department and who offer or provide managed health care plans. Nothing in this subsection shall be construed to prevent a person, other than a health maintenance organization, from electing to apply for and obtain separate licenses as an insurer under Title 36 of the Oklahoma Statutes and as a ~~prepaid~~ managed health care plan under ~~Section 2501 et seq. of this title~~ the Managed Health Care Standards and Patient Protection Act.

~~C.~~ E. Each application or reapplication for a license or annual license renewal pursuant to the provisions of this section shall be accompanied by an application fee of Five Thousand Dollars ($5,000.00).

SECTION 5. AMENDATORY 63 O.S. 1991, Section 2505, as amended by Section 5, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1994, Section 2505), is amended to read as follows:

Section 2505. ~~Health~~ Managed health care plans shall provide services and health maintenance organizations and prepaid health plans shall provide comprehensive health services directly or by contract or agreement with other persons, corporations, institutions, associations, foundations or other legal entities, public or private, the services required of it in accordance with this act and the laws governing such professions and services. Such organizations and plans may contract or agree with other persons to provide actuarial, underwriting, marketing, billing, fiscal, and other services as may be required for the operation of a health maintenance organization or prepaid health plan. Health maintenance organizations and prepaid health plans may contract to provide certain selected comprehensive health services for organizations or corporations which provide certain other comprehensive health services to their members or employees through alternative health care plans. A health maintenance organization or prepaid health plan shall not engage in the practice of medicine or any other profession except as provided by law. A health maintenance organization or prepaid health plan may adjust its prepaid premium to permit financial risk-sharing with other organizations or corporations which contract with the health maintenance organization or prepaid health plan to provide such selected services.

SECTION 6. AMENDATORY 63 O.S. 1991, Section 2506, as amended by Section 6, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1994, Section 2506), is amended to read as follows:

Section 2506. ~~Health maintenance organizations and prepaid~~ Managed health care plans may provide any services included in state or federal health care programs, such as state employees benefits, the state basic health benefits program, "Medicare," "Medicaid,"

"Champus" and Veterans Administrations and other health programs provided in whole or in part by state or federal funds, in accordance with the state and federal laws and agency rules governing such programs.

SECTION 7. AMENDATORY 63 O.S. 1991, Section 2507, as amended by Section 7, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1994, Section 2507), is amended to read as follows:

Section 2507. A. ~~Comprehensive~~ Managed health care services as herein provided may be furnished to enrollees of managed health ~~maintenance organizations~~ care plans 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 in a managed health care plan in this state 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 managed health ~~maintenance organization~~ care plan shall not be construed as an indemnity ~~and no~~. 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 health care ~~organization~~ plan, 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 reasonable promptness.

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.

SECTION 8. AMENDATORY 63 O.S. 1991, Section 2508, as amended by Section 8, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1994, Section 2508), is amended to read as follows:

Section 2508. A. The State Department of Health shall:

1. Fix and collect license fees for the operation of managed health care plans, including but not limited to health maintenance organizations and prepaid health plans;

2. Enforce the provisions of ~~this act~~ the Managed Health Care Standards and Patient Protection Act;

3. Promulgate rules and regulations as necessary to effectuate the purposes of ~~this act~~ the Managed Health Care Standards and Patient Protection Act, to protect the public and to ensure the sound, proper and efficient operation and quality assurance of ~~health maintenance organizations and prepaid~~ managed health care plans in this state; ~~and~~

4. Have authority to suspend, revoke ~~any~~ or refuse to renew the license of any managed health care plan for violation of any of the rules or any violation of law or for other good cause; and

5. Establish a system of receiving and investigating complaints made by individuals covered by or enrolled in a managed health care plan or by health care providers. The State Department of Health shall annually prepare a summary report of the complaints and the disposition of such complaints filed against managed health care plans. The report shall be submitted to the Governor, the Speaker of the Oklahoma House of Representatives and the President Pro Tempore of the Oklahoma State Senate, and shall be made available to members of the public upon request.

B. The rules promulgated by the State Board of Health pursuant to the Managed Health Care Standards and Patient Protection Act shall include but not be limited to:

1. Requirements that ensure prospective enrollees or persons to be covered by the managed health care plans are provided adequate and appropriate information as to the terms and conditions of the plan so that they may make informed decisions about enrolling in or accepting coverage by the plan. Such information shall include but not be limited to:

a. information regarding coverage provisions, benefits, limitations, and any exclusions by category of service, provider or physician, and, if applicable, by specific service,

b. prior authorization or other utilization review requirements, and

c. the financial responsibility of the enrollee or covered person with regard to coinsurance or noncovered or out-of-plan services, and, as applicable, other areas of financial responsibility of the enrollee or covered person;

2. Requirements that assure that a managed health care plan has made adequate arrangements to assure that enrollees have adequate access to physicians and other health care providers in a timely fashion;

3. Requirements for the utilization of objective criteria and standards of quality for the credentialing of physicians and as other health care providers;

4. Financial requirements as necessary to assure the financial stability and viability of managed health care plans;

5. Minimum standards for the administration and operation of managed health care plans. Said standards shall be in accordance with and substantially similar to nationally recognized standards

for the administration and operation of managed health care plans and shall include but not be limited to:

a. requirements for the establishment of quality assurance programs and appropriate methods of internal quality and utilization review within the managed health care plan and appropriate arrangements for the external review of quality and utilization,

b. minimum standards for quality assurance programs and for the internal and external review of quality and utilization,

c. grievance procedures for patients for the appeal of a decision of a managed health care plan denying access to a specific covered treatment or treatment modality or continuation of an existing treatment, and

d. notice and hearing procedures for the withdrawal of credentials or the termination of a contract with a health care provider by a managed health care provider; and

6. With regard to those managed health care plans that offer or provide behavioral health services, including but not limited to mental health and substance abuse services, standards related to patient access to services, and the quality and utilization of behavioral health services. Standards promulgated in accordance with this paragraph shall be developed in consultation and coordination with the Commissioner of Mental Health and Substance Abuse Services; provided such services shall be medically necessary and shall substantially conform with the rules promulgated by the State Department of Health regarding mental health and substance abuse services provided by managed health care plans, including but not limited to a specified number of annual outpatient mental health visits as appropriate and necessary for short-term evaluative or crisis intervention, or both, and for diagnostic, medical treatment

and referral services for substance abuse or addiction. The rules may also provide for supplemental services, including but not limited to vocational rehabilitation services.

C. All actions of the Department shall be subject to the provisions of the Oklahoma Administrative Procedures Act.

~~C.~~ D. License fees collected shall be deposited in the Public Health Special Fund of the State Treasury.

SECTION 9. AMENDATORY 63 O.S. 1991, Section 2509, as amended by Section 9, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1994, Section 2509), is amended to read as follows:

Section 2509. Each ~~health maintenance organization and prepaid~~ managed health care plan shall furnish a surety bond in an amount satisfactory to the State Department of Health, or deposit with the Department, cash or securities acceptable to the Department in at least the same amount as a guarantee that the obligations to the enrollees will be performed. ~~The~~ With the written concurrence of the Insurance Commissioner, the Department may waive this requirement whenever satisfied that the assets of the organization or plan or its contracts with insurers, governments or other entities are sufficient to reasonably assure the performance of its obligations.

SECTION 10. AMENDATORY 63 O.S. 1991, Section 2510, as amended by Section 10, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1994, Section 2510), is amended to read as follows:

Section 2510. A. No ~~health maintenance organization or prepaid~~ managed health care plan, or representative thereof, shall cause or knowingly permit the use of advertising which is untrue or misleading, or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive.

1. A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may

be significant to an enrollee of, or person considering enrollment in, a health care plan;

2. A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan, if such benefit or advantage or absence of limitation, exclusion or disadvantage does in fact exist;

3. An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage therefor, to expect benefits, services, charges or other advantages which evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

B. An enrollment may not be canceled or nonrenewed except for the failure to pay the charge for such coverage or, in the case of Title XIX enrollees for loss of eligibility for medical assistance, or for such other reasons as may be promulgated by the Department.

C. No ~~health maintenance organization or prepaid~~ managed health care plan, unless licensed as an insurer, may use in its name, contracts or literature, any of the words "insurance," "casualty," "surety," "mutual" or any other words descriptive of the insurance, casualty or surety business or deceptively similar to the name or

description of any insurance or surety corporation doing business in this state.

D. Every managed health care plan shall inform the individuals covered by or enrolled in the plan of the right to file a complaint with the State Department of Health. The information shall be provided in writing and shall include the name, address and telephone number of the person or unit within the Department designated to receive and investigate such complaints.

SECTION 11. AMENDATORY Section 11, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1994, Section 2511), is amended to read as follows:

Section 2511. No person may proceed to operate a ~~health maintenance organization or prepaid~~ managed health care plan or imply directly or indirectly that it is authorized to operate a ~~health maintenance organization or prepaid~~ managed health care plan, unless that person first applies for and is granted a license by the Department under ~~Section 2501 et seq. of this title~~ the Managed Health Care Standards and Patient Protection Act. Any person who operates a ~~health maintenance organization or prepaid~~ managed health care plan without first having obtained a license as required herein, shall be deemed guilty of a misdemeanor, and upon conviction, shall be punishable by payment or a fine of not less than One Hundred Dollars ($100.00) nor more than Five Hundred Dollars ($500.00). If the State Department of Health, through one of its agents or representatives, notifies in writing, through certified mail, the person who has unlawfully commenced the operation of a ~~health maintenance organization or prepaid~~ managed health care plan to cease and desist, then each day that such person continues such offering or development shall be a separate offense. If any person continues to operate a ~~health maintenance organization or prepaid~~ managed health care plan after the issuance of a cease

and desist order, the Department shall seek an injunction to prohibit the continued offering or development.

SECTION 12. AMENDATORY Section 12, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1994, Section 2512), is amended to read as follows:

Section 2512. Any person who has been determined by the State Department of Health to have violated any provision of ~~Section 2501 et seq. of this title~~ the Managed Health Care Standards and Patient Protection Act or any rule promulgated or order issued pursuant to the provisions of said sections, may be liable for an administrative penalty of not more than One Hundred Dollars ($100.00) for each day that said violation continues. The maximum administrative penalty shall not exceed Twenty Thousand Dollars ($20,000.00) for any related series of violations.

SECTION 13. This act shall become effective on November 1, 1995.

Passed the House of Representatives the 13th day of March, 1995.

Speaker of the House of Representatives

Passed the Senate the ____ day of _____, 1995.

President of the Senate