STATE OF OKLAHOMA

2nd Session of the 45th Legislature (1996)

HOUSE BILL NO. 2756 By: Anthony

AS INTRODUCED

An Act relating to public health and safety; creating the Fairness in Managed Care Act; specifying purposes; defining terms; adding to powers and duties of the Oklahoma State Board of Health and the Oklahoma State Department of Health; requiring process for certification of managed care plans and utilization review programs; providing for promulgation of rules; authorizing termination of certification; making certain organizations eligible; providing for content of rules for certification; specifying certain requirements; requiring point-of-service plans; authorizing additional premiums; providing for codification; and declaring an emergency.

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

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-3000.1 of Title 63, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Fairness in Managed Care Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-3000.2 of Title 63, unless there is created a duplication in numbering, reads as follows:

The Legislature hereby finds and declares that:

1. Managed care plans have become a significant part of this state's health care delivery system. Managed care plans utilize various managed care techniques that include decisions regarding coverage and the appropriateness of health care. It is a vital state governmental function to ensure fairness in the delivery of managed care; and

2. The Fairness in Managed Care Act requires the Oklahoma State Board of Health to promulgate rules establishing standards for the certification of qualified managed care plans. Standards shall ensure patient protection, physician and provider fairness, and utilization review safeguards. The rules shall provide that patient choice of physicians and other providers will be enhanced through an optional point-of-service plan which may be offered by qualified managed care plans.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-3000.3 of Title 63, unless there is created a duplication in numbering, reads as follows:

For purposes of the Fairness in Managed Care Act:

1. "Qualified managed care plan" means a managed care plan that the Commissioner has certified as meeting the requirements of this section;

2. "Qualified utilization review program" means a utilization review program that meets the certification requirements of the Fairness in Managed Care Act;

3. "Managed care plan" means a plan operated by a managed care entity that provides for the financing and delivery of health care services to persons enrolled in such plan through:

a. arrangements with selected providers to furnish health care services,

b. standards for the selection of participating providers,

c. organizational arrangements for ongoing quality assurance, utilization review programs, and dispute resolution, and

d. financial incentives for persons enrolled in the plan to use the participating providers and procedures provided by the plan;

4. "Managed care entity" includes a licensed insurance company, hospital or medical service plan, health maintenance organization, an employer or employee organization, or a managed care contractor;

5. "Managed care contractor" means a person that:

a. establishes, operates or maintains a network of participating providers,

b. conducts or arranges for utilization review activities, and

c. contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan;

6. "Participating provider" means a physician, hospital, pharmacy, laboratory, or other appropriately state-licensed or otherwise state-recognized provider of health care services or supplies which has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a managed care plan;

7. "Out-of-network" or "point-of-service" plan is a product issued by a qualified managed care plan that provides additional

coverage and/or access to services by a health care provider who is not a member of the plan's provider network; and

8. "Provider network" means those health care professionals who have entered into a contract or agreement with the plan under which such professionals are obligated to provide items and services to eligible individuals enrolled in the plan.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-3000.4 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma State Board of Health shall promulgate rules:

1. Establishing a process for certification of managed care plans meeting the requirements of paragraph 3 of this subsection and of utilization review programs meeting the requirements of subsection B of this section;

2. Identifying the procedures for the periodic review and recertification of qualified managed care plans and qualified utilization review programs; and

3. For the certification of qualified managed care plans that conduct business in this state, including standards whereby:

a. prospective enrollees in health insurance plans must be provided information as to the terms and conditions of the plan so that they can make informed decisions about accepting a certain system of health care delivery. When the plan is described orally to enrollees, easily understood, truthful, and objective terms must be used. All written plan descriptions shall be in a readable and understandable format language. Specific items that must be included are:

(1) coverage provisions, benefits, and any exclusions by category of service, provider or physician, and if applicable, by specific service,

(2) any and all prior authorization or other utilization review requirements and any procedures that may lead the patient to be denied coverage for or not be provided a particular service,

(3) explanation of how plan limitations impact enrollees including information on enrollee financial responsibility for payment for coinsurance or other noncovered or out-of-plan services, and

(4) enrollee satisfaction statistics including but not limited to percent reenrollment and reasons for leaving plans,

b. plans must demonstrate that they have adequate access to physicians and other providers, so that all covered health care services will be provided in a timely fashion,

c. plans must meet financial requirements that are established to assure the ability to pay for covered services. An indemnity fund as set forth by the Commissioner of Health must be established to provide for plan failures even when a plan has met the reserve requirements,

d. all plans shall be required to establish a mechanism under which physicians participating in the plan provide input into the plan's medical policy including but not limited to coverage of new technology and procedures, utilization review criteria and procedures, quality and credentialing criteria, and medical management procedures, and

e. all plans shall be required to credential physicians within the plan:

(1) such a credentialing process shall begin upon the execution of an agreement for services between the managed care plan and the physician,

(2) credentialing shall be based on objective standards of quality with input from physicians credentialed in the plan, and such standards shall be available to physician applicants and participating physicians. When economic considerations are part of the decision, objective criteria must be used and must be available to physician applicants and participating physicians. When graduate medical education is a consideration in a credentialing, equal recognition will be given to training programs accredited by the Accrediting Council on Graduate Medical Education and by the American Osteopathic Association. Each application shall be reviewed by a credentialing committee of physicians. The lack of board certification or board eligibility shall not be the only criterion for denial of application,

(3) plans shall be prohibited from discriminating against enrollees with expensive medical conditions by excluding practitioners with practices containing a substantial number of such patients,

(4) the health care professional applicant shall be provided with all reasons used if the application is denied or the contract not renewed,

(5) plans shall not be allowed to include clauses in physician or other professional contracts that

allow for the plan to terminate the contract without cause,

(6) there shall be a due process appeal at the request of the health care professional from all adverse credentialing or termination of participation decisions,

(7) prior to initiation of a proceeding leading to termination of a contract "for cause", if the health care professional desires, the health care professional shall be provided notice, an opportunity for discussion, and an opportunity to enter into and complete a corrective action plan, except in cases where there is imminent harm to patient health or an action by a state medical board or other licensing board or any government agency that effectively impairs the physician's ability to practice medicine, and

(8) no contract with a health professional shall be allowed to include clauses limiting health professionals from criticizing the provisions or conduct of the plan.

B. Qualified utilization review programs specified by paragraph 3 of subsection A of this section shall comply with the following requirements:

1. Prior authorization is not required for an emergency that is a life- or limb-threatening condition or urgent care, that is a condition that needs immediate care. Patient or physician requests for prior authorization of a nonemergency service shall be answered within two (2) business days, and qualified personnel shall be available for same-day telephone responses to inquiries about medical necessity including certification of continued length of stay;

2. Emergency or urgent care required out-of-area does not require prior authorization. Follow-up care will be covered out-of-area as long as the care is necessitated by the emergency or urgent situation;

3. Plans shall ensure that enrollees, in plans where preauthorization is a condition to coverage of a service, are required to sign medical information release consent forms upon enrollment for use where services requiring prior authorization are recommended or proposed by their physician. In addition plans are prohibited from disclosing to employers any medical information about an enrollee without that person's specific prior authorization;

4. When prior approval for a service or other covered item is obtained, it shall be considered approval for all purposes, and the service shall be considered to be covered unless there was fraud or incorrect information provided at the time such prior approval was obtained; and

5. Contested claims for payment must be evaluated by individuals with comparable education, training, and expertise to review adequately the specific clinical issues involved in the claim and require that claims originally denied due to lack of information be completed within thirty (30) days of receipt of the necessary information.

C. 1. Rules shall be promulgated pursuant to this section by not later than twelve (12) months after the effective date of the Fairness in Managed Care Act. In developing rules for promulgation by the Board under this section, the Commissioner shall:

a. review standards in use by national private accreditation organizations and the National Association of Insurance Commissioners,

b. recognize, to the extent appropriate, differences in the organizational structure and operation of managed care plans, and

c. establish procedures for the timely consideration of applications for certification by managed care plans and utilization review programs.

2. The Commissioner shall periodically review the standards established pursuant to this section, and may revise the standards from time to time to assure that such standards continue to reflect appropriate policies and practices for the cost-effective and medically appropriate use of services within managed care plans.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-3000.5 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The Commissioner of Health shall terminate the certification of a previously qualified managed care plan or a qualified utilization review program if the Commissioner determines that such plan or program no longer meets the applicable requirements for certification.

B. 1. An eligible organization as defined in Section 1876(B) of the Social Security Act shall be deemed to meet the requirements of Section 4 of this act for certification as a qualified managed care plan.

2. If the Commissioner finds that a national accreditation body establishes a requirement or requirements for accreditation of a managed care plan or utilization review program that are at least equivalent to the requirements established pursuant to Section 4 of this act, the Commissioner may, to the extent appropriate, treat a managed care plan or a utilization review program thus accredited as meeting the requirements of Section 4 of this act.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-3000.6 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Each qualified managed care plan including such plans provided, offered or made available by voluntary health purchasing cooperatives, employers, and self-insurers that limits coverage for out-of-network services may offer to all eligible enrollees coverage for such services through a "point-of-service" plan.

B. A qualified managed care plan may charge an alternative premium for point-of-service coverage that takes into account the actuarial value of such coverage.

C. Where a sponsor intends to offer only an HMO plan to covered persons, a point-of-service option or its equivalent must also be offered. The enrollee must be able to exercise the point-of-service option and no member shall be required to expend more than Three Thousand Dollars ($3,000.00) per year out-of-pocket (Five Thousand Dollars ($5,000.00) per year per family).

SECTION 7. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

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