STATE OF OKLAHOMA

1st Session of the 46th Legislature (1997)

COMMITTEE SUBSTITUTE
FOR ENGROSSED
HOUSE BILL NO. 1416 By: Boyd (Betty) of the House

and

Henry of the Senate

COMMITTEE SUBSTITUTE

(Public health and safety - Fairness In Managed Care Act - certification of managed care plans - codification - 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 2525.2 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 2525.3 of Title 63, unless there is created a duplication in numbering, reads as follows:

For purposes of the Fairness In Managed Care Act:

1. "Emergency care" means emergency room screening and stabilization as needed for conditions that reasonably appear to constitute a life or limb threatening emergency, based on the presenting symptoms of the patient;

2. "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;

3. "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;

4. "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 for by the plan;

5. "Out of network" or "point of service" plan is a product issued by a qualified managed care plan that provides additional coverage or access to services by a health care provider who is not a member of the plan's provider network;

6. "Participating provider" means a physician as defined in Section 725.2 of Title 59 of the Oklahoma Statutes, hospital, pharmacy, laboratory, or other appropriately state licensed or

otherwise state recognized provider of health care services or supplies, that 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. "Provider network" means those providers who have entered into a contract or agreement with the plan under which such providers are obligated to provide items and services to eligible individuals enrolled in the plan;

8. "Qualified managed care plan" means a managed care plan that the State Commissioner of Health has certified as meeting the requirements of this act;

9. "Qualified utilization review program" means a utilization review program that meets the certification requirements of the Fairness In Managed Care Act; and

10. "Urgent care" means the care necessary to treat those conditions that arise suddenly and require treatment to prevent scarring and minor disabilities including, but not limited to, skin lacerations, joint sprains, significant abrasions, or infections.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2525.4 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. 1. The State Board of Health shall promulgate rules:

a. For certification of managed care plans which satisfy the requirements of subsection A of Section 5 of this act and for certification of utilization review programs which satisfy the requirements of subsection B of Section 5 of this act; and

b. Identifying procedures for periodic review and recertification of qualified managed care plans and qualified utilization review programs.

2. a. The Board shall promulgate rules not later than twelve (12) months after the effective date of the Fairness

In Managed Care Act. In developing such rules, the Board shall:

(1) review standards in use by national private accreditation organizations and the National Association of Insurance Commissioners,

(2) recognize, to the extent appropriate, differences in the organizational structure and operation of managed care plans, and

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

b. The Board shall periodically review the standards established under this section and may revise the standards from time to time to ensure that such standards continue to reflect appropriate policies and practices for the cost effective and medically appropriate use of services within managed care plans.

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

C. 1. An eligible organization as defined in Section 1876(b) of the Social Security Act shall be deemed to meet the requirements of Section 5 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 5 of this act, the Commissioner shall, to the extent appropriate, treat a

managed care plan or a utilization review program thus accredited as meeting the requirements of Section 5 of this act.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2525.5 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The rules promulgated by the State Board of Health for certification of qualified managed care plans that conduct business in this state shall include, but not be limited to, standards whereby:

1. Enrollees and prospective enrollees in health insurance plans shall be provided information as to the terms and conditions of the plan so that they can make an informed decision about continuing in or choosing a certain system of health care delivery. The verbal description of the plan, when presented to such enrollees, shall be easily understood and truthful, and shall utilize objective terms. All written plan descriptions shall be in a readable and understandable language format. Specific items that shall be included are:

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

b. drug formulary provisions, if any, including provisions for disclosure to any enrollee or prospective enrollee who requests such information, as to whether individual drugs are included or excluded from coverage,

c. a description of procedures followed by the health plan in making decisions about which drugs to include in the plan's drug formulary,

d. 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,

e. explanation of how plan limitations affect enrollees, including information on enrollee financial responsibility for payment for coinsurance or other noncovered or out-of-plan services, and

f. enrollee satisfaction statistics including, but not limited to, percent reenrollment and reasons for leaving plans;

2. Plans shall 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;

3. Plans shall meet financial requirements established to assure the ability to pay for covered services and to pay for such services in a timely fashion. An indemnity fund as set forth by the State Commissioner of Health shall be established to provide for plan failures even when a plan has met the reserve requirements;

4. 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

5. All plans shall be required to credential physicians within the plan.

a. Such credentialing process shall begin prior to the execution of an agreement for services between the managed care plan and the physician.

b. Credentialing shall be based on objective standards of quality, with input from physicians credentialed in the plan, which shall be available to physician applicants and participating physicians. When

economic considerations are part of the credentialing decision, objective criteria shall be used and shall be available to physician applicants and participating physicians. When graduate medical education is a consideration in the credentialing process, equal recognition shall be given to training programs accredited by the Accrediting Council on Graduate Medical Education and by the American Osteopathic Association or Council on Optometric Education. 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 a denial of an application is based.

c. Plans shall not discriminate against enrollees with expensive medical conditions by excluding practitioners with practices containing a substantial number of such patients.

d. Plans shall provide a physician applicant whose application is denied or whose contract is not renewed with reasons for such denial or nonrenewal.

e. Plans shall not include clauses in physician or other provider contracts that allow termination of a contract without providing reasons for such termination if the physician requests such reasons.

f. A physician shall be entitled to a due process appeal regarding any decisions that result in adverse credentialing or termination of participation.

g. Prior to initiation of a proceeding leading to termination of a contract, if desired, a physician shall be provided notice, an opportunity for discussion, and an opportunity to enter into and complete a corrective action plan where

appropriate; provided, however, such provision shall not apply where there is imminent harm to patient health, or where there isan action by a state medical board or other government agency that effectively impairs the ability of the physician to practice medicine.

h. Health plans, by contract, shall not prohibit physicians from communicating with patients concerning medical care or medically appropriate treatment options, whether covered or not.

B. Rules promulgated by the Board for qualified utilization review programs shall include, but not be limited to, the following requirements:

1. Prior authorization:

a. shall not be required for emergency care, and

b. requests by patients or physicians for nonemergency services shall be answered within five (5) business days of such request;

2. Qualified personnel shall be available for same-day telephone responses to inquiries about medical necessity including certification of continued length of stay;

3. Out of area emergency care shall not require prior authorization. Follow-up care shall be covered out of area as long as the care is necessitated by the emergency or urgent situation;

4. 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. Plans are prohibited from disclosing to employers any medical information about an enrollee without such person's specific prior authorization. Preauthorization requests shall be considered only by a physician

licensed by the State Board of Medical Licensure and Supervision or the Oklahoma State Board of Osteopathic Examiners, subject to the jurisdiction of the Oklahoma courts;

5. When prior approval for a specific service or other specific covered item is obtained, it shall be considered approval for that purpose, and the specific service shall be considered covered unless there was fraud or incorrect information provided at the time such prior approval was obtained; and

6. Contested denials of service by the attending physician in cases where there are not medically agreed upon guidelines shall be evaluated only by physicians of the same or similar specialty or training as the attending physician who is contesting the denial.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2525.6 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, associations, self-insurers, or any other private group 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. Such additional charges may be paid by the enrollee rather than the sponsor.

C. Where a sponsor including, but not limited to, an employer, association, or private group intends to offer only a health maintenance organization plan to covered persons, a point of service option or its equivalent may also be offered. This optional coverage for out of network care may be subject to an additional premium, and shall require that the out of network care provider

shall indemnify the plan for any harm or problems arising from such care.

D. A managed care entity shall not require a participating provider to enroll in more than one of its managed care plans.

SECTION 6. 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.

46-1-1247 CJ