ENGROSSED SENATE
BILL NO. 642

By: Taylor and Monson of the Senate

and

Benson of the House

[managed care - licensure and registration of managed health care plans - codification - recodification - 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. 1996, Section 2501), is amended to read as follows:

Section 2501. 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 prepaid health care, including comprehensive medically necessary managed care services and comprehensive health maintenance services in this state. Further, it is the intent of the Legislature to ensure that the citizens of this state have access to quality health care and to adequate information for making informed decisions when choosing managed health care plans. While it is the intent of Section 2501 et seq. of this ~~act~~ title to provide an opportunity for the development of prepaid health plans ~~and~~, health maintenance organizations, and other managed health care plans, there is no intention to impair the present system of delivery of health

services. It shall be the policy of this state to eliminate legal barriers to the organization, promoting and expansion of alternative delivery systems of comprehensive prepaid health care.

SECTION 2. AMENDATORY 63 O.S. 1991, Section 2502, as amended by Section 2, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1996, Section 2502), is amended to read as follows:

Section 2502. Notwithstanding any law to the contrary, any person may, in compliance with the provisions of Section 2501 et seq. of this title, 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. 1996, 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 or with other managed health care plans for covered 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~~.~~;

8. "Managed health care plan" means any organization or entity, including, but not limited to, a health maintenance organization, prepaid health plan, preferred provider organization, or provider service network, that offers to provide 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; or

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

9. "Preferred provider organization" means any organization or entity that contracts to provide health care services to enrollees from selected, participating providers; and

10. "Provider service network" means a provider-owned managed care entity, including, but not limited to, physician-hospital organizations (PHOs) and integrated provider organizations (IPO), organized for the purpose of providing, financing, and managing the risk of health care services provided to enrollees.

SECTION 4. AMENDATORY 63 O.S. 1991, Section 2504, as amended by Section 4, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1996, Section 2504), is amended to read as follows:

Section 2504. A. ~~Upon compliance with the provisions of Section 2501 et seq. of this title, any organization, association, or corporation, public or private, may be licensed by the State Department of Health to organize, operate and maintain a health maintenance organization or a prepaid health plan for its duly~~

~~enrolled members and their dependents in this state~~ 1. No person may proceed to operate a health maintenance organization or prepaid health plan or imply directly or indirectly that it is authorized to operate a health maintenance organization or prepaid health plan, unless that person first applies for and is granted a license by the State Department of Health under Section 2501 et seq. of this title.

2. 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.

3. The Insurance Commissioner, after notice and hearing, may promulgate such reasonable rules as are necessary to provide for the licensing of agents.

4. The Department shall annually determine if each health maintenance organization or prepaid health 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. Every health maintenance organization and prepaid health plan may be relicensed, annually, upon compliance with the provisions of Section 2501 et seq. of this title and any ~~regulations~~ rules promulgated pursuant to the provisions of Section 2501 et seq. of this title.

5. 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. Nothing

in this subsection shall be construed to prevent a person from electing to apply for and obtain separate licenses as an insurer under Title 36 of the Oklahoma Statutes and as a prepaid health plan under Section 2501 et seq. of this title.

C. Each application or reapplication for a license or annual license renewal pursuant to the provisions of this section shall be accompanied by ~~an application~~ a nonrefundable fee ~~of~~ not to exceed Five Thousand Dollars ($5,000.00).

SECTION 5. AMENDATORY Section 6, Chapter 349, O.S.L. 1996 (63 O.S. Supp. 1996, Section 2513), is amended to read as follows:

Section 2513. A. 1. No person may proceed to operate a preferred provider organization or provider service network or imply directly or indirectly that it is authorized to operate a preferred provider organization or provider service network, unless that person first applies for and is granted a license or registration by the State Department of Health as provided herein.

2. A preferred provider organization or provider service network which assumes full risk shall be licensed pursuant to the provisions of Section 2504 of this title and shall be subject to similar standards for solvency, network capacity to deliver promised services, quality assurance, accreditation, grievance procedures, and other such standards, as are applied to health maintenance organizations.

3. a. A preferred provider organization or provider service network which assumes partial risk shall be licensed by the State Department of Health and shall be subject to standards for solvency, network capacity to deliver promised services, quality assurance, accreditation, grievance procedures, and other such standards, as are appropriate to the risk assumed and the scope of

services to be provided, as determined by rule of the State Board of Health.

b. Each application or reapplication for a license or annual license renewal made pursuant to the provisions of this paragraph shall be accompanied by a nonrefundable fee not to exceed Five Thousand Dollars ($5,000.00).

4. a. A preferred provider organization or provider service network which assumes downstream risk or no risk shall be registered by the State Department of Health and shall be subject to standards for solvency, network capacity to deliver promised services, quality assurance, accreditation, grievance procedures, and other such standards, as are appropriate to the risk assumed and the scope of services to be provided, as determined by rule of the State Board of Health.

b. Each application or reapplication for registration or annual registration renewal shall be accompanied by a nonrefundable fee not to exceed Five Thousand Dollars ($5,000.00).

B. The State Board of Health shall promulgate rules regarding the establishment, licensure and registration of preferred provider organizations and provider service networks under this section and the operation of such preferred provider organizations and provider service networks ~~(PSNs)~~ which shall address, at a minimum, the following:

1. Procedures to allow health care providers within a service area to enter into voluntary agreements to improve access to and the quality or affordability of health care;

2. Procedures for reviewing the plan of operation of a preferred provider organization and provider service network and standards for approval or disapproval of such plan; and

3. Financial solvency and network capacity standards to ensure a preferred provider organization's and provider service network's ability to deliver promised services.

~~B. The rules promulgated by the Board shall provide that provider service networks shall be subject to the same quality assurance standards established by law or by rules promulgated by the Board for health maintenance organizations.~~

C. As used in this section~~, "provider service network" means a provider-based managed care entity, including physician-hospital organizations (PHOs), organized for the purpose of providing, financing, and managing the risk of health care services to subscribers~~:

1. "Full risk" means the financial risk assumed by a preferred provider organization or provider service network which contracts directly with the employer or a representative of the employer and is paid on a prepaid, capitated basis for all health care services;

2. "Partial risk" means the financial risk assumed by a preferred provider organization or provider service network which contracts directly with the employer or a representative of the employer and is paid a budgeted amount for services provided for a set period of time and which may be liable for a portion of additional expenses above the budgeted amount or eligible for a share of any savings achieved pursuant to the terms of the contract;

3. "Downstream risk" means the financial risk assumed by a preferred provider organization or provider service network which contracts with an insurer or health care plan to provide health care coverage pursuant to a group policy or plan and is paid on a prepaid, capitated basis; and

4. "No risk" means the absence of financial risk which occurs when a preferred provider organization or provider service network contracts directly with an employer or representative of an employer or an insurer to provide health care services on a fee-for-service

basis and the employer or insurer retains the full risk for the cost of employee health care services.

SECTION 6. AMENDATORY 63 O.S. 1991, Section 2505, as amended by Section 5, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1996, Section 2505), is amended to read as follows:

Section 2505. A. 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.

B. 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 7. AMENDATORY 63 O.S. 1991, Section 2506, as amended by Section 6, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1996, Section 2506), is amended to read as follows:

Section 2506. ~~Health maintenance organizations and prepaid health plans~~ 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 laws governing such programs.

SECTION 8. AMENDATORY 63 O.S. 1991, Section 2507, as amended by Section 7, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1996, 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 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 9. AMENDATORY 63 O.S. 1991, Section 2508, as amended by Section 8, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1996, Section 2508), is amended to read as follows:

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

1. Fix and collect an annual and renewal license ~~fees~~ and registration application fee for the operation of ~~health maintenance organizations and prepaid health~~ managed health care plans which shall not exceed Five Thousand Dollars ($5,000.00) and shall be commensurate with risk to be assumed, scope of services to be provided, and number of members to be served;

2. Enforce the provisions of ~~this act~~ Section 2501 et seq. of this title;

3. Promulgate rules ~~and regulations~~ as necessary to effectuate the purposes of ~~this act~~ Section 2501 et seq. of this title, to protect the public and ensure access to quality health care, and to ensure the sound, proper and efficient operation of ~~health maintenance organizations and prepaid health~~ managed health care plans in this state; and

4. Have authority to revoke any license or registration for violation of any of the rules or any violation of law or for other good cause.

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

C. License and registration application fees collected shall be deposited in the Public Health Special Fund of the State Treasury.

SECTION 10. AMENDATORY Section 2, Chapter 95, O.S.L. 1995, as renumbered by Section 9, Chapter 204, O.S.L. 1995 (63 O.S. Supp. 1996, Section 2508.1), is amended to read as follows:

Section 2508.1 The Oklahoma State Board of Health shall promulgate rules which will authorize health maintenance

organizations, prepaid health plans and other managed health care entities, as a consideration and valuation of their net worth with regard to requirements for protection against insolvency required by the Board, to include real property and improvements thereon and any other capital or fixed assets owned by the managed health care entity which are unencumbered with any financial obligations of the managed care entity.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2508.2 of Title 63, unless there is created a duplication in numbering, reads as follows:

The State Board of Health shall promulgate rules or take other appropriate action to address the following:

1. Information to be provided by managed health care plans which will enable consumers to make informed choices about enrolling in or accepting coverage offered by a 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. Criteria designed to ensure that managed health care plans which seek to expand into delivery of services to special needs populations have the requisite capabilities to meet those needs and an appropriate avenue for dialogue between the plan and advocates for special needs populations;

3. The definition of emergency care to ensure that conditions which reasonably appear to constitute an emergency are covered under managed health care plans;

4. Standardization and centralization of information and forms used in the credentialing process;

5. Minimum standards for the administration and operation of managed health care plans. Said standards shall hold comparable managed health care entities to nationally recognized minimum standards for quality assurance and accreditation and shall endorse regular quality assessment for managed health care plans which shall address, at a minimum, the following:

a. quality improvement,

b. credentialing,

c. members rights and responsibilities,

d. preventive health services,

e. utilization management, and

f. medical records; and

6. An appeal process for plans which meets the following criteria:

a. timely notice to patients when:

(1) the plan makes an adverse coverage recommendation or decision, or

(2) the member disagrees with the provider treatment recommendation,

b. an easily understood description of the patient's appeal rights and the timeframe for an appeal,

c. an expedited appeal process for situations in which the normal timeframe could jeopardize a patient's life or health, and

d. a method for ensuring that decisions are rendered as rapidly as warranted by the member's condition and coverage issue.

SECTION 12. AMENDATORY 63 O.S. 1991, Section 2509, as amended by Section 9, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1996, Section 2509), is amended to read as follows:

Section 2509. Each ~~health maintenance organization and prepaid health~~ managed health care plan shall furnish, commensurate with risk assumed and scope of services to be provided, 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 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 13. AMENDATORY 63 O.S. 1991, Section 2510, as last amended by Section 1, Chapter 139, O.S.L. 1996 (63 O.S. Supp. 1996, Section 2510), is amended to read as follows:

Section 2510. A. No ~~health maintenance organization or prepaid health~~ 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 managed 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 health~~ 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. When contracting with educational entities within the meaning of Section 1303 of Title 74 of the Oklahoma Statutes, effective for the plan year beginning July 1, 1997, and for each year thereafter, in setting health insurance premiums for active employees and for retirees under sixty-five (65) years of age, health maintenance organizations, self-insured plans ~~and~~, prepaid plans, and other managed health care plans shall set the monthly

premium for active employees at a maximum of Ninety Dollars ($90.00) less than the monthly premium for retirees under sixty-five (65) years of age.

E. No managed health care plan shall engage in the practice of medicine or other profession except as provided by law nor include any provision in provider contracts which precludes or discourages a plan's providers from:

1. Informing patients of the care they require, including treatments or services not provided or reimbursed under their plan; or

2. Advocating on behalf of a patient before the managed health care plan.

SECTION 14. AMENDATORY Section 11, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1996, Section 2511), is amended to read as follows:

Section 2511. No person may proceed to operate a ~~health maintenance organization or prepaid health~~ managed health care plan or imply directly or indirectly that it is authorized to operate a ~~health maintenance organization or prepaid health~~ managed health care plan, unless that person first applies for and is granted a license or registration by the Department under Section 2501 et seq. of this title. Any person who operates a ~~health maintenance organization or prepaid health~~ 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 health~~ 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 health~~ 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 15. AMENDATORY Section 12, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1996, Section 2512), is amended to read as follows:

Section 2512. Any person who, after notice and hearing, has been determined by the State Department of Health to have violated any provision of Section 2501 et seq. of this title 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 16. RECODIFICATION Section 6, Chapter 349, O.S.L. 1996 (63 O.S. Supp. 1996, Section 2513), as amended by Section 5 of this act, shall be recodified as Section 2504.1 of Title 63 of the Oklahoma Statutes, unless there is created a duplication in numbering.

SECTION 17. This act shall become effective January 1, 1998.

Passed the Senate the 13th day of March, 1997.

President of the Senate

Passed the House of Representatives the ____ day of _____, 1997.

Speaker of the House of Representatives