

1 STATE OF OKLAHOMA

2 1st Session of the 47th Legislature (1999)

3 CONFERENCE COMMITTEE SUBSTITUTE
4 FOR ENGROSSED
5 HOUSE BILL NO. 1681

By: Seikel, Collins, Kirby,
Maddux and Nations of the
House

6 and

7 Monson of the Senate

8
9
10 CONFERENCE COMMITTEE SUBSTITUTE

11 An Act relating to insurance; defining terms;
12 requiring referral to a specialist by a managed care
13 plan under certain conditions and terms and stating
14 procedures; stating exception; providing for
15 compliance with certain terms; prohibiting certain
16 referrals; requiring treatment plans; providing for
17 certain treatment; prohibiting certain additional
18 costs; providing for certain procedures; providing
19 procedures for continuation of certain coverage;
20 providing for certain appeals; requiring certain
21 notice; requiring certain agreements for continued
22 coverage; providing procedures for approval or
23 disapproval of requests for certain drugs; providing
24 for deemed approvals; requiring certain time periods;
25 requiring certain supplies; prohibiting certain
26 additional costs; requiring certain copies of
27 procedures be provided; amending Section 2, Chapter
28 289, O.S.L. 1997, Section 3, Chapter 289, O.S.L.
29 1997, Section 4, Chapter 289, O.S.L. 1997, as amended
30 by Section 1, Chapter 396, O.S.L. 1997, and Section
31 5, Chapter 289, O.S.L. 1997 (63 O.S. Supp. 1998,
32 Sections 2525.3, 2525.4, 2525.5 and 2525.6), which
relate to the Oklahoma Managed Care Act; deleting
certain definition; deleting provisions related to
certification of managed care plans; expanding and
modifying requirements for information included in
plan descriptions; requiring promulgation of
specified rules; prohibiting certain fees; clarifying
references and language; providing for codification;
and providing an effective date.

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 2550.1 of Title 63, unless there
is created a duplication in numbering, reads as follows:

As used in Sections 1 through 4 of this act:

1 1. "Covered person" means an individual who receives medical
2 care and treatment through a managed care plan. In the case of a
3 minor child, the term includes the parent or legal guardian of the
4 child and, in the case of an incapacitated or partially
5 incapacitated person, the legal guardian of that person;

6 2. "Degenerative and disabling condition or disease" means a
7 condition or disease caused by a congenital or acquired injury or
8 illness that requires a specialized rehabilitation program or a high
9 level of care, service, resources or continued coordination of care
10 in the community;

11 3. "Designee of the covered person" means an individual
12 designated by the covered person to represent the interests of the
13 covered person, including the covered person's provider;

14 4. "Managed care plan" means a plan operated by a managed care
15 entity, including the Oklahoma State and Education Employees Group
16 Insurance Board, that provides for the financing and delivery of
17 health care services to persons enrolled in such plan through:

- 18 a. arrangements with selected providers to furnish health
19 care services,
 - 20 b. standards for the selection of participating
21 providers,
 - 22 c. organizational arrangements for ongoing quality
23 assurance, utilization review programs, and dispute
24 resolution, and
 - 25 d. financial incentives for persons enrolled in the
26 managed care plan to use the participating providers
27 and procedures provided for by the managed care plan;
- 28 provided, however, the term "managed care plan" shall not include a
29 certified workplace medical plan as defined in Section 14.2 of Title
30 85 of the Oklahoma Statutes;

1 5. "Provider" shall have the same meaning as such term is
2 defined by a health maintenance organization, an indemnity plan or a
3 preferred provider organization; and

4 6. "Treatment plan" means a proposal developed for a covered
5 person that is specifically tailored to the individual's treatment
6 needs for a specific illness or condition, and that includes, but is
7 not limited to:

8 a. a statement of treatment goals or objectives, based
9 upon and related to a medical evaluation,

10 b. treatment methods and procedures to be used to obtain
11 these goals, and

12 c. identification of the types of professional personnel
13 who will carry out the treatment procedures.

14 SECTION 2. NEW LAW A new section of law to be codified
15 in the Oklahoma Statutes as Section 2550.2 of Title 63, unless there
16 is created a duplication in numbering, reads as follows:

17 A. A managed care plan that has no participating provider for
18 a covered benefit requiring a specialist shall arrange for a
19 referral to a specialist with expertise in treating the covered
20 benefit. The specialist shall agree to abide by the terms of the
21 plan's provider contract if the terms are commensurate with the
22 terms of contracts for similar specialists.

23 B. 1. A managed care plan shall include procedures by which a
24 covered person in a managed care plan, upon diagnosis by a primary
25 care provider of a condition that without specialized treatment
26 would result in deleterious outcomes that would threaten life or
27 limb or a degenerative and disabling condition or disease, either of
28 which requires specialized medical care over a prolonged period of
29 time, may be referred to a specialist with expertise in treating
30 such condition or disease.

31 2. The specialist may be responsible for and may provide and
32 coordinate the covered person's primary and specialty care only if

1 the specialist is willing to abide by the terms of the plan's
2 contract and capable of providing such care.

3 3. If the managed care plan, or the primary care provider in
4 consultation with the managed care plan and the specialist, if any,
5 determines that the most appropriate coordinator of the covered
6 person's care is a specialist, the managed care plan shall authorize
7 a referral of the covered person to the specialist. In no event
8 shall a managed care plan be required to permit a covered person to
9 elect treatment by a nonparticipating specialist, except pursuant to
10 the provisions of subsection A of this section.

11 C. 1. A referral pursuant to this section shall be pursuant
12 to a treatment plan agreed to by the managed care plan, the
13 specialist and the primary care provider which complies with the
14 covered benefits of the health plan and which is developed in
15 consultation with the primary care provider, if appropriate, the
16 specialist, and the covered person or the designee of the covered
17 person.

18 2. Subject to the terms of the treatment plan agreed to by the
19 managed care plan, the specialist and the primary care provider and
20 subject to the terms of the plan's contract, a specialist shall be
21 permitted to treat the covered person without a referral from the
22 covered person's primary care provider and may authorize referrals,
23 procedures, tests and other medical services as the covered person's
24 primary care provider would otherwise be permitted to provide or
25 authorize.

26 3. If a managed care plan refers a covered person to a
27 nonparticipating specialist, services provided pursuant to the
28 treatment plan shall be provided pursuant to the provisions of
29 subsection A of this section at no additional cost to the covered
30 person beyond what the covered person would otherwise pay for
31 services received within the network of the managed care plan.
32

1 D. A managed care plan shall implement procedures for a
2 standing referral to a specialist if the primary care provider
3 determines in consultation with the specialist and the managed care
4 plan that a covered person needs continuing care from a specialist.
5 The referral shall be made pursuant to a treatment plan that
6 complies with covered benefits of the managed care plan.

7 SECTION 3. NEW LAW A new section of law to be codified
8 in the Oklahoma Statutes as Section 2550.3 of Title 63, unless there
9 is created a duplication in numbering, reads as follows:

10 A. Every managed care plan shall establish procedures
11 governing termination of a participating provider who is terminated
12 for reasons other than cause. The procedures shall include
13 assurance of continued coverage of services, at the contract terms
14 and price by a terminated provider for up to ninety (90) calendar
15 days from the date of notice to the covered person, for a covered
16 person who:

- 17 1. Has a degenerative and disabling condition or disease;
- 18 2. Has entered the third trimester of pregnancy. Additional
19 coverage of services by the terminated provider shall continue
20 through at least six (6) weeks of postpartum evaluation; or
- 21 3. Is terminally ill.

22 B. 1. If a participating provider voluntarily chooses to
23 discontinue participation as a network provider in a managed care
24 plan, the managed care plan shall permit a covered person to
25 continue an ongoing course of treatment with the disaffiliated
26 provider during a transitional period:

- 27 a. of up to ninety (90) days from the date of notice to
28 the managed care plan of the provider's disaffiliation
29 from the managed care plan's network, or
- 30 b. that includes delivery and postpartum care if the
31 covered person has entered the third trimester of
32

1 pregnancy at the time of the provider's
2 disaffiliation.

3 2. If a provider voluntarily chooses to discontinue
4 participation as a network provider participating in a managed care
5 plan, such provider shall give at least a ninety-day notice of the
6 disaffiliation to the managed care plan. The managed care plan
7 shall immediately notify the disaffiliated provider's patients of
8 that fact.

9 3. Notwithstanding the provisions of paragraph 1 of this
10 subsection, continuing care shall be authorized by the managed care
11 plan during the transitional period only if the disaffiliated
12 provider agrees to:

13 a. continue to accept reimbursement from the managed
14 care plan at the rates applicable prior to the start
15 of the transitional period as payment in full,

16 b. adhere to the managed care plan's quality assurance
17 requirements and to provide to the managed care plan
18 necessary medical information related to such care,
19 and

20 c. otherwise adhere to the managed care plan's policies
21 and procedures, including, but not limited to,
22 policies and procedures regarding referrals, and
23 obtaining preauthorization and treatment plan
24 approval from the managed care plan.

25 SECTION 4. NEW LAW A new section of law to be codified
26 in the Oklahoma Statutes as Section 2550.4 of Title 63, unless there
27 is created a duplication in numbering, reads as follows:

28 A. A managed care plan that has a closed formulary or that
29 requires prior authorization to obtain certain drugs shall approve
30 or disapprove a provider's or a covered person's request for a
31 nonformulary drug or a drug that requires prior authorization within
32 twenty-four (24) hours of receipt of such request.

1 B. If the managed care plan does not render a decision within
2 twenty-four (24) hours, the provider or covered person shall be
3 entitled to a seventy-two-hour supply of the drug. The managed care
4 plan shall then approve or disapprove the request for a nonformulary
5 drug or prior authorized drug within the additional seventy-two-hour
6 period.

7 C. Failure of the managed care plan to respond within the
8 subsequently allowed seventy-two-hour period shall be deemed as
9 approval of the request for the nonformulary drug or prior
10 authorized drug; provided, however, the approval shall be subject to
11 the terms of the managed care plan's drug formulary; provided
12 further, the purchase of the approved drug shall be at no additional
13 cost to the covered person beyond what the covered person would
14 otherwise pay for a prescription pursuant to the managed care plan.

15 D. All providers and covered persons in a managed care plan
16 shall be provided with a copy of the plan's drug prior authorization
17 process upon initial contracting or enrollment and at the time of
18 enactment of any subsequent changes to the process.

19 SECTION 5. AMENDATORY Section 2, Chapter 289, O.S.L.
20 1997 (63 O.S. Supp. 1998, Section 2525.3), is amended to read as
21 follows:

22 Section 2525.3 For purposes of the Oklahoma Managed Care Act:

23 1. "Emergency care" means emergency department screening and
24 care to achieve stabilization as needed for conditions that
25 reasonably appear to constitute a life- or limb-threatening
26 emergency based on the presenting symptoms of the patient;

27 2. "Managed care contractor" means a person that:

- 28 a. establishes, operates or maintains a network of
29 participating providers,
30 b. conducts or arranges for utilization review
31 activities, and
32

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

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

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

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

14 b. standards for the selection of participating
15 providers,

16 c. organizational arrangements for ongoing quality
17 assurance, utilization review ~~programs~~, and dispute
18 resolution, and

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

22 provided, however, the term "managed care plan" shall not include a
23 certified workplace medical plan as defined in Section 14.2 of Title
24 85 of the Oklahoma Statutes;

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

29 6. "Participating provider" means a physician as defined in
30 Section 725.2 of Title 59 of the Oklahoma Statutes, hospital,
31 pharmacy, laboratory, or other appropriately state-licensed or
32 otherwise state-recognized provider of health care services or

1 supplies, that has entered into an agreement with a managed care
2 entity to provide such services or supplies to a patient enrolled in
3 a managed care plan;

4 7. "Provider network" means those providers who have entered
5 into a contract or agreement with the plan under which such
6 providers are obligated to provide items and services to eligible
7 individuals enrolled in the plan;

8 ~~8. "Certified managed care plan" means a managed care plan that~~
9 ~~the State Commissioner of Health has certified as meeting the~~
10 ~~requirements of the Oklahoma Managed Care Act;~~

11 ~~9.~~ "Qualified utilization review program" means a utilization
12 review program that meets the ~~certification~~ requirements of the
13 Oklahoma Managed Care Act; and

14 ~~10.~~ 9. "Urgent care" means the treatment for an unexpected
15 illness or injury which is severe or painful enough to require
16 treatment within twenty-four (24) hours.

17 SECTION 6. AMENDATORY Section 3, Chapter 289, O.S.L.
18 1997 (63 O.S. Supp. 1998, Section 2525.4), is amended to read as
19 follows:

20 Section 2525.4 A. ~~1.~~ The State Board of Health shall
21 promulgate rules:

22 ~~a. for~~

23 1. For ~~certification of~~ managed care plans which satisfy the
24 requirements of subsection A of Section 4 2525.5 of this ~~act~~ title,
25 and for ~~certification of~~ utilization review programs which satisfy
26 the requirements of subsection B of Section 4 2525.5 of this ~~act~~,
27 title; and

28 ~~b. identifying~~

29 2. Identifying procedures for periodic review ~~and~~
30 ~~recertification of certified~~ managed care plans and qualified
31 utilization review programs.

32 ~~2. a.~~

1 B. 1. The Board shall promulgate rules not later than ~~twelve~~
2 ~~(12) months after the effective date of this act~~ November 1, 2000.

3 In developing ~~such~~ rules, the Board shall:

4 ~~(1)~~ a. review standards in use by national private
5 accreditation organizations and the National
6 Association of Insurance Commissioners,

7 ~~(2)~~ b. recognize, to the extent appropriate, differences
8 in the organizational structure and operation of
9 managed care plans, and

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

13 ~~b.~~

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

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

24 ~~C. 1. An eligible organization as defined in Section 1876(b)~~
25 ~~of the Social Security Act shall be deemed to meet the requirements~~
26 ~~of Section 4 of this act for certification as a certified managed~~
27 ~~care plan.~~

28 ~~2.~~ If the State Commissioner of Health finds that a national
29 accreditation body establishes a requirement or requirements for
30 accreditation of a managed care plan or utilization review program
31 that are at least ~~equivalent to~~ as restrictive as the requirements
32 established pursuant to Section 4 2525.5 of this act title, the

1 Commissioner shall, to the extent appropriate, treat a managed care
2 plan or a utilization review program thus accredited as meeting the
3 requirements of Section 4 2525.5 of this ~~act~~ title.

4 SECTION 7. AMENDATORY Section 4, Chapter 289, O.S.L.
5 1997, as amended by Section 1, Chapter 396, O.S.L. 1997 (63 O.S.
6 Supp. 1998, Section 2525.5), is amended to read as follows:

7 Section 2525.5 A. The rules promulgated by the State Board of
8 Health for ~~certification of~~ managed care plans that conduct business
9 in this state shall ~~include, but not be limited to, standards~~
10 ~~whereby~~ at a minimum require:

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

- 20 a. coverage provisions, benefits, detailed disclosure of
21 pharmacy benefits, including which drugs are included
22 on the formulary, and any exclusions by category of
23 service, provider or physician, and if applicable, by
24 specific service,
- 25 b. any and all prior authorization or other utilization
26 review requirements, and any procedures that may lead
27 the patient to be denied coverage for or not be
28 provided a particular service,
- 29 c. explanation of how plan limitations affect enrollees,
30 including information on enrollee financial
31 responsibility for payment for coinsurance or other
32 noncovered or out-of-plan services, and

1 d. enrollee satisfaction statistics including, but not
2 limited to, percent reenrollment and reasons for
3 leaving plans;

4 2. Plans shall demonstrate that they have adequate access to
5 physicians and other providers, so that all covered health care
6 services will be provided in a timely fashion;

7 3. Plans shall meet financial requirements established to
8 assure the ability to pay for covered services ~~and to pay for such~~
9 ~~services~~ in a timely fashion;

10 4. All plans shall be required to establish a mechanism under
11 which physicians participating in the plan may provide input into
12 the plan's medical policy including, but not limited to, coverage of
13 new technology and procedures, utilization review criteria and
14 procedures, quality and credentialing criteria, and medical
15 management procedures; and

16 5. a. Physician credentialing shall be based on objective
17 standards, with input from physicians credentialed in
18 the plan, which shall be available to physician
19 applicants and participating physicians. When
20 economic considerations are part of the credentialing
21 decision, objective criteria shall be used and shall
22 be available to physician applicants and participating
23 physicians. When graduate medical education is a
24 consideration in the credentialing process, equal
25 recognition shall be given to training programs
26 accredited by the Accrediting Council on Graduate
27 Medical Education and by the American Osteopathic
28 Association. When graduate medical education is
29 considered for optometric physicians, consideration
30 shall be given for educational accreditation by the
31 Council on Optometric Education. Each application
32 shall be reviewed by a credentialing committee of

1 physicians. The lack of board certification or board
2 eligibility shall not be the only criterion upon which
3 a denial of an application is based.

4 b. Plans shall not discriminate against enrollees with
5 expensive medical conditions by excluding
6 practitioners with practices containing a substantial
7 number of ~~such~~ these patients.

8 c. Plans shall provide, upon request, to a physician
9 whose contract is terminated or not renewed for cause
10 the reasons for termination or nonrenewal. Plans
11 shall not contractually prohibit such requests.

12 d. No managed health care plan shall engage in the
13 practice of medicine or any other profession except as
14 provided by law nor shall ~~such~~ a plan include any
15 provision in a provider contract which precludes or
16 discourages a plan's providers from:

17 (1) informing a patient of the care the patient
18 requires, including treatments or services not
19 provided or reimbursed under the patient's plan;
20 or

21 (2) advocating on behalf of a patient before the
22 managed health care plan.

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

26 1. Prior authorization:

- 27 a. shall not be required for emergency care, and
28 b. requests by patients or physicians for nonemergency
29 services shall be answered within five (5) business
30 days of ~~such~~ the request;

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

4 3. Out-of-area urgent follow-up care will be covered as long as
5 the care is necessitated to stabilize the urgent situation, complies
6 with health plan provisions, and complies with federal guidelines;

7 4. Plans shall ensure that enrollees, in plans where
8 preauthorization is a condition to coverage of a service, are
9 required to sign medical information release ~~consent~~ forms upon
10 enrollment for use where services requiring prior authorization are
11 recommended or proposed by their physician. Plans are prohibited
12 from disclosing to employers any medical information about an
13 enrollee without ~~such person's~~ specific prior authorization from the
14 enrollee. With the exception of insured benefit plans,
15 preauthorization requests may be denied only by a physician licensed
16 by the State Board of Medical Licensure and Supervision or the
17 Oklahoma State Board of Osteopathic Examiners, subject to the
18 jurisdiction of the Oklahoma courts;

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

24 6. Contested denials of service by the attending physician in
25 cases where there are ~~not~~ no medically agreed upon guidelines shall
26 be evaluated in consultation with physicians of the same or similar
27 specialty or training as the attending physician who is contesting
28 the denial.

29 SECTION 8. AMENDATORY Section 5, Chapter 289, O.S.L.
30 1997 (63 O.S. Supp. 1998, Section 2525.6), is amended to read as
31 follows:
32

1 Section 2525.6 A. Each ~~certified~~ managed care plan, including
2 such plans provided, offered, or made available by voluntary health
3 purchasing cooperatives, employers, associations, self-insurers, or
4 any other private group, that limits coverage for out-of-network
5 services, may offer coverage through a point-of-service plan.

6 B. A ~~certified~~ managed care plan may charge an alternative
7 premium for point-of-service coverage that takes into account the
8 actuarial value of ~~such~~ the coverage. ~~Such~~ The plan may require
9 additional charges ~~may~~ to be paid by the enrollee rather than the
10 sponsor.

11 C. Where a sponsor of fifty or more employees including, but
12 not limited to, an employer, association, or private group, intends
13 to offer only a health maintenance organization plan to covered
14 persons, a point-of-service option or its equivalent shall also be
15 offered. This optional coverage for out-of-network care may be
16 subject to an additional premium, deductible, and copayment, and
17 such charges may be paid by the enrollee rather than the sponsor.
18 For the purposes of this section ~~only~~, the term "sponsor" shall not
19 include the Oklahoma Health Care Authority.

20 SECTION 9. NEW LAW A new section of law to be codified
21 in the Oklahoma Statutes as Section 2525.7 of Title 63, unless there
22 is created a duplication in numbering, reads as follows:

23 The State Board of Health shall promulgate rules for the
24 licensing of managed care entities that are not currently licensed
25 by the State Department of Health as a health maintenance
26 organization or pre-paid health plan or as an insurer by the
27 Insurance Commissioner. Such rules may include provisions for a fee
28 to cover the Department's administrative costs related to the
29 licensing process.

30 SECTION 10. This act shall become effective November 1, 1999.

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32 47-1-7296 KSM 6/11/15