

By: Morgan of the House  
and  
Brown of the Senate

An Act relating to health care; amending Section 1, Chapter 289, O.S.L. 1997, Section 2, Chapter 289, O.S.L. 1997, as amended by Section 5, Chapter 361, O.S.L. 1999 and Section 4, Chapter 289, O.S.L. 1997, as last amended by Section 7, Chapter 361, O.S.L. 1999 (63 O.S. Supp. 1999, Sections 2525.2, 2525.3 and 2525.5), which relate to the Oklahoma Managed Care Act; clarifying statutory cites; deleting and modifying definitions; providing criteria for coverage of emergency services; prohibiting denial of coverage for emergency services based on notification; requiring compensation of providers for certain emergency-related services; providing for coverage of emergency services after certain determination is made; and providing an effective date.

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

SECTION 1. AMENDATORY Section 1, Chapter 289, O.S.L. 1997 (63 O.S. Supp. 1999, Section 2525.2), is amended to read as follows:

Section 2525.2 ~~This act~~ Sections 2525.2 through 2525.7 of this title shall be known and may be cited as the "Oklahoma Managed Care Act".

SECTION 2. AMENDATORY Section 2, Chapter 289, O.S.L. 1997, as amended by Section 5, Chapter 361, O.S.L. 1999 (63 O.S. Supp. 1999, Section 2525.3), is amended to read as follows:

Section 2525.3 For purposes of the Oklahoma Managed Care Act:

1. ~~"Emergency care" means emergency department screening and care to achieve 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.~~ 2. "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.~~ 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 the plan through any of the following means:

- 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, and dispute resolution, ~~and~~ or
- d. financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan;

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

~~5.~~ 4. "Out-of-network" or "point-of-service" plan is a product issued by a 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.~~ 5. "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.~~ 6. "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.~~ 7. "Qualified utilization review program" means a utilization review program that meets the requirements of the Oklahoma Managed Care Act; and

~~9.~~ 8. "Urgent care" means the treatment for an unexpected illness or injury which is severe or painful enough to require treatment within twenty-four (24) hours.

SECTION 3. AMENDATORY Section 4, Chapter 289, O.S.L. 1997, as last amended by Section 7, Chapter 361, O.S.L. 1999 (63 O.S. Supp. 1999, Section 2525.5), is amended to read as follows:

Section 2525.5 A. The rules promulgated by the State Board of Health for managed care plans that conduct business in this state shall at a minimum require:

1. Enrollees and prospective enrollees in health insurance plans shall be provided the terms and conditions of the plan so that they can make an informed decision about choosing a system of health care delivery. The verbal description of the plan, when presented to enrollees, shall be easily understood and truthful, and shall

utilize objective terms. All written plan descriptions shall be in a readable and understandable format. Specific items that shall be included are:

- a. coverage provisions, benefits, detailed disclosure of pharmacy benefits, including which drugs are included on the formulary, and any exclusions by category of service, provider or physician, and if applicable, by specific service,
- b. 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,
- c. 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
- d. 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 in a timely fashion;

4. All plans shall be required to establish a mechanism under which physicians participating in the plan may 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. a. Physician credentialing shall be based on objective standards, 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. When graduate medical education is considered for optometric physicians, consideration shall be given for educational accreditation by the 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 upon which a denial of an application is based.

- b. Plans shall not discriminate against enrollees with expensive medical conditions by excluding practitioners with practices containing a substantial number of these patients.
- c. Plans shall provide, upon request, to a physician whose contract is terminated or not renewed for cause the reasons for termination or nonrenewal. Plans shall not contractually prohibit such requests.
- d. No managed health care plan shall engage in the practice of medicine or any other profession except as provided by law nor shall a plan include any provision in a provider contract which precludes or discourages a plan's providers from:

- (1) informing a patient of the care the patient requires, including treatments or services not provided or reimbursed under the patient's plan;  
or
- (2) advocating on behalf of a patient before the managed health care plan;

6. Decisions by a managed care plan to authorize or deny coverage for an emergency service shall be based on the patient presenting symptoms arising from any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in serious:

- a. jeopardy to the health of the patient,
- b. impairment to bodily functions, or
- c. dysfunction of any bodily organ or part;

7. Plans shall not deny an otherwise covered emergency service based solely upon lack of notification to the plan; and

8. Plans shall compensate a provider for patient screening, evaluation, and examination services that are reasonably calculated to assist the provider in determining whether the condition of the patient requires emergency service. If the provider determines that the patient does not require emergency service, coverage for services rendered subsequent to that determination shall be governed by the plan contract.

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 the request;

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

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

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 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 specific prior authorization from the enrollee. With the exception of insured benefit plans, preauthorization requests may be denied 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 authorization for a specific service or other specific covered item is obtained, it shall be considered authorization for that purpose, and the specific service shall be considered covered unless there was fraud or incorrect information provided at the time prior authorization was obtained; and

6. Contested denials of service by the attending physician in cases where there are no medically agreed upon guidelines shall be evaluated in consultation with physicians of the same or similar specialty or training as the attending physician who is contesting the denial.

SECTION 4. This act shall become effective November 1, 2000.

Passed the House of Representatives the 1st day of March, 2000.

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Speaker of the House of  
Representatives

Passed the Senate the \_\_\_\_ day of \_\_\_\_\_, 2000.

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President of the Senate