

ENGROSSED HOUSE
BILL NO. 2183

By: Adair, Easley, Seikel,
Wells, Culver and Reese of
the House

and

Morgan of the Senate

An Act relating to health care; amending 63 O.S. 1991, Section 2505, as last amended by Section 4, Chapter 404, O.S.L. 1997 (63 O.S. Supp. 1999, Section 2505), which relates to health maintenance organizations; requiring insurance contracts and health benefit plans, Medicaid contracts, managed care contracts, preferred provider contracts, state-purchased and state-subsidized health plans and other health plans which include services for vision care or medical treatment and diagnosis for the eye to allow optometrists to be providers of and to receive equal compensation for certain services within the scope of practice of optometry; providing for construction of section; requiring a patient choice between ophthalmologists and optometrists; requiring certain set of standards and procedures; requiring certain drafting content; prohibiting insurance contracts and health benefit plans, managed care contracts, preferred provider contracts, state-purchased and state-subsidized health plans, Medicaid contracts and other health plans which require optometrists to meet qualifications which are in addition to requirements for licensure; prohibiting construction which prevents determination of adequacy of network; providing for equal compensation; providing for construction of section; prohibiting construction which would limit or expand practice of optometry; requiring extensions and renewals of insurance contracts and health benefit plans, managed care contracts, preferred provider contracts and other health plans to comply with requirements; 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 3634.11 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Any health benefit plan which offers services for vision care or medical diagnosis and treatment for the eye shall allow optometrists to be providers of those services.

B. With respect to optometric services, any health benefit plan which uses a gatekeeper or equivalent for referrals for services for vision care or for medical diagnosis and treatment of the eye shall require such covered services be provided on a referral basis within the medical group or network at the request of an enrollee who has a condition requiring vision care or medical diagnosis and treatment of the eye if:

1. A referral is necessitated in the judgment of the primary care physician; and

2. Treatment for the condition falls within the licensed scope of practice of an optometrist.

C. Each health benefit plan shall have a defined set of standards and procedures for selecting providers, including specialists, to serve enrollees. The standards and procedures shall be drafted in such a manner that they are applicable to all categories of providers and shall be utilized by the health benefit plan in a manner that is without bias for or discrimination against a particular category or categories of providers.

D. No health benefit plan shall require a provider to have hospital privileges if hospital privileges are not usual and customary for the services the provider provides.

E. Health benefit plans shall provide that optometrists be equally compensated for covered services and procedures provided to an insured on the basis of charges prevailing in the same geographical area or in similar-sized communities for similar services and procedures as provided in the Health Care Freedom of Choice Act, if the services are within the scope of practice of optometry.

F. Nothing in this section shall be construed to:

1. Prohibit a health benefit plan which offers services for vision care or medical diagnosis and treatment for the eye from determining the adequacy of the size of its network;

2. Prohibit an optometrist from agreeing to a fee schedule;

3. Limit, expand, or otherwise affect the scope of practice of optometry; or

4. Alter, repeal, modify or affect the laws of this state except where such laws are in conflict or are inconsistent with the express provisions of this section.

G. Existing health benefit plans shall comply with the requirements of this section upon issuance or renewal on or after the effective date of this act.

H. As used in this section, "health benefit plan" means individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, any program funded under Title XIX of the Social Security Act or such other publicly funded program, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions.

SECTION 2. AMENDATORY 63 O.S. 1991, Section 2505, as last amended by Section 4, Chapter 404, O.S.L. 1997 (63 O.S. Supp. 1999, 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, in accordance with Section 2501 et seq. of this title and the laws governing such professions and services.

B. Each health maintenance organization or prepaid health plan shall have a defined set of standards and procedures for selecting providers, including specialists, to serve enrollees. The standards and procedures shall be drafted in such a manner that they are applicable to all categories of providers and shall be utilized by the health maintenance organization or prepaid health plan in a manner that is without bias for or discrimination against a particular category or categories of providers.

C. With respect to chiropractic services, such covered services shall be provided on a referral basis within the network at the request of an enrollee who has a condition of an orthopedic or neurological nature if:

1. A referral is necessitated in the judgment of the primary care physician; and

2. Treatment for the condition falls within the licensed scope of practice of a chiropractic physician.

~~B.~~ D. 1. Any health maintenance organization or prepaid health plan which offers services for vision care or medical diagnosis and treatment for the eye shall allow optometrists to be providers of those services.

2. Once a fee schedule has been negotiated, ophthalmologists and optometrists shall be paid equally for the same services so long as the services provided by the optometrists are within the scope of the practice of optometry.

3. No health maintenance organization or prepaid health plan shall require a provider of vision care or medical diagnosis and treatment for the eye to have hospital privileges if hospital privileges are not usual and customary for the services the provider provides.

4. With respect to optometric services, such covered services shall be provided on a referral basis within the medical group or

network at the request of an enrollee who has a condition requiring vision care or medical diagnosis and treatment of the eye if:

- a. a referral is necessitated in the judgment of the primary care physician, and
- b. treatment for the condition falls within the licensed scope of practice of an optometrist.

5. Nothing in this subsection shall be construed to:

- a. prohibit any health maintenance organization or prepaid health plan which offers services for vision care or medical diagnosis and treatment for the eye from determining the adequacy of the size of its network,
- b. limit, expand or otherwise affect the scope of practice of optometry, or
- c. alter, repeal, modify or affect the laws of this state except where such laws are in conflict or are inconsistent with the express provisions of this section.

6. Existing contracts shall comply with the requirements of this subsection upon issuance or renewal on or after the effective date of this act.

E. 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.

~~E.~~ F. 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.

~~D.~~ G. 1. A health maintenance organization or prepaid health plan shall not:

- a. engage in the practice of medicine or any other profession except as provided by law, or
- b. prohibit or restrict a primary care physician from referring a patient to a specialist within the network if such referral is deemed medically necessary in the judgment of the primary care physician.

2. A health maintenance organization or prepaid health plan shall provide comprehensive health services in a manner that is reasonably geographically convenient to residents of the service area for which it seeks a license.

~~E.~~ H. 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 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5011.1 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. All state-purchased and state-subsidized health care benefit plans, including but not limited to Medicaid, which offer services for vision care or medical diagnosis and treatment for the eye shall allow optometrists to be providers of those services. Such state-purchased and state-subsidized health care benefit plans shall also require equal payment for the same services provided by an optometrist if the services are within the scope of practice of optometry.

B. With respect to optometric services, any state-purchased and state-subsidized health care benefit plan, including but not limited to Medicaid, which uses a gatekeeper or equivalent for referrals for services for vision care or for medical diagnosis and treatment of

the eye, shall require such covered services be provided on a referral basis within the medical group or network at the request of an enrollee who has a condition requiring vision care or medical diagnosis and treatment of the eye if:

1. A referral is necessitated in the judgment of the primary care physician; and

2. Treatment for the condition falls within the licensed scope of practice of an optometrist.

C. All state-purchased and state-subsidized health care benefit plans shall have a defined set of standards and procedures for selecting providers, including specialists, to serve enrollees. The standards and procedures shall be drafted in such a manner that they are applicable to all categories of providers and shall be utilized by the health plan in a manner that is without bias for or discrimination against a particular category or categories of providers.

D. No health care benefit plan specified by this section shall require a provider to have hospital privileges if hospital privileges are not usual and customary for the services the provider provides.

E. Nothing in this section shall be construed to:

1. Prohibit any state-purchased and state-subsidized health care benefit plan which offers services for vision care or medical diagnosis and treatment for the eye from determining the adequacy of the size of its network;

2. Prohibit an optometrist from agreeing to a fee schedule;

3. Limit, expand, or otherwise affect the scope of practice of optometry; or

4. Alter, repeal, modify or affect the laws of this state except where such laws are in conflict or are inconsistent with the express provisions of this section.

F. Existing state-purchased and state-subsidized health care benefit plans shall comply with the requirements of this section upon issuance or renewal on or after the effective date of this act.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1327 of Title 74, unless there is created a duplication in numbering, reads as follows:

A. All health benefit plans offered by the State and Education Employees Group Insurance Board which provide for services for vision care or medical diagnosis and treatment for the eye shall allow optometrists to be providers of those services. All such health benefit plans shall also require equal payment for the same services provided by an optometrist if the services are within the scope of practice of optometry.

B. With respect to optometric services, any health benefit plan offered by the State and Education Employees Group Insurance Board which uses a gatekeeper or equivalent for referrals for services for vision care or for medical diagnosis and treatment of the eye, shall require such covered services be provided on a referral basis within the medical group or network at the request of an enrollee who has a condition requiring vision care or medical diagnosis and treatment of the eye if:

1. A referral is necessitated in the judgment of the primary care physician; and

2. Treatment for the condition falls within the licensed scope of practice of an optometrist.

C. All health benefit plans offered by the State and Education Employees Group Insurance Board shall have a defined set of standards and procedures for selecting providers, including specialists, to serve enrollees. The standards and procedures shall be drafted in such a manner that they are applicable to all categories of providers and shall be utilized by the health maintenance organization in a manner that is without bias for or

discrimination against a particular category or categories of providers.

D. No health benefit plan specified by this section shall require a provider to have hospital privileges if hospital privileges are not usual and customary for the services the provider provides.

E. Nothing in this section shall be construed to:

1. Prohibit a health benefit plan offered by the State and Education Employees Group Insurance Board which provides for services for vision care or medical diagnosis and treatment for the eye from determining the adequacy of the size of its network;

2. Prohibit an optometrist from agreeing to a fee schedule;

3. Limit, expand, or otherwise affect the scope of practice of optometry; or

4. Alter, repeal, modify or affect the laws of this state except where such laws are in conflict or are inconsistent with the express provisions of this section.

F. Existing health benefit plans offered by the State and Education Employees Group Insurance Board shall comply with the requirements of this section upon issuance or renewal on or after the effective date of this act.

SECTION 5. This act shall become effective November 1, 2000.

Passed the House of Representatives the 7th day of March, 2000.

Speaker of the House of
Representatives

Passed the Senate the ____ day of _____, 2000.

President of the Senate