ENROLLED HOUSE
BILL NO. 1681

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

and

Monson of the Senate

An Act relating to insurance; defining terms; requiring referral to a specialist by a managed care plan under certain conditions and terms and stating procedures; stating exception; providing for compliance with certain terms; prohibiting certain referrals; requiring treatment plans; providing for certain treatment; prohibiting certain additional costs; providing for certain procedures; providing procedures for continuation of certain coverage; providing for certain appeals; requiring certain notice; requiring certain agreements for continued coverage; providing procedures for approval or disapproval of requests for certain drugs; providing for deemed approvals; requiring certain time periods; requiring certain supplies; prohibiting certain additional costs; requiring certain copies of procedures be provided; amending Section 2, Chapter 289, O.S.L. 1997, Section 3, Chapter 289, O.S.L. 1997, Section 4, Chapter 289, O.S.L. 1997, as amended by Section 1, Chapter 396, O.S.L. 1997, and Section 5, Chapter 289, O.S.L. 1997 (63 O.S. Supp. 1998, 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. “Covered person” means an individual who receives medical care and treatment through a managed care plan. In the case of a minor child, the term includes the parent or legal guardian of the

child and, in the case of an incapacitated or partially incapacitated person, the legal guardian of that person;

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

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

4. "Managed care plan" means a plan operated by a managed care entity, including the Oklahoma State and Education Employees Group Insurance Board, 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 managed care plan to use the participating providers and procedures provided for by the managed care 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. "Provider" shall have the same meaning as such term is defined by a health maintenance organization, an indemnity plan or a preferred provider organization; and

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

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

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

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

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

A. A managed care plan that has no participating provider for a covered benefit requiring a specialist shall arrange for a referral to a specialist with expertise in treating the covered

benefit. The specialist shall agree to abide by the terms of the plan's provider contract if the terms are commensurate with the terms of contracts for similar specialists.

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

2. The specialist may be responsible for and may provide and coordinate the covered person's primary and specialty care only if the specialist is willing to abide by the terms of the plan's contract and capable of providing such care.

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

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

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

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

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

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

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

1. Has a degenerative and disabling condition or disease;

2. Has entered the third trimester of pregnancy. Additional coverage of services by the terminated provider shall continue through at least six (6) weeks of postpartum evaluation; or

3. Is terminally ill.

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

a. of up to ninety (90) days from the date of notice to the managed care plan of the provider's disaffiliation from the managed care plan's network, or

b. that includes delivery and postpartum care if the covered person has entered the third trimester of pregnancy at the time of the provider's disaffiliation.

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

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

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

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

c. otherwise adhere to the managed care plan's policies and procedures, including, but not limited to, policies and procedures regarding referrals, and

obtaining preauthorization and treatment plan approval from the managed care plan.

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

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

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

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

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

SECTION 5. AMENDATORY Section 2, Chapter 289, O.S.L. 1997 (63 O.S. Supp. 1998, 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. "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~~ the 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;

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. "Out-of-network" or "point-of-service" plan is a product issued by a ~~certified~~ 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. ~~"Certified managed care plan" means a managed care plan that the State Commissioner of Health has certified as meeting the requirements of the Oklahoma Managed Care Act;~~

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

~~10.~~ 9. "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 6. AMENDATORY Section 3, Chapter 289, O.S.L. 1997 (63 O.S. Supp. 1998, Section 2525.4), is amended to read as follows:

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

~~a. for~~

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

~~b. identifying~~

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

~~2. a.~~

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

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

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

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

~~b.~~

2. 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 certified 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 4 of this act for certification as a certified managed care plan.~~

~~2.~~ If the State Commissioner of Health 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~~ as restrictive as the requirements established pursuant to Section ~~4~~ 2525.5 of this ~~act~~ title, 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 ~~4~~ 2525.5 of this ~~act~~ title.

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

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

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, 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 ~~and to pay for such 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 ~~such~~ 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 ~~such~~ 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.

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~~ 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 ~~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 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 ~~such~~ prior authorization was obtained; and

6. Contested denials of service by the attending physician in cases where there are ~~not~~ 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 8. AMENDATORY Section 5, Chapter 289, O.S.L. 1997 (63 O.S. Supp. 1998, Section 2525.6), is amended to read as follows:

Section 2525.6 A. Each ~~certified~~ 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 coverage through a point-of-service plan.

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

C. Where a sponsor of fifty or more employees 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 shall also be offered. This optional coverage for out-of-network care may be subject to an additional premium, deductible, and copayment, and such charges may be paid by the enrollee rather than the sponsor. For the purposes of this section ~~only~~, the term "sponsor" shall not include the Oklahoma Health Care Authority.

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

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

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

Passed the House of Representatives the 26th day of May, 1999.

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Speaker of the House of Representatives

Passed the Senate the 27th day of May, 1999.

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President of the Senate