THE STATE SENATE
Thursday, March 25, 1999

ENGROSSED

House Bill No. 1681

As Amended

EHB 1681

ENGROSSED HOUSE BILL NO. 1681 - By: SEIKEL, COLLINS, KIRBY, MADDUX and NATIONS of the House and MONSON of the Senate.

(managed care plans - certain referrals under certain circumstances - Oklahoma Managed Care External Review Act - internal reviews - external reviews - codification - effective date)

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. In any case where a managed care plan has no participating providers to provide a covered benefit, the managed care plan shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers.

B. A managed care plan shall have a procedure by which a new covered person upon enrollment in a managed care product, or a covered person in a managed care product upon diagnosis, with:

1. A life-threatening condition or disease; or

2. A degenerative and disabling condition or disease,

either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating the insured's primary and specialty care. If the managed care plan, or primary care provider in consultation with the managed care plan and the specialist, if any, determines that the covered person's care would most appropriately be coordinated by such a specialist, the managed care plan shall refer the covered person to such specialist. In no event shall a managed care plan be required to permit a covered person to elect to have a nonparticipating specialist, except pursuant to the provisions of subsection A of this section. Such referral shall be pursuant to a treatment plan approved by the managed care plan, in consultation with the primary care provider if appropriate, the specialist, and the covered person or the covered person's designee. Such specialist shall be permitted to treat the covered person without a referral from the covered person's primary care provider and may authorize such referrals, procedures, tests and other medical services as the covered person's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. If a managed care plan refers a covered person to a nonparticipating provider, services provided pursuant to

the approved treatment plan shall be provided 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.

C. A managed care plan that does not allow direct access to all specialists shall establish and implement a procedure by which a covered person may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if a primary care provider determines in consultation with a specialist that a covered person needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the managed care plan in consultation with the primary care provider, a specialist, and the covered person. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care provider with regular reports on the health care provided to the covered person.

D. When a managed care plan uses a formulary for prescription drugs, such managed care plan shall include a written procedure whereby covered persons can obtain, without penalty and in a timely fashion, specific drugs and medications not included in the formulary when:

1. The formulary's equivalent has been ineffective in the treatment of the covered person's disease or condition; or

2. The formulary's drug causes or is reasonably expected to cause adverse or harmful reactions in the covered person.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.8 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Every managed care plan shall establish procedures governing termination of participating providers. The procedures shall include assurance of continued coverage of services at the contract price by a terminated provider for up to one hundred twenty (120) calendar days in cases where it is medically necessary for the member to continue treatment with the terminated provider. In cases of the pregnancy of a member, medical necessity shall be deemed to have been demonstrated and coverage of services by the terminated provider shall continue to the postpartum evaluation of the member, up to six (6) weeks after delivery. The policy shall clearly state that the determination as to the medical necessity of a covered person's continued treatment with a terminated provider shall be subject to the appeal procedures of the managed care plan.

B. 1. If the covered person's health care provider leaves the managed care plan's in-network benefits portion of its network of providers for a managed care product for reasons other than those

for which the provider would not be eligible to receive a hearing pursuant to the grievance procedures established by the managed care plan for participating providers, the managed care plan shall permit the covered person to continue an ongoing course of treatment with the covered person's current health care provider during a transitional period of:

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

b. if the covered person has entered the second trimester of pregnancy at the time of the provider's disaffiliation, for a transitional period that includes the provision of postpartum care directly related to the delivery.

2. 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 health care provider agrees:

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

c. to otherwise adhere to the managed care plan's policies and procedures including, but not limited to, procedures regarding referrals and obtaining preauthorization and a treatment plan approved by the managed care plan.

C. 1. If a new covered person whose health care provider is not a member of the managed care plan's in-network benefits portion of the provider network enrolls in the managed care product, the managed care plan shall permit the covered person to continue an ongoing course of treatment with the covered person's current health care provider during a transitional period of up to sixty (60) days from the effective date of enrollment, if:

a. the covered person has a life-threatening disease or condition or a degenerative and disabling disease or condition, or

b. the covered person has entered the second trimester of pregnancy at the time of enrollment, in which case the transitional period shall include the provision of postpartum care directly related to the delivery.

2. If a covered person elects to continue to receive care from such health care provider pursuant to paragraph 1 of this subsection, such care shall be authorized by the managed care plan for the transitional period only if the health care provider agrees:

a. to accept reimbursement from the managed care plan at rates established by the insurer as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the in-network benefits portion of the managed care plan's network for such services,

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

c. to otherwise adhere to the managed care plan's policies and procedures including, but not limited to, procedures regarding referrals and obtaining preauthorization and a treatment plan approved by the managed care plan.

3. In no event shall this section be construed to require a managed care plan to provide coverage for benefits not otherwise covered or to diminish or impair preexisting condition limitations contained within the covered person's contract.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6481 of Title 36, unless there is created a duplication in numbering, reads as follows:

Sections 3 through 12 of this act shall be known and may be cited as the "Oklahoma Managed Care External Review Act".

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6482 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Oklahoma Managed Care External Review Act:

1. "Health benefit plan" means an individual or group hospital or medical insurance coverage, not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization, a preferred provider plan, the State and Education Employees Group Insurance Plan, coverage provided by a Multiple Employer Welfare Arrangement or self-insured plan;

2. "Insured person" means an individual who received medical care and treatment through a health benefit 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 the person;

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

4. "Independent review organization" means an entity certified by the State Department of Health to conduct external reviews;

5. "Internal review" means procedures established by a health benefit plan, pursuant to the provisions of Section 6 of this act, for an internal reevaluation of an initial decision to deny reimbursement for or coverage of a medical treatment or service that is otherwise a covered benefit and a determination by the health benefit plan to grant or deny coverage or reimbursement; and

6. "External review" means a review of a decision by a health benefit plan to deny reimbursement for or coverage of a medical treatment or service that is otherwise a covered benefit by an independent review organization upon the request of an insured person or the representative of an insured person and a determination to uphold or reverse the denial of coverage or reimbursement made by the health benefit plan.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6483 of Title 36, unless there is created a duplication in numbering, reads as follows:

An insured person or the parent, guardian, or representative of the insured person shall have the right to an external review by an independent review organization of a decision under a health benefit plan to deny reimbursement for or coverage of a medical treatment or service that is otherwise a covered benefit when:

1. All applicable internal appeals procedures established by the health benefit plan have been exhausted;

2. The denial is based on a determination by the health benefit plan that the service or treatment is not medically necessary, medically appropriate, or medically effective;

3. The cost of the service or treatment for which coverage or reimbursement was denied by the health benefit plan exceeds Two Thousand Five Hundred Dollars ($2,500.00); and

4. The insured person or the representative of the insured person agrees to the terms and conditions of external review as provided by Section 4 of this act.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6484 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as specifically provided by this section, every health benefit plan that is offered, issued or renewed after November 1, 1999, shall provide for an external review process by an independent review organization in accordance with the provisions of the Oklahoma Managed Care External Review Act. The following shall not be subject to the provisions of the Oklahoma Managed Care External Review Act:

1. Health benefit plans that do not deny coverage of or reimbursement for a medical service or treatment on the grounds that

the medical service or treatment is not medically necessary, medically appropriate, or is medically ineffective;

2. Health benefit plans and health care provided pursuant to Titles XVIII, XIX or XXI of the federal Social Security Act; and

3. Workers' compensation benefits or coverage subject to Title 85 of the Oklahoma Statutes.

B. Every health benefit plan subject to this act shall establish internal appeals procedures in accordance with rules promulgated by the State Board of Health and the Insurance Commissioner. The State Board of Health and the Insurance Commissioner shall respectively promulgate rules for internal review procedures for the health benefit plans subject to licensure or regulation by the State Department of Health and the Insurance Department and subject to the provisions of the Oklahoma Managed Care External Review Act. The rules shall include provisions for expedited internal review procedures in emergency situations. In the development and promulgation of the rules, the State Board of Health and the Insurance Commissioner shall collaborate on the development and promulgation of the rules in order to avoid unnecessary conflict between the rules of the two agencies and duplication of effort by the health benefit plans.

C. Upon the verbal or written request of an insured person or the representative of an insured person, every health benefit plan

shall immediately provide the requester with clear information about the terms, conditions and procedures of the internal review process or the external review process, or both.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6485 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An insured person or representative of an insured person shall be required to pay One Hundred Dollars ($100.00) toward the cost of the external review.

1. The payment is due at the time the preliminary screening is completed and the insured person or the representative of the insured person is notified of a determination by the independent review organization to accept the appeal for a full external review.

2. Whenever the insured person or the representative of the insured person prevails at the completion of the external review, the payment shall be refunded.

3. The health benefit plan shall be responsible for the remaining costs related to the external review process.

B. The determination of the independent review organization is binding on the health benefit plan, the covered person, and the health care provider for the covered person. A condition of completing the external review process shall be the agreement by the parties to waive the right to file a court action to resolve the

issue in dispute, either during or at the completion of the external review process.

C. The number of appeals for an external review by a covered person or a representative of a covered person shall be limited to one external review per condition or treatment.

D. The health benefit plan may, at its discretion, determine that additional information provided by the insured person or the representative or physician of the insured person justifies a reconsideration of the denial of coverage or reimbursement. Upon notice to the covered person or the representative of the covered person and the independent review organization, a decision by the health benefit plan to grant coverage or reimbursement shall terminate the external review.

E. Nothing in the Oklahoma Managed Care External Review Act shall:

1. Create any new private right or cause of action for or on behalf of any covered person; or

2. Render the health benefit plan liable for damages arising from any act or omission of the independent review organization.

F. Independent review organizations and expert reviewers assigned by an independent review organization to conduct an external review are not liable for damages arising from determinations made pursuant to the Oklahoma Managed Care External

Review Act. This provision shall not apply to an act or omission that is made in bad faith or that involves gross negligence.

G. After an appeal has been accepted for external review by an independent review organization, an informed consent form signed by the insured person or the representative of the insured person acknowledging that they have received a copy of the terms and conditions of the external review process as provided by this section and understand and consent to them shall be required prior to initiating a full external review.

H. A health benefit plan shall not remove a physician from its plan or refuse to renew the physician with the plan or otherwise discipline a physician for advocating on behalf of an insured person in either an internal or an external review.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6486 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An appeal from a decision by a health benefit plan to deny coverage or reimbursement for a service or treatment and request for an external review shall be initiated in writing by the insured person or the representative of the insured person. The request shall be delivered to the health benefit plan within thirty (30) days after receipt of written notification from the health benefit plan of the denial after completion of the internal review process.

B. Upon receipt of the request for an external review, the health benefit plan shall immediately notify an independent review organization selected from a list of independent review organizations certified by the State Department of Health and inform the covered person or the representative of the covered person as to the independent review organization selected.

C. Within five (5) business days of notification as to the independent review organization, the insured person or representative of the insured person shall provide the independent review organization with the following documents:

1. A written request for an external review of the decision by the health benefit plan to deny coverage or reimbursement and a statement of the reasons for the request;

2. A copy of the final decision of denial made by the health benefit plan; and

3. A fully executed release authorizing the independent review organization to obtain necessary medical records from the health benefit plan and any relevant health care providers.

D. Upon receipt of a written request for an external review and the documentation as provided by subsection C of this section, the independent review organization shall conduct a preliminary review of the appeal and shall accept it for a full review when the independent review organization determines that:

1. The individual on whose behalf the appeal is made is or was an insured person or is the representative of an insured person;

2. The subject of the coverage desired or for which reimbursement is asked is a covered service, or treatment or a service or treatment provided by contract to the insured person;

3. The insured person or the representative of the insured person has exhausted the internal review procedures of the health benefit plan; and

4. The insured person or the representative of the insured person has notified the health benefit plan of the request for an external review.

E. Upon the completion of the preliminary review, the independent review organization shall immediately make written notification of its determination whether or not to accept the appeal for full external review to the insured person or the designee of the insured person, the health benefit plan and, if possible, the physician of the insured person. If the appeal is not accepted for full external review, a statement of the reasons for nonacceptance shall be included with the notification.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6487 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Upon receipt of notification of acceptance of an appeal for full external review from an independent review organization, the health benefit plan shall provide the independent review organization with the following documents within five (5) business days after receipt of a request for an external review:

1. Any information that was submitted to the health benefit plan by the insured person or the representative or physician of the insured person in support of the request for coverage or reimbursement pursuant to the internal review process; and

2. A copy of the contract provisions upon which the denial of coverage or reimbursement was based, any statement by the health benefit plan explaining the reasons for the decision of the health plan not to provide coverage or to deny reimbursement, and any other relevant documents used by the health benefit plan in reaching its decision.

B. Upon the request of the covered person or the representative of the insured person, the health benefit plan shall provide the information required by subsection A of this section to the insured person or the representative or physician of the insured person.

C. The independent review organization shall notify the insured person or the representative of the insured person of any additional information it requires within five (5) business days after receipt of the information submitted by the health benefit plan. The

insured person or the representative of the insured person shall submit the additional information, or an explanation as to why the additional information cannot be submitted, within five (5) business days of receipt of the request for additional information.

D. The independent review organization shall maintain the confidentiality of medical records submitted to it in accordance with state and federal law, and shall maintain the confidentiality of proprietary information submitted by the health benefit plan.

E. The independent review organization shall make a written determination on the appeal stating the reasons why the desired service or treatment, or reimbursement for service or treatment, should or should not be made by the health benefit plan. The determination shall be delivered to the insured person or designee of the insured person, the physician of the insured person, and the health benefit plan of its determination within thirty (30) days after acceptance of the appeal for external review and receipt of the documentation required by this section.

F. When the physician of the insured person certifies in writing that the times provided for by this section could jeopardize the life or health of the patient, the decision shall be rendered as rapidly as warranted by the condition of the patient but shall in no event exceed seventy-two (72) hours.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6488 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The determination of the independent review organization as to the resolution of the appeal shall be based upon a review of the written record before it. In reaching this determination, the independent review organization shall apply any applicable health benefit plan policy or contract provisions, taking into consideration all pertinent medical records, consulting physician reports, medical and scientific evidence, and other documentation submitted by the parties.

B. Medical and scientific evidence includes, but is not limited to, the following sources:

1. Peer-reviewed scientific studies published by medical journals that meet nationally recognized requirements for scientific manuscripts in that most of the published articles are submitted for review by experts who are not part of the editorial staff;

2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in index medicus, excerpta medicus ("EMBASE"), medline, and Medlars data base of health services technology assessment research ("HSTAR");

3. Medical journals recognized by the United States Secretary of Health and Human Services, pursuant to Section 1861(t)(2) of the federal Social Security Act;

4. The following standard reference compendia:

a. the American Hospital Formulary Service-Drug Information,

b. the American Medical Association Drug Evaluation,

c. the American Dental Association Accepted Dental Therapeutics, and

d. the United States Pharmacopoeia-Drug Information.

5. Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes for Health, the National Cancer Institute, the National Academy of Sciences, the Health Care Financing Administration, the Congressional Office of Technology Assessment, and the national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6489 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The State Board of Health shall promulgate rules for the certification of independent review organizations. The rules promulgated by the Board shall:

1. Establish minimum standards that:

a. ensure the independence of the review organization and the review process,

b. ensure the independence of the health care professionals providing analyses, recommendations, and other information requested of them,

c. provide for the confidentiality of medical records,

d. provide for expedited appeals in emergency situations, and

e. ensure fair business practices by the independent review organizations.

B. Any independent review organization accredited by a nationally recognized accrediting organization for the accreditation of external review organizations shall be deemed to meet the standards promulgated by the Board.

C. The State Department of Health shall certify, refuse to certify, renew certification and refuse to renew certification of independent review organizations and shall enforce the rules promulgated by the Board.

D. The following organizations are not eligible for certification as an independent review organization:

1. Professional trade associations of health care providers or their subsidiaries or affiliates; or

2. Health plans or health plan associations or their subsidiaries or affiliates.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6490 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Persons assigned by an independent review organization as expert reviewers shall be physicians and shall:

1. Be expert in the medical condition of the insured person and have knowledge regarding the recommended service or treatment through actual clinical experience;

2. Hold a nonrestricted license in a state of the United States;

3. Be currently certified by a recognized American medical specialty board in the areas appropriate to the subject of review; and

4. Have no history of disciplinary action or sanctions related to quality of care, fraud, or other criminal activity.

B. Neither the expert reviewer nor the independent review organization shall have any material, professional, familial or financial conflict of interest with:

1. The health benefit plan;

2. Any officer, director, or management employee of the health benefit plan;

3. The physician, the physician's medical group, or the independent practice association proposing the treatment or service;

4. The institution at which the treatment or service would be provided;

5. The development or manufacture of the principal drug, device, procedure or other therapy proposed for the insured person whose treatment is under review; or

6. The insured person or representative of the insured person who requested the external review.

C. Potential expert reviewers shall disclose any information regarding a potential conflict of interest to the independent review organization.

D. As used in this section, the term "conflict of interest" shall not be interpreted to include a contract under which an academic medical center, or other similar medical center, provides health services to covered persons.

SECTION 13. This act shall become effective November 1, 1999.

COMMITTEE REPORT BY: COMMITTEE ON BUSINESS & LABOR, dated 3-22-99 - DO PASS, As Amended.