STATE OF OKLAHOMA

1st Session of the 47th Legislature (1999)

HOUSE BILL NO. 1384 By: Roach

AS INTRODUCED

An Act relating to Public Health and Safety; creating the Oklahoma Women's and Children's Accessibility to Health Services Act; defining terms; requiring certain obstetricians and gynecologists as primary care practitioners; providing for construction of section; providing for when referrals are necessary; requiring certain pediatric care services; specifying when referrals are required; requiring certain standing referrals; requiring sufficient network; providing for access; providing for determination of sufficiency; 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:

This act shall be known and may be cited as the "Oklahoma Women's and Children's Accessibility to Health Services Act".

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:

For purposes of the Oklahoma Women's and Children's Accessibility to Health Services Act:

1. "Enrollee" means an individual who is enrolled in, subscribes to or is covered by a health benefit plan;

2. "Health benefit plan" includes any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, renewed in this state by a health care insurer, health maintenance organization, accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation,

nonprofit medical service corporation, preferred provider organization, health care service plan, or any other person, firm, corporation, joint venture, or other similar business entity that pays for, purchases, or furnishes health care services to patients, insureds, or beneficiaries in this state. A health benefit plan located or domiciled outside of the State of Oklahoma is deemed to be subject to the provisions of the Oklahoma Women's and Children's Accessibility to Health Services Act if it receives, processes, adjudicates, pays, or denies claims for health care services submitted by or on behalf of patients, insureds, or beneficiaries who reside in this state or who receive health care services in this state;

3. "Health care provider" means a clinic, hospital, health care professional, physician organization, preferred provider organization, independent practice association, or other appropriately licensed provider of health care services or supplies;

4. "Health care professional" means a physician or other health care practitioner licensed to provide health care services in this state;

5. "Health care services" means services for the diagnosis, prevention or treatment of a health condition, illness, injury or disease;

6. "Obstetrician or gynecologist" means a physician currently licensed to practice medicine in this state and who is board eligible or board certified by the American Board of Obstetricians and Gynecologists;

7. "Participating obstetrician or participating gynecologist or participating pediatrician" means an obstetrician, a gynecologist, or a pediatrician who is employed by or under contract with a health benefit plan; and

8. "Primary care practitioner" means a health care professional under contract with a health benefit plan, who has been designated

by the plan to coordinate, supervise, and/or provide ongoing care to the enrollee. "Primary care practitioner" shall include family practice and general practice physicians, internists, obstetricians, gynecologists and pediatricians.

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. Each health benefit plan which is issued, delivered, issued for delivery, or renewed in this state on or after January 1, 2000, shall allow obstetricians and gynecologists as primary care practitioners. This subsection shall not be construed to require an individual obstetrician or gynecologist to accept primary care practitioner status if the obstetrician or gynecologist does not wish to be designated as a primary care practitioner, nor to interfere with the credentialing and other selection criteria usually applied by a health benefit plan with respect to other health care professionals within its network.

B. For women not using an obstetrician or gynecologist as their primary care practitioner, no health benefit plan which is issued, delivered, issued for delivery, or renewed in this state on or after January 1, 2000, shall require as a condition to the coverage of the services of a participating obstetrician or a participating gynecologist that an enrollee first obtain a referral from another primary care practitioner. It is the intent of this subsection that a woman shall at all times have direct access to the services of a participating obstetrician or a participating gynecologist, or both, under any health benefit 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 health benefit plan that requires an enrollee to designate a participating primary care practitioner and provides for dependent

care coverage shall permit a dependent minor enrollee to access a pediatrician for pediatric care services as a primary care practitioner.

B. A health benefit plan shall not require a referral for access under subsection A of this section to a pediatrician who is a participating pediatrician. A health benefit plan may require prior authorization or referral for access to a nonparticipating pediatrician; provided, each health benefit plan shall develop and maintain written policies and procedures for the provision of standing referrals to enrollees for pediatric care services. The standing referral shall be for a period not to exceed twelve (12) months. Under such procedures, the primary care practitioner shall not be required to see the enrollee following the initial referral to the pediatrician at least until the beginning of the plan year following such referral.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2550.5 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Each health benefit plan shall maintain a network that is sufficient in numbers and types of participating obstetricians, participating gynecologists and participating pediatricians to assure that all covered benefits to enrollees or their dependents will be accessible without unreasonable delay. In the case of emergency services, enrollees or their dependents shall have access to health care services twenty-four (24) hours per day, seven (7) days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to any reasonable criteria used by the health benefit plan, including but not limited to:

1. Provider - covered person ratios by specialty;

2. Primary care provider - enrollee ratios;

3. Geographic accessibility;

4. Waiting times for appointments with participating obstetricians, participating gynecologists and participating pediatricians;

5. Hours of operation; and

6. The volume of technological and specialty services available to serve the needs of enrollees or their dependents requiring obstetric, gynecological or pediatric care.

B. In addition to establishing the standards required pursuant to subsection A of this section, the network of the health benefit plan shall demonstrate the following:

1. An adequate number of accessible acute care hospital services, within a reasonable distance or travel time, or both;

2. An adequate number of accessible primary care providers, within a reasonable distance or travel time, or both; the standard for this paragraph shall be not more than thirty (30) miles or thirty (30) minutes;

3. An adequate number of accessible specialists and sub-specialists, within a reasonable distance or travel time, or both;

4. The procedures for making referrals within and outside its network that, at a minimum, must include the following:

a. a comprehensive listing, made available to covered persons and health care providers, of the plan's network participating providers and facilities,

b. a provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services,

c. timely referral for access to specialty care,

d. a process for expediting the referral process when indicated by a medical condition, and

e. a provision that referrals approved by the plan cannot be retrospectively denied except for fraud or abuse;

5. The process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in plans;

6. The quality assurance standards, adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care; and

7. The efforts to address the needs of covered persons with limited English proficiency.

SECTION 6. This act shall become effective November 1, 1999.

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