STATE OF OKLAHOMA

1st Session of the 47th Legislature (1999)

HOUSE BILL NO. 1837 By: Calvey

AS INTRODUCED

An Act relating to public health and safety; creating the Oklahoma Patient Protection Act; defining terms; requiring certain evaluation and payment for certain emergency care; requiring obstetricians and gynecologists to be primary care physicians; providing exceptions; requiring internal system for resolution of complaints; specifying procedures; requiring maintenance of records; requiring disclosure of certain information; specifying content; requiring point-of-service plans; authorizing additional premiums; amending Section 1, Chapter 249, O.S.L. 1995, Section 2, Chapter 249, O.S.L. 1995, as amended by Section 1, Chapter 183, O.S.L. 1996, and Section 3, Chapter 249, O.S.L. 1995, as amended by Section 2, Chapter 183, O.S.L. 1996 (63 O.S. Supp. 1998, Sections 2621, 2622 and 2623), which relate to the Medical Savings Account Act; clarifying 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:

This act shall be known and may be cited as the "Oklahoma Patient Protection 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 Patient Protection Act:

1. "Appeal" means a formal process whereby an enrollee, whose care has been reduced, denied, or terminated, or who deems the care inappropriate, can contest an adverse grievance decision by the health care services plan;

2. “Emergency condition” means any medical condition of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

a. placing the patient’s health in serious jeopardy,

b. serious impairment to bodily functions, or

c. serious dysfunction of any bodily organ or part;

3. “Enrollee” means an individual who is enrolled in the managed care plan;

4. “Expedited review” means a review process which takes place no more than seventy-two (72) hours after the review is commenced;

5. “Grievance” means a written complaint submitted by or on behalf of the enrollee;

6. “Health care provider” means a clinic, hospital, physician, physician’s organization, preferred provider organization, independent practice association, or other appropriately licensed provider of health care services or supplies;

7. “Health care professional” means a physician or other health care practitioner providing health care services;

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

9. “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;

10. "Managed care entity" includes, but is not limited to, a licensed insurance company, hospital or medical service plan, health maintenance organization, limited health services organization, preferred provider organization, third-party administrator, an employer or employee organization, a managed care contractor or any person or entity that establishes, operates, or maintains a network of participating health care professionals;

11. "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 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;

12. "Out-of-network" or "point-of-service" plan means 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;

13. "Participating provider" means a health care provider, 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;

14. “Point-of-service option” means an option for the enrollee to choose to receive service from a nonparticipating health care professional or provider;

15. “Primary care practitioner” means a health care professional under contract with the managed care 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, and obstetrician/gynecologists;

16. “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;

17. “Prudent layperson” is a person without specific medical training for the illness or condition in question who acts as a reasonable person would under similar circumstances;

18. “Quality assurance” means the ongoing evaluation of the quality of health care provided to enrollees; and

19. “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. 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:

No managed care entity shall prohibit or restrict any participating provider from discussing with or disclosing to any enrollee or other individual any medically appropriate health care information that such provider deems appropriate regarding the nature of treatment options, the risks or alternatives thereto, the process used or the decision made by such enrollee to approve or deny health care services, the availability of alternate therapies, consultations, or tests, or from advocating on behalf of the

enrollee within the utilization review or grievance processes established by the managed care entity or appeals process.

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. Once an enrollee with an emergency condition presents himself or herself to an emergency medical provider for emergency services, that person shall be evaluated by medical personnel. This evaluation may include diagnostic testing to assess the extent of the condition, sickness, or injury if such testing is appropriate to stabilize the patient's condition.

B. If, in the opinion of the attending physician, the evaluation provided under subsection A of this section warrants, the attending physician may initiate appropriate intervention to stabilize the condition of the enrollee without seeking or receiving prospective authorization by a managed care entity. No managed care entity may subsequently deny payment for an evaluation, diagnostic testing, or treatment provided as part of such intervention for an emergency condition.

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 managed care plan shall allow obstetricians and gynecologists as primary care physicians. This subsection shall not be construed to require an individual obstetrician or gynecologist to accept primary care physician status if the obstetrician or gynecologist does not wish to be designated as a primary care physician, nor to interfere with the credentialing and other selection criteria usually applied by a managed care plan with respect to other physicians within its network.

B. 1. For women not using an obstetrician or gynecologist as their primary care physician, no managed care plan 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 physician.

2. 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 managed care plan.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2550.6 of Title 63, unless there is created a duplication in numbering, reads as follows:

Each managed care entity in this state shall establish and maintain an internal system for the resolution of complaints, including a process for the notice and appeal of any dissatisfaction expressed by a complainant, orally or in writing, to the managed care entity with any aspect of the managed care entity's operation, including, but not limited to, dissatisfaction with plan administration; appeal of an adverse determination; the denial, reduction, or termination of a service; the way a service is provided; or disenrollment decisions expressed by a complainant. Such complaint procedure shall include provisions to meet the following requirements:

1. If a complainant notifies the managed care entity orally or in writing of a complaint, the managed care entity shall send to the complainant a letter acknowledging the date of the managed care entity's receipt of the complaint. The acknowledgement letter shall include a description of the complaint procedures and time frames. If the managed care entity is responding to oral complaints, the managed care entity shall also enclose a one-page complaint form;

2. The managed care entity shall investigate each oral and written complaint received in accordance with its own policies and in compliance with the Oklahoma Patient Protection Act;

3. The total time for acknowledgement, investigation, and resolution of the complaint by the managed care entity shall not exceed thirty (30) calendar days after the date the managed care entity receives the complaint from the complainant;

4. Paragraphs 1 and 3 of this subsection do not apply to complaints concerning emergency care or denials of continued stays for hospitalization. Investigation and resolution of complaints concerning emergency care or denials of continued stays for hospitalization shall be concluded in accordance with the medical or dental immediacy of the case;

5. After the managed care entity has investigated a complaint, the managed care entity shall issue a response letter to the complainant explaining the managed care entity's resolution of the complaint within the time frames set forth in paragraph 3 of this subsection. If the resolution is to deny services based on an adverse determination of medical necessity, the clinical basis used to reach that decision shall be enclosed. The response letter shall contain a full description of the process for appeal, including but not limited to, the time frames for the appeals process and the time frames for the final decision on the appeal;

6. In the event the complaint is not resolved to the satisfaction of the complainant, the managed care entity shall provide an appeals process which shall include the right of the complainant either to appear in person before a complaint appeal panel where the enrollee normally receives health care services, unless another site is agreed to by the complainant, or to address a written appeal to the complaint appeal panel. The managed care entity shall complete the following appeals process within thirty (30) calendar days after the request for the appeal;

7. The managed care entity shall appoint members to the complaint appeal panel which shall advise the managed care entity on the resolution of the dispute;

8. The complainant and a person acting on behalf of the complainant shall have the right to appear in person before the complaint appeal panel, to present alternative expert testimony, and to request the presence of and question the person or persons responsible for making the prior determination which resulted in the appeal;

9. Investigation and resolution of appeals relating to ongoing emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the medical or dental immediacy of the case. Due to the ongoing emergency or continued hospital stay and at the complainant's request, the managed care entity shall in lieu of a complaint appeal panel provide a review by a participating provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal. The provider reviewer may interview the patient or the patient's representative and shall render a decision on the appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within three (3) days. Investigation and resolution of appeals after emergency care has been provided shall be conducted in accordance with the process set out in this subsection, including the right to a review by an appeal panel;

10. Notice of the final decision of the managed care entity on the appeal shall include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision;

11. The managed care entity shall maintain a record of all complaints and any complaint proceedings for three (3) years. The complainant has a right to a copy of the record; and

12. The managed care entity shall maintain a complaint and appeal log of each complaint.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2550.7 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Each managed care entity shall supply each enrollee, and upon request each prospective enrollee prior to enrollment, written disclosure information, which may be incorporated into the enrollee contract or certificate, containing at least the information set forth below. In the event of any inconsistency between any separate written disclosure statement and the subscriber contract or certificate, the terms of the subscriber contract or certificate shall be controlling. The information to be disclosed shall include at least the following:

1. A description of coverage provisions; health care benefits; benefit maximums, including benefit limitations; and exclusions of coverage, including the definition of "medical necessity" used in determining whether benefits will be covered;

2. A description of all prior authorization or other requirements for treatments and services;

3. A description of utilization review policies and procedures used by the managed care entity, including:

a. the circumstances under which utilization review will be undertaken,

b. the toll-free telephone number of the utilization review agent,

c. the time frames under which utilization review decisions must be made for prospective, retrospective, and concurrent decisions,

d. the right to reconsideration,

e. the right to an appeal, including the expedited and standard appeals processes and the time frames for such appeals,

f. the right to designate a representative,

g. a notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision,

h. a notice of the right to an appeal and the time frames for such appeals, and

i. further appeal rights, if any;

4. A description prepared annually of the types of methodologies the managed care entity uses to reimburse providers, specifying the type of methodology that is used to reimburse particular types of providers or reimburse for the provision of particular types of services; provided, however, that nothing in this paragraph should be construed to require disclosure of individual contracts or the specific details of any financial arrangement between a managed care entity and a participating provider;

5. An explanation of an enrollee’s financial responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charges, annual limits on an enrollee’s financial responsibility, caps on payments for covered services and financial responsibility for noncovered health care procedures, treatments, or services;

6. An explanation, where applicable, of an enrollee’s financial responsibility for payment when services are provided by a health care provider who is not part of the managed care entity’s network of providers or by any provider without required authorization;

7. A description of the grievance procedures to be used to resolve disputes between the managed care entity and an enrollee, including: the right to file a grievance regarding any dispute between the managed care entity and an enrollee; the right to file a grievance orally when the dispute is about referrals or covered benefits; the toll-free telephone number which enrollees may use to

file an oral grievance; the time frames and circumstances for expedited and standard grievances; the right to appeal a grievance determination and the procedures for filing such an appeal; the time frames and circumstances for expedited and standard appeals; the right to designate a representative; a notice that all disputes involving clinical decisions will be made by qualified clinical personnel and that all notices of determination will include information about the basis of the decision and further appeal rights, if any;

8. A description of the procedure for obtaining emergency services. Such description shall include a definition of emergency services, notice that emergency services are not subject to prior approval, and shall describe the enrollee's financial and other responsibilities regarding obtaining such services, including when such services are received outside the managed care entity's service area, if any;

9. Notice of all appropriate mailing addresses and telephone numbers to be utilized by enrollees seeking information or authorization;

10. Where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including but not limited to facilities, and in addition, in the case of physicians, board certification; and

11. A description of the mechanisms by which subscribers may participate in the development of the policies of the managed care entity.

B. Each managed care entity, upon request of an enrollee or prospective enrollee shall:

1. Provide a list of the names, business addresses and official positions of the membership of the board of directors, officers, and members of the managed care entity;

2. Provide a copy of the most recent annual certified financial statement of the managed care entity, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant;

3. Provide a copy of the most recent individual, direct pay enrollee contracts;

4. Provide information relating to consumer complaints compiled as required by law;

5. Provide the procedures for protecting the confidentiality of medical records and other enrollee information;

6. Provide a written description of the organizational arrangements and ongoing procedures of the managed care entity's quality assurance program, if any;

7. Provide a description of the procedures followed by the managed care entity in making decisions about the experimental or investigational nature of individual drugs, medical devices, or treatments in clinical trials;

8. Provide individual health care providers affiliations with participating hospitals, if any; and

9. Upon written request, provide specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which the managed care entity might consider in its utilization review, and the managed care entity may include with the information a description of how it will be used in the utilization review process; provided, however, that to the extent such information is proprietary to the managed care entity, the subscriber or prospective subscriber shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the managed care entity.

C. Nothing in this section shall prevent a managed care entity from changing or updating the materials that are made available to enrollees.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2550.8 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Each managed care entity shall offer coverage through a point-of-service plan.

B. A managed care entity may charge an alternative premium for point-of-service coverage that takes into account the actuarial value of such coverage. Such additional charges may 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.

SECTION 9. AMENDATORY Section 1, Chapter 249, O.S.L. 1995 (63 O.S. Supp. 1998, Section 2621), is amended to read as follows:

Section 2621. Sections ~~1 through 3~~ 2622 and 2623 of this ~~act~~ title shall be known and may be cited as the "Medical Savings Account Act".

SECTION 10. AMENDATORY Section 2, Chapter 249, O.S.L. 1995, as amended by Section 1, Chapter 183, O.S.L. 1996 (63 O.S. Supp. 1998, Section 2622), is amended to read as follows:

Section 2622. As used in the Medical Savings Account Act:

1. "Account holder" means the individual including but not limited to an employee of an employer or dependents of the

individual on whose behalf the medical savings account is established;

2. "Dependent child" means any person under the age of twenty-one (21) years or any person who is legally entitled or subject to a court order for the provision of proper and necessary subsistence, education, medical care, or any other care necessary for the health, or well-being of such person, and who is not otherwise emancipated, married or a member of the Armed Forces of the United States, or who is mentally or physically incapacitated and cannot provide for ~~themselves~~ himself or herself;

3. "Eligible medical expenses" means an expense paid by the taxpayer for medical care described in Section 213(d) of the Internal Revenue Code;

4. "Medical savings account" or "account" means an account established in this state pursuant to a medical savings account program to pay the eligible medical expenses of an account holder and the dependents of the account holder;

5. "Medical savings account program" or "program" means a program that includes all of the following:

a. the purchase by an individual or employer of a qualified higher deductible health benefit plan which is approved by the State Department of Health and offered by an entity regulated by the State Department of Health or is approved by the Insurance Commissioner and offered by an entity regulated by the Insurance Commissioner or is offered by the State and Education Employees Group Insurance Board for the benefit of the individual or an employee of the employer and the dependents of that individual or the employee,

b. the deposit by an individual into a medical savings account or the contribution on behalf of an employee into a medical care account by an employer of all or

part of the premium differential realized by the employer based on the purchase of a qualified higher deductible health plan for the benefit of the employee. An employer that did not previously provide a health plan or provide a health coverage policy, certificate, or contract for employees may contribute all or part of the deductible of a qualified higher deductible health benefit plan; and

6. "Trustee" means a chartered state bank, savings and loan association, licensed securities dealer or trust company authorized to act as a fiduciary; a national banking association or savings and loan association authorized to act as a fiduciary; or an insurance company.

SECTION 11. AMENDATORY Section 3, Chapter 249, O.S.L. 1995, as amended by Section 2, Chapter 183, O.S.L. 1996 (63 O.S. Supp. 1998, Section 2623), is amended to read as follows:

Section 2623. A. For taxable years beginning after December 31, 1995, an individual who is a resident of this state or an employer shall be allowed to deposit contributions to a medical savings account. The amount of deposit for the first taxable year subsequent to the effective date of this act shall not exceed:

1. Two Thousand Dollars ($2,000.00) for the account holder;

2. Two Thousand Dollars ($2,000.00) for the spouse of the account holder; and

3. One Thousand Dollars ($1,000.00) for each dependent child of the account holder.

B. The maximum allowable amount of deposit for subsequent years shall be increased annually by a percentage equal to the previous year's increase in the national Consumer Price Index (CPI).

C. Contributions made to and interest earned on a medical savings account shall be exempt from taxation as adjusted gross

income in this state as provided for in Section 2358 of Title 68 of the Oklahoma Statutes.

D. 1. Upon agreement between an employer and employee, an employee may either have the employer contribute to the employee's medical savings account under a medical savings account program or continue to make contributions under the employee's existing health insurance policy or program, subject to the restrictions in paragraph ~~1~~ 2 of subsection E of this section~~.~~; and

2. For purposes of the Medical Savings Account Act, an employer shall include a participating employer as defined in the Oklahoma State Employees Benefits Act.

E. 1. The medical savings account shall be established as a trust under the laws of this state and placed with a trustee~~.~~;

~~1.~~ 2. The trustee shall utilize the funds held in a medical savings account solely for the purpose of paying the eligible medical expenses of the account holder or the dependents of the account holder or to purchase a health benefit plan, certification, or contract if the account holder does not otherwise have health insurance coverage. Funds held in a medical savings account shall not be used to cover medical expenses of the account holder or dependents of the account holder that are otherwise covered by other means, including but not limited to medical expenses covered pursuant to an automobile insurance policy, a workers' compensation insurance policy or self-insured plan, or another health coverage policy, certificate, or contract~~.~~;

~~2.~~ 3. The account holder may submit prior to the end of the tax year documentation of medical expenses paid by the account holder during that tax year to the trustee and the trustee shall reimburse the account holder for eligible medical expenses from the medical savings account~~.~~; and

~~3.~~ 4. Any funds remaining in a medical savings account at the end of the tax year after all medical expenses have been paid unless

withdrawn as provided for in this section shall remain in the account and may be used by the account holder for payment of future medical expenses.

F. An account holder may withdraw money from the medical savings account of the account holder for any purpose other than a purpose listed in paragraph ~~1~~ 2 of subsection E of this section, only on the last business day of the trustee's business year. If money is withdrawn on that date, pursuant to this subsection, it shall be considered income for income tax purposes and shall not be eligible for the exemption provided in Section 2358 of Title 68 of the Oklahoma Statutes.

G. If the account holder withdraws money for any purpose, other than a purpose described in paragraph ~~1~~ 2 of subsection E of this section, at any time other than on the last business day of the trustee's business year, all of the following shall apply:

1. The amount of the withdrawal shall be considered income for income tax purposes and shall not be eligible for the tax exemption provided in Section 2358 of Title 68 of the Oklahoma Statutes;

2. The trustee shall withhold and shall pay on behalf of the account holder a penalty to the Oklahoma Tax Commission equal to ten percent (10%) of the amount of the withdrawal; and

3. All interest earned on the account during the tax year in which a withdrawal occurs shall be considered income for income tax purposes.

H. Upon the death of the account holder, the account principal, as well as any interest accumulated thereon, shall be distributed to the estate of the account holder and shall be taxed as part of the estate.

I. 1. If an employee is no longer employed by an employer that participates in a medical savings account program and the employee, not more than sixty (60) days after the final day of employment, transfers the account to a new trustee or requests in writing to the

trustee of the former employer that the account remain with that trustee and that trustee agrees to retain the account, the money in the medical savings account may be utilized for the benefit of the account holder or the dependents of the account holder subject to this act, and the money shall remain exempt from taxation pursuant to Section 2358 of Title 68 of the Oklahoma Statutes~~.~~;

2. Not more than thirty (30) days after the expiration of the sixty-day transfer period, if the account holder has not transferred the account or the trustee has not accepted the account of the former employee, the employer shall mail a check to the last-known address of the former employee in an amount equal to the amount in the account on the date the check is mailed~~.~~; and

3. The amount shall be taxed and subject to penalty as provided for in subsection G of this section. If an employee becomes employed with a different employer that participates in a medical savings account program before the expiration of the sixty-day transfer period, the employee may transfer the medical savings account to the trustee of the new employer without penalty.

SECTION 12. This act shall become effective November 1, 1999.

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