

ENGROSSED HOUSE AMENDMENT  
TO  
ENGROSSED SENATE BILL NO. 676

By: Monson and Price of the  
Senate

and

Winchester of the House

( public health and safety - managed care plans -  
effective date )

AMENDMENT NO. 1. Strike the stricken title, enacting clause and  
entire bill and insert

"An Act relating to insurance and public health and safety; amending Section 2, Chapter 289, O.S.L. 1997, as last amended by Section 2, Chapter 292, O.S.L. 2000 and Section 4, Chapter 289, O.S.L. 1997, as last amended by Section 3, Chapter 292, O.S.L. 2000 (63 O.S. Supp. 2000, Sections 2525.3 and 2525.5), which relate to the Oklahoma Managed Care Act; adding definition; providing for rules governing managed care plans; requiring all managed care plans and health benefit plans to establish credentialing for physicians and other health care providers based upon certain criteria; defining terms; providing exceptions; providing for uniform credentialing application and contents; requiring the plans to make information on physician credentialing criteria available to specified persons; providing for application and documentation; providing for application process; requiring certain notification; requiring contents; requiring evaluation; specifying certain time periods; authorizing assessment of administrative penalties; providing for clean application; authorizing extensions limiting time period for credentialing process; restricting denial of applications in certain situations; 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 4405.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in this section:

1. a. "Health benefit plan" means:

- (1) group hospital or medical insurance coverages,
- (2) not-for-profit hospital or medical service or indemnity plans,
- (3) prepaid health plans,
- (4) health maintenance organizations,
- (5) preferred provider plans,
- (6) the State and Education Employees Group Insurance Plan,
- (7) Multiple Employer Welfare Arrangements (MEWA), or
- (8) employer self-insured plans that are not exempt pursuant to the federal Employee Retirement Income Security Act (ERISA) provisions, and

b. the term "health benefit plan" shall not include:

- (1) individual plans,
- (2) plans that only provide coverage for a specified disease, accidental death, or dismemberment for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury or as a supplement to liability insurance,
- (3) Medicare supplemental policies as defined in Section 1882(g)(1) of the federal Social Security Act (42 U.S.C., Section 1395ss),
- (4) workers' compensation insurance coverage,
- (5) medical payment insurance issued as a part of a motor vehicle insurance policy, or

(6) long-term care policies including nursing home fixed indemnity policies, unless the Insurance Commissioner determines that the policy provides comprehensive benefit coverage sufficient to meet the definition of a health benefit plan; and

2. "Credentialing" means, as applied to physicians and other health care providers, the process of accessing and validating the qualifications of such persons to provide health care services to the beneficiaries of a health benefit plan. Credentialing may include, but is not limited to, an evaluation of license status, education, training, experience, competence and professional judgment.

Credentialing is a prerequisite to the final decision of a health care plan to permit initial or continued participation by a physician or other health care provider.

B. 1. Any health benefit plan that is offered, issued or renewed in this state shall provide for credentialing of physicians and other health care providers based on criteria provided in the Uniform Credentialing Application required by Section 1-106.2 of Title 63 of the Oklahoma Statutes.

2. Plans shall make information on such criteria available to physician and other health care provider applicants, and participating physicians and other participating health care providers and shall provide applicants with a checklist of materials required in the application process.

3. Physicians or other health care providers under consideration to provide health care services under a health benefit plan in this state shall apply for credentialing on the Uniform Credentialing Application, and provide the documentation as outlined by the plan's checklist of required materials that accompanies the application.

C. A health benefit plan shall determine whether a credentialing application is complete. If an application is determined not to be complete, the plan shall notify the applicant in writing within ten (10) calendar days of receipt of the application. The written notice shall specify the portion of the application that is causing a delay in processing and explain any additional information or corrections needed.

D. 1. In reviewing the application, the health benefit plan shall evaluate each application according to the plan's checklist of required materials that accompanies the application.

2. When an application is deemed complete, the plan shall initiate requests for primary source verification and malpractice history within seven (7) calendar days.

3. A malpractice carrier shall have twenty-one (21) calendar days within which to respond after receipt of an inquiry from a health benefit plan. Any malpractice carrier that fails to respond to an inquiry within the time frame may be assessed an administrative penalty by the Insurance Commissioner.

E. 1. Upon receipt of primary source verification and malpractice history by the plan, the plan shall determine if the application is a clean application. If the application is deemed clean, a plan shall have forty-five (45) calendar days within which to credential a physician or other health care provider. As used in this paragraph, "clean application" means an application that has no defect, misstatement of facts, improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing.

2. If a plan is unable to credential a physician or other health care provider due to an application not being clean, the plan may extend the credentialing process for sixty (60) calendar days. At the end of sixty (60) calendar days, if the plan is awaiting

documentation to complete the application, the provider shall be notified of the delay by certified mail. The provider may extend the sixty-day period upon written notice to the plan within ten (10) calendar days; otherwise the application shall be deemed withdrawn. In no event shall the entire credentialing process exceed one hundred eighty (180) calendar days.

3. A health benefit plan shall be prohibited from solely basing a denial of an application for credentialing on the lack of board certification or board eligibility and from adding new requirements that delay an application.

4. Any health benefit plan that violates the provisions of this section may be assessed an administrative penalty by the Commissioner.

SECTION 2. AMENDATORY Section 2, Chapter 289, O.S.L. 1997, as last amended by Section 2, Chapter 292, O.S.L. 2000 (63 O.S. Supp. 2000, Section 2525.3), is amended to read as follows:

Section 2525.3 For purposes of the Oklahoma Managed Care Act:

1. "Credentialing" means, as applied to physicians and other health care providers, the process of accessing and validating the qualifications of such persons to provide health care services to the beneficiaries of a health benefit plan. Credentialing may include, but is not limited to, an evaluation of license status, education, training, experience, competence and professional judgment. Credentialing is a prerequisite to the final decision of a health care plan to permit initial or continued participation by a physician or other health care provider;

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;

~~2.~~ 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;

~~3.~~ 4. "Managed care plan" or "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 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, 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 preferred provider organization (PPO) as defined in Section 6054 of Title 36 of the Oklahoma Statutes, or a certified workplace medical plan as defined in Section 14.2 of Title 85 of the Oklahoma Statutes;

~~4.~~ 5. "Out-of-network" or "point-of-service" plan is a product issued by a 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;

~~5.~~ 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;

~~6.~~ 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;

~~7.~~ 8. "Qualified utilization review program" means a utilization review program that meets the requirements of the Oklahoma Managed Care Act; and

~~8.~~ 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 3. AMENDATORY Section 4, Chapter 289, O.S.L. 1997, as last amended by Section 3, Chapter 292, O.S.L. 2000 (63 O.S. Supp. 2000, Section 2525.5), is amended to read as follows:

Section 2525.5 A. The rules promulgated by the State Board of Health for managed care plans that conduct business in this state shall at a minimum require that:

1. Enrollees and prospective enrollees in health ~~insurance~~ benefit plans shall be provided information on the terms and conditions of the plan ~~so that they can~~ in order to make an informed decision about choosing a system of health care delivery. The verbal description of the plan, when presented to enrollees, shall be easily understood and truthful, and shall utilize objective terms. ~~All~~ Any written plan ~~descriptions~~ description shall be in a readable and understandable format. ~~Specific~~ The plan shall include the following 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~~ being 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 in a timely fashion;

4. ~~All plans~~ 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;

5. a. Physician credentialing shall be based on ~~objective standards,~~ criteria as provided in the Uniform Credentialing Application required by Section 1-106.2 of this title with input from physicians ~~credentialled in the plan, which~~ and other health care providers.

b. Plans shall be make information on credentialing criteria available to physician applicants and other health care providers, and participating physicians and other participating health care providers and shall provide applicants with a checklist of materials required in the application process.

c. 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;~~

6. a. Physicians or other health care providers under consideration to provide health care services as a provider under a health benefit plan doing business in this state shall apply to such health benefit plan for credentialing on the Uniform Credentialing Application and provide the documentation as outlined by the health benefit plan's checklist of required materials that accompanies the application.

b. A health benefit plan shall determine whether a credentialing application is complete. If an application is determined not to be complete, the plan shall notify the applicant in writing within ten (10)

calendar days of receipt of the application. The written notice shall specify the portion of the application that is causing a delay in processing and explain any additional information or corrections needed;

7. a. In reviewing the application, the health benefit plan shall evaluate each application according to the plan's checklist of required materials that accompanies the application.
  - b. When an application is deemed complete, the plan shall initiate requests for primary source verification and malpractice history within seven (7) calendar days.
  - c. A malpractice carrier shall have twenty-one (21) calendar days within which to respond after receipt of an inquiry from a health benefit plan. Any malpractice carrier that fails to respond to an inquiry within the time frame may be assessed an administrative penalty by the State Commissioner of Health;
8. a. Upon receipt of primary source verification and malpractice history by the plan, the plan shall determine if the application is a clean application. If the application is deemed clean, a plan shall have forty-five (45) calendar days within which to credential a physician or other health care provider. As used in this subparagraph, "clean application" means an application that has no defect, misstatement of facts, improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing.

- b. If a plan is unable to credential a physician or other health care provider due to an application's not being clean, the plan may extend the credentialing process for sixty (60) calendar days. At the end of sixty (60) calendar days, if the plan is awaiting documentation to complete the application, the provider shall be notified of the delay by certified mail. The provider may extend the sixty-day period upon written notice to the plan within ten (10) calendar days; otherwise the application shall be deemed withdrawn.
- c. In no event shall the entire credentialing process exceed one hundred eighty (180) days;
9. a. A health benefit plan shall be prohibited from solely basing a denial of an application for credentialing on the lack of board certification or board eligibility shall not be the only criterion upon which a denial of an application is based and from adding new requirements that delay an application.
- b. Any health insurance plan that violates the provisions of this subsection may be assessed an administrative penalty by the Commissioner of Health;
10. a. Plans shall not discriminate against enrollees with expensive medical conditions by excluding practitioners with practices containing a substantial number of these patients.
- ~~e.~~ b. 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.~~ c. No managed health care plan shall engage in the practice of medicine or any other profession except as

provided by law nor shall 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;

~~6.~~ 11. Decisions by a managed care plan to authorize or deny coverage for an emergency service shall be based on the patient presenting symptoms arising from any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in serious:

- a. jeopardy to the health of the patient,
- b. impairment of bodily function, or
- c. dysfunction of any bodily organ or part;

~~7.~~ 12. Plans shall not deny an otherwise covered emergency service based solely upon lack of notification to the plan;

~~8.~~ 13. Plans shall compensate a provider for patient screening, evaluation, and examination services that are reasonably calculated to assist the provider in determining whether the condition of the patient requires emergency service. If the provider determines that the patient does not require emergency service, coverage for services rendered subsequent to that determination shall be governed by the plan contract;

~~9.~~ 14. If within a period of thirty (30) minutes after receiving a request from a hospital emergency department for a specialty consultation, a plan fails to identify an appropriate specialist who is available and willing to assume the care of the enrollee, the emergency department may arrange for emergency

services by an appropriate specialist that are medically necessary to attain stabilization of an emergency medical condition, and the plan shall not deny coverage for the services due to lack of prior authorization; and

~~10.~~ 15. The reimbursement policies and patient transfer requirements of a plan shall not, directly or indirectly, require a hospital emergency department or provider to violate the federal Emergency Medical Treatment and Active Labor Act. If a member of a plan is transferred from a hospital emergency department facility to another medical facility, the plan shall reimburse the transferring facility and provider for services provided to attain stabilization of the emergency medical condition of the member in accordance with the federal Emergency Medical Treatment and Active Labor Act.

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;~~

2. Requests by patients or physicians for nonemergency services shall be answered within five (5) business days of the request;

~~2.~~ 3. Qualified personnel shall be available for same business day telephone responses to inquiries about medical necessity including certification of continued length of stay;

~~3.~~ 4. 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.~~ 5. Plans shall ensure that enrollees, in plans where preauthorization is a condition to coverage of a service, are required to sign medical information release forms upon enrollment for use where services requiring prior authorization are recommended

or proposed by ~~their~~ a physician. Plans are prohibited from disclosing to employers any medical information about an enrollee without 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.~~ 6. 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 prior authorization was obtained; and

~~6.~~ 7. Contested denials of service by the attending physician, l in cases where there are no medically agreed upon guidelines, l 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 4. This act shall become effective November 1, 2001."

Passed the House of Representatives the 16th day of April, 2001.

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Presiding Officer of the House of  
Representatives

Passed the Senate the \_\_\_\_ day of \_\_\_\_\_, 2001.

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Presiding Officer of the Senate