

STATE OF OKLAHOMA

1st Session of the 55th Legislature (2015)

HOUSE BILL 2097

By: Moore

AS INTRODUCED

An Act relating to insurance; exempting insurers from offering certain benefits; requiring insurers to offer certain health insurance policies; amending 36 O.S. 2011, Sections 6907 and 6933, which relate to the Health Maintenance Organization Act of 2003; removing factors health maintenance organizations shall consider when authorizing or denying certain coverage; removing requirement that certain coverage not be denied when solely based on lack of certain notification or authorization; eliminating requirement that providers be compensated for certain services; eliminating requirement that chiropractic services be provided in a certain manner; eliminating requirement that vision care be provided in a certain manner; repealing 36 O.S. 2011, Sections 6058, 6060, 6060.1, 6060.2, 6060.3, 6060.3a, 6060.4, 6060.5, 6060.6, 6060.7, 6060.8, 6060.8a, 6060.9 and 6060.11, and Section 1, Chapter 115, O.S.L. 2013 (36 O.S. Supp. 2014, Section 6060.9a), which relate to required health benefits; repealing 63 O.S. 2011, Section 1-2605, which relates to the Kidney Health Planning Act of Oklahoma; 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 4416 of Title 36, unless there is created a duplication in numbering, reads as follows:

1 Insurers shall not be required to offer or provide state-
2 mandated health benefits required by Oklahoma law or rule in health
3 insurance policies sold to Oklahoma residents. Any insurer that
4 provides health insurance policies in this state shall offer at
5 least one health insurance policy that does not provide any of the
6 mandated health benefits required by Oklahoma law or rule.

7 SECTION 2. AMENDATORY 36 O.S. 2011, Section 6907, is
8 amended to read as follows:

9 Section 6907. A. Every health maintenance organization shall
10 establish procedures that ensure that health care services provided
11 to enrollees shall be rendered under reasonable standards of quality
12 of care consistent with prevailing professionally recognized
13 standards of medical practice. The procedures shall include
14 mechanisms to assure availability, accessibility and continuity of
15 care.

16 B. The health maintenance organization shall have an ongoing
17 internal quality assurance program to monitor and evaluate its
18 health care services, including primary and specialist physician
19 services and ancillary and preventive health care services across
20 all institutional and noninstitutional settings. The program shall
21 include, but need not be limited to, the following:

22 1. A written statement of goals and objectives that emphasizes
23 improved health status in evaluating the quality of care rendered to
24 enrollees;

1 2. A written quality assurance plan that describes the
2 following:

- 3 a. the health maintenance organization's scope and
4 purpose in quality assurance,
- 5 b. the organizational structure responsible for quality
6 assurance activities,
- 7 c. contractual arrangements, where appropriate, for
8 delegation of quality assurance activities,
- 9 d. confidentiality policies and procedures,
- 10 e. a system of ongoing evaluation activities,
- 11 f. a system of focused evaluation activities,
- 12 g. a system for credentialing and recredentialing
13 providers, and performing peer review activities, and
14 h. duties and responsibilities of the designated
15 physician responsible for the quality assurance
16 activities;

17 3. A written statement describing the system of ongoing quality
18 assurance activities including:

- 19 a. problem assessment, identification, selection and
20 study,
- 21 b. corrective action, monitoring, evaluation and
22 reassessment, and
23
24

1 c. interpretation and analysis of patterns of care
2 rendered to individual patients by individual
3 providers;

4 4. A written statement describing the system of focused quality
5 assurance activities based on representative samples of the enrolled
6 population that identifies method of topic selection, study, data
7 collection, analysis, interpretation and report format; and

8 5. Written plans for taking appropriate corrective action
9 whenever, as determined by the quality assurance program,
10 inappropriate or substandard services have been provided or services
11 that should have been furnished have not been provided.

12 C. The organization shall record proceedings of formal quality
13 assurance program activities and maintain documentation in a
14 confidential manner. Quality assurance program minutes shall be
15 available to the State Commissioner of Health.

16 D. The organization shall ensure the use and maintenance of an
17 adequate patient record system which will facilitate documentation
18 and retrieval of clinical information for the purpose of the health
19 maintenance organization's evaluating continuity and coordination of
20 patient care and assessing the quality of health and medical care
21 provided to enrollees.

22 E. Enrollee clinical records shall be available to the State
23 Commissioner of Health or an authorized designee for examination and
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1 review to ascertain compliance with this section, or as deemed
2 necessary by the State Commissioner of Health.

3 F. The organization shall establish a mechanism for periodic
4 reporting of quality assurance program activities to the governing
5 body, providers and appropriate organization staff.

6 G. The organization shall be required to establish a mechanism
7 under which physicians participating in the plan may provide input
8 into the plan's medical policy including, but not limited to,
9 coverage of new technology and procedures, utilization review
10 criteria and procedures, quality, credentialing and recredentialing
11 criteria, and medical management procedures.

12 H. As used in this section "credentialing" or
13 "recredentialing", as applied to physicians and other health care
14 providers, means the process of accessing and validating the
15 qualifications of such persons to provide health care services to
16 the beneficiaries of a health maintenance organization.
17 "Credentialing" or "recredentialing" may include, but need not be
18 limited to, an evaluation of licensure status, education, training,
19 experience, competence and professional judgment. Credentialing or
20 recredentialing is a prerequisite to the final decision of a health
21 maintenance organization to permit initial or continued
22 participation by a physician or other health care provider.

23 1. Physician credentialing and recredentialing shall be based
24 on criteria as provided in the uniform credentialing application

1 required by Section 1-106.2 of Title 63 of the Oklahoma Statutes,
2 with input from physicians and other health care providers.

3 2. Organizations shall make information on credentialing and
4 recredentialing criteria available to physician applicants and other
5 health care providers, participating physicians, and other
6 participating health care providers and shall provide applicants
7 with a checklist of materials required in the application process.

8 3. When economic considerations are part of the credentialing
9 and recredentialing decision, objective criteria shall be used and
10 shall be available to physician applicants and participating
11 physicians. When graduate medical education is a consideration in
12 the credentialing and recredentialing process, equal recognition
13 shall be given to training programs accredited by the Accrediting
14 Council on Graduate Medical Education and by the American
15 Osteopathic Association. When graduate medical education is
16 considered for optometric physicians, consideration shall be given
17 for educational accreditation by the Council on Optometric
18 Education.

19 4. Physicians or other health care providers under
20 consideration to provide health care services under a managed care
21 plan in this state shall apply for credentialing and recredentialing
22 on the uniform credentialing application and provide the
23 documentation as outlined by the plan's checklist of materials
24 required in the application process.

1 5. A health maintenance organization (HMO) shall determine
2 whether a credentialing or recredentialing application is complete.
3 If an application is determined to be incomplete, the plan shall
4 notify the applicant in writing within ten (10) calendar days of
5 receipt of the application. The written notice shall specify the
6 portion of the application that is causing a delay in processing and
7 explain any additional information or corrections needed.

8 6. In reviewing the application, the health maintenance
9 organization (HMO) shall evaluate each application according to the
10 plan's checklist of materials required in the application process.

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

14 8. A malpractice carrier shall have twenty-one (21) calendar
15 days within which to respond after receipt of an inquiry from a
16 health maintenance organization (HMO). Any malpractice carrier that
17 fails to respond to an inquiry within the allotted time frame may be
18 assessed an administrative penalty by the State Commissioner of
19 Health.

20 9. Upon receipt of primary source verification and malpractice
21 history by the HMO, the HMO shall determine if the application is a
22 clean application. If the application is deemed clean, the HMO
23 shall have forty-five (45) calendar days within which to credential
24 or recredential a physician or other health care provider. As used

1 in this paragraph, "clean application" means an application that has
2 no defect, misstatement of facts, improprieties, including a lack of
3 any required substantiating documentation, or particular
4 circumstance requiring special treatment that impedes prompt
5 credentialing or recredentialing.

6 10. If a health maintenance organization is unable to
7 credential or recredential a physician or other health care provider
8 due to an application's not being clean, the HMO may extend the
9 credentialing or recredentialing process for sixty (60) calendar
10 days. At the end of sixty (60) calendar days, if the HMO is
11 awaiting documentation to complete the application, the physician or
12 other health care provider shall be notified of the delay by
13 certified mail. The physician or other health care provider may
14 extend the sixty-day period upon written notice to the HMO within
15 ten (10) calendar days; otherwise the application shall be deemed
16 withdrawn.

17 11. In no event shall the entire credentialing or
18 recredentialing process exceed one hundred eighty (180) calendar
19 days.

20 12. A health maintenance organization shall be prohibited from
21 solely basing a denial of an application for credentialing or
22 recredentialing on the lack of board certification or board
23 eligibility and from adding new requirements solely for the purpose
24 of delaying an application.

1 13. Any HMO that violates the provisions of this subsection may
2 be assessed an administrative penalty by the State Commissioner of
3 Health.

4 I. Health maintenance organizations shall not discriminate
5 against enrollees with expensive medical conditions by excluding
6 practitioners with practices containing a substantial number of
7 these patients.

8 J. Health maintenance organizations shall, upon request,
9 provide to a physician whose contract is terminated or not renewed
10 for cause the reasons for termination or nonrenewal. Health
11 maintenance organizations shall not contractually prohibit such
12 requests.

13 K. No HMO shall engage in the practice of medicine or any other
14 profession except as provided by law nor shall an HMO include any
15 provision in a provider contract that precludes or discourages a
16 health maintenance organization's providers from:

17 1. Informing a patient of the care the patient requires,
18 including treatments or services not provided or reimbursed under
19 the patient's HMO; or

20 2. Advocating on behalf of a patient before the HMO.

21 ~~L. Decisions by a health maintenance organization to authorize~~
22 ~~or deny coverage for an emergency service shall be based on the~~
23 ~~patient presenting symptoms arising from any injury, illness, or~~
24 ~~condition manifesting itself by acute symptoms of sufficient~~

1 ~~severity, including severe pain, such that a reasonable and prudent~~
2 ~~layperson could expect the absence of medical attention to result in~~
3 ~~serious:~~

4 1. ~~Jeopardy to the health of the patient;~~

5 2. ~~Impairment of bodily function; or~~

6 3. ~~Dysfunction of any bodily organ or part.~~

7 M. ~~Health maintenance organizations shall not deny an otherwise~~
8 ~~covered emergency service based solely upon lack of notification to~~
9 ~~the HMO.~~

10 N. ~~Health maintenance organizations shall compensate a provider~~
11 ~~for patient screening, evaluation, and examination services that are~~
12 ~~reasonably calculated to assist the provider in determining whether~~
13 ~~the condition of the patient requires emergency service. If the~~
14 ~~provider determines that the patient does not require emergency~~
15 ~~service, coverage for services rendered subsequent to that~~
16 ~~determination shall be governed by the HMO contract.~~

17 O. ~~If within a period of thirty (30) minutes after receiving a~~
18 ~~request from a hospital emergency department for a specialty~~
19 ~~consultation, a health maintenance organization fails to identify an~~
20 ~~appropriate specialist who is available and willing to assume the~~
21 ~~care of the enrollee, the emergency department may arrange for~~
22 ~~emergency services by an appropriate specialist that are medically~~
23 ~~necessary to attain stabilization of an emergency medical condition,~~

1 ~~and the HMO shall not deny coverage for the services due to lack of~~
2 ~~prior authorization.~~

3 P. The reimbursement policies and patient transfer requirements
4 of a health maintenance organization shall not, directly or
5 indirectly, require a hospital emergency department or provider to
6 violate the federal Emergency Medical Treatment and Active Labor
7 Act. If a member of an HMO is transferred from a hospital emergency
8 department facility to another medical facility, the HMO shall
9 reimburse the transferring facility and provider for services
10 provided to attain stabilization of the emergency medical condition
11 of the member in accordance with the federal Emergency Medical
12 Treatment and Active Labor Act.

13 SECTION 3. AMENDATORY 36 O.S. 2011, Section 6933, is
14 amended to read as follows:

15 Section 6933. A. A health maintenance organization shall
16 provide basic health care services directly or by contract or
17 agreement with other persons, corporations, institutions,
18 associations, foundations or other legal entities, public or
19 private, in accordance with the laws governing such professions and
20 services.

21 B. Each health maintenance organization shall have a defined
22 set of standards and procedures for selecting providers, including
23 specialists, to serve enrollees. The standards and procedures shall
24 be drafted in such a manner as to be applicable to all categories of

1 providers and shall be utilized by the health maintenance
2 organization in a manner that is without bias for or discrimination
3 against a particular category or categories of providers.

4 ~~C. With respect to chiropractic services, such covered services~~
5 ~~shall be provided on a referral basis within the network at the~~
6 ~~request of an enrollee who has a condition of an orthopedic or~~
7 ~~neurological nature if:~~

8 ~~1. A referral is necessitated in the judgment of the primary~~
9 ~~care physician; and~~

10 ~~2. Treatment for the condition falls within the licensed scope~~
11 ~~of practice of a chiropractic physician.~~

12 ~~D. 1. Any health maintenance organization that offers services~~
13 ~~for vision care or medical diagnosis and treatment for the eye shall~~
14 ~~allow optometrists to be providers of those services.~~

15 ~~2. Once a fee schedule has been negotiated, ophthalmologists~~
16 ~~and optometrists shall be paid equally for the same services so long~~
17 ~~as the services provided by the optometrists are within the scope of~~
18 ~~the practice of optometry.~~

19 ~~3. No health maintenance organization shall require a provider~~
20 ~~of vision care or medical diagnosis and treatment for the eye to~~
21 ~~have hospital privileges if hospital privileges are not usual and~~
22 ~~customary for the services the provider provides.~~

23 ~~4. With respect to optometric services, such covered services~~
24 ~~shall be provided on a referral basis within the medical group or~~

1 ~~network at the request of an enrollee who has a condition requiring~~
2 ~~vision care or medical diagnosis and treatment of the eye if:~~

- 3 a. ~~a referral is necessitated in the judgment of the~~
4 ~~primary care physician, and~~
- 5 b. ~~treatment for the condition falls within the licensed~~
6 ~~scope of practice of an optometrist.~~

7 ~~5. Nothing in this subsection shall be construed to:~~

- 8 a. ~~prohibit any health maintenance organization that~~
9 ~~offers services for vision care or medical diagnosis~~
10 ~~and treatment for the eye from determining the~~
11 ~~adequacy of the size of its network,~~
- 12 b. ~~limit, expand or otherwise affect the scope of~~
13 ~~practice of optometry, or~~
- 14 c. ~~alter, repeal, modify or affect the laws of this state~~
15 ~~except where such laws are in conflict or are~~
16 ~~inconsistent with the express provisions of this~~
17 ~~section.~~

18 ~~6. Existing contracts shall comply with the requirements of~~
19 ~~this subsection upon issuance or renewal on or after the effective~~
20 ~~date of this act.~~

21 ~~E.~~ 1. A health maintenance organization shall not:

- 22 a. engage in the practice of medicine or any other
23 profession except as provided by law, or
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1 b. prohibit or restrict a primary care physician from
2 referring a patient to a specialist within the network
3 if such referral is deemed medically necessary in the
4 judgment of the primary care physician.

5 2. A health maintenance organization shall provide basic health
6 care services in a manner that is reasonably geographically
7 convenient to residents of the service area for which it seeks a
8 license.

9 SECTION 4. REPEALER 36 O.S. 2011, Sections 6058, 6060,
10 6060.1, 6060.2, 6060.3, 6060.3a, 6060.4, 6060.5, 6060.6, 6060.7,
11 6060.8, 6060.8a, 6060.9 and 6060.11, and Section 1, Chapter 115,
12 O.S.L. 2013 (36 O.S. Supp. 2014, Section 6060.9a), are hereby
13 repealed.

14 SECTION 5. REPEALER 63 O.S. 2011, Section 1-2605, is
15 hereby repealed.

16 SECTION 6. This act shall become effective November 1, 2015.

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