As Engrossed: 3/17/95 3/30/95

State of Arkansas
80th General Assembly
Regular Session, 1995
By: Representative Mitchell

A Bill

HOUSE BILL 2094

For An Act To Be Entitled

"AN ACT TO PROVIDE THAT THE ARKANSAS DEPARTMENT OF HEALTH SHALL ESTABLISH STANDARDS FOR THE CERTIFICATION OF QUALIFIED MANAGED CARE PLANS; AND FOR OTHER PURPOSES."

Subtitle

"AN ACT TO PROVIDE THAT THE ARKANSAS DEPARTMENT OF HEALTH SHALL ESTABLISH STANDARDS FOR THE CERTIFICATION OF QUALIFIED MANAGED CARE PLANS."

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS

SECTION 1. The General Assembly hereby finds and declares that:

(1) As this state_s health care market becomes increasingly dominated by health plans that utilize various managed care techniques that include decisions regarding coverage and the appropriateness of health care, it is a vital state governmental function to protect patients from unfair managed care practices; and

(2) Increasingly, insurance companies and other managed care organizations are aggressively discontinuing physicians from their networks, making inappropriate decisions to refuse or terminate health care and other decisions that negatively affect patients_ health, and restricting patients_ ability to make choices concerning their health care providers; it is essential to assure fairness in managed care plans and provide a mechanism for delineating necessary protections for both physicians and patients.

SECTION 2. The Arkansas Department of Health shall establish standards for the certification of qualified managed care plans. Standards are

required to ensure patient protection, physician and provider fairness, utilization reviews, and safeguards.

SECTION 3. For purposes of this act:

(1) "Commissioner" means the Insurance Commissioner;

(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;

(3) "Managed care entity" means a licensed insurance company, hospital or medical service plan, health maintenance organization, an employer or employee organization, or a managed care contractor that operates a managed care plan;

(4) "Managed care plan" means a plan operated by a managed care entity that provides for the financing an delivery of health care services to persons enrolled in such plan through:

(a) arrangements with selected providers to furnish health care services;

(b) explicit 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;

(5) "Participating provider" means a physician, 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) "Qualified managed care plan" means a managed care plan that the Insurance Commissioner certifies, upon application by the program, as meeting the requirements of this act;

(7) "Qualified utilization review program" means a utilization review program that the Insurance Commissioner certifies, upon application by the program, as meeting the requirements of this act;

(8) "Utilization review program" means a system of reviewing the medical necessity, appropriateness, or quality of health care services and supplies provided under a health insurance plan or a managed care plan using specified guidelines. Such a system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.

SECTION 4. Nothing in this act shall be construed as prohibiting the following:

(1) An individual from purchasing any health care services with that individual_s own funds, whether such services are covered within the individual_s standard benefit package or from another health care provider or plan; or

(2) Employers from providing coverage for benefits in addition to the comprehensive benefit package.

SECTION 5. (a)(1) The commissioner shall establish a process for certification of managed care plans meeting the requirements of paragraph 1 of subsection (b) of this section and of utilization review programs meeting the requirements of paragraph 2 of subsection (b) of this section.

(2) The commissioner shall establish procedures for the periodic review and recertification of qualified managed care plans and qualified utilization review programs.

(3) The commissioner shall terminate the certification of a previously qualified managed care plan or a qualified utilization review program if the commissioner determines that such plan or program no longer meets the applicable requirements for certification. Before effecting a termination, the commissioner shall provide the plan notice and opportunity for a hearing on the proposed termination.

(4)(A) An eligible organization, as defined in Section 1876(b) of the Social Security Act, shall be deemed to meet the requirements

of subsection (b) of this section for certification as a qualified managed care plan.

(B) If the commissioner finds that a national accreditation body establishes a requirement or requirements for accreditation of a managed care plan or utilization review program that are at least equivalent to a requirement established under subsection (b) of this section, the commissioner may, to the extent appropriate, treat a managed care plan or a utilization review program thus accredited as meeting the requirement of subsection (b) of this section.

(b)(1) The commissioner shall establish standards for the certification of qualified managed care plans that conduct business in this state, including standards whereby:

(A) prospective enrollees in health insurance plans must be provided information as to the terms and conditions of the plan so that they can make informed decisions about accepting a certain system of health care delivery. Where the plan is described orally to enrollees, easily understood, truthful, and objective terms must be used. All written plan descriptions must be in a readable and understandable format, consistent with standards developed for supplemental insurance coverage under Title XVIII of the Social Security Act. This format must be standardized so that customers can compare the attributes of the plans. Specific items that must be included are:

(i) coverage provisions, benefits, and any exclusions by category of service, provider or physician, and if applicable, by specific service;

(ii) any and all prior authorization or other review requirements including preauthorization review, concurrent review, post-service review, post payment review and any procedures that may lead the patient to be denied coverage for or not be provided a particular service;

(iii) financial arrangements or contractual provisions with hospitals, review companies, physicians or any other provider of health care services that would limit the services offered, restrict referral or treatment options, or negatively affect the physician_s fiduciary responsibility to his or her patients, including, but not limited to, financial incentives not to provide medical or other services;

(iv) explanation of how plan limitations impact enrollees, including information on enrollee financial responsibility for payment for coinsurance or other noncovered or out-of-plan services;

(v) loss ratios; and

(vi) enrollee satisfaction statistics.

(B) plans must 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. This requirement cannot be waived and must be met in all areas where the plan has enrollees, including rural areas;

(C) plans must meet financial reserve requirements that are established to assure proper payment for covered services provided. An indemnity fund should be established to provide for plan failures even when a plan has met the reserve requirements;

(D) all plans shall be required to establish a mechanism, with defined rights, under which physicians participating in the plan provide input into the plan_s medical policy, utilization review criteria and procedures, quality and credentialing criteria, and medical management procedures;

(E) all plans shall be required to credential physicians within the plan, and will allow all physicians within the plan_s geographic service area to apply for such credentials.

(i) Such a credentialing process shall begin upon application of a physician to the plan for inclusion.

(ii) Each application shall be reviewed by a credentialing committee with appropriate representation of the applicant_s medical specialty.

(iii) Credentialing shall be based on objective standards of quality with input from physicians credentialed in the plan and such standards shall be available to applicants and enrollees. When economic considerations are part of the decision, objective criteria must be used and must be available to applicants, participating physicians and enrollees. Any economic profiling of physicians must be adjusted to recognize case mix, severity of illness, age of patients and other features of a physician_s practice that may account for higher than or lower than expected costs. Profiles must be made available to those so profiled. When graduate medical

education is a consideration in credentialing, equal recognition will be given to training programs accredited by the Accrediting Council on Graduate Medical Education and by the American Osteopathic Association.

(iv) Plans shall be prohibited from discriminating against enrollees with expensive medical conditions by excluding practitioners with practices containing a substantial number of such patients.

(v) All decisions shall be made on the record, and the applicant shall be provided with all reasons used if the application is denied or the contract not renewed.

(vi) Plans shall not be allowed to include clauses in physician or other provider contracts that allow for the plan to terminate the contract _without cause_.

(vii) There shall be a due process appeal from all adverse decisions. The commissioner shall establish due process appeal mechanism.

(viii) The same standards and procedures used for an application for credentials shall also be used in those cases where the plan seeks to reduce or withdraw such credentials. Prior to initiation of a proceeding leading to termination of a contract _for cause_, the physician shall be provided notice, an opportunity for discussion, and an opportunity to enter into and complete a corrective action plan, except in cases where there is imminent harm to patient health or an action by a state medical board or other government agency that effectively impairs the physician_s ability to practice medicine within the jurisdiction.

(F) procedures shall be established to ensure that all applicable federal and state laws designed to protect the confidentiality of provider and individual medical records are followed.

(2) The commissioner shall establish standards for the certification of qualified utilization review programs. All plans must have a medical director responsible for all clinical decisions by the plan and provide assurances that the medical review or utilization practices they use, and the medical review or utilization practices of payers or reviewers with whom they contract, comply with the following requirements:

(A) screening criteria, weighting elements, and computer

algorithms utilized in the review process and their method of development, must be released to physicians and the public;

(B) such criteria must be based on sound scientific principles and developed in cooperation with practicing physicians and other affected health care providers;

(C) any person who recommends denial of coverage or payment, or determines that a service should not be provided, based on medical necessity standards, must be of the same medical branch and specialties as recognized by the American Board of Medical Specialties or the American Osteopathic Association as the practitioner who provided the service;

(D) each claimant or provider, upon assignment of a claimant, who has had a claim denied as not medically necessary must be provided an opportunity for a due process appeal to a medical consultant or peer review group not involved in the organization that performed the initial review;

(E) any individual making a negative judgment or recommendation about the necessity or appropriateness of services or the site of service must be a physician licensed to practice medicine in this state;

(F) upon request, physicians will be provided the names and credentials of all individuals conducting medical necessity or appropriateness review, subject to reasonable safeguards and standards;

(G) prior authorization is not required for emergency care, and patient or physician requests for prior authorization of a nonemergency service must be answered within two business days, and qualified personnel must be available for same-day telephone responses to inquiries about medical necessity, including certification of continued length of stay;

(H) plans must ensure that enrollees, in plans where prior authorization is a condition to coverage of a service, are required to sign medical information release consent forms upon enrollment for use where services requiring prior authorization are recommended or proposed by their physician;

(I) when prior approval for a service or other covered item is obtained, it shall be considered approval for all purposes, and the service shall be considered to be covered unless there was fraud or incorrect information provided at the time such prior approval was obtained; and

(J) procedures for ensuring that all applicable federal and state laws designed to protect the confidentiality of provider and individual medical records are followed.

(3) application of standards:

(A) Standards shall first be established under this subsection by not later than twelve (12) months after the date of the enactment of this section. In developing standards under this subsection, the commissioner shall:

(i) review standards in use by national private accreditation organizations and the National Association of Insurance Commissioners;

(ii) recognize, to the extent appropriate, differences in the organizational structure and operation of managed care plans; and

(iii) establish procedures for the timely consideration of applications for certification by managed care plans and utilization review programs.

(B) The commissioner shall periodically review the standards established under this subsection, and may revise the standards from time to time to assure that such standards continue to reflect appropriate policies and practices for the cost-effective and medically appropriate use of services within managed care plans and utilization review programs.

SECTION 6. Every managed care contractor shall, after payment is made to a health care provider, inform the insured of the amount of the fee paid the health care provider for each health care service rendered by the provider.

SECTION *7*. All provisions of this act of a general and permanent nature are amendatory to the Arkansas Code of 1987 Annotated and the Arkansas Code Revision Commission shall incorporate the same in the Code.

SECTION *8*. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect

other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

SECTION *9*. All laws and parts of laws in conflict with this act are hereby repealed.

/s/Rep. Mitchell