

State of South Dakota

SEVENTY-THIRD SESSION
LEGISLATIVE ASSEMBLY, 1998

346B0130

SENATE BILL NO. 186

Introduced by: Senators Kloucek, Dunn (Rebecca), Flowers, Hunhoff, Hutmacher, Lange, Lawler, Morford, Olson, Reedy, and Valandra and Representatives Fischer-Clemens, Barker, Chicoine, Collier, Davis, Kazmerzak, Koetzle, Lucas, Moore, and Weber

1 FOR AN ACT ENTITLED, An Act to ensure that enrollees receive health care services under
2 certain managed care systems.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

4 Section 1. Terms used in this Act mean:

- 5 (1) "Appeal," a formal process whereby an enrollee, whose care has been reduced,
6 denied, or terminated, or whereby the enrollee deems the care inappropriate, may
7 contest an adverse grievance decision by the health care services plan;
- 8 (2) "Emergency," a medical condition, the onset of which is sudden and unexpected, that
9 manifests itself by symptoms of sufficient severity, that a prudent layperson, who
10 possesses an average knowledge of health and medicine, could reasonably assume that
11 the condition requires immediate medical treatment, and could expect that the absence
12 of medical attention to result in serious impairment to bodily functions or place the
13 person's health in serious jeopardy;
- 14 (3) "Enrollee," any person who is enrolled in a managed care entity;

- 1 (4) "Expedited review," a review process which takes no more than seventy-two hours
2 from commencement to completion;
- 3 (5) "Experimental treatment," treatment that, while not commonly used for a particular
4 condition or illness, nevertheless is recognized for treatment of the particular
5 condition or illness, if there is no clearly superior, nonexperimental treatment
6 alternative available to the enrollee;
- 7 (6) "Grievance," a written complaint submitted by or on behalf of the enrollee;
- 8 (7) "Health care provider," a clinic, hospital physician organization, preferred provider
9 organization, independent practice association, or other appropriately licensed
10 provider of health care services or supplies;
- 11 (8) "Health care professional," a licensed health care practitioner in the state providing
12 health care services within the health care practitioner's authorized scope of practice;
- 13 (9) "Health care services," services for the diagnosis, prevention, or treatment of a health
14 condition, illness, injury, or disease;
- 15 (10) "Managed care entity," any entity including a licensed insurance company, hospital or
16 medical service plan, health maintenance organization, employer or employee
17 organization, preferred provider organization, or any managed care contractor that
18 operates a managed care plan;
- 19 (11) "Managed care plan," a plan operated by a managed care entity that provides for the
20 financing and delivery of health care services to persons enrolled in the plan, with
21 financial incentives for persons enrolled in the plan to use the participating health care
22 professionals and procedures covered by the plan;
- 23 (12) "Participating practitioner," a health care professional who has entered into an
24 agreement with a managed care entity to provide health care services to an enrollee
25 in the managed care plan;

- 1 (13) "Point of service option," an option for the enrollee to choose to receive service from
2 a nonparticipating health care professional or provider;
- 3 (14) "Primary care practitioner," a health care professional under contract with the plan,
4 who has been designated by the plan to coordinate, supervise, or provide ongoing
5 care to the enrollee;
- 6 (15) "Prudent layperson," a person without specific medical training for the illness or
7 condition in question who acts as a reasonable person would under similar
8 circumstances;
- 9 (16) "Quality assurance," the ongoing evaluation of the quality of health care provided to
10 enrollees;
- 11 (17) "Specialist," a health care professional who falls outside the definition of a primary
12 care practitioner.

13 Section 2. This Act applies to all managed care entities operating within the state.

14 Section 3. Each managed care plan shall include a sufficient number and type of primary care
15 practitioners and specialists, throughout the service area, to meet the needs of enrollees and to
16 provide meaningful choice. Each managed care plan shall demonstrate that it offers:

- 17 (1) An adequate number of accessible acute care hospital services, within a reasonable
18 distance or travel time;
- 19 (2) An adequate number of accessible primary care practitioners, within a reasonable
20 distance or travel time. Primary care practitioners include family practice and general
21 practice physicians, physician's assistants, nurse practitioners, internists,
22 obstetrician/gynecologists, pediatricians, chiropractors, dentists, and optometrists;
- 23 (3) An adequate number of accessible specialists and sub-specialists, within a reasonable
24 distance or travel time. When the type of medical specialist needed for a specific
25 condition is not represented on the speciality panel, enrollees shall have access to

1 nonparticipating health care professionals;

2 (4) The availability of specialty medical services, including physical therapy, occupational
3 therapy, and rehabilitation services; and

4 (5) The availability of nonpanel specialists, if a patient's unique medical circumstances
5 warrant it.

6 Section 4. Each managed care plan shall provide for continuity of care with established
7 primary care practitioners, if the health care professional's contract is terminated. The plan shall
8 allow enrollees, at no additional out-of-pocket cost, to continue receiving services from a
9 primary care practitioner whose contract with the plan is terminated without cause. This
10 continuation shall be effective for sixty days if the enrollee requests continued care.

11 Section 5. Each managed care plan shall provide telephone access to the managed care plan
12 for sufficient time during business and evening hours to ensure enrollee access for routine care,
13 and twenty-four hour telephone access to either the plan or a participating provider or
14 practitioner, for emergency care or authorization for care.

15 Section 6. Each managed care plan shall establish reasonable standards for waiting times to
16 obtain appointments. Such standards shall include appointment scheduling guidelines based on
17 the type of health care service, including prenatal care appointments, well-child visits and
18 immunizations, routine physicals, follow-up appointments for chronic conditions, and urgent
19 care. However, for emergency services, each managed care plan shall cover and reimburse
20 expenses for emergency care obtained, without prior authorization, in situations in which a
21 prudent layperson could reasonably believe the condition required immediate attention at the
22 nearest facility.

23 Section 7. Each managed care plan shall demonstrate that it has developed an access plan to
24 meet the needs of vulnerable and under-served populations. The plan shall provide culturally
25 appropriate services to the greatest extent possible. If a significant number of enrollees in the

1 plan speaks a first language other than English, the plan shall provide access to personnel fluent
2 in languages other than English, to the greatest extent possible. The plan shall develop standards
3 for continuity of care following enrollment, including sufficient information on how to access
4 care within the plan.

5 Section 8. Each managed care plan shall hold harmless enrollees, against claims from
6 participating practitioners in the managed care plan, for payment of the cost of covered health
7 services.

8 Section 9. Each enrollee shall have adequate choice among managed care plan health care
9 professionals who are accessible and qualified. Each managed care plan shall permit enrollees to
10 choose their own primary care practitioner from a list of health care professionals within the plan.
11 This list shall be updated as health care professionals are added or removed and shall include:

- 12 (1) A sufficient number of primary care practitioners who are accepting new enrollees;
- 13 and
- 14 (2) A sufficient mix of primary care practitioners that reflects a diversity that is adequate
- 15 to meet the needs of the enrolled population's varied characteristics, including age,
- 16 gender, race, and health status.

17 Each managed care plan shall develop a system to permit enrollees to use a medical specialist
18 primary care practitioner, if the enrollee's medical condition warrants it. This may include
19 enrollees suffering from chronic diseases as well as those with other special needs.

20 Each managed care plan shall provide continuity of care and appropriate referral to specialists
21 within the plan, if specialty care is warranted. Enrollees shall have access to medical specialists
22 on a timely basis and a choice of specialists if a referral is made.

23 Each managed care plan shall offer a point-of-service option. The point-of-service option
24 may require that the enrollee in the plan pay a reasonable portion of the costs not to exceed
25 twenty percent of such out-of-plan care.

1 Each plan shall provide enrollees with access to a consultation for a second opinion.

2 Section 10. A managed care plan may not contract with a health care provider to limit the
3 health care professional's disclosure to an enrollee or on behalf of an enrollee any information
4 relating to the enrollee's medical condition or treatment options.

5 A health care professional may not be penalized, nor may the health care professional's
6 contract with the managed care plan terminated, because the health care professional offers
7 referrals, or discusses medically necessary or appropriate care with, or on behalf of, the enrollee.
8 All treatment options may be discussed, and other information, determined by the health care
9 professional to be in the best interests of the enrollee may be disclosed.

10 A health care professional may not be penalized for discussing financial incentives and
11 financial arrangements between the health care professional and the managed care entity.

12 Section 11. Each managed care plan shall provide coverage for FDA-approved drugs and
13 devices, whether or not that drug or device has been approved for the specific treatment or
14 condition, if the primary care practitioner or other medical specialist treating the enrollee
15 determines the drug or device is medically necessary and appropriate for the enrollee's condition.

16 Each managed care service plan shall establish and operate a drug utilization review program
17 that includes retrospective review of prescription drugs furnished to enrollees, and the education
18 of physicians, enrollees, and pharmacists regarding the appropriate use of prescription drugs.

19 Each managed care service plan shall provide for a drug utilization review program with
20 ongoing periodic examination of data on outpatient prescription drugs to ensure quality
21 therapeutic outcomes for enrollees. The drug utilization review program's primary emphasis shall
22 be to enhance quality of care for enrollees by assuring appropriate drug therapy. The drug
23 utilization review program shall include the following:

- 24 (1) Clinically relevant criteria and standards for drug therapy;
- 25 (2) Nonproprietary criteria and standards, developed and revised through an open,

1 professional consensus process; and

2 (3) Interventions which focus on improving therapeutic outcomes.

3 The confidentiality of the relationship between enrollees and health care professionals shall
4 be protected at all times.

5 The health care services plan shall provide an educational outreach program as part of the
6 drug utilization review program. The outreach program shall be directed to enrollees,
7 pharmacists, and other health care professionals. The outreach program shall emphasize the
8 appropriate use of prescription drugs.

9 Prospective review of drug therapy may only deny services in cases of enrollee ineligibility,
10 coverage limitations, or fraud.

11 The prescribing health care professional shall determine the appropriate drug therapy for the
12 enrollee. No substitutions may be made without the direct approval of the prescriber or recipient.

13 Section 12. A managed care plan which limits coverage for services shall define the limitation
14 and disclose the limits in any agreement or certificate of coverage. This disclosure shall include
15 who is authorized to make such a determination, and the criteria the plan uses to determine
16 whether a service is experimental.

17 A managed care plan that denies coverage for an experimental treatment, procedure, drug,
18 or device for an enrollee who has a terminal condition or illness shall provide the enrollee with
19 a denial letter within twenty working days of the submitted request. The letter shall include:

20 (1) The name and title of the individual making the decision;

21 (2) A statement setting forth the specific medical and scientific reasons for denying
22 coverage;

23 (3) A description of alternative treatment, services, or supplies covered by the plan, if
24 any; and

25 (4) A copy of the plan's grievance and appeal procedure.

1 Section 13. The managed care plan shall develop comprehensive quality assurance standards,
2 adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality
3 of care. These standards shall include:

- 4 (1) An ongoing, written, internal quality assurance program;
- 5 (2) Specific written guidelines for quality of care studies and monitoring, including
6 attention to vulnerable populations;
- 7 (3) Performance and clinical outcomes-based criteria;
- 8 (4) A procedure for remedial action to correct quality problems, including written
9 procedures for taking appropriate corrective action;
- 10 (5) A plan for data gathering and assessment; and
- 11 (6) A peer review process which utilizes South Dakota health care professionals from the
12 same profession.

13 Section 14. Each managed care plan shall have a process for selection of health care
14 professionals who are on the plan's participating practitioner list, with written policies and
15 procedures for review and approval used by the plan. The plan shall establish minimum
16 professional requirements. The plan shall demonstrate that it has consulted with appropriately
17 qualified health care professionals to establish the requirements. The plan's process shall include
18 verification of the individual practitioner's license, history of suspension or revocation, and
19 liability claims history. Each managed care plan shall establish a formal, written, ongoing process
20 for the re-evaluation of all participating physicians within a specified number of years after the
21 initial acceptance. Any re-evaluation shall include updates of the previous review criteria and an
22 assessment of the performance pattern based on criteria including enrollee clinical outcomes,
23 number of complaints, and malpractice actions.

24 The plan may not use a health care professional beyond, or outside of, the professional's
25 authorized scope of practice.

1 Section 15. The managed care plan shall provide information on a plan's structure, decision
2 making process, health care benefits and exclusions, cost and cost sharing requirements, list of
3 contracting providers and health care professionals, and grievance and appeal procedures to all
4 potential enrollees, all enrollees covered by the plan, and to the Division of Insurance.

5 The managed care plan shall collect and report annually to the division specified data
6 including:

- 7 (1) Gross outpatient and hospital utilization data;
- 8 (2) The number and types of enrollee grievances or complaints during the year, the status
9 of decisions, and the average time required to reach a decision; and
- 10 (3) The number, amount, and disposition of malpractice claims resolved during the year
11 by the managed care plan and any of its participating health care professionals.

12 The information required by this section shall be reported to the division and shall be
13 available to the public on a timely basis.

14 Section 16. The managed care plan shall establish written policies and procedures for the
15 handling of medical records and enrollee communications to ensure enrollee confidentiality. The
16 managed care plan shall ensure the confidentiality of specified enrollee information, including
17 prior medical history, medical record information, and claims information, unless disclosure of
18 this information is required by law. The managed care plan may not release any enrollee's patient
19 record information, unless such a release is authorized in writing by the enrollee.

20 Section 17. The managed care plan shall appoint a director who is a health care professional
21 in the state. The director is responsible for treatment policies, protocols, quality assurance
22 activities, and utilization management decisions of the plan.

23 Section 18. The managed care plan shall inform enrollees of the financial arrangements
24 between the plan and contracting health care professionals and pharmacists, if those
25 arrangements include incentives or bonuses for restriction of services.

1 Section 19. The Division of Insurance shall oversee managed care plans operating within the
2 state. Each managed plan shall be legally authorized by the division prior to beginning
3 operations. The division shall perform audits on an annual basis, to review enrollee clinical
4 outcome data, enrollee service data, and operational and other financial data. Nothing in this Act
5 precludes the division from investigating complaints, grievances, or appeals on behalf of enrollees
6 or health care professionals.

7 The division shall provide, by rules promulgated pursuant to chapter 1-26:

- 8 (1) Standards for compliance of plans regarding mandated requirements; and
- 9 (2) Penalties for violations.

10 Section 20. The managed care plan shall provide written notification to enrollees in plain
11 language regarding the right to file a grievance. At a minimum, notification shall be given prior
12 to enrollment in the plan and at the time care is denied or limited under the plan.

13 At the time of a denial, the plan shall notify the enrollee of the right to file a grievance. The
14 notice shall be written and shall include the reason for denial, the name of the person responsible
15 for the decision, the criteria for determination, and the enrollee's right to file a grievance. The
16 grievance procedure shall include:

- 17 (1) Identification of the reviewing body and an explanation of the process of review;
- 18 (2) An initial investigation and review;
- 19 (3) Notification within a reasonable amount of time of the outcome of the grievance; and
- 20 (4) An appeal procedure.

21 The managed care plan shall set reasonable time limits for each part of the review process,
22 but in no case may the review extend beyond thirty days.

23 The managed care plan shall provide for expedited review for cases involving an imminent,
24 emergent, or serious threat to the health of the enrollee. The plan shall immediately inform the
25 enrollee of this right. The plan shall provide the enrollee with a written statement of the

1 disposition or pending status of the grievance within seventy-two hours of the commencement
2 of the review process.

3 Section 21. The managed care plan shall report to the Division of Insurance, the number of
4 grievances and appeals received by the plan within a specified time period, including, if
5 applicable, the outcomes or current status of the grievance or appeals, or both, as well as the
6 average time taken to resolve both grievances and appeals.

7 Section 22. This Act may be cited as the South Dakota Health Care Consumers' Bill of
8 Rights Act.