STATE OF OKLAHOMA

2nd Session of the 47th Legislature (2000)

COMMITTEE SUBSTITUTE
FOR ENGROSSED
HOUSE BILL 2710

By: Toure, Settle, Lindley, Roach, Frame, Blackburn, Collins, Corn, Leist, Nations, Ostrander, Paulk, Taylor and Wells of the House

and

Henry of the Senate

COMMITTEE SUBSTITUTE

An Act relating to health care; creating the Managed Health Care Reform and Accountability Act and providing short title; declaring purpose; defining terms; stating duty of defined health care entities to exercise ordinary care in health care treatment decisions; providing for liability for damages; stating obligation to provide care; limiting liability of specified employers and employer group purchasing organizations; prohibiting removal of certain health care providers for advocating appropriate and medically necessary health care; prohibiting attempts to obtain certain indemnification from health care providers; declaring certain provisions of contracts to be void and unenforceable; prohibiting certain defenses; stating that section does not create new or additional liability for certain entities for medical negligence of health care providers; requiring insured and enrollee to comply with certain requirements for civil actions; stating prerequisites for civil actions; requiring specified notice; providing for tolling of limitations; allowing specified remedies under certain circumstances; providing for codification; providing an effective date; and declaring an emergency.

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 6591 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. This act shall be known and may be cited as the "Managed Health Care Reform and Accountability Act".

B. The Legislature hereby declares that the public good and the general welfare of the citizens of this state require the enactment of this measure under the police power of the state as part of and in furtherance of the regulation of the business of insurance.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6592 of Title 36, unless there is created a duplication in numbering, reads as follows:

For purposes of this act:

1. "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents;

2. "Health care plan" means any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the costs of any health care services for an enrollee;

3. "Health care provider" means a physician, hospital, pharmaceutical company, pharmacy, laboratory, or other state-licensed or state-recognized provider of health care services;

4. "Health care treatment decision" means a determination made when medical services are rendered under a health care plan and a decision is made which affects the quality of the diagnosis, care, or treatment provided to the enrollee of the plan;

5. "Health insurance carrier" means an insurance company that issues policies of accident and health insurance and is or should be licensed to sell insurance in this state;

6. "Health maintenance organization" means an organization which is or should be licensed by the State Department of Health pursuant to Section 2501 et seq. of Title 63 of the Oklahoma Statutes;

7. "Managed care entity" means any entity which delivers, administers, or indemnifies health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of such services to a defined enrollee population, but does not include an employer purchasing

coverage for or on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer;

8. "Medically necessary" means services or supplies provided by a health care provider that are:

a. appropriate for the symptoms and diagnosis or treatment of the enrollee's condition, illness, disease, or injury,

b. in accordance with standards of good medical practice,

c. not primarily for the convenience of the enrollee or the enrollee's health care provider, and

d. the most appropriate supply or level of service that can safely be provided to the enrollee;

9. "Ordinary care" means, in the case of a health insurance carrier, health maintenance organization, or managed care entity, the degree of care that a health insurance carrier, health maintenance organization, or managed care entity of reasonable prudence would use under the same or similar circumstances. In the case of a person who is an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization, or managed care entity, "ordinary care" means the degree of care that a reasonably prudent person in the same profession, specialty, or field of practice as that person would use in the same or similar circumstance. An employer which does not make health care treatment decisions is not an employee, agent, ostensible agent, or representative of a health insurance carrier, health maintenance organization, or managed care entity; and

10. "Physician" means an individual licensed to practice medicine in this state pursuant to Section 725.2 of Title 59 of the Oklahoma Statutes.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6593 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and shall be liable for damages for harm to an enrollee proximately caused by breach of the duty to exercise ordinary care if:

1. The failure to exercise ordinary care resulted in the denial, significant delay, or modification of the health care service recommended for, or furnished to, an insured or enrollee; and

2. The insured or enrollee suffered harm.

B. A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan shall be liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its employees, agents, ostensible agents, or representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which result in the failure to exercise ordinary care.

C. The standards in subsections A and B of this section create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide treatment to an insured or enrollee which is not covered by the health care plan of the entity.

D. This act does not create any liability on the part of an employer or an employer group purchasing organization that purchases coverage or assumes risk on behalf of its employees.

E. A health care plan, health insurance carrier, health maintenance organization, or managed care entity may not remove a health care provider from its plan or refuse to renew the health care provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

F. A health insurance carrier, health maintenance organization, or other managed care entity shall not seek indemnification from a health care provider, whether contractual or equitable, for liability imposed by this act. Any provision in a contract to the contrary is void and unenforceable.

G. Nothing in any law of this state prohibiting a health insurance carrier, health maintenance organization, or other managed care entity from practicing medicine or being licensed to practice medicine may be asserted as a defense by a health insurance carrier, health maintenance organization, or other managed care entity in an action brought against it pursuant to this section or any other law of this state.

H. This section shall not create any new or additional liability on the part of a health insurance carrier, health maintenance organization, or managed care entity for harm caused that is attributable to the medical negligence of a health care provider.

I. An insured or enrollee who files an action under this act shall comply with all requirements relating to cost bonds, deposits, and expert reports.

J. This act shall not apply to insurance agents licensed by the Insurance Department.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6594 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A person may not maintain a cause of action under this act against a health insurance carrier, health maintenance organization, or other managed care entity unless the affected insured or enrollee, or the representative of the insured or enrollee, has exhausted any appeal and review process applicable under the utilization review requirements of the plan and any applicable external review system of the health insurance carrier, health

maintenance organization, or managed care entity, and gives written notice of the claim as provided in subsection B of this section.

B. The notice required by subsection A of this section shall be delivered or mailed to the health insurance carrier, health maintenance organization, or managed care entity against whom the action will be brought at least thirty (30) days before the action is filed.

C. If the insured or enrollee, or the representative of the insured or enrollee, exhausts the appeal and review process and gives notice as required by subsection A of this section before the statute of limitations applicable to a claim against a managed care entity has expired, the limitations period is tolled until thirty (30) days after the date the insured or enrollee or the representative of the insured or enrollee has exhausted the process for appeal and review applicable under the utilization review requirements of the plan.

D. The provisions of this section shall not prohibit an insured or enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or other relief available under law, if the requirement of exhausting the process for appeal and review places the health of the insured or enrollee in serious jeopardy.

SECTION 5. AMENDATORY Section 5, Chapter 160, O.S.L. 1999 (63 O.S. Supp. 1999, Section 2528.5), is amended to read as follows:

Section 2528.5 A. 1. An insured person or the designee of an insured person shall be required to pay Fifty Dollars ($50.00) to the health benefit plan toward the cost of an external review.

a. Such payment shall be due at the time the preliminary screening is completed and the insured person or the designee of the insured person is notified of a decision by the independent review organization to

accept the appeal, pursuant to procedures specified in the Oklahoma Managed Care External Review Act, for a full external review.

b. At the completion of the external review, if the insured person prevails, the payment shall be refunded by the health benefit plan.

2. The health benefit plan shall be responsible for the remaining costs related to the external review process.

B. ~~A determination in favor of the health benefit plan shall create a rebuttable presumption in any subsequent action at law that the plan's coverage determination was appropriate.~~

~~C.~~ The number of appeals for an external review by an insured person or a designee of the insured person shall be limited to one appeal per authorization decision.

~~D.~~ C. The health benefit plan may, at its discretion, determine that additional information provided by the insured person or the designee or physician of the insured person justifies a reconsideration of the decision to deny coverage or reimbursement. Upon notice to the insured person or the designee of the insured person and the independent review organization, a subsequent decision by the health benefit plan to grant coverage or reimbursement based upon such reconsideration shall terminate the external review.

~~E.~~ D. Nothing in the Oklahoma Managed Care External Review Act shall be construed to:

1. Create any new private right or cause of action for or on behalf of any insured person; or

2. Render the health benefit plan liable for injuries or damages arising from any act or omission of the independent review organization.

~~F.~~ E. Independent review organizations and expert reviewers assigned by an independent review organization to conduct an

external review shall not be liable for injuries or damages arising from decisions made pursuant to the Oklahoma Managed Care External Review Act. This provision shall not apply to any act or omission by independent review organizations or expert reviewers that is made in bad faith or that involves gross negligence.

~~C.~~ F. After an appeal has been accepted for external review by an independent review organization, an informed consent form, signed by the insured person or the designee of the insured person acknowledging receipt of a copy of the terms and conditions of the external review process as provided by this section and acknowledging understanding of and consent to such terms and conditions, shall be required prior to initiating a full external review.

~~H.~~ G. A health benefit plan shall not remove a physician from its plan, refuse to renew a physician with the plan, or otherwise discipline a physician for advocating on behalf of an insured person in either an internal review or external review.

SECTION 6. This act shall become effective July 1, 2000.

SECTION 7. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

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