ENGROSSED HOUSE
BILL NO. 2647

By: Morgan, Liotta, Perry, Dank, Phillips, Calvey, Miller and Smith (Hopper) of the House

and

Dunlap of the Senate

An Act relating to health care; requiring health benefit plans to establish an internal review procedure; stating purpose of review procedure; directing the Insurance Commissioner to promulgate rules establishing a standardized internal review procedure; stating minimum criteria for the review process; providing definitions; amending Section 2, Chapter 289, O.S.L. 1997, as amended by Section 5, Chapter 361, O.S.L. 1999 (63 O.S. Supp. 1999, Section 2525.3), which relates to definitions used in the Oklahoma Managed Care Act; adding definition; amending Sections 2 and 4, Chapter 160, O.S.L. 1999 (63 O.S. Supp. 1999, Sections 2528.2 and 2528.4), which relate to the Oklahoma Managed Care External Review Act; modifying definition; deleting requirement for the State Board of Health and the Insurance Commissioner to promulgate certain rules; making managed care entities liable for certain harm under certain circumstances; defining term; specifying certain conditions in order to maintain a cause of action; directing the State Board of Health to coordinate with the Insurance Commissioner and promulgate certain rules; 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 6052.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Every health benefit plan shall establish an internal review procedure by which an insured person may appeal an adverse decision made by the health benefit plan.

B. The Insurance Commissioner shall promulgate rules establishing a standardized internal review procedure. The rules

promulgated by the Commissioner shall establish minimum standards that:

1. Establish a procedure by which a health benefit plan maintains a record of internal reviews;

2. Provides that the internal review procedure be set forth in writing and made available to all insured persons;

3. Standardizes the number of steps involved in the review process;

4. Standardizes the time frames for the review process; and

5. Provides provisions for an expedited internal review process.

C. As used in this section:

1. "Adverse decision" means a determination by a health benefit plan or a utilization review organization designated by the plan that an admission, continued stay, or other health care service has been reviewed and based upon the information provided, does not meet the requirements established by the plan for medical necessity, appropriateness, health care setting, level of care, level of effectiveness, and therefore the requested service is denied, reduced, or terminated; and

2. "Health benefit plan" means those entities subject to the Oklahoma Managed Care External Review Act.

SECTION 2. AMENDATORY Section 2, Chapter 289, O.S.L. 1997, as amended by Section 5, Chapter 361, O.S.L. 1999 (63 O.S. Supp. 1999, Section 2525.3), is amended to read as follows:

Section 2525.3 For purposes of the Oklahoma Managed Care Act:

1. <u>"Emergency" means a 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:</u>

<u>a. jeopardy to the patient's health,</u>

b. impairment to bodily functions, or

c. dysfunction of any bodily organ or part;

2. "Emergency care" means emergency department screening and care to achieve stabilization as needed for conditions that reasonably appear to constitute a life- or limb-threatening emergency based on the presenting symptoms of the patient;

~~2.~~ 3. "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.~~ 4. "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;

~~4.~~ 5. "Managed care 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 certified workplace medical plan as defined in Section 14.2 of Title 85 of the Oklahoma Statutes;

~~5.~~ 6. "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;

~~6.~~ 7. "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;

~~7.~~ 8. "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;

~~8.~~ 9. "Qualified utilization review program" means a utilization review program that meets the requirements of the Oklahoma Managed Care Act; and

~~9.~~ 10. "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 2, Chapter 160, O.S.L. 1999 (63 O.S. Supp. 1999, Section 2528.2), is amended to read as follows:

Section 2528.2 As used in the Oklahoma Managed Care External Review Act:

1. “Designee of an insured person” means an individual designated through expressed written consent by an insured person to represent the interests of the insured person, including, but not limited to, the insured person’s physician or where applicable such person’s primary care physician;

2. “External review” means a review of a decision by a health benefit plan to deny coverage of or reimbursement for a medical treatment or service that is otherwise a covered benefit by an independent review organization upon the request of an insured person or the designee of an insured person, and the organization’s subsequent decision to uphold or reverse the denial of such coverage or reimbursement made by the health benefit plan;

3. “Health benefit plan” means individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization, a preferred provider plan, the State and Education Employees Group Insurance Plan, coverage provided by a Multiple Employer Welfare Arrangement (MEWA), or a self-insured plan;

4. “Independent review organization” means an entity certified by the State Department of Health to conduct external reviews;

5. “Insured person” means an individual who receives medical care and treatment through a health benefit plan. In the case of a minor child, the term includes the parent or legal guardian of the child and, in the case of an incapacitated or partially incapacitated person, the legal guardian of such person;

6. “Internal review” means procedures established by a health benefit plan, pursuant to the provisions of Section ~~4~~ 1 of this act~~, for an internal reevaluation of an initial decision to deny coverage of or reimbursement for a medical treatment or service that is otherwise a covered benefit, and the subsequent decision by the~~

~~health benefit plan to grant or deny such coverage or reimbursement~~ and rules established pursuant to Section 5 of this act; and

7. "Physician" means and includes each of the classes of persons listed by Section 725.2 of Title 59 of the Oklahoma Statutes.

SECTION 4. AMENDATORY Section 4, Chapter 160, O.S.L. 1999 (63 O.S. Supp. 1999, Section 2528.4), is amended to read as follows:

Section 2528.4 A. Except as specifically provided by this section, every health benefit plan that is offered, issued or renewed after February 1, 2000, shall provide for an external review process by an independent review organization in accordance with the provisions of the Oklahoma Managed Care External Review Act. The following shall not be subject to the provisions of the Oklahoma Managed Care External Review Act:

1. Health benefit plans that do not use a primary care physician-based prior authorization system and that have written procedures that permit external review;

2. Health benefit plans and health care provided pursuant to Titles XVIII, XIX or XXI of the federal Social Security Act; and

3. Workers' compensation benefits or coverage subject to the provisions of Title 85 of the Oklahoma Statutes.

B. Every health benefit plan subject to the provisions of the Oklahoma Managed Care External Review Act shall establish internal appeals procedures in accordance with rules promulgated by the state regulatory entity of the health benefit plan. ~~The State Board of Health and the Insurance Commissioner shall respectively promulgate rules for internal review procedures for the health benefit plans subject to licensure or regulation by the State Department of Health or the Insurance Department as applicable. The rules shall include but not be limited to provisions for expedited internal review procedures in emergency situations.~~

C. Upon the request of an insured person or the representative of an insured person, every health benefit plan shall provide the requester with clear information about the terms, conditions and procedures of the internal review process and the external review process.

D. 1. For services rendered on or after November 1, 2000, a managed care entity, in administering benefits and settling claims, shall have a duty to provide benefits when it has become clear that a health care service for an enrollee is medically necessary and is a benefit provided under the enrollee's plan. A managed care entity shall be liable for harm proximately caused by its failure to act in good faith in such situations, but only when both of the following apply:

a. the failure to act in good faith resulted in the denial, unreasonable delay, or adverse modification of the health care service recommended by a health care provider for, or furnished to, an enrollee, and

b. the enrollee suffered substantial harm. "Substantial harm" means loss of life, loss of or significant impairment of limb or bodily function, significant disfigurement, or severe and chronic physical pain.

2. A person may not maintain a cause of action against a managed care entity for failure of the managed care entity to exercise good faith, as described in paragraph 1 of this subsection, unless the subscriber or enrollee:

a. has exhausted the managed care entity's internal review and external review processes, and

b. the managed care entity refuses to abide by the decision of the last reviewer. If the managed care entity complies with the decision of the reviewer, no cause of action may be brought.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2528.11 of Title 63, unless there is created a duplication in numbering, reads as follows:

The State Board of Health shall coordinate with the Insurance Commissioner and promulgate rules for internal review procedures for health benefit plans subject to the licensure or regulation by the State Department of Health which are consistent with the provisions of Section 1 of this act.

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

Passed the House of Representatives the 6th day of March, 2000.

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Speaker of the House of Representatives

Passed the Senate the ____ day of _____, 2000.

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President of the Senate