

ENGROSSED HOUSE
BILL NO. 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

(health care accountability - Health Care
Accountability Act - ordinary care in health care
treatment decisions - amending 63 O.S., Section
2528.5 - codification - effective date -
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 21.1 of Title 76, unless there
is created a duplication in numbering, reads as follows:

Sections 1 through 4 of this act shall be known and may be cited
as the "Health Care Accountability Act".

SECTION 2. NEW LAW A new section of law to be codified
in the Oklahoma Statutes as Section 21.2 of Title 76, unless there
is created a duplication in numbering, reads as follows:

For purposes of the Health Care Accountability Act:

1. "Appropriate and medically necessary" means the standard for
health care services as determined by physicians and health care
providers in accordance with Section 20.1 of Title 76 of the
Oklahoma Statutes;

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

3. "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;

4. "Health care provider" means a physician as defined in Section 725.2 of Title 59 of the Oklahoma Statutes, hospital, pharmacy, laboratory, or other state-recognized provider of health care services;

5. "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;

6. "Health insurance carrier" means an authorized insurance company that issues policies of accident and health insurance and is licensed to sell insurance in this state;

7. "Health maintenance organization" means an organization licensed by the State Department of Health pursuant to Section 2501 et seq. of Title 63 of the Oklahoma Statutes;

8. "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 or action on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer or a pharmacy licensed by this state;

9. "Physician" means:

- a. an individual, as defined in Section 725.2 of Title 59 of the Oklahoma Statutes,

- b. a professional association of physicians organized in this state or a nonprofit health corporation certified in this state, or
- c. another entity wholly owned by physicians; and

10. "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 ordinary 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 person of ordinary prudence in the same profession, specialty, or area of practice as that person would use in the same or similar circumstance. "Ordinary care" shall be defined by national standards.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 21.3 of Title 76, 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 its failure to exercise ordinary care.

B. A health insurance carrier, health maintenance organization or other managed care entity for a managed care plan is also liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its:

- 1. Employees;
- 2. Agents;
- 3. Ostensible agents; or

4. 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 has resulted in the failure to exercise ordinary care.

C. It shall be a defense to any action asserted against a health insurance carrier, health maintenance organization, or other managed care entity for a health care plan that:

1. Neither the health insurance carrier, health maintenance organization, or other managed care entity, nor any employee, agent, ostensible agent, or representative for whose conduct the health insurance carrier, health maintenance organization, or other managed care entity is liable under subsection B of this section, controlled, influenced, or participated in the health care treatment decision; and

2. The health insurance carrier, health maintenance organization, or other managed care entity did not deny or delay payment for any treatment prescribed or recommended by a provider to the insured or enrollee.

D. 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 to an insured or enrollee treatment which is not covered by the health care plan of the entity.

E. The Health Care Accountability Act does not create any liability on the part of an employer, an employer group purchasing organization, or a pharmacy licensed by this state that purchases coverage or assumes risk on behalf of its employees.

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

for appropriate and medically necessary health care for the enrollee.

G. A health insurance carrier, health maintenance organization, or other managed care entity shall not enter into a contract with a physician, hospital, or other health care provider or pharmaceutical company which includes an indemnification or hold harmless clause for the acts or conduct of the health insurance carrier, health maintenance organization, or other managed care entity. Any indemnification or hold harmless clause in an existing contract is declared void.

H. 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.

I. In an action against a health insurance carrier, health maintenance organization, or managed care entity, a finding that a physician or other health care provider is an employee, agent, ostensible agent, or representative of the health insurance carrier, health maintenance organization, or managed care entity shall not be based solely on proof that the person's name appears in a listing of approved physicians or health care providers made available to insureds or enrollees under a health care plan.

J. The Health Care Accountability Act shall not apply to workers' compensation insurance plans.

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

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 21.4 of Title 76, unless there is created a duplication in numbering, reads as follows:

A. A person may not maintain a cause of action under the Health Care Accountability 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 the appeals and review process applicable under the utilization review requirements of the health insurance carrier, health maintenance organization, or managed care entity and gives written notice of the claim as provided by 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 is brought not less than thirty (30) days before the date the action is filed.

C. If the insured or enrollee or the representative of the insured or enrollee exhausts the appeals and review process and provides notice, as required by subsection A of this section, the commencement of the statute of limitations applicable to a claim against a managed care entity is tolled until after the date the insured or enrollee or the representative of the insured or enrollee has exhausted the process for appeals and review applicable under the utilization review requirements of the entity.

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 appeals 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.

~~G.~~ 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. No cause of action brought pursuant to this act shall be certified as a class action.

SECTION 7. This act shall become effective July 1, 2000.

SECTION 8. 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.

Passed the House of Representatives the 29th day of February, 2000.

Speaker of the House of
Representatives

Passed the Senate the ____ day of _____, 2000.

President of the Senate