ENGROSSED SENATE
BILL NO. 1206

By: Henry of the Senate

and

Settle and Lindley of the House

[health care - Health Care Liability Act – terms – duties - liability – requirements - 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:

This act shall be known and may be cited as “The HMO Reform and 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 this act:

1. "Medically necessary” means services or supplies provided by a hospital, physician, or other 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 provider,

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

e. hospitalization is required due to the nature of the services rendered or the enrollee's condition, and the enrollee cannot receive safe or adequate care as an outpatient;

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 licensed to practice medicine in this state,

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.

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 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, a subscriber or enrollee; and

2. The subscriber 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. 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. This 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. 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 treating physician or other treating health care provider.

K. This act shall not apply to workers' compensation insurance plans.

L. 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 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 the appeals and review process applicable under the utilization review requirements 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 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 later 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, 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 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. This act shall become effective July 1, 2000.

SECTION 6. 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 Senate the 15th day of March, 2000.

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President of the Senate

Passed the House of Representatives the ____ day of _____, 2000.

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Speaker of the House of Representatives