

STATE OF OKLAHOMA

2nd Session of the 47th Legislature (2000)

HOUSE BILL HB2647

By: Morgan

AS INTRODUCED

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 Sections 2 and 4, Chapter 160, O.S.L. 1999 (63 O.S. Supp. 1999, Section 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; 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 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 4 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 3. 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.

SECTION 4. 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 5. This act shall become effective November 1, 2000.

47-2-8508            KB            6/12/15