ESB 890

THE HOUSE OF REPRESENTATIVES
Tuesday, April 10, 2007

ENGROSSED

Senate Bill No. 890

ENGROSSED SENATE BILL NO. 890 - By: CRAIN of the Senate and SULLIVAN of the House.

An Act relating to public health and safety; amending 63 O.S. 2001, Section 5051.1, as amended by Section 1, Chapter 91, O.S.L. 2005 (63 O.S. Supp. 2006, Section 5051.1), which relates to recovery from tortfeasors; prioritizing payment of certain damages; capping certain amount; modifying language; authorizing certain liens to be considered valid in specified circumstance; prohibiting the approval of a certain trust in specified circumstance; requiring certain notification; amending 63 O.S. 2001, Section 5051.2, which relates to reimbursement for medical services; requiring certain insurers to accept specified right; prohibiting certain insurers to deny Oklahoma Health Care Authority claims in specified circumstances; requiring certain insurers to make specified payments; setting certain time limit; amending Section 12, Chapter 464, O.S.L. 2003 (63 O.S. Supp. 2006, Section 5051.5), which relates to data file comparisons; expanding list of parties required to compare certain data; specifying information which must be provided in certain circumstance; specifying manner in which certain information must be transmitted; deleting certain requirement for plan administrators; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

1 SECTION 1. AMENDATORY 63 O.S. 2001, Section 5051.1, as amended by
2 Section 1, Chapter 91, O.S.L. 2005 (63 O.S. Supp. 2006, Section 5051.1), is amended to
3 read as follows:
4 Section 5051.1 A. 1. The payment of medical expenses by the Oklahoma Health
5 Care Authority for or on behalf of or the receipt of medical assistance by a person who

has been injured or who has suffered a disease as a result of the negligence or act of another person creates a debt to the Authority, subject to recovery by legal action pursuant to this section. Damages for medical costs are considered a priority over all other damages and should be paid by the tortfeasor prior to other damages being allocated or paid.

2. The payment of medical expenses by the Authority for or on behalf of a person who has been injured or who has suffered a disease, and either has a claim or may have a claim against an insurer, to the extent recoverable, creates a debt to the Authority whether or not such person asserts or maintains a claim against an insurer.

B. The Authority shall provide notice to all recipients of medical assistance at the time of application for such assistance of their obligation to report any claim or action, and any judgment, settlement or compromise arising from the claim or action, for injury or illness for which the Authority makes payments for medical assistance.

C. The recipient of medical assistance from the Authority for an injury or disease who asserts a claim or maintains an action against another on account of the injury or disease, or the recipient's legal representative, shall notify the Authority of the claim or action and of any judgment, settlement or compromise arising from the claim or action prior to the final judgment, settlement or compromise.

D. If the injured or diseased person asserts or maintains a claim against another person or tortfeasor on account of the injury or disease, the Authority:

1. Shall have a lien upon payment of the medical assistance to the extent of the amount so paid upon that part going or belonging to the injured or diseased person of any

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recovery or sum had or collected or to be collected by the injured or diseased person up to the amount of the damages for the total medical expenses, or by the heirs, personal representative or next of kin in case of the death of the person, whether by judgment or by settlement or compromise. The lien authorized by this subsection shall:

a. be inferior only to ~~any~~ a lien or claim of ~~any~~ the attorney or attorneys ~~for~~ handling the claim on behalf of the injured or diseased person, the heirs or personal representative,

b. not be applied or considered valid against any temporary or permanent disability award of the claimant due under the Workers' Compensation Act, ~~and~~

c. be applied and considered valid as against any insurer adjudged responsible for medical expenses under the Workers' Compensation Act, and

d. be applied and considered valid as to the entire settlement, after the claim of the attorney or attorneys for fees and costs, unless a more limited allocation of damages to medical expenses is shown by clear and convincing evidence;

2. May take any other legal action necessary to recover the amount so paid or to be paid to the injured or diseased person or to the heirs, personal representative or next of kin in case of the death of the person; and

3. Shall have the right to file a written notice of its lien in any action commenced by the injured or diseased person.

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E. The Authority, to secure and enforce the right of recovery or reimbursement on behalf of the injured or diseased person, may initiate and prosecute any action or proceeding against any other person or tortfeasor who may be liable to the injured or diseased person, if the injured or diseased person has not initiated any legal proceedings against the other person or tortfeasor.

F. Any person or insurer that has been notified by the Authority of a claim of lien authorized by this section and who, directly or indirectly, pays to the recipient any money as a settlement or compromise of the recipient's claim arising out of the injury shall be liable to the Authority for the money value of the medical assistance rendered by the Authority in an amount not in excess of the amount to which the recipient was entitled to recover from the tortfeasor or insurer because of the injury.

G. A Medicaid special needs trust for the purposes of establishing or maintaining Medicaid eligibility shall not be approved until such time as the Authority has been made whole and paid in full for all paid medical claims which are associated with the action.

H. A Medicaid recipient must notify the Authority prior to a compromise or settlement against a third party in which the Authority has provided or has become obligated to provide medical assistance.

I. As used in this section:

1. "Medical expenses" includes the cost of hospital, medical, surgical and dental services, care and treatment, rehabilitation, and prostheses and medical appliances, and nursing and funeral services;

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2. "Person" includes, in addition to an individual, the guardian of an individual, and the administrator or executor of the estate of an individual, and a corporation; and

3. "Insurer" means any insurance company that administers accident and health policies or plans or that administers any other type insurance policy containing medical provisions, and any nonprofit hospital service and indemnity and medical service and indemnity corporation, actually engaged in business in the state, regardless of where the insurance contract is written, or plan is administered or where such corporation is incorporated.

SECTION 2. AMENDATORY 63 O.S. 2001, Section 5051.2, is amended to read as follows:

Section 5051.2 A. Whenever the Oklahoma Health Care Authority pays for medical services or renders medical services, for or on behalf of a person who has been injured or suffered an illness or disease, the right of the provider of the services to reimbursement shall be automatically assigned to the Oklahoma Health Care Authority, upon notice to the insurer or other party obligated as a matter of law or agreement to reimburse the provider on behalf of the patient.

B. Upon the assignment, the Authority, for purposes of the claim for reimbursement, becomes a provider of medical services.

C. The assignment of the right to reimbursement shall be applied and considered valid against any employer or insurer under the Workers' Compensation Act in this state.

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D. Each insurer, upon receiving a claim from the Oklahoma Health Care Authority, shall accept the state's right of recovery, to process and, if appropriate, pay the claim to the same extent that the plan would have been liable if it had been billed at the point of sale or by the original provider of services. Insurer shall not deny the Authority claims on the basis of the date of submission, the format of the claim, or for failure to present proper documentation of coverage at the point of sale.

E. Insurer shall make appropriate payments to the Authority as long as the claim is submitted for consideration within three (3) years from the date the service was furnished. Any action by the Authority to enforce the payment of the claim shall be commenced within six (6) years of the submission of the claim by the Authority.

SECTION 3. AMENDATORY Section 12, Chapter 464, O.S.L. 2003 (63 O.S. Supp. 2006, Section 5051.5), is amended to read as follows:

Section 5051.5 A. 1. On or after November 1, 2003, any entity that provides health insurance in this state including, but not limited to, a licensed insurance company, not-for-profit hospital service ~~or~~, medical indemnity corporation ~~or a health maintenance~~, managed care organization, self-insured plan, pharmacy benefit manager or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service is hereby required to compare data from its files with data in files provided to the entity by the Oklahoma Health Care Authority. Data files requested by or provided to the Authority shall ~~be limited to information necessary to determine whether a state Medicaid program recipient has health coverage with an insurer~~ provide the Authority with eligibility and coverage information that will enable

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the Authority to determine the existence of third party coverage for Medicaid recipients and the necessary information to determine during what period Medicaid recipients may be or may have been covered by the health insurer and the nature of the coverage that is or was provided, including the name, address, and identifying number of the plan.

2. The insurer shall transmit to the Authority, in a manner prescribed by the Centers for Medicare and Medicaid Services or as agreed between insurer and the Authority, an electronic file of all identified subscribers or policyholders, or their dependents, for whom there is data corresponding to the information contained in subsection C of this section.

B. 1. An insurer shall comply with a request under the provisions of this subsection no later than sixty (60) days after the date of transmission by the Authority and shall only be required to provide the Authority with the information required by subsection C of this section. ~~The provisions of this section shall apply to a plan administrator in the same manner and to the same extent as an insurer.~~

2. The Authority may make such request for data from an insurer no more than once every six (6) months, as determined by the date of the Authority's original request.

C. Each insurer shall maintain a file system containing the name, address, group policy number, coverage type, social security number, and date of birth of each subscriber or policyholder, and each dependent of the subscriber or policyholder covered by the insurer, including policy effective and termination dates, claim submission address, and employer's mailing address.

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D. The Oklahoma Health Care Authority Board shall promulgate rules governing the exchange of information under this section. Such rules shall be consistent with all laws relating to the confidentiality or privacy of personal information or medical records including, but not limited to, provisions under the federal Health Insurance Portability and Accountability Act (HIPAA).

SECTION 4. This act shall become effective November 1, 2007.

COMMITTEE REPORT BY: COMMITTEE ON PUBLIC HEALTH, dated 04-09-07 - DO PASS.

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