Session of 2002

HOUSE BILL No. 2918

By Representatives Findley, Barnes, Crow, Dillmore, Flaharty, Gilbert, Kirk, Kuether, Levinson, Loganbill, McClure, E. Peterson, Ruff, Sharp, Spangler, Storm, Swenson and Winn

2-13

AN ACT concerning health care; establishing the managed care responsibility act.

Be it enacted by the Legislature of the State of Kansas:

Section 1. As used in this act:

(a) "Appropriate and medically necessary" means the standard for health care services as determined by physicians and health care providers in accordance with the prevailing practices and standards of the medical profession.

(b) "Emergency service system" shall have the meaning ascribed to it in K.S.A. 65-6112, and amendments thereto.

(c) For the purposes of this section, "emergency telephone service" shall have the meaning ascribed to it in K.S.A. 12-5301 and amendments thereto.

(d) "Enrollee" means an individual who is enrolled in a health benefit plan, including covered dependents.

(e) "Health benefit plan" shall have the means ascribed to it in K.S.A. 40-4602, and amendments thereto.

(f) "Health care treatment decision" means a determination made when medical services are to be provided by the health care plan and a decision which affects the quality of the diagnosis, care or treatment provided to any insured or enrollee of such plan.

(g) "Health insurer" shall have the meaning ascribed to it in K.S.A. 40-4602, and amendments thereto.

(h) "Ordinary care" means, in the case of a health insurer, that degree of care that a health insurer 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 insurer, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty or area of practice as such person would use in the same or similar circumstances.

(i) "Physician" shall have the meaning ascribed to it in K.S.A. 40-4602, and amendments thereto.

(j) "Provider" shall have the meaning ascribed to it in K.S.A. 40-4602, and amendments thereto.

Sec. 2. (a) A health insurer for a health benefit plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee caused by its failure to exercise such ordinary care.

(b) A health insurer for a health benefit plan is also liable for damages for harm to an insured or enrollee 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 result in the failure to exercise ordinary care.

(c) It shall be a defense to any action asserted against a health insurer for a health benefit plan that:

(1) Neither the health insurer, nor any employee, agent, ostensible agent, or representative for whose conduct such health insurer is liable under subsection (b), controlled, influenced or participated in the health care treatment decision; and

(2) the health insurer did not deny or delay any treatment prescribed or recommended by a provider to the insured or enrollee.

(d) The standards in subsections (a) and (b) create no obligation on the part of the health insurer to provide to an insured or enrollee treatment which is not covered by the health care benefit 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 under K.S.A. 65-1626 *et seq.*, and amendments thereto, that purchases coverage or assumes risk on behalf of its employees.

(f) A health insurer may not remove a provider from its plan or refuse to renew the provider with its plan for advocating on behalf of an enrollee for appropriate and medically necessary health care for the enrollee.

(g) A health insurer shall not enter into a contract with a provider or pharmaceutical company which includes an indemnification or hold harmless clause for the acts or conduct of the health insurer. Any such indemnification or hold harmless clause in an existing contract is hereby declared void as being against public policy.

(h) Nothing in any law of this state prohibiting a health insurer from practicing medicine or being licensed to practice medicine may be asserted as a defense by such health insurer in an action brought against it pursuant to this section or any other law.

(i) In an action against a health insurer, a finding that a physician or

other health benefit plan is an employee, agent, ostensible agent, or representative of such health insurer shall not be based solely on proof that such person's name appears in a listing of participating providers made available to any insured or enrollee under a health benefit plan.

(j) This act does not apply to workers' compensation insurance coverage as defined in K.S.A. 44-501 *et seq.*, and amendments thereto.

Sec. 3. (a) A person may not maintain a cause of action under this act against a health insurer that is required to comply with the utilization review requirements of K.S.A. 40-2213 through 40-2216, and amendments thereto, unless the affected insured or enrollee or the insured's or enrollee's representative:

(1) Has exhausted the appeals and review applicable under the utilization review requirements; or

(2) before instituting the action:

(A) Gives written notice of the claim as provided by subsection (b); and

(B) agrees to submit the claim to a review by an independent review organization under K.S.A. 40-2213 through 40-2216, and amendments thereto, as required by subsection (c).

(b) The notice required by paragraph (2) of subsection (a) shall be delivered or mailed to the health insurer against whom the action is made not later than the 30th day before the date the claim is filed.

(c) The insured or enrollee or the insured's or enrollee's representative shall submit the claim to a review by an independent review organization if the health insurer against whom the claim is made requests the review not later than the 14th day after the date notice under paragraph (2) of subsection (a) is received by the health insurer. If the health insurer does not request the review within the period specified by this subsection, the insured or enrollee or the insured's or enrollee's representative is not required to submit the claim to independent review before maintaining the action.

(d) A review conducted under subsection (c) as requested by a health insurer shall be performed in accordance with K.S.A. 40-2213 through 40-2216, and amendments thereto. The health insurer requesting the review shall agree to comply with K.S.A. 40-2213 through 40-2216, and amendments thereto.

(e) Subject to subsection (f), if the enrollee has not complied with subsection (a), an action under this section shall not be dismissed by the court, but the court may, in its discretion, order the parties to submit to an independent review or mediation or other nonbinding alternative dispute resolution and may abate the action for a period of not to exceed 30 days for such purposes. Such orders of the court shall be the sole remedy available to a party complaining of an enrollee's failure to comply with

subsection (a).

(f) The enrollee is not required to comply with subsection (c) and no abatement or other order pursuant to subsection (e) for failure to comply shall be imposed if the enrollee has filed a pleading alleging in substance that:

(1) Harm to the enrollee has already occurred because of the conduct of the health insurer or because of an act or omission of an employee, agent, ostensible agent, or representative of such health insurer, as set forth in subsection (b) of section 2, and amendments thereto, for whose conduct it is liable; and

(2) the review would not be beneficial to the enrollee, unless the court, upon motion by a defendant health insurer finds after hearing that such pleading was not made in good faith, in which case the court may enter an order pursuant to subsection (d).

(g) If the insured or enrollee or the insured's or enrollee's representative seeks to exhaust the appeals and review or provides notice, as required by subsection (a), before the statute of limitations applicable to a claim against a health insurer has expired, the limitations period is tolled until the later of:

(1) The 30th day after the date the insured or enrollee or the insured's or enrollee's representative has exhausted the process for appeals and review applicable under the utilization review requirements; or

(2) the 40th day after the date the insured or enrollee or the insured's or enrollee's representative gives notice under paragraph (2) of subsection (a).

(h) This section does not prohibit an insured or enrollee from pursuing any other appropriate remedy or relief available under law, if the requirement of exhausting the process for appeal and review places the insured's or enrollee's health in serious jeopardy.

Sec. 4. The provisions of sections 1 through 3, and amendments thereto, shall apply only to any cause of action which accrues on and after the effective date of this act. Any action which accrued prior to the effective date of this act shall be governed by the law applicable to such cause of action on the day preceding the effective date of this act.

Sec. 5. (a) For the purposes of this section, "emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

(1) Placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

(b) No health insurer shall require an insured or enrollee to obtain

prior authorization before accessing the 911 system or any emergency medical system for an emergency medical condition.

(c) No health insurer shall prohibit any insured or enrollee from accessing any emergency telephone service or any emergency medical service for an emergency medical condition.

Sec. 6. This act shall be known and may be cited as the managed care responsibility act.

Sec. 7. This act shall take effect and be in force from and after its publication in the statute book.