

ENROLLED SENATE
BILL NO. 192

By: Shurden of the Senate

and

Erwin of the House

An Act relating to insurance; amending 36 O.S. 1991, Section 1219, as last amended by Section 50, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 2000, Section 1219), which relates to unfair claim settlement practices and policy loans; deleting requirement for payment of insurance claims within specified period; stating time period for payment of clean claims by certain health maintenance entities; deleting language requiring interest payments on certain claims; deleting definition; adding definitions; requiring notice of claim defects within a stated time period; specifying contents of notice; stating requirements for prima facie evidence; requiring payment or denial of claim within stated time period after receipt of information curing defects; stating when payment is considered made; requiring interest on overdue payments; amending Section 1, Chapter 236, O.S.L. 1998 (63 O.S. Supp. 2000, Section 2514), which relates to reimbursement of claims; modifying language; decreasing time period for payment of clean claims; decreasing time period for notice of defective claims; stating requirements for prima facie evidence; decreasing time period for payment of accurate portion of claim; decreasing time period for payment or denial of cured claim; providing for attorney fees; requiring State and Education Employees Group Insurance Plan to maintain clean claims in same manner as certain health maintenance entities; providing for codification; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 1991, Section 1219, as last amended by Section 50, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 2000, Section 1219), is amended to read as follows:

Section 1219. A. In the administration, servicing, or processing of any accident and health insurance policy, ~~it shall be an unfair claim settlement practice for any insurer to fail to notify a policyholder or assignee of record in writing of the cause for delay in payment of any claim where the claim is not paid within~~

~~thirty (30) days after receipt of proof of loss. Failure of an insurer to provide a policyholder or assignee of record with such notification shall constitute prima facie evidence that the claim will be paid in accordance with the terms of the policy every insurer shall reimburse all clean claims of an insured, an assignee of the insured, or a health care provider within forty-five (45) calendar days after receipt of the claim by the insurer.~~

~~B. If a claim is not paid within sixty (60) days after receipt of proof of loss, the insurer shall pay interest which shall be the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year as certified to the Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two (2) percentage points, which shall accrue from the sixty-first day after receipt of proof of loss until the claim is paid.~~

~~C. As used in this section:~~

~~1. "Accident and health insurance policy" or "policy" means any policy, certificate, contract, agreement or other instrument that provides accident and health insurance, as defined in Section 703 of this title, to any person in this state; and~~

~~2. "Proof of loss" means written documents such as claim forms, medical bills, or other reasonable evidence of a claim, but shall not include information not necessary for determination of proof of loss and not pertinent to filed claims, such as any medical reports that the insurer wants to secure merely for completion of business records or files. "Clean claim" means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt payment; and~~

~~3. "Insurer" means any entity that provides an accident and health insurance policy in this state, including but not limited to, a licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a fraternal benefit society, a multiple employer welfare arrangement, or any other entity subject to regulation by the Insurance Commissioner.~~

~~C. If a claim or any portion of a claim is determined to have defects or improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment, the insured, assignee of the insured, or health care provider shall be notified in writing within thirty (30) calendar days after receipt of the claim by the insurer. The written notice shall specify the portion of the claim that is causing a delay in processing and explain any additional information or corrections needed. Failure of an insurer to provide the insured, assignee of the insured, or health care provider with the notice shall constitute prima facie evidence that the claim will be paid in accordance with the terms of the policy.~~

~~D. Upon receipt of the additional information or corrections which led to the claim's being delayed and a determination that the information is accurate, an insurer shall either pay or deny the~~

claim or a portion of the claim within forty-five (45) calendar days.

E. Payment shall be considered made on:

1. The date a draft or other valid instrument which is equivalent to the amount of the payment is placed in the United States mail in a properly addressed, postpaid envelope; or

2. If not so posted, the date of delivery.

F. An overdue payment shall bear simple interest at the rate of ten percent (10%) per year.

~~D.~~ G. In the event litigation should ensue based upon such a claim, the prevailing party shall be entitled to recover a reasonable attorney's fee to be set by the court and taxed as costs against the party or parties who do not prevail.

~~E.~~ H. The provisions of this section shall not apply to the Oklahoma Life and Health Insurance Guaranty Association or to the Oklahoma Property and Casualty Insurance Guaranty Association.

SECTION 2. AMENDATORY Section 1, Chapter 236, O.S.L. 1998 (63 O.S. Supp. 2000, Section 2514) is amended to read as follows:

Section 2514. ~~A. The State and Education Employees Group Insurance Plan, Every~~ health maintenance organizations organization, prepaid health plan, and every medical group which contracts with a health maintenance organization or prepaid health plan shall reimburse all clean claims of an enrollee, an assignee of the enrollee, or a health care provider within ~~sixty (60)~~ forty-five (45) calendar days after receipt of ~~such~~ the claim by such entity.

B. As used in this section, "clean claim" means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt payment.

~~B.~~ C. 1. If a claim or any portion of a claim is determined to have defects, or improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment, the enrollee, assignee of the enrollee, or health care provider shall be notified in writing within ~~forty-five (45)~~ thirty (30) calendar days after receipt of the claim by the ~~State and Education Employees Group Insurance Plan,~~ health maintenance organization, prepaid health plan, or contracting medical group. The written notice shall specify ~~what~~ the portion of the claim that is causing a delay in processing and explain ~~what~~ any additional information or corrections ~~are~~ needed. Failure of a health maintenance organization, prepaid health plan, or contracting medical group to provide the enrollee, assignee of the enrollee, or health care provider with such notice shall constitute prima facie evidence that the claim will be paid in accordance with the terms of the health benefit contract.

2. The portion of the claim that is accurate shall be paid within ~~sixty (60)~~ forty-five (45) calendar days after receipt of the claim by the ~~State and Education Employees Group Insurance Plan,~~ health maintenance organization, prepaid health plan, or contracting medical group.

~~C.~~ D. Upon receipt of the additional information or corrections which led to the ~~claim~~ claim's being delayed and a determination that the information is accurate, ~~the State and Education Employees Group Insurance Plan,~~ a health maintenance organization, prepaid health plan, or medical group which contracts with a health maintenance organization or prepaid health plan shall either pay or deny the claim or a portion of the claim within ~~ninety (90)~~ forty-five (45) calendar days.

~~D.~~ E. Payment shall be considered made on:

1. The date a draft or other valid instrument which is equivalent to the amount of the payment is placed in the United States mail in a properly addressed, postpaid envelope; or

2. If not so posted, the date of delivery.

~~E.~~ F. An overdue payment shall bear simple interest at the rate of ten percent (10%) per year.

G. In the event litigation should ensue based upon such a claim, the prevailing party shall be entitled to recover a reasonable attorney's fee to be set by the court and taxed as costs against the party or parties who do not prevail.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1328 of Title 74, unless there is created a duplication in numbering, reads as follows:

A. The State and Education Employees Group Insurance Plan shall reimburse all clean claims of an enrollee, an assignee of the enrollee, or a health care provider within forty-five (45) calendar days after receipt of the claim by the entity.

B. As used in this section, "clean claim" means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt payment.

C. 1. If a claim or any portion of a claim is determined to have defects or improprieties, including a lack of any required substantiating documentation, or a particular circumstance requiring special treatment, the enrollee, assignee of the enrollee, or health care provider shall be notified in writing within thirty (30) calendar days after receipt of the claim by the State and Education Employees Group Insurance Plan. The written notice shall specify the portion of the claim that is causing a delay in processing and explain any additional information or corrections needed. Failure of the Plan to provide the enrollee, assignee of the enrollee, or health care provider with such notice shall constitute prima facie

evidence that the claim will be paid in accordance with the terms of the health benefit contract.

2. The portion of the claim that is accurate shall be paid within forty-five (45) calendar days after receipt of the claim by the State and Education Employees Group Insurance Plan.

D. Upon receipt of the additional information or corrections which led to the claim's being delayed and a determination that the information is accurate, the State and Education Employees Group Insurance Plan shall either pay or deny the claim or a portion of the claim within forty-five (45) calendar days.

E. Payment shall be considered made on:

1. The date a draft or other valid instrument which is equivalent to the amount of the payment is placed in the United States mail in a properly addressed, postpaid envelope; or

2. If not so posted, the date of delivery.

F. An overdue payment shall bear simple interest at the rate of ten percent (10%) per year.

G. In the event litigation should ensue based upon such a claim, the prevailing party shall be entitled to recover a reasonable attorney's fee to be set by the court and taxed as costs against the party or parties who do not prevail.

SECTION 4. This act shall become effective November 1, 2001.

Passed the Senate the 27th day of February, 2001.

Presiding Officer of the Senate

Passed the House of Representatives the 3rd day of April, 2001.

Presiding Officer of the House
of Representatives

