

STATE OF OKLAHOMA

1st Session of the 48th Legislature (2001)

SENATE BILL 637

By: Robinson

AS INTRODUCED

An Act relating to accident and health insurance policies; 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 delay in payment of claims; eliminating specified unfair claim settlement; requiring reimbursement of all clean claims of an insured within specified time period; modifying payment of interest requirement; modifying and adding definitions; requiring notification if claim is not clean; construing phrase; specifying contents of written notice; limiting action to specified time period on claims needing additional information or corrections; construing when payment on claim shall be considered made; providing for penalties; amending Section 1, Chapter 236 O.S.L. 1998 (63 O.S. Supp. 2000, Section 2514), which relates to reimbursement of claims; modifying list of entities required to reimburse clean claims; decreasing time limit on reimbursement of clean claims; modifying definition; decreasing time periods for specified notification and for paying claims; providing for penalties; allowing prevailing parties in litigation to recover a reasonable attorney's fee; requiring the State and Education Employees Group Insurance Plan to adhere to same standards of paying claims as other insurers; requiring payment of clean claim within specified time period; defining term; requiring notification of unclean claim within specified time period; stating contents of notice; stating certain prima facie evidence standard; requiring payment of portion of claim that is accurate within specified time period; requiring action on claim upon receipt of information within specified time period; stating grounds upon which payment shall be considered to be made; stating penalties for overdue payments; allowing prevailing party in litigation to recover a reasonable attorney's fee; 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 every insurer to fail to notify a policyholder or shall reimburse all clean claims of an insured, an 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 insured, or a health care provider within forty-five (45) days after receipt of the claim will be paid in accordance with the terms of the policy 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 defects or improprieties, including a lack of any required substantiating

documentation, or no particular circumstance requiring special treatment that impedes prompt payment. In a preferred provider organization arrangement, a claim is considered a clean claim if that claim satisfies the provisions spelled out in the provider contract with respect to, but not limited by, scope of practice, medical necessity, of proven efficacy, or any other criteria specifically provided for in the contract; and

3. "Insurer" means any entity that provides an accident and health insurance policy licensed to do business in this state including, but not limited to, a licensed insurance company, a health maintenance organization, a preferred provider organization, 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. 1. a. If a claim or any portion of a claim is determined to have defects, 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.

b. As used in this paragraph, the phrase "defects, improprieties, including a lack of any required substantiating documentation" shall not include such information that is not deemed to be known by the provider such as personal information on the insured including, but not limited to, the insured's place of business, personal telephone numbers or any other information that should be known by the insurer.

2. 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.

3. Failure of an insurer to provide the insured, the assignee of the insured, or the health care provider with the notice required by this subsection 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 that led to the claim's delay, and a determination that the information is accurate and complete, an insurer shall either pay or deny the claim or portion of the claim within forty-five (45) calendar days.

E. Payment shall be considered made on either:

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 a penalty of Two Hundred Fifty Dollars (\$250.00) per occurrence, or simple interest at the rate of ten percent (10%) per year, whichever is greater.

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 and every

~~medical group which contracts with a health maintenance organization~~
insurer licensed to do business in this state including, but not
limited to, a health maintenance organization, a preferred provider
organization, a not-for-profit hospital service and medical
indemnity corporation, a fraternal benefit society, a multiple
employer welfare arrangement, or any other insurance entity subject
to regulation by the Insurance Commissioner 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 claim by ~~such~~ 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~~ shall have the same
meaning as defined in Section 1219 of Title 36 of the Oklahoma
Statutes.

~~B.~~ C. 1. If a claim or any portion of a claim is determined to
have defects, 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 ~~forty-five (45)~~
thirty (30) calendar days after receipt of the claim by the ~~State~~
~~and Education Employees Group Insurance Plan,~~ health maintenance
organization or contracting medical group, preferred provider
organization or any other insuring entity under the regulation of
the Insurance Commissioner. The written notice shall specify what
portion of the claim is causing a delay in processing and explain
what additional information or corrections are needed.

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 ~~or,~~ contracting medical group,

preferred provider organization, or other insuring entity under the regulation of the Insurance Commissioner.

~~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 and complete, the ~~State and Education Employees Group Insurance Plan,~~ a health maintenance organization ~~or,~~ medical group, preferred provider organization or other insuring entity under the regulation of the Insurance Commissioner which contracts with a health maintenance organization shall either pay or deny the claim or 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 a penalty of Two Hundred Fifty Dollars (\$250.00) per occurrence or simple interest at the rate of ten percent (10%) per year, whichever is greater. In the case of a preferred provider organization or other such contracting insurer, failure of the insurer to pay in a timely fashion as outlined in this act will be deemed a violation of the stated contract between the insurer and the provider and will therefore waive the insurer's right to the predetermined discounted fee schedule.

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" has the same meaning as the term is defined in Section 1219 of Title 36 of the Oklahoma Statutes.

C. 1. If a claim or any portion of a claim is determined to have defects, improprieties, including a lack of any required substantiating documentation, or a particular circumstance requiring special treatment, the enrollee, the assignee of the enrollee, or the 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 the notice required by this paragraph 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 and complete, the State and Education Employees Group Insurance Plan shall either pay or deny the claim or portion of the claim within forty-five (45) calendar days.

E. Payment shall be considered made on either:

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 a fee of Two Hundred Fifty Dollars (\$250.00) per occurrence or simple interest at the rate of ten percent (10%) per year, whichever is greater.

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.

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CJ

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