SENATE CHAMBER

STATE OF OKLAHOMA

DISPOSITION

☐ FLOOR AMENDMENT No. _____ _____

☐ COMMITTEE AMENDMENT _____

(Date)

Mr./Madame President:

I move to amend House Bill No. 1012, by substituting the attached floor substitute for the title, enacting clause and entire body of the measure.

Submitted by:

_____

Senator Garvin

Garvin-NP-FS-Req#2089
4/19/2021 2:01 PM

(Floor Amendments Only) Date and Time Filed: _____

☐ Untimely ☐ Amendment Cycle Extended ☐ Secondary Amendment

STATE OF OKLAHOMA

1st Session of the 58th Legislature (2021)

FLOOR SUBSTITUTE
FOR ENGROSSED
HOUSE BILL NO. 1012 By: Bush of the House

and

Garvin of the Senate

FLOOR SUBSTITUTE

[insurance - prohibited discounted reimbursements, clean claims, application of unfair practices and unfair claim settlement practices - anesthetist services - emergency]

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

SECTION 1. AMENDATORY 36 O.S. 2011, Section 1219.3, is amended to read as follows:

Section 1219.3. A. An insurer or third-party administrator shall not reimburse a health care provider on a discounted fee basis for covered services that are provided to an insured unless:

1. The insurer or third-party administrator has contracted with either:

a. the health care provider, or

b. a preferred provider organization which has contracted with the health care provider;

2. The health care provider has agreed to provide health care services under the terms of the contract; and

3. The insurer or third-party administrator has agreed to provide coverage for those health care services under an accident and health insurance policy.

B. A party to a preferred provider contract~~,~~ including a contract with a preferred provider organization, may not sell, lease~~,~~ or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority and prior adequate notification of the other contracting parties.

C. No private insurance company shall discount, reduce or differentiate payments for anesthesia services provided by a qualified nonphysician anesthetist when billed under the same billing code and modifier used by another qualified nonphysician anesthesia provider in the same region or area of this state.

SECTION 2. AMENDATORY 36 O.S. 2011, Section 1219, is amended to read as follows:

Section 1219. A. In the administration, servicing~~,~~ or processing of any accident and health insurance policy, every insurer shall reimburse all clean claims of an insured, an assignee of the insured~~,~~ or a health care provider based upon the use of

designated billing code and modifiers within forty-five (45) calendar days after receipt of the claim by the insurer.

B. 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 any subscriber certificate or any evidence of coverage issued by a health maintenance organization to any person in this state;

2. "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 health maintenance organization, 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, enrollee or subscriber, assignee of

the insured, enrollee or subscriber~~,~~ and 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, enrollee or subscriber, assignee of the insured, enrollee or subscriber~~,~~ and 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. Provided, if a claim is not submitted into the system due to a failure to meet basic Electronic Data Interchange (EDI) and/or Health Insurance Portability and Accountability Act (HIPAA) edits, electronic notification of the failure to the submitter shall be deemed compliance with this subsection. Provided further, health maintenance organizations shall not be required to notify the insured, enrollee or subscriber, or assignee of the insured, enrollee or subscriber of any claim defect or impropriety.

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.

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

H. The Insurance Commissioner shall develop a standardized prompt pay form for use by providers in reporting violations of prompt pay requirements. The form shall include a requirement that documentation of the reason for the delay in payment or documentation of proof of payment must be provided within ten (10) days of the filing of the form. The Commissioner shall provide the form to health maintenance organizations and providers.

I. 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 3. AMENDATORY 36 O.S. 2011, Section 1250.3, is amended to read as follows:

Section 1250.3. A. The provisions of the Unfair Claims Settlement Practices Act shall apply to all claims arising under an insurance policy or insurance contract issued by any insurer.

B. It is an unfair claim settlement practice for any insurer to commit any act set out in Section 1250.5 of this title, or to commit a violation of any other provision of the Unfair Claims Settlement Practices Act, if:

1. It is committed flagrantly and in conscious disregard of ~~this act~~ the Unfair Claims Settlement Practices Act or any rules promulgated hereunder; ~~or~~

2. It has been committed with such frequency as to indicate a general business practice to engage in that type of conduct; or

3. It has been committed with conscious disregard to payment rates on designated billing codes and modifiers to indicate a general business practice to engage in that type of conduct.

SECTION 4. AMENDATORY 36 O.S. 2011, Section 1250.5, as amended by Section 1, Chapter 105, O.S.L. 2012 (36 O.S. Supp. 2020, Section 1250.5), is amended to read as follows:

Section 1250.5. Any of the following acts by an insurer, if committed in violation of Section 1250.3 of this title, constitutes an unfair claim settlement practice exclusive of paragraph 16 of this section which shall be applicable solely to health benefit plans:

1. Failing to fully disclose to first party claimants, benefits, coverages, or other provisions of any insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim;

2. Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;

3. Failing to adopt and implement reasonable standards for prompt investigations of claims arising under its insurance policies or insurance contracts;

4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

5. Failing to comply with the provisions of Section 1219 of this title;

6. Denying a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so;

7. Except where there is a time limit specified in the policy, making statements, written or otherwise, which require a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if the time limit is not complied with unless the failure to comply with the time limit prejudices the rights of an insurer;

8. Requesting a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment;

9. Issuing checks or drafts in partial settlement of a loss or claim under a specified coverage which contain language releasing an insurer or its insured from its total liability;

10. Denying payment to a claimant on the grounds that services, procedures~~,~~ or supplies provided by a treating physician or a hospital were not medically necessary unless the health insurer or administrator, as defined in Section 1442 of this title, first obtains an opinion from any provider of health care licensed by law and preceded by a medical examination or claim review, to the effect that the services, procedures or supplies for which payment is being denied were not medically necessary. Upon written request of a claimant, treating physician~~,~~ or hospital, the opinion shall be set forth in a written report, prepared and signed by the reviewing physician. The report shall detail which specific services, procedures~~,~~ or supplies were not medically necessary, in the opinion of the reviewing physician, and an explanation of that conclusion. A copy of each report of a reviewing physician shall be mailed by the health insurer, or administrator, postage prepaid, to the claimant, treating physician or hospital requesting same within fifteen (15) days after receipt of the written request. As used in this paragraph, "physician" means a person holding a valid license to practice medicine and surgery, osteopathic medicine, podiatric medicine, dentistry, chiropractic~~,~~ or optometry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes;

11. Compensating a reviewing physician, as defined in paragraph 10 of this subsection, on the basis of a percentage of the amount by which a claim is reduced for payment;

12. Violating the provisions of the Health Care Fraud Prevention Act, Section 1219.1 et seq of this title;

13. Compelling, without just cause, policyholders to institute suits to recover amounts due under its insurance policies or insurance contracts by offering substantially less than the amounts ultimately recovered in suits brought by them, when the policyholders have made claims for amounts reasonably similar to the amounts ultimately recovered;

14. Failing to maintain a complete record of all complaints which it has received during the preceding three (3) years or since the date of its last financial examination conducted or accepted by the Commissioner, whichever time is longer. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint~~,~~ and the time it took to process each complaint. For the purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance;

15. Requesting a refund of all or a portion of a payment of a claim made to a claimant or health care provider more than twenty-four (24) months after the payment is made. This paragraph shall not apply:

a. if the payment was made because of fraud committed by the claimant or health care provider, or

b. if the claimant or health care provider has otherwise agreed to make a refund to the insurer for overpayment of a claim;

16. Failing to pay, or requesting a refund of a payment, for health care services covered under the policy if a health benefit plan, or its agent, has provided a preauthorization or precertification and verification of eligibility for those health care services. This paragraph shall not apply if:

a. the claim or payment was made because of fraud committed by the claimant or health care provider,

b. the subscriber had a preexisting exclusion under the policy related to the service provided, or

c. the subscriber or employer failed to pay the applicable premium and all grace periods and extensions of coverage have expired; ~~or~~

17. Denying or refusing to accept an application for life insurance, or refusing to renew, cancel, restrict or otherwise terminate a policy of life insurance, or charge a different rate based upon the lawful travel destination of an applicant or insured as provided in Section 4024 of this title; or

18. Compelling, without just cause, a health care provider to institute suits to recover amounts due under its insurance contract

on claims filed based upon the use of designated billing codes and/or code modifiers that are paid at different rates from other qualified health care providers using the same billing codes and/or code modifiers or where such claims are discounted or reduced by the insurer in violation of Section 1219.3 of this title.

SECTION 5. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

58-1-2089 NP 4/19/2021 2:01:19 PM