STATE OF OKLAHOMA

2nd Session of the 57th Legislature (2020)

SENATE BILL 1556 By: Newhouse

AS INTRODUCED

An Act relating to health insurance; amending 36 O.S. 2011, Section 1219, which relates to defective claims; modifying appeal process for claims or partial claims; requiring insurer to provide specific reason for denial and instructions for appeal; authorizing certain persons to submit written appeal after denial; requiring insurer to provide certain response to appeal and contact information of appeal department; establishing time period for insurer response; and providing an effective date.

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

SECTION 1. 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 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~~ any 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~~ denied for any reason, 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 in detail the portion of the claim that is causing a delay in processing or the reason for the denial and

explain any additional information or corrections needed including instructions on where a person or entity that received notification may respond through dedicated facsimile or electronic mail message or the address or electronic mail message address of the department of appeals of the insurer. Upon receiving written notice of denial, a recipient may submit a detailed appeal in writing, explaining why the claim should be approved. If the insurer denies the claim for a second time, the insurer shall address in writing the specific details included in the written appeal, provide the phone number of a health plan representative at the department of appeals of the insurer, and designate a date and time to discuss the claim within twenty-one (21) calendar days of receipt of the appeal. 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 2. This act shall become effective November 1, 2020.

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