

1 STATE OF OKLAHOMA

2 1st Session of the 58th Legislature (2021)

3 SENATE BILL 550

By: Newhouse

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5
6 AS INTRODUCED

7 An Act relating to health insurance; amending 36 O.S.
8 2011, Section 1219, which relates to processing
9 claims; requiring insurer to provide specific reason
10 for denial of clean claims and partial clean claims
11 to certain persons within thirty days; requiring
12 insurer to include instructions for appealing denial;
13 authorizing certain persons to submit written appeal
14 after denial; requiring insurer to provide certain
15 response to appeal and contact information of
16 department of appeals; and providing an effective
17 date.

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

19 SECTION 1. AMENDATORY 36 O.S. 2011, Section 1219, is
20 amended to read as follows:

21 Section 1219. A. In the administration, servicing, or
22 processing of any accident and health insurance policy, every
23 insurer shall reimburse all clean claims of an insured, an assignee
24 of the insured, or a health care provider within forty-five (45)
25 calendar days after receipt of the claim by the insurer.

26 B. As used in this section:

1 1. "Accident and health insurance policy" or "policy" means any
2 policy, certificate, contract, agreement or other instrument that
3 provides accident and health insurance, as defined in Section 703 of
4 this title, to any person in this state, and any subscriber
5 certificate or any evidence of coverage issued by a health
6 maintenance organization to any person in this state;

7 2. "Clean claim" means a claim that has no defect or
8 impropriety, including a lack of any required substantiating
9 documentation, or particular circumstance requiring special
10 treatment that impedes prompt payment; and

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

18 C. If a claim or any portion of a claim is determined to have
19 defects or improprieties, including a lack of any required
20 substantiating documentation, or particular circumstance requiring
21 special treatment, the insured, enrollee or subscriber, assignee of
22 the insured, enrollee or subscriber, and health care provider shall
23 be notified in writing within thirty (30) calendar days after
24 receipt of the claim by the insurer. The written notice shall

1 specify the portion of the claim that is causing a delay in
2 processing and explain any additional information or corrections
3 needed. Failure of an insurer to provide the insured, enrollee or
4 subscriber, assignee of the insured, enrollee or subscriber, and
5 health care provider with the notice shall constitute prima facie
6 evidence that the claim will be paid in accordance with the terms of
7 the policy. Provided, if a claim is not submitted into the system
8 due to a failure to meet basic Electronic Data Interchange (EDI)
9 and/or Health Insurance Portability and Accountability Act (HIPAA)
10 edits, electronic notification of the failure to the submitter shall
11 be deemed compliance with this subsection. Provided further, health
12 maintenance organizations shall not be required to notify the
13 insured, enrollee or subscriber, or assignee of the insured,
14 enrollee or subscriber of any claim defect or impropriety.

15 ~~D.~~ Upon receipt of the additional information or corrections
16 which led to the claim's being delayed and a determination that the
17 information is accurate, an insurer shall either pay or deny the
18 claim or a portion of the claim within forty-five (45) calendar
19 days.

20 D. If a clean claim or any portion of a clean claim is denied
21 for any reason, the insured, enrollee or subscriber, assignee of the
22 insured, enrollee or subscriber, and health care provider shall be
23 notified in writing within thirty (30) calendar days after receipt
24 of the claim by the insurer. The written notice shall specify in

1 detail the reason for the denial including instructions on where a
2 person or entity that received notification may respond through
3 dedicated facsimile or electronic mail message or the address or
4 electronic mail message address of the department of appeals of the
5 insurer. Upon receiving written notice of denial, a recipient may
6 submit a detailed appeal in writing explaining why the claim should
7 be approved. If the insurer denies the appeal, the insurer shall
8 address in writing the specific details included in the written
9 appeal and provide the phone number of a health plan representative
10 at the department of appeals of the insurer.

11 E. Payment shall be considered made on:

- 12 1. The date a draft or other valid instrument which is
13 equivalent to the amount of the payment is placed in the United
14 States mail in a properly addressed, postpaid envelope; or
15 2. If not so posted, the date of delivery.

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

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

22 H. The Insurance Commissioner shall develop a standardized
23 prompt pay form for use by providers in reporting violations of
24 prompt pay requirements. The form shall include a requirement that

1 documentation of the reason for the delay in payment or
2 documentation of proof of payment must be provided within ten (10)
3 days of the filing of the form. The Commissioner shall provide the
4 form to health maintenance organizations and providers.

5 I. The provisions of this section shall not apply to the
6 Oklahoma Life and Health Insurance Guaranty Association or to the
7 Oklahoma Property and Casualty Insurance Guaranty Association.

8 SECTION 2. This act shall become effective November 1, 2021.

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