STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 1703 By: Daniels

COMMITTEE SUBSTITUTE

An Act relating to the state Medicaid program; amending 63 O.S. 2021, Section 5051.2, which relates to recovery of expenses; prohibiting certain insurers and third-party administrators from denying claims on specified grounds; requiring acceptance of certain authorization; requiring response to certain inquiry within specified time frame; clarifying language; and declaring an emergency.

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

SECTION 1. AMENDATORY 63 O.S. 2021, Section 5051.2, is amended to read as follows:

Section 5051.2. A. Whenever the Oklahoma Health Care Authority pays for medical services or renders medical services, for or on behalf of a person who has been injured or suffered an illness or disease, the right of the provider of the services to reimbursement shall be automatically assigned to the Oklahoma Health Care Authority, upon notice to the insurer or other party obligated as a matter of law or agreement to reimburse the provider on behalf of the patient.

B. Upon the assignment, the Authority, for purposes of the claim for reimbursement, becomes a provider of medical services.

C. The assignment of the right to reimbursement shall be applied and considered valid against any employer or insurer under the Administrative Workers' Compensation Act in this state.

D. Each insurer, upon receiving a claim from the Oklahoma Health Care Authority, shall accept the state's right of recovery, to process and, if appropriate, pay the claim to the same extent that the plan would have been liable if it had been billed at the point of sale or by the original provider of services. ~~Insurer~~ The insurer shall not deny the Authority claims on the basis of the date of submission, the format of the claim, or for failure to present proper documentation of coverage at the point of sale.

E. An insurer or third-party administrator, except a Medicare Advantage plan, shall not deny the Authority claims solely on the basis that a claimed item or service did not receive prior authorization under the rules or coverage policies of the insurer or third-party administrator. The insurer or third-party administrator shall accept an authorization provided by the Authority for an item or service covered under the state Medicaid program or under a home- and community-based services waiver for such individual as if such authorization was made by the insurer or third-party administrator for such item or service.

F. If the Authority submits an inquiry regarding a claim to an insurer or third-party administrator not later than three (3) years after the date of provision of the claimed item or service, the insurer or third-party administrator shall respond to the inquiry within sixty (60) days of receiving the inquiry.

G. ~~Insurer~~ An insurer shall make appropriate payments to the Authority as long as the claim is submitted for consideration within three (3) years from the date the service was furnished. Any action by the Authority to enforce the payment of the claim shall be commenced within six (6) years of the submission of the claim by the Authority.

SECTION 2. 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.

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