BILL SUMMARY

2nd Session of the 59th Legislature

Bill No.:	**SB 1703**
Version:	**ENGR**
Request Number:	
Author:	**Rep. McEntire**
Date:	**3/28/2024**
Impact:	**$0**

Research Analysis

Engrossed Senate Bill 1703 mandates that insurers and third-party administrators, with the exception of Medicare Advantage plans, cannot reject Oklahoma Health Care Authority claims solely because a claimed item or service lacks prior authorization according to their rules or coverage policies. Instead, they must honor authorizations provided by the Authority for Medicaid-covered items or services, including those under home and community-based services waivers. Furthermore, the measure stipulates that insurers and third-party administrators must respond within 60 days to inquiries about claims for items or services rendered within the past three years.

Prepared By: Matthew Brenchley

Fiscal Analysis

SB 1703 prohibits insurers and third-party administrators, except a Medicare Advantage plan, from denying claims submitted by the Oklahoma Health Care Authority (OHCA) exclusively upon the service or item not receiving prior authorization. Furthermore, this measure requires an insurer or third-party administrator to respond to inquiries submitted by OHCA within sixty (60) days if the claim is for a service or item that occurred within a three (3) year time frame.

In its current form, this measure is not anticipated to have a direct fiscal impact on the state budget or appropriation.

Prepared By: Alexandra Ladner, House Fiscal Staff

Other Considerations

None.

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