STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

SENATE BILL 1703 By: Daniels

AS INTRODUCED

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 from denying claims on specified grounds; requiring insurer to accept certain authorization; requiring insurer to respond to certain inquiry within specified time frame; clarifying language; and providing an effective date.

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, 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. The insurer 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 for such item or service.

F. If the Authority submits an inquiry regarding a claim to an insurer not later than three (3) years after the date of provision

of the claimed item or service, the insurer 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. This act shall become effective November 1, 2024.

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