

STATE OF OKLAHOMA

1st Session of the 43rd Legislature (1991)

COMMITTEE SUBSTITUTE
FOR ENGROSSED
SENATE BILL NO. 266

BY: LONG (Lewis) of the SENATE

and

TAYLOR of the HOUSE

COMMITTEE SUBSTITUTE AN ACT RELATING TO INSURANCE; AMENDING SECTION 8, CHAPTER 315, O.S.L. 1986, SECTION 16, CHAPTER 251, O.S.L. 1986, AS AMENDED BY SECTION 1, CHAPTER 238, O.S.L. 1989, SECTION 18, CHAPTER 251, O.S.L. 1986, AS AMENDED BY SECTION 11, CHAPTER 175, O.S.L. 1987 AND SECTION 20, CHAPTER 251, O.S.L. 1986 (36 O.S. SUPP. 1990, SECTIONS 1224, 1254, 1256 AND 1258), WHICH RELATE TO INSURANCE CLAIMS; ALLOWING CLAIMANT TO FILE SUIT AGAINST INSURER FOR VIOLATION OF UNFAIR CLAIM SETTLEMENT PRACTICES ACT; PROHIBITING DENIAL OF CLAIMS ON CERTAIN GROUNDS WITHOUT CERTAIN PROCEDURES; DEFINING TERM; PROHIBITING CERTAIN COMPENSATION SCHEME FOR REVIEWING PROVIDERS; ALLOWING CLAIMANT TO FILE SUIT AGAINST INSURER FOR VIOLATION OF CLAIMS RESOLUTION ACT; CLARIFYING THAT CERTAIN PENALTIES ARE NOT TO BE EXCLUSIVE REMEDY; AND PROVIDING AN EFFECTIVE DATE.

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

SECTION 1. AMENDATORY Section 8, Chapter 315, O.S.L. 1986 (36 O.S. Supp. 1990, Section 1224), is amended to read as follows:

Section 1224. A. The Insurance Commissioner may hire additional employees and examiners as needed for the enforcement of the provisions of the Unfair Claim Settlement Practices Act.

B. The Insurance Commissioner shall compile the information received from an insurer pursuant to Section 7 1223 of this ~~act~~ title in such a manner as to enable him to compare it to a minimum standard of performance which shall be promulgated by the Insurance Commissioner. If the Insurance Commissioner, after such comparison is made, finds that the insurer falls below the minimum standard of performance, he shall cause an investigation to be made of said insurer as to the reason, if any, for the substandard performance.

C. The Insurance Commissioner shall also provide for the receiving and processing of individual complaints alleging violations of the Unfair Claim Settlement Practices Act by both insurers who are required to make periodic reports and those who are not required to make such reports. If the Insurance Commissioner in his complaint experience determines that the number and type of complaints against an insurer do not meet the minimum standard of performance or are out of proportion to those against other insurers writing similar lines of insurance, the Insurance Commissioner shall cause an investigation to be made of the insurer.

D. Any claimant may file suit directly against an insurer who has violated any provision of Section 1221 et seq. of this title regardless of actions taken by or with the Insurance Commissioner.

SECTION 2. AMENDATORY Section 16, Chapter 251, O.S.L. 1986, as amended by Section 1, Chapter 238, O.S.L. 1989 (36 O.S. Supp. 1990, Section 1254), is amended to read as follows:

Section 1254. 1. No insurer shall fail to fully disclose to first party claimants, benefits, coverages, or other provisions of

any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

2. No agent shall conceal from first party claimants, benefits, coverages, or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

3. No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

4. No insurer, except where there is a time limit specified in the policy, shall make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices an insurer's rights.

5. No insurer shall request a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

6. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specified coverage which contain language which releases an insurer or its insured from its total liability.

7. No insurer shall deny payment to a claimant on the grounds that services, procedures or supplies provided by a treating physician or a hospital were not medically necessary, or on similar grounds, unless the insurer first obtains a report prepared and signed by a licensed health care provider, and preceded by a medical examination or claim review, stating that the services, procedures or supplies for which payment is being denied were not medically necessary. The report shall detail which specific services, procedures and supplies were not medically necessary, in the opinion

of the reviewing health care provider, and an explanation of that conclusion. A copy of each report of a reviewing health care provider shall be mailed by the insurer, postage prepaid, to the claimant or the treating physician or hospital requesting same within fifteen (15) days after receipt of a written request. As used in this subsection, "physician" means a person holding a valid license to practice medicine and surgery, osteopathy, chiropractic or optometry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes.

8. No insurer shall compensate a reviewing health care provider on the basis of a percentage of the amount by which a claim is reduced for payment.

9. All payment or satisfaction of a claim for a motor vehicle which has been transferred by title to the insurer shall be paid by check or draft, payable on demand.

SECTION 3. AMENDATORY Section 18, Chapter 251, O.S.L. 1986, as amended by Section 11, Chapter 175, O.S.L. 1987 (36 O.S. Supp. 1990, Section 1256), is amended to read as follows:

Section 1256. A. Within forty-five (45) business days after receipt by a property and casualty insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer, or if further investigation is necessary. No property and casualty insurer shall deny a claim because of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. A denial shall be given to any claimant in writing, and the claim file of the property and casualty insurer shall contain a copy of the denial. If there is a reasonable basis supported by specific information available for review by the Commissioner that the first party claimant has fraudulently caused or contributed to the loss by arson, a property

and casualty insurer shall be relieved from the requirements of this subsection.

B. If a claim is denied for reasons other than those described in subsection A of this section, and is made by any other means than writing, an appropriate notation shall be made in the claim file of the property and casualty insurer until such time as a written confirmation can be made.

C. Every property and casualty insurer shall complete investigation of a claim within forty-five (45) business days after notification of proof of loss unless such investigation cannot reasonably be completed within such time. If such investigation cannot be completed, or if a property and casualty insurer needs more time to determine whether a claim should be accepted or denied, it shall so notify the claimant within forty-five (45) business days after receipt of the proofs of loss, giving reasons why more time is needed. If the investigation remains incomplete, a property and casualty insurer shall, forty-five (45) business days from the date of the initial notification and every forty-five (45) business days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

D. Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

E. Insurers shall not continue or delay negotiations for settlement with a claimant who is neither an attorney nor represented by an attorney, for a length of time which causes the claimant's rights to be affected by a statute of limitations, or a policy or contract time limit, without giving the claimant written notice that the time limit is expiring and may affect the claimant's rights. Such notice shall be given to first party claimants thirty (30) days, and to third party claimants sixty (60) days, before the date on which such time limit may expire.

F. No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form of release is not completed within a given period of time unless the statement is given for the purpose of notifying a third party claimant of the provision of a statute of limitations.

G. Any claimant may file suit directly against an insurer who has violated any provision of Section 1251 et seq. of this title regardless of actions taken by or with the Insurance Commissioner.

~~G.~~ H. If a lawsuit on the claim is initiated, the time limits provided for in this section shall not apply.

SECTION 4. AMENDATORY Section 20, Chapter 251, O.S.L. 1986 (36 O.S. Supp. 1990, Section 1258), is amended to read as follows:

Section 1258. A. For any violation of the Claims Resolution Act, the Commissioner may, after a hearing, subject a person to a ~~civil~~ an administrative fine of not less than One Hundred Dollars (\$100.00) nor more than One Thousand Dollars (\$1,000.00) for each occurrence. Such fine may be enforced in the same manner in which civil judgments may be enforced. Such fines shall be placed in the Insurance Commissioner's Revolving Fund.

B. The provisions of this section are not intended to be an exclusive remedy and are in addition to any civil remedy for damages sustained by any claimant who has been caused damage as a result of a violation of the provisions of Section 1251 et seq. of this title by an insurer.

SECTION 5. This act shall become effective September 1, 1991.

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