

STATE OF OKLAHOMA

2nd Session of the 46th Legislature (1998)

CONFERENCE COMMITTEE SUBSTITUTE

FOR ENGROSSED

HOUSE BILL NO. 2841

By: Frame of the House

and

Stipe of the Senate

CONFERENCE COMMITTEE SUBSTITUTE

An Act relating to insurance; directing the Insurance

Commissioner to promulgate rules requiring certain insurers to report certain information; stating contents of the report; stating date of first report; stating date of subsequent reports; amending 36 O.S. 1991, Section 612.2, which relates to required capital and surplus; prohibiting certain insurers from transacting title insurance business without certain surplus; amending 36 O.S. 1991, Sections 1219, as last amended by Section 50, Chapter 418, O.S.L. 1997, and 1254, as renumbered by Section 20, Chapter 342, O.S.L. 1994, and as last amended by Section 52, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 1997, Sections 1219 and 1250.5), which relate to acts constituting unfair claims settlement practices; providing for payment of interest on claims not paid within certain time period; establishing interest rate; modifying

requirement for an opinion before denying claim; making request for a refund after a certain period an unfair claims settlement practice; providing certain exceptions; amending Section 60, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 1997, Section 1424.11), which relates to insurance agent licensing requirements; adding category of limited insurance representative license; amending 36 O.S. 1991, Sections 6054 and 6055, as last amended by Sections 1 and 2, Chapter 76, O.S.L. 1996 (36 O.S. Supp. 1997, Sections 6054 and 6055), which relate to the Health Care Freedom of Choice Act; adding definition of a preferred provider organization (PPO); deleting certain exclusion for certain types of contracts; providing for codification; and providing an effective date.

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

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 310.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner shall promulgate rules requiring the fifty (50) largest property and casualty insurers based on direct written premiums in Oklahoma who are authorized to write liability insurance, including professional liability insurance, to report the following information:

1. The amount collected in premiums in this state for professional liability coverage in this state for the current calendar year ending on the thirty-first day of December;

2. The amounts paid out in professional liability claims in this state for the current calendar year ending on the thirty-first day of December which shall show the amount paid as a result of judgments and the amount paid as a result of settlements;

3. The professions for which the insurer writes professional liability coverage;

4. The amount collected in premiums in this state for any type of liability insurance affording coverage for personal injury and wrongful death for the current calendar year ending on the thirty-first day of December;

5. The amounts paid out in personal injury and wrongful death claims in this state for the current calendar year ending on the thirty-first day of December which shall show the amount paid as a result of judgments and the amount paid as a result of settlements;

6. The aggregate number of judgments or settlements that required the insurer to make payments of over Two Hundred Fifty Thousand Dollars (\$250,000.00) for each of the previous two (2) years ending on the thirty-first day of December and, if the payment exceeded One Million Dollars (\$1,000,000.00), the amount of the payment; and

7. Company policies or incentives for encouraging the insured to develop a risk management plan.

B. The first report required by this section shall be filed with the Insurance Commissioner no later than March 1, 1999. Subsequent reports shall be filed annually, on or before the first day of March, with the office of the Insurance Commissioner.

SECTION 2. AMENDATORY 36 O.S. 1991, Section 612.2, is amended to read as follows:

Section 612.2 A. After November 1, 1987, no insurer who requests to write workers' compensation insurance in this state shall be permitted to transact the business of workers' compensation insurance in this state unless the insurer possesses and maintains a

surplus as regards policyholders, as defined in Section 610 of Title 36 of the Oklahoma Statutes, in excess of Five Million Dollars (\$5,000,000.00). Should the surplus as regards policyholders fall below Five Million Dollars (\$5,000,000.00), the insurer shall not be permitted to write any additional workers' compensation insurance until the surplus meets the statutory requirements as established in this section.

B. No insurer authorized to write title insurance in this state but who is not issuing title insurance on November 1, 1998, nor any insurer who requests to write title insurance in this state on or after November 1, 1998, shall be permitted to transact the business of title insurance in this state unless the insurer possess and maintains a surplus as regards policyholders in excess of Five Million Dollars (\$5,000,000.00).

SECTION 3. AMENDATORY 36 O.S. 1991, Section 1219, as last amended by Section 50, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 1997, Section 1219), is amended to read as follows:

Section 1219. A. In the administration, servicing, or processing of any accident and health insurance policy, it shall be an unfair claim settlement practice for any insurer to fail to notify a policyholder or assignee of record in writing of the cause for delay in payment of any claim where the claim is not paid within thirty (30) days after receipt of proof of loss. Failure of an insurer to provide a policyholder or assignee of record with such notification shall constitute prima facie evidence that the claim will be paid in accordance with the terms of the policy.

B. 1. If a claim is not paid within sixty (60) days after receipt of proof of loss, the insurer shall pay interest which shall be the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year as certified to the Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two (2) percentage

points, which shall accrue from the sixty-first day after receipt of proof of loss until the claim is paid.

2. If a claim is not paid within six (6) months after receipt of proof of loss, the insurer shall pay interest which shall be the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year as certified to the Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus four (4) percentage points, which shall accrue from the sixty-first day after receipt of proof of loss until the claim is paid.

C. As used in this section:

1. "Accident and health insurance policy" or "policy" means any policy, certificate, contract, agreement or other instrument that provides accident and health insurance, as defined in Section 703 of this title, to any person in this state; and

2. "Proof of loss" means written documents such as claim forms, medical bills, or other reasonable evidence of a claim, but shall not include information not necessary for determination of proof of loss and not pertinent to filed claims, such as any medical reports that the insurer wants to secure merely for completion of business records or files.

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

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

SECTION 4. AMENDATORY 36 O.S. 1991, Section 1254, as renumbered by Section 20, Chapter 342, O.S.L. 1994, and as last amended by Section 52, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 1997, Section 1250.5), is amended to read as follows:

Section 1250.5 Any of the following acts by an insurer, if committed in violation of Section 1250.3 of this title, constitutes an unfair claim settlement practice:

1. Failing 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. Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;

3. Failing to adopt and implement reasonable standards for prompt investigations of claims arising under its insurance policies or insurance contracts;

4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

5. Failing to comply with the provisions of Section 1219 of this title;

6. Denying a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so;

7. Except where there is a time limit specified in the policy, making statements, written or otherwise, which require 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;

8. Requesting a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment;

9. Issuing 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;

10. Denying payment to a claimant on the grounds that services, procedures, or supplies provided by a treating physician or a

hospital were not medically necessary unless the health insurer or administrator, as defined in Section 1442 of this title, first obtains an opinion from ~~any provider of a licensed~~ health care licensed by law provider and preceded by a medical examination or claim review, to the effect that the services, procedures or supplies for which payment is being denied were not medically necessary. Upon written request of a claimant, treating physician, or hospital, ~~such:~~

- a. the opinion shall be reevaluated by a reviewing physician who holds the same type of physician's license as the treating physician; and
- b. the reevaluation shall be set forth in a written report, prepared and signed by the reviewing physician.

The report shall detail which specific services, procedures, or supplies were not medically necessary, in the opinion of the reviewing physician, and an explanation of that conclusion. A copy of each report of a reviewing physician shall be mailed by the health insurer, or administrator, postage prepaid, to the claimant, treating physician or hospital requesting same within fifteen (15) days after receipt of such written request. As used in this paragraph, "physician" means a person holding a valid license to practice medicine and surgery, osteopathic medicine, podiatric medicine, dentistry, chiropractic, or optometry, ~~pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes;~~

11. Compensating a reviewing physician, as defined in paragraph 10 of this subsection, on the basis of a percentage of the amount by which a claim is reduced for payment;

12. Compelling, without just cause, policyholders to institute suits to recover amounts due under its insurance policies or insurance contracts by offering substantially less than the amounts ultimately recovered in suits brought by them, when such

policyholders have made claims for amounts reasonably similar to the amounts ultimately recovered; ~~or~~

13. Failing to maintain a complete record of all complaints which it has received during the preceding three (3) years or since the date of its last financial examination conducted or accepted by the Commissioner, whichever time is longer. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For the purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance; or

14. Requesting a refund of all or a portion of payment of a claim made to a claimant or health care provider more than twenty-four (24) months after the payment is made. This paragraph shall not apply:

- a. if the payment was made because of fraud committed by the claimant or health care provider, or
- b. if the claimant or health care provider has otherwise agreed to make a refund to the insurer for overpayment of a claim.

SECTION 5. AMENDATORY Section 60, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 1997, Section 1424.11), is amended to read as follows:

Section 1424.11 A. No person shall act as or hold himself or herself out to be an insurance agent, surplus lines insurance broker, limited insurance representative, managing general agent, consultant, or customer service representative unless duly licensed. Salaried employees in the office of an insurance agent, surplus lines insurance broker, limited insurance representative, managing general agent or consultant, who devote full time to clerical and administrative services, with incidental receiving of insurance applications and premiums in the office of the employer and who do

not receive any commissions for the applications nor a compensation that is varied by the volume of applications or premiums taken or received, shall be exempt from any licensing requirement.

B. No insurance agent, surplus lines insurance broker, or limited insurance representative shall make application for, procure, negotiate for, or place for others any policies for any lines of insurance for which he or she is not then qualified and duly licensed.

C. An insurance agent may receive qualification for a license in one or more of the following categories or lines of insurance:

1. Life insurance, including fraternal agents licensed pursuant to Section 2733.1 of this title;

2. Accident and health insurance, including fraternal agents licensed pursuant to Section 2733.1 of this title;

3. Property and casualty insurance;

4. Variable annuity contracts, including fraternal agents licensed pursuant to Section 2733.1 of this title; and

5. Title insurance.

D. A limited insurance representative may receive qualification for a license in one or more of the following categories:

1. As a ticket-selling agent of a common carrier who acts only with reference to the issuance of insurance on personal effects carried as baggage, in connection with the transportation provided by such common carrier;

2. To engage in the sale of only limited travel accident insurance;

3. To engage in the sale of motor vehicle insurance at a vehicle rental counter or at any other point of sale at which motor vehicle insurance is offered or sold in connection with the short-term renting or leasing of motor vehicles;

4. To engage in the sale of credit life insurance or credit accident and health insurance or both credit life insurance and

credit accident and health insurance in connection with a credit transaction by which satisfaction of a debt in whole or in part is a benefit provided;

~~4.~~ 5. To engage in the sale of personal property floater insurance upon personal effects against loss or damage from any cause in connection with a credit transaction of not more than Five Thousand Dollars (\$5,000.00) by which satisfaction of the credit transaction debt in whole or in part is a benefit provided, and such personal effects are used as collateral on the debt;

~~5.~~ 6. To engage in the sale of nonfiling insurance relating to mortgages and security interests arising under the Uniform Commercial Code, Section 1-101 et seq. of Title 12A of the Oklahoma Statutes;

~~6.~~ 7. Prepaid legal liability insurance, which means the assumption of an enforceable contractual obligation to provide specified legal services or to reimburse policyholders for specified legal expenses, pursuant to the provisions of a group or individual policy;

~~7.~~ 8. Job loss insurance, which means the sale of involuntary unemployment insurance in connection with a credit transaction by which satisfaction of a debt in whole or in part is a benefit provided;

~~8.~~ 9. Crop hail and multiperil crop hail insurance; and

~~9.~~ 10. Prepaid dental insurance, provided the individual selling the prepaid dental insurance has been appointed by the prepaid dental plan organization to sell such insurance.

E. 1. An insurance agent or limited insurance representative may solicit applications for and issue travel accident policies or baggage insurance by means of mechanical vending machines supervised by the agent or representative only if the Insurance Commissioner shall determine that the form of policy to be sold is reasonably suited for sale and issuance through vending machines, that use of

vending machines for the sale of said policies would be of convenience to the public, and that the type of vending machine to be used is reasonably suitable and practical for the sale and issuance of said policies. Policies so sold do not have to be countersigned.

2. The Commissioner shall issue to the insurance agent or limited insurance representative a special vending machine license for each such machine to be used. The license shall specify the name and address of the insurer and licensee, the kind of insurance and type of policy to be sold, and the place where the machine is to be in operation. The license shall expire, be renewable, and be suspended or revoked coincidentally with the insurance agent license or limited representative license of the licensee. The license fee for each vending machine shall be that stated in the provisions of Section 1425 of this title. Proof of existence of the license shall be displayed on or about each machine in such manner as the Commissioner may reasonably require.

SECTION 6. AMENDATORY 36 O.S. 1991, Section 6054, as last amended by Section 1, Chapter 76, O.S.L. 1996 (36 O.S. Supp. 1997, Section 6054), is amended to read as follows:

Section 6054. As used in the Health Care Freedom of Choice Act:

1. "Accident and health insurance policy" or "policy" means any policy, certificate, contract, agreement or other instrument that provides accident and health insurance, as defined in Section 703 of this title, to any person in this state;

2. "Hospital" means any facility as defined in Section 1-701 of Title 63 of the Oklahoma Statutes;

3. "Insured" means any person entitled to reimbursement for expenses of health care services and procedures under an accident and health insurance policy issued by an insurer;

4. "Insurer" means any entity that provides an accident and health insurance policy in this state, including but not limited to

a licensed insurance company, a not-for-profit hospital service and/or medical indemnity corporation, a fraternal benefit society, a multiple employer welfare arrangement or any other entity subject to regulation by the Insurance Commissioner; ~~and~~

5. "Practitioner" means any person holding a valid license to practice medicine and surgery, osteopathic medicine, chiropractic, podiatric medicine, optometry or dentistry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes; and

6. "Preferred provider organization (PPO)" means a network of practitioners, hospitals, medical groups and other health care providers who have entered into an agreement with an insurer to provide health care services under the terms and conditions established in the agreement.

SECTION 7. AMENDATORY 36 O.S. 1991, Section 6055, as last amended by Section 2, Chapter 76, O.S.L. 1996 (36 O.S. Supp. 1997, Section 6055), is amended to read as follows:

Section 6055. A. Under any accident and health insurance policy, hereafter renewed or issued for delivery from out of Oklahoma or in Oklahoma by any insurer and covering an Oklahoma risk, the services and procedures may be performed by any practitioner selected by the insured or the insured's parent or guardian if the insured is a minor and if the services and procedures fall within the licensed scope of practice of the practitioner providing the service.

B. An accident and health insurance policy may:

1. Exclude or limit coverage for a particular illness, disease, injury or condition; but, except for such exclusions or limits, shall not exclude or limit particular services or procedures that can be provided for the diagnosis and treatment of a covered illness, disease, injury or condition, if such exclusion or limitation has the effect of discriminating against a particular

class of practitioner. However, such services and procedures, in order to be a covered medical expense, must:

- a. be medically necessary,
- b. be of proven efficacy, and
- c. fall within the licensed scope of practice of the practitioner providing same; and

2. Provide for the application of deductibles and copayment provisions, when equally applied to all covered charges for services and procedures that can be provided by any practitioner for the diagnosis and treatment of a covered illness, disease, injury or condition. This provision shall not be construed to prohibit differences in deductibles and copayment provisions between participating network practitioners and nonparticipating network practitioners.

C. Benefits available under an accident and health insurance policy, at the option of the insured, shall be assignable to a practitioner or hospital who has provided services and procedures which are covered under the policy. A practitioner or hospital shall be compensated directly by an insurer for services and procedures which have been provided when the following conditions are met:

1. Benefits available under a policy have been assigned in writing by an insured to the practitioner or hospital;

2. A copy of the assignment has been provided by the practitioner or hospital to the insurer;

3. A claim has been submitted by the practitioner or hospital to the insurer on a uniform health insurance claim form prescribed by the Insurance Commissioner pursuant to Section 6581 of this title; and

4. A copy of the claim has been provided by the practitioner or hospital to the insured.

D. The provisions of subsection C of this section shall not apply to:

1. Any preferred provider organization (PPO) ~~contract, as defined by generally accepted industry standards;~~ or

2. Any statewide provider network which:

- a. provides that a practitioner or hospital who joins the provider network shall be compensated directly by the insurer,
- b. does not have any terms or conditions which have the effect of discriminating against a particular class of practitioner, and
- c. allows any hospital or practitioner, except a practitioner who has a prior felony conviction, to become a network provider if said hospital or practitioner is willing to comply with the terms and conditions of a standard network provider contract.

E. A practitioner shall be equally compensated for covered services and procedures provided to an insured on the basis of charges prevailing in the same geographical area or in similar sized communities for similar services and procedures provided to similarly ill or injured persons regardless of the branch of the healing arts to which the practitioner may belong, if:

1. The practitioner does not authorize or permit false and fraudulent advertising regarding the services and procedures provided by the practitioner; and

2. The practitioner does not aid or abet the insured to violate the terms of the policy.

F. Nothing in the Health Care Freedom of Choice Act shall prohibit a practitioner from contracting with an insurer for alternative levels or methods of payment.

SECTION 8. This act shall become effective November 1, 1998.

