

ENGROSSED HOUSE
BILL NO. 1918

By: Erwin of the House
and
Stipe of the Senate

An Act relating to insurance; 36 O.S. 1991, Section 1219, as amended by Section 1, Chapter 74, O.S.L. 1992 (36 O.S. Supp. 1996, Section 1219), which relates to unfair practices and frauds; modifying application to certain types of policies; making violation an unfair claim settlement practice; requiring notification to be by certified mail; amending 36 O.S. 1991, Sections 1221, as amended by Section 1, Chapter 342, O.S.L. 1994, and as renumbered by Section 20, Chapter 342, O.S.L. 1994, 1227, as last amended by Section 3, Chapter 342, O.S.L. 1994, and as renumbered by Section 20, Chapter 342, O.S.L. 1994, and 1254, as last amended by Section 5, Chapter 342, O.S.L. 1994, and as renumbered by Section 20, Chapter 342, O.S.L. 1994 (36 O.S. Supp. 1996, Sections 1250.1, 1250.3 and 1250.5), which relate to the Unfair Claims Settlement Practices Act; clarifying statutory cites and language; making certain acts an unfair claim settlement practice; modifying name of certain categories of physician; amending 36 O.S. 1991, Section 6056, as amended by Section 3, Chapter 76, O.S.L. 1996 (36 O.S. Supp. 1996, Section 6056), which relates to the Health Care

Freedom of Choice Act; modifying provision relating to where services may be performed; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 1991, Section 1219, as amended by Section 1, Chapter 74, O.S.L. 1992 (36 O.S. Supp. 1996, Section 1219), is amended to read as follows:

Section 1219. A. In the administration, servicing or processing of any ~~individual, group or blanket~~ accident and health insurance policy, it shall be an unfair ~~trade~~ 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 said claim is not paid within thirty (30) days after receipt of proof of loss. The notification shall be by certified mail with return receipt requested. 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. 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 State 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.

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 2. AMENDATORY 36 O.S. 1991, Section 1221, as amended by Section 1, Chapter 342, O.S.L. 1994, and as renumbered by Section 20, Chapter 342, O.S.L. 1994 (36 O.S. Supp. 1996, Section 1250.1), is amended to read as follows:

Section 1250.1 Sections ~~4~~ 1250.1 through ~~16~~ 1250.16 of this ~~act~~ title shall constitute a part of the Oklahoma Insurance Code and shall be known and may be cited as the "Unfair Claims Settlement Practices Act".

SECTION 3. AMENDATORY 36 O.S. 1991, Section 1227, as last amended by Section 3, Chapter 342, O.S.L. 1994, and as renumbered by Section 20, Chapter 342, O.S.L. 1994 (36 O.S. Supp. 1996, Section 1250.3), is amended to read as follows:

Section 1250.3 A. The provisions of the Unfair Claims Settlement Practices Act shall apply to all claims arising under an insurance policy or insurance contract issued by any insurer.

B. It is an unfair claim settlement practice for any insurer to commit any act set out in Section ~~5~~ 1250.5 of this ~~act~~ title, or to

commit a violation of any other provision of the Unfair Claims Settlement Practices Act, if:

1. It is committed flagrantly and in conscious disregard of this act or any rules promulgated hereunder; or

2. It has been committed with such frequency as to indicate a general business practice to engage in that type of conduct.

SECTION 4. AMENDATORY 36 O.S. 1991, Section 1254, as last amended by Section 5, Chapter 342, O.S.L. 1994, and as renumbered by Section 20, Chapter 342, O.S.L. 1994 (36 O.S. Supp. 1996, 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 ~~3~~ 1250.3 of this ~~act~~ 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 promptly pay a claim after giving verbal or written assurance to a claimant, treating physician or hospital that the claim would be paid;

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

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

~~6.~~ 8. 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;

~~7.~~ 9. Requesting a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment;

~~8.~~ 10. 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;

~~9.~~ 11. 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 health care licensed by law 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 opinion 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 ~~subsection~~ paragraph, "physician" means a person holding a valid license to practice medicine and surgery, ~~osteopathy~~ osteopathic medicine, ~~pediatry~~ podiatric medicine, chiropractic or

optometry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes;

~~10.~~ 12. Compensating a reviewing physician on the basis of a percentage of the amount by which a claim is reduced for payment;

~~11.~~ 13. 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

~~12.~~ 14. 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 examination by the Commissioner, whichever time is shorter. 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.

SECTION 5. AMENDATORY 36 O.S. 1991, Section 6056, as amended by Section 3, Chapter 76, O.S.L. 1996 (36 O.S. Supp. 1996, Section 6056), is amended to read as follows:

Section 6056. Services and procedures covered under an accident and health insurance policy may be performed at ~~any~~:

1. Any hospital where a practitioner is authorized to practice,
~~doctor's; or~~

2. The office or clinic of a practitioner.

The place where services are performed shall be at the choice of the insured, or the ~~insured's~~ parent or guardian of the insured if the insured is a minor, and the practitioner who is providing the services and procedures.

SECTION 6. This act shall become effective November 1, 1997.

Passed the House of Representatives the 5th day of March, 1997.

Speaker of the House of
Representatives

Passed the Senate the ____ day of _____, 1997.

President of the Senate