STATE OF OKLAHOMA

1st Session of the 47th Legislature (1999)

COMMITTEE SUBSTITUTE
FOR ENGROSSED
SENATE BILL NO. 411 By: Stipe of the Senate

and

Frame of the House

COMMITTEE SUBSTITUTE

An Act relating to insurance; amending 36 O.S. 1991, Sections 1219, as last amended by Section 50, Chapter 418, O.S.L. 1997, 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, 6054, as last amended by Section 1, Chapter 76, O.S.L. 1996, and 6055, as last amended by Section 2, Chapter 76, O.S.L. 1996 (36 O.S. Supp. 1998, Sections 1219, 1250.5, 6054 and 6055), which relate to payment of claims, prohibited acts, definitions and performance of services and procedures; requiring payment of interest if claim is not paid within certain time period; providing for accrual of interest; adding act which constitutes unfair claim settlement practice; defining term; modifying application of provision of law; 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 last amended by Section 50, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 1998, 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 at a rate which shall be the same 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. Such interest 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 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. 1998, 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 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 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 3. AMENDATORY 36 O.S. 1991, Section 6054, as last amended by Section 1, Chapter 76, O.S.L. 1996 (36 O.S. Supp. 1998, 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 such agreement.

SECTION 4. AMENDATORY 36 O.S. 1991, Section 6055, as last amended by Section 2, Chapter 76, O.S.L. 1996 (36 O.S. Supp. 1998, 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 5. This act shall become effective November 1, 1999.

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