

STATE OF OKLAHOMA

1st Session of the 47th Legislature (1999)

HOUSE BILL NO. 1745

By: Frame

AS INTRODUCED

An Act relating to insurance; amending 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), which relate to payment of claims; providing rate of interest to be assessed on claims not paid within certain time; amending 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), which relates to the Unfair Claims Settlement Practices Act; modifying and adding to list of acts which constitute unfair claim settlement practices; 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 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 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 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 3. This act shall become effective November 1, 1999.

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