

and

Hastings of the House

An Act relating to insurance; amending 36 O.S. 2001, Sections 1250.2 and 1250.5, which relate to the Unfair Claims Settlement Practices Act; modifying certain definition; including third-party administrator as party to an unfair claim settlement practice; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2001, Section 1250.2, is amended to read as follows:

Section 1250.2 As used in the Unfair Claims Settlement Practices Act:

1. "Agent" means any individual, corporation, association, partnership, or other legal entity authorized to represent an insurer with respect to a claim;

2. "Claimant" means either a first party claimant, a third party claimant, or both, and includes such claimant's designated legal representatives and includes a member of the claimant's immediate family designated by the claimant;

3. "Commissioner" means the Insurance Commissioner;

4. "First party claimant" means an individual, corporation, association, partnership, or other legal entity, including a subscriber under any plan providing health services, asserting a right to payment pursuant to an insurance policy or insurance contract for an occurrence of contingency or loss covered by such policy or contract;

5. "Insurance policy or insurance contract" means any contract of insurance, certificate, indemnity, medical or hospital service,

suretyship, or annuity issued, proposed for issuance, or intended for issuance by any entity subject to this Code;

6. "Insurer" means a person licensed by the Commissioner to issue or who issues any insurance policy or insurance contract in this state, including the State Insurance Fund, and any third-party administrator;

7. "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

8. "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim; and

9. "Third party claimant" means any individual, corporation, association, partnership, or other legal entity asserting a claim against any individual, corporation, association, partnership, or other legal entity insured under an insurance policy or insurance contract.

SECTION 2. AMENDATORY 36 O.S. 2001, Section 1250.5, is amended to read as follows:

Section 1250.5 Any of the following acts by an insurer or third-party administrator as defined in Section 1442 of this title, 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. Violating the provisions of the Health Care Fraud Prevention Act;

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;

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 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

15. Requesting a refund of all or a portion of a 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, 2002.

Passed the Senate the 18th day of March, 2002.

Presiding Officer of the Senate

Passed the House of Representatives the ____ day of _____,
2002.

Presiding Officer of the House
of Representatives