

1 ENGROSSED HOUSE  
2 BILL NO. 1055

By: Cox, Shelton, Kern,  
Williams and Dorman of the  
House

3  
4 and

Brown of the Senate  
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8 An Act relating to insurance; amending 36 O.S. 2001,  
9 Sections 1250.2, as last amended by Section 1,  
10 Chapter 170, O.S.L. 2005 and 1250.5 (36 O.S. Supp.  
11 2008, Section 1250.2), which relate to the Unfair  
12 Claims Settlement Practices Act; modifying  
13 definition; providing for failure to pay or request  
14 for a refund of a payment in certain circumstance as  
15 an unfair claim settlement practice; providing  
16 exception; and providing an effective date.

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

18 SECTION 1. AMENDATORY 36 O.S. 2001, Section 1250.2, as  
19 last amended by Section 1, Chapter 170, O.S.L. 2005 (36 O.S. Supp.  
20 2008, Section 1250.2), is amended to read as follows:

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

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

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

5           3. "Commissioner" means the Insurance Commissioner;

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

12           5. "Insurance policy or insurance contract" means any contract  
13 of insurance, certificate, indemnity, medical or hospital service,  
14 suretyship, annuity, subscriber certificate or any evidence of  
15 coverage of a health maintenance organization issued, proposed for  
16 issuance, or intended for issuance by any entity subject to this  
17 Code;

18           6. "Insurer" means a person licensed by the Commissioner to  
19 issue or who issues any insurance policy or insurance contract in  
20 this state, including Compsource, and also includes health  
21 maintenance organizations. Provided that, for the purposes of  
22 ~~paragraph~~ paragraphs 15 and 16 of Section 1250.5 of this title,  
23 "insurer" shall include the ~~Oklahoma~~ State and Education Employees  
24 Group Insurance Board;

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

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

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

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

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

19       1. Failing to fully disclose to first party claimants,  
20 benefits, coverages, or other provisions of any insurance policy or  
21 insurance contract when ~~such~~ the benefits, coverages or other  
22 provisions are pertinent to a claim;

23       2. Knowingly misrepresenting to claimants pertinent facts or  
24 policy provisions relating to coverages at issue;

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

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

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

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

11 7. Except where there is a time limit specified in the policy,  
12 making statements, written or otherwise, which require a claimant to  
13 give written notice of loss or proof of loss within a specified time  
14 limit and which seek to relieve the company of its obligations if  
15 ~~such a~~ the time limit is not complied with unless the failure to  
16 comply with ~~such~~ the time limit prejudices ~~an insurer's~~ the rights  
17 of an insurer;

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

20 9. Issuing checks or drafts in partial settlement of a loss or  
21 claim under a specified coverage which contain language ~~which~~  
22 ~~releases~~ releasing an insurer or its insured from its total  
23 liability;

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1        10. Denying payment to a claimant on the grounds that services,  
2 procedures, or supplies provided by a treating physician or a  
3 hospital were not medically necessary unless the health insurer or  
4 administrator, as defined in Section 1442 of this title, first  
5 obtains an opinion from any provider of health care licensed by law  
6 and preceded by a medical examination or claim review, to the effect  
7 that the services, procedures or supplies for which payment is being  
8 denied were not medically necessary. Upon written request of a  
9 claimant, treating physician, or hospital, ~~such~~ the opinion shall be  
10 set forth in a written report, prepared and signed by the reviewing  
11 physician. The report shall detail which specific services,  
12 procedures, or supplies were not medically necessary, in the opinion  
13 of the reviewing physician, and an explanation of that conclusion.  
14 A copy of each report of a reviewing physician shall be mailed by  
15 the health insurer, or administrator, postage prepaid, to the  
16 claimant, treating physician or hospital requesting same within  
17 fifteen (15) days after receipt of ~~such~~ the written request. As  
18 used in this paragraph, "physician" means a person holding a valid  
19 license to practice medicine and surgery, osteopathic medicine,  
20 podiatric medicine, dentistry, chiropractic, or optometry, pursuant  
21 to the state licensing provisions of Title 59 of the Oklahoma  
22 Statutes;

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1 11. Compensating a reviewing physician, as defined in paragraph  
2 10 of this subsection, on the basis of a percentage of the amount by  
3 which a claim is reduced for payment;

4 12. Violating the provisions of the Health Care Fraud  
5 Prevention Act;

6 13. Compelling, without just cause, policyholders to institute  
7 suits to recover amounts due under its insurance policies or  
8 insurance contracts by offering substantially less than the amounts  
9 ultimately recovered in suits brought by them, when ~~such~~ the  
10 policyholders have made claims for amounts reasonably similar to the  
11 amounts ultimately recovered;

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

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

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

6 16. Failing to pay, or requesting a refund of a payment, for  
7 health care services preauthorized or precertified by the insurer or  
8 its agent, if coverage was in force on the date the service or  
9 services were provided. This paragraph shall not apply if the claim  
10 or payment was made because of fraud committed by the claimant or  
11 health care provider.

12 SECTION 3. This act shall become effective November 1, 2009.

13 Passed the House of Representatives the 24th day of February,  
14 2009.

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17 Presiding Officer of the House of  
18 Representatives

19 Passed the Senate the \_\_\_\_ day of \_\_\_\_\_, 2009.

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22 Presiding Officer of the Senate  
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