ENROLLED HOUSE
BILL NO. 1055

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

and

Brown of the Senate

An Act relating to insurance; amending 36 O.S. 2001, Sections 1250.2, as last amended by Section 1, Chapter 170, O.S.L. 2005 and 1250.5 (36 O.S. Supp. 2008, Section 1250.2), which relate to the Unfair Claims Settlement Practices Act; modifying definition; adding definitions; modifying what constitutes an unfair claim settlement practice; requiring the Insurance Commissioner to develop certain affidavit; creating the State Employee Health Insurance Review Working Group; providing composition; providing for initial meeting; designating a quorum; requiring quorum for certain action; providing for designation of cochairs; providing that members serve at pleasure of appointing authority; providing for travel reimbursement; providing duties and powers; requiring certain study and specifying scope of study; providing for selection of consultant; providing for staffing and expenses; providing for final report; sunsetting certain provisions and the Working Group on a certain date; providing for codification; providing for noncodification; providing effective dates; and declaring an emergency.

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

SECTION 1. AMENDATORY 36 O.S. 2001, Section 1250.2, as last amended by Section 1, Chapter 170, O.S.L. 2005 (36 O.S. Supp. 2008, 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. "Health benefit plan" means group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions. The term shall not include short-term accident, fixed indemnity, or specified disease policies, disability income contracts, limited benefit or credit disability insurance, workers' compensation insurance coverage, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance;

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

~~6.~~ 7. "Insurer" means a person licensed by the Commissioner to issue or who issues any insurance policy or insurance contract in this state, including Compsource, and also includes health maintenance organizations. Provided that, for the purposes of ~~paragraph~~ paragraphs 15 and 16 of Section 1250.5 of this title, "insurer" shall include the ~~Oklahoma~~ State and Education Employees Group Insurance Board;

~~7.~~ 8. "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.~~ 9. "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.~~ 10. "Preauthorization/precertification" means a determination by a health benefit plan, based on the information presented at the time by the health care provider, that health care services proposed by the health care provider are medically necessary. The term shall include "authorization", "certification" and any other term that would be a reliable determination by a health benefit plan. A preauthorization/precertification from a previous health plan shall not bind a succeeding health benefit plan;

11. "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; and

12. "Verification of eligibility" means a representation by a health benefit plan to a health care provider that a claimant is entitled to covered benefits under the policy. Such verification of eligibility shall be valid for four (4) business days from the date given by the health benefit plan.

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, if committed in violation of Section 1250.3 of this title, constitutes an unfair claim settlement practice exclusive of paragraph 16 of this section which shall be applicable solely to health benefit plans:

1. Failing to fully disclose to first party claimants, benefits, coverages, or other provisions of any insurance policy or insurance contract when ~~such~~ the 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~~ the time limit is not complied with unless the failure to comply with ~~such~~ the time limit prejudices ~~an insurer's~~ the rights of an insurer;

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~~ releasing 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~~ the 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~~ the 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~~ the 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; or

16. Failing to pay, or requesting a refund of a payment, for health care services covered under the policy of a health benefit plan, or its agent, has provided a preauthorization or precertification and verification of eligibility for those health care services. This paragraph shall not apply if:

a. the claim or payment was made because of fraud committed by the claimant or health care provider,

b. the subscriber had a pre-existing exclusion under the policy related to the service provided, or

c. the subscriber or employer failed to pay the applicable premium and all grace periods and extensions of coverage have expired.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1250.17 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Insurance Commissioner shall develop, by rule, an affidavit to be presented to patients by health care providers prior to rendering nonemergency services. The affidavit shall be designed to seek information from the patient to further determine the eligibility of the patient for benefits under the patient's insurance policy. Making false statements on the affidavit shall carry the same penalties under law as perjury.

SECTION 4. NEW LAW A new section of law not to be codified in the Oklahoma Statutes, reads as follows:

A. There is hereby created the State Employee Health Insurance Review Working Group.

B. The Working Group shall consist of five (5) members to be appointed or selected as follows:

1. Two members, who shall be members of the Oklahoma House of Representatives, to be appointed by the Speaker of the Oklahoma House of Representatives;

2. Two members, who shall be members of the Oklahoma State Senate, to be appointed by the President Pro Tempore of the State Senate; and

3. The Insurance Commissioner or designee.

C. The Working Group shall hold its first meeting not later than July 1, 2009. The first meeting shall be called by the cochairs of the Working Group. A majority of the members present at the initial meeting or any subsequent meeting shall constitute a quorum for the purpose of any action taken including the preparation and approval of the final report required by subsection N of this section.

D. The Speaker of the Oklahoma House of Representatives and the President Pro Tempore of the Oklahoma State Senate shall designate which of their respective appointments shall serve as cochairs of the Working Group.

E. Members of the Working Group shall serve at the pleasure of the appointing authority.

F. The Working Group shall be authorized to meet as necessary in order to perform the duties imposed upon it. Legislative members of the Working Group shall be reimbursed for travel expenses pursuant to the provisions of Section 456 of Title 74 of the Oklahoma Statutes. Other members of the Working Group shall be reimbursed as provided by the appointing authority.

G. Due to the increase in the cost of state employees' health care coverage, the Working Group shall study and examine the most efficient and cost-effective way to leverage state dollars to ensure

the highest level of health care for state employees at a competitive price.

H. The study shall include, but shall not be limited to:

1. Ways to reduce costs of state employee health care coverage to the taxpayers, state employees and their dependents;

2. Health care coverage plan design that will promote patient care that is safe, effective, patient-centered, efficient, and equitable;

3. Offering consumer choice of health care plan designs that allow state employees the opportunity to determine what coverage and costs of such coverage best meet their needs; and

4. Ways to maximize the state's leverage in purchasing medical services and supplies and plans' support services.

I. The Working Group shall have the authority to request the Legislative Service Bureau to review authoritative consultants with expertise in state plan design and health care purchasing and assess the ability of the consultants to examine the objectives listed in subsection H of this section in addition to other objectives, as necessary.

J. After the review required by subsection I of this section, the Legislative Service Bureau shall recommend one or more qualified consultants to the Oklahoma State Employees Benefits Council and the State and Education Employees Group Insurance Board. The Oklahoma State Employees Benefits Council and the State and Education Employees Group Insurance Board jointly shall contract with one of the recommended consultants for the study required by subsection G of this section.

K. The consultant shall advise the Working Group on recommendations to fulfill the objectives outlined in subsections G and H of this section.

L. The Working Group shall have the authority to request of related agencies any information, records or reports necessary to ensure the study of objectives outlined in subsection H of this section. Agencies shall respond to the Working Group in a timely manner to meet necessary reporting deadlines imposed upon the Working Group.

M. Staff assistance for the Working Group shall be provided by the staff of the Oklahoma House of Representatives and the State Senate. Funding for the study, other than costs otherwise provided for in this section, shall be provided equally by the Oklahoma State Employees Benefits Council and the State and Education Employees Group Insurance Board.

N. The Working Group shall produce a final written report of its findings and any recommendations regarding effective and cost-efficient purchasing and delivery of Oklahoma state employees' health care. The report shall be submitted to the Governor, the Speaker of the Oklahoma House of Representatives and the President Pro Tempore of the State Senate not later than December 31, 2009.

O. The provisions of this section shall cease to have the force and effect of law and the Working Group shall terminate effective January 1, 2010.

SECTION 5. Sections 1 and 2 of this act shall become effective July 1, 2010.

SECTION 6. Section 3 of this act shall become effective November 1, 2009.

SECTION 7. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

Passed the House of Representatives the 19th day of May, 2009.

Presiding Officer of the House of Representatives

Passed the Senate the 20th day of May, 2009.

Presiding Officer of the Senate