

THE HOUSE OF REPRESENTATIVES
Thursday, February 19, 2009

House Bill No. 1055

HOUSE BILL NO. 1055 - By: COX AND SHELTON 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; providing for failure to pay or request for a refund of a payment in certain circumstance as an unfair claim settlement practice; providing exception; and providing an effective date.

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

- 1 SECTION 1. AMENDATORY 36 O.S. 2001, Section 1250.2, as last amended by
2 Section 1, Chapter 170, O.S.L. 2005 (36 O.S. Supp. 2008, Section 1250.2), is amended to
3 read as follows:
- 4 Section 1250.2 As used in the Unfair Claims Settlement Practices Act:
- 5 1. "Agent" means any individual, corporation, association, partnership, or other
6 legal entity authorized to represent an insurer with respect to a claim;
- 7 2. "Claimant" means either a first party claimant, a third party claimant, or both,
8 and includes such claimant's designated legal representatives and includes a member of
9 the claimant's immediate family designated by the claimant;
- 10 3. "Commissioner" means the Insurance Commissioner;

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

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

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

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

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

21 9. "Third party claimant" means any individual, corporation, association,
22 partnership, or other legal entity asserting a claim against any individual, corporation,

1 association, partnership, or other legal entity insured under an insurance policy or
2 insurance contract.

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

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

- 7 1. Failing to fully disclose to first party claimants, benefits, coverages, or other
8 provisions of any insurance policy or insurance contract when ~~such~~ the benefits,
9 coverages or other provisions are pertinent to a claim;
- 10 2. Knowingly misrepresenting to claimants pertinent facts or policy provisions
11 relating to coverages at issue;
- 12 3. Failing to adopt and implement reasonable standards for prompt investigations
13 of claims arising under its insurance policies or insurance contracts;
- 14 4. Not attempting in good faith to effectuate prompt, fair and equitable settlement
15 of claims submitted in which liability has become reasonably clear;
- 16 5. Failing to comply with the provisions of Section 1219 of this title;
- 17 6. Denying a claim for failure to exhibit the property without proof of demand and
18 unfounded refusal by a claimant to do so;
- 19 7. Except where there is a time limit specified in the policy, making statements,
20 written or otherwise, which require a claimant to give written notice of loss or proof of
21 loss within a specified time limit and which seek to relieve the company of its obligations

1 if ~~such a~~ the time limit is not complied with unless the failure to comply with ~~such the~~
2 time limit prejudices ~~an insurer's~~ the rights of an insurer;

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

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

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

1 surgery, osteopathic medicine, podiatric medicine, dentistry, chiropractic, or optometry,
2 pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes;

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

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

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

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

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

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

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

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

10 COMMITTEE REPORT BY: COMMITTEE ON ECONOMIC DEVELOPMENT AND
11 FINANCIAL SERVICES, dated 02-18-09 - DO PASS, As Coauthored.