

STATE OF OKLAHOMA

2nd Session of the 58th Legislature (2022)

COMMITTEE SUBSTITUTE
FOR

HOUSE BILL NO. 4279

By: Sneed

COMMITTEE SUBSTITUTE

An Act relating to insurance; amending 36 O.S. 2021,
Section 1250.5, which relates to acts by an insurer
constituting an unfair claim settlement practice;
modifying requirement applicability; and providing an
effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2021, 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

1 insurance contract when the benefits, coverages or other provisions
2 are pertinent to a claim;

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

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

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

11 5. Failing to comply with the provisions of Section 1219 of
12 this title;

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

15 7. Except where there is a time limit specified in the policy,
16 making statements, written or otherwise, which require a claimant to
17 give written notice of loss or proof of loss within a specified time
18 limit and which seek to relieve the company of its obligations if
19 the time limit is not complied with unless the failure to comply
20 with the time limit prejudices the rights of an insurer. Any policy
21 that specifies a time limit covering damage to a roof due to wind or
22 hail must include a provision allowing the filing of claims after
23 the first anniversary but no later than twenty-four (24) months
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1 after the date of the loss, if the damage is not evident without
2 inspection;

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

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

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

1 fifteen (15) days after receipt of the written request. As used in
2 this paragraph, "physician" means a person holding a valid license
3 to practice medicine and surgery, osteopathic medicine, podiatric
4 medicine, dentistry, chiropractic, or optometry, pursuant to the
5 state licensing provisions of Title 59 of the Oklahoma Statutes;

6 11. Compensating a reviewing physician, as defined in paragraph
7 10 of this section, on the basis of a percentage of the amount by
8 which a claim is reduced for payment;

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

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

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

3 15. Requesting a refund of all or a portion of a payment of a
4 claim made to a claimant more than twelve (12) months or health care
5 provider more than ~~twenty-four (24)~~ eighteen (18) months after the
6 payment is made. This paragraph shall not apply:

- 7 a. if the payment was made because of fraud committed by
- 8 the claimant or health care provider, or
- 9 b. if the claimant or health care provider has otherwise
- 10 agreed to make a refund to the insurer for overpayment
- 11 of a claim;

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

- 17 a. the claim or payment was made because of fraud
- 18 committed by the claimant or health care provider,
- 19 b. the subscriber had a preexisting exclusion under the
- 20 policy related to the service provided, or
- 21 c. the subscriber or employer failed to pay the
- 22 applicable premium and all grace periods and
- 23 extensions of coverage have expired;

1 17. Denying or refusing to accept an application for life
2 insurance, or refusing to renew, cancel, restrict or otherwise
3 terminate a policy of life insurance, or charge a different rate
4 based upon the lawful travel destination of an applicant or insured
5 as provided in Section 4024 of this title; or

6 18. a. As a health insurer that provides pharmacy benefits or
7 a pharmacy benefits manager that administers pharmacy
8 benefits for a health plan, failing to include any
9 amount paid by an enrollee or on behalf of an enrollee
10 by another person when calculating the enrollee's
11 total contribution to an out-of-pocket maximum,
12 deductible, copayment, coinsurance or other cost-
13 sharing requirement.

14 b. If under federal law, application of subparagraph a of
15 this paragraph would result in health savings account
16 ineligibility under Section 223 of the federal
17 Internal Revenue Code, as amended, this requirement
18 shall apply only for health savings accounts with
19 qualified high deductible health plans with respect to
20 the deductible of such a plan after the enrollee has
21 satisfied the minimum deductible, except with respect
22 to items or services that are preventive care pursuant
23 to Section 223(c)(2)(C) of the federal Internal
24 Revenue Code, as amended, in which case the

requirements of subparagraph a of this paragraph shall
apply regardless of whether the minimum deductible has
been satisfied.

SECTION 2. This act shall become effective November 1, 2022.

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