STATE OF OKLAHOMA

2nd Session of the 58th Legislature (2022)

HOUSE BILL 4279 By: Sneed

AS INTRODUCED

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 insurance contract when 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 the time limit is not complied with unless the failure to comply with the time limit prejudices 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, drafts or electronic payment in partial settlement of a loss or claim under a specified coverage which contain language 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, 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 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 section, 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 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;

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;

16. Failing to pay, or requesting a refund of a payment, for health care services covered under the policy if 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 preexisting 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;

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

18. a. As a health insurer that provides pharmacy benefits or a pharmacy benefits manager that administers pharmacy benefits for a health plan, failing to include any amount paid by an enrollee or on behalf of an enrollee

by another person when calculating the enrollee's total contribution to an out-of-pocket maximum, deductible, copayment, coinsurance or other cost-sharing requirement.

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

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

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