

1 **HOUSE OF REPRESENTATIVES - FLOOR VERSION**

2 STATE OF OKLAHOMA

3 1st Session of the 58th Legislature (2021)

4 COMMITTEE SUBSTITUTE  
5 FOR ENGROSSED  
6 SENATE BILL NO. 92

By: McCortney, Rader,  
Montgomery, Jett and  
Stanley of the Senate

7 and

8 McEntire of the House

9  
10  
11 COMMITTEE SUBSTITUTE

12 An Act relating to insurance; amending 36 O.S. 2011,  
13 Section 1250.5, as amended by Section 1, Chapter 105,  
14 O.S.L. 2012 (36 O.S. Supp. 2020, Section 1250.5),  
15 which relates to the Unfair Claims Settlement  
16 Practices Act; expanding actions that constitute  
17 unfair claims settlement practices; updating  
18 references; and providing an effective date.

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

19 SECTION 1. AMENDATORY 36 O.S. 2011, Section 1250.5, as  
20 amended by Section 1, Chapter 105, O.S.L. 2012 (36 O.S. Supp. 2020,  
21 Section 1250.5), is amended to read as follows:

22 Section 1250.5 Any of the following acts by an insurer, if  
23 committed in violation of Section 1250.3 of this title, constitutes  
24 an unfair claim settlement practice exclusive of paragraph 16 of

1 this section which shall be applicable solely to health benefit  
2 plans:

3 1. Failing to fully disclose to first party claimants,  
4 benefits, coverages, or other provisions of any insurance policy or  
5 insurance contract when the benefits, coverages or other provisions  
6 are pertinent to a claim;

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

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

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

15 5. Failing to comply with the provisions of Section 1219 of  
16 this title;

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

19 7. Except where there is a time limit specified in the policy,  
20 making statements, written or otherwise, which require a claimant to  
21 give written notice of loss or proof of loss within a specified time  
22 limit and which seek to relieve the company of its obligations if  
23 the time limit is not complied with unless the failure to comply  
24 with the time limit prejudices the rights of an insurer;

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

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

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

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

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

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

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

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

23 15. Requesting a refund of all or a portion of a payment of a  
24 claim made to a claimant or health care provider more than twenty-

1 four (24) months after the payment is made. This paragraph shall  
2 not apply:

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

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

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

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

1       18. As a health insurer that provides pharmacy benefits or a  
2 pharmacy benefits manager that administers pharmacy benefits for a  
3 health plan, failing to include any amount paid by an enrollee or on  
4 behalf of an enrollee by another person, as defined in Section 104  
5 of this title, when calculating the total contribution to an out-of-  
6 pocket maximum of the enrollee, deductible, copayment, coinsurance  
7 or other cost-sharing requirement.

8           SECTION 2. This act shall become effective November 1, 2021.

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10       COMMITTEE REPORT BY: COMMITTEE ON INSURANCE, dated 04/01/2021 - DO  
11       PASS, As Amended.

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