

1 STATE OF OKLAHOMA

2 1st Session of the 58th Legislature (2021)

3 SENATE BILL 92

By: McCortney

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5
6 AS INTRODUCED

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

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

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

18 Section 1250.5. Any of the following acts by an insurer, if
19 committed in violation of Section 1250.3 of this title, constitutes
20 an unfair claim settlement practice exclusive of paragraph 16 of
21 this section which shall be applicable solely to health benefit
22 plans:

23 1. Failing to fully disclose to first party claimants,
24 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;

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

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

4 10. Denying payment to a claimant on the grounds that services,
5 procedures, or supplies provided by a treating physician or a
6 hospital were not medically necessary unless the health insurer or
7 administrator, as defined in Section 1442 of this title, first
8 obtains an opinion from any provider of health care licensed by law
9 and preceded by a medical examination or claim review, to the effect
10 that the services, procedures or supplies for which payment is being
11 denied were not medically necessary. Upon written request of a
12 claimant, treating physician, or hospital, the opinion shall be set
13 forth in a written report, prepared and signed by the reviewing
14 physician. The report shall detail which specific services,
15 procedures, or supplies were not medically necessary, in the opinion
16 of the reviewing physician, and an explanation of that conclusion.
17 A copy of each report of a reviewing physician shall be mailed by
18 the health insurer, or administrator, postage prepaid, to the
19 claimant, treating physician or hospital requesting same within
20 fifteen (15) days after receipt of the written request. As used in
21 this paragraph, "physician" means a person holding a valid license
22 to practice medicine and surgery, osteopathic medicine, podiatric
23 medicine, dentistry, chiropractic, or optometry, pursuant to the
24 state licensing provisions of Title 59 of the Oklahoma Statutes;

1 11. Compensating a reviewing physician, as defined in paragraph
2 10 of this ~~subsection~~ section, on the basis of a percentage of the
3 amount by which a claim is reduced for payment;

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

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

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

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

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

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

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

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

23 18. As a health insurer that provides pharmacy benefits or a
24 pharmacy benefits manager that administers pharmacy benefits for a

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

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

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