HOUSE OF REPRESENTATIVES - FLOOR VERSION

STATE OF OKLAHOMA

1st Session of the 59th Legislature (2023)

ENGROSSED SENATE
BILL NO. 557 By: Montgomery of the Senate

and

Sneed and **Waldron** of the House

An Act relating to the Unfair Claims Settlement Practices Act; amending 36 O.S. 2021, Section 1250.5, as amended by Section 1, Chapter 266, O.S.L. 2022 (36 O.S. Supp. 2022, Section 1250.5), which relates to acts by an insurer; providing that denial of payment to claimant for certain services by certain providers shall constitute an unfair claim settlement practice; requiring review of certain mental health and substance use disorder claims by provider with certain credentials; 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, as amended by Section 1, Chapter 266, O.S.L. 2022 (36 O.S. Supp. 2022, 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. Any policy

that specifies a time limit covering damage to a roof due to wind or hail must allow the filing of claims after the first anniversary but no later than twenty-four (24) months after the date of the loss, if the damage is not evident without inspection;

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, or person or entity licensed or otherwise authorized to provide health care services 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. In the event that claims for mental health or substance use disorder treatments and services are under review, the reviewing health care provider shall have appropriate, qualified, and specialized credentials with respect to the services and treatments. Upon written request of a claimant, treating physician, ~~or~~ hospital, or

authorized person or entity, 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, or authorized person or entity 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 more than twelve (12) months or a health care provider more than eighteen (18) 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. 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.

However, if, under federal law, application 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, 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 this paragraph shall apply regardless of whether the minimum deductible has been satisfied.

SECTION 2. This act shall become effective November 1, 2023.

COMMITTEE REPORT BY: COMMITTEE ON INSURANCE, dated 04/04/2023 - DO PASS, As Coauthored.