

1 ENGROSSED HOUSE
2 BILL NO. 4279

By: Sneed and Phillips of the
House

3 and

4 Quinn of the Senate
5

6
7 An Act relating to insurance; amending 36 O.S. 2021,
8 Section 1250.5, which relates to acts by an insurer
9 constituting an unfair claim settlement practice;
10 modifying requirement applicability; and providing an
11 effective date.

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

13 SECTION 1. AMENDATORY 36 O.S. 2021, Section 1250.5, is
14 amended to read as follows:

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

20 1. Failing to fully disclose to first party claimants,
21 benefits, coverages, or other provisions of any insurance policy or
22 insurance contract when the benefits, coverages or other provisions
23 are pertinent to a claim;
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1 2. Knowingly misrepresenting to claimants pertinent facts or
2 policy provisions relating to coverages at issue;

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

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

9 5. Failing to comply with the provisions of Section 1219 of
10 this title;

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

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

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

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

1 to practice medicine and surgery, osteopathic medicine, podiatric
2 medicine, dentistry, chiropractic, or optometry, pursuant to the
3 state licensing provisions of Title 59 of the Oklahoma Statutes;

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

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

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

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

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

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

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

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

22 17. Denying or refusing to accept an application for life
23 insurance, or refusing to renew, cancel, restrict or otherwise
24 terminate a policy of life insurance, or charge a different rate

1 based upon the lawful travel destination of an applicant or insured
2 as provided in Section 4024 of this title; or

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

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

