ENGROSSED SENATE AMENDMENT
TO
ENGROSSED HOUSE
BILL NO. 4279

By: Sneed and Phillips of the House

and

Quinn of the Senate

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.

AMENDMENT NO. 1. Page 1, strike the title, enacting clause and entire bill and insert

"An Act relating to insurance; amending 36 O.S. 2021, Sections 6413, 6414, 6415, 6417, and 6418, which relate to the Market Assistance Association Act; modifying the definition of insurer; modifying the definition of member; modifying policies of insurance required by members to issue; clarifying that act applies to homeowners' liability insurance; modifying notification requirements of member insurers; modifying procedure for amendments to the plan of operation; modifying Market Assistance Association Board of Directors membership; modifying the term of members; specifying that the remaining Board of Directors shall fill vacancies; directing that the Board of Directors shall consider whether all Association member insurers are fairly represented; clarifying that the Association shall submit instead of file a statement; clarifying that liability insurance means homeowners' liability insurance; updating statutory language; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2021, Section 6413, is amended to read as follows:

Section 6413. As used in the Market Assistance Association Act:

1. "Association" means the Market Assistance Association established pursuant to ~~this act~~ the Market Assistance Association Act;

2. "Board" means the Board of Directors of the Market Assistance Association;

3. "Commissioner" means the Insurance Commissioner;

4. "Insurer" means any entity licensed to issue homeowners' or homeowners' liability insurance; and

5. "Member" means all property and casualty insurers licensed in ~~the State of Oklahoma or~~ this state and writing homeowners' or homeowners' liability insurance in the state. These entities are required to be a participant in the Association as a condition of doing business in Oklahoma.

SECTION 2. AMENDATORY 36 O.S. 2021, Section 6414, is amended to read as follows:

Section 6414. A. The Association created pursuant to the Market Assistance Association Act shall have the power on behalf of its members to:

1. Require members to issue policies of insurance~~, including primary, excess, and incidental coverages,~~ to applicants, subject to limitations specified in the plan of operation required by the Market Assistance Association Act; ~~irregardless~~ regardless of the type of insurance coverage, the limits of liability for homeowners' liability insurance, shall be governed by the amounts specified in subsection A of Section 154 of Title 51 of the Oklahoma Statutes; and

2. Call upon member insurers who have expertise or familiarity with a particular line of homeowners' liability insurance to assist in underwriting such insurance.

B. The Board after consultation with the Association, the Insurance Commissioner and other affected entities, shall promulgate a plan of operation consistent with the provisions of this section, to become effective no later than ninety (90) days after the date of the inception of the Association.

1. The plan of operation shall provide for economic, fair and nondiscriminatory administration and for prompt and efficient provision of insurance, and shall contain other provisions including, but not limited to, the following:

a. preliminary assessment of all members for initial expenses necessary to commence operations of the Association,

b. establishment of necessary facilities,

c. management of the Association,

d. assessment of members, and assessment of policyholders if a market assistance association for professionals is declared, to defray losses and expenses,

e. establishment of committees as may be necessary to facilitate the administration of the Association,

f. procedures providing that an insured shall have proof that he or she has coverage that has been canceled or nonrenewed by his or her current carrier and has subsequently requested and been refused homeowners' or homeowners' liability coverage from two insurers licensed to do business in this state, or that his or her premium has been increased by seventy-five percent (75%) or more from the previous year, before requesting insurance coverage from the Association,

g. appointment of members of the Association on a rotating basis to provide homeowners' and homeowners' liability insurance coverage based upon direct premiums for homeowners' and homeowners' liability insurance, written in the state in the preceding calendar year,

h. procedures for determining amounts of insurance to be provided by members of the Association, and

i. procedures for two or more member insurers to share an insured risk if coverage for that risk is beyond the ability for one insurer~~,~~

~~j. procedures requiring member insurers to notify their insureds not less than forty-five (45) days prior to the renewal date for a policy, if the premium to be assessed will be increased to a rate greater than the rate assessed for the previous year. If such notification is not timely, then the premium shall be the same as the premium which was assessed for the coverage in the previous year~~.

2. The plan of operation shall provide that any balance remaining in the funds of the Association at the close of its fiscal year shall be added to the reserves of the Association and may be used for expenses of the Association or any successor association.

3. Amendments to the plan of operation may be made by the ~~board, subject to the approval of the Commissioner~~ Board.

C. All insurers who are members of the Association shall participate in the Association's writings, expenses, and losses in the proportion that the net direct premiums of each such member written during the preceding calendar year bears to the aggregate net direct premiums written in this state by all members of the Association. Each insurer's proportion of participation in the Association shall be determined annually on the basis of such net

direct premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the insurer that may be required by the ~~board of directors~~ Board of Directors. No member shall be obligated in any one (1) year to write liability insurance business from the Association ~~which~~ that would result in the member insurer writing more than ten percent (10%) of its total annual liability insurance, from all lines of liability insurance, from the Association. Likewise, no member shall be obligated in any one (1) year to write homeowners' insurance business from the Association ~~which~~ that would result in the member insurer writing more than ten percent (10%) of its total annual homeowners' insurance, from the Association.

D. An applicable insurer ceasing to be licensed or authorized to transact insurance business pursuant to the Insurance Code shall automatically cease to be a member of the Association effective at 12:01 a.m. on the day following the termination or expiration of its certificate of authority and shall no longer be subject to the plan of operation or requirements of the Association; provided, however, such insurer shall remain liable for any annual assessments of the Association based on expenses incurred by the Association while such license or authority was in effect.

SECTION 3. AMENDATORY 36 O.S. 2021, Section 6415, is amended to read as follows:

Section 6415. A. The business and functions of the Association shall be managed and administered by a ~~board~~ Board of ~~eleven (11) directors composed of two directors selected by the American Insurance Association, who are representatives of Association members; two directors selected by the Alliance of American Insurers, who are representatives of Association members; two directors selected by the National Association of Independent Insurers, who are representatives of Association members; two directors appointed by the Commissioner, who are representatives of Oklahoma domestic insurers who are Association members; one director who shall be the President of the Oklahoma Surplus Lines Association; and two directors appointed by the Commissioner, who are representatives of nonaffiliated foreign or alien insurers who are Association members~~ eight (8) directors composed of four directors representing Association members, two directors who are representatives of Oklahoma domestic insurers who are Association members, one director who represents a surplus lines carrier who is an Association member, and the Insurance Commissioner or an Insurance Department staff member chosen as a designee by the Insurance Commissioner. Each director shall designate a full-time salaried employee of the insurer to represent the director as an alternate in the absence of the director on the Board. ~~Each director shall serve for a term of two (2) years or until the Association is terminated, whichever comes first. The appointment~~

~~to the board of directors shall be subject to approval by the Commissioner.~~ The term of office of each director shall continue until the appointment and qualification of a successor. Any vacancy on the Board shall be filled for the remaining period of the term by ~~appointment by the appointing authority which originally filled the vacant post, subject to the approval of the Commissioner~~ the remaining Board directors. ~~If no directors are selected and appointed within sixty (60) days after the effective date of the inception of the Association, the Commissioner shall appoint the initial directors of the Board.~~

B. The chairman shall call all meetings of the Board and shall give reasonable notice of meetings to all directors. At any meeting of the Board, each Board director or his predesignated alternate shall have one vote. Six members of the Board or their predesignated alternates shall constitute a quorum for the transaction of business and the acts of a majority of the Board members present at a meeting at which a quorum is present shall be the acts of the Board. The Board shall meet as often as may be required to perform the general duties of administration of the Association, but not less frequently than annually.

C. In approving selections to the Board, the ~~Commissioner~~ Board of Directors shall consider, among other things, whether all Association member insurers are fairly represented.

D. Members of the Board and their predesignated alternates shall serve without compensation but may be reimbursed from the assets of the Association for all actual and necessary expenses incurred by them in performance of their duties for the Board.

SECTION 4. AMENDATORY 36 O.S. 2021, Section 6417, is amended to read as follows:

Section 6417. A. The Association shall ~~file with~~ submit to the Insurance Commissioner, annually, from the date of its inception, a statement prepared by an independent certified public accountant which shall contain information with respect to its transactions, condition, operations, and affairs during the preceding calendar year. The statement shall contain such matters and information as are prescribed and shall be in such form as is approved by the Commissioner. The Commissioner may, at any time, require the ~~association~~ Association to furnish additional information with respect to its transactions, condition, operations, and affairs, or any matter connected therewith considered to be material and of assistance in evaluating the scope, operation and experience of the Association.

B. The books of account, records, reports and other documents of the Association shall be open and free for examination to the Commissioner at all reasonable times.

C. The books of account, records, reports and other documents of the Association shall be open to inspection by the members at

such times and under such conditions and regulations as the Board shall determine.

D. The Association shall provide for the making of detailed reports of liability approved or canceled, for the drawing up of annual budgets of the Association and for the rendering of accounts to each ~~member~~ Board member at least every twelve (12) months.

SECTION 5. AMENDATORY 36 O.S. 2021, Section 6418, is amended to read as follows:

Section 6418. Each member insurer shall use the filed rate for the homeowners' liability and homeowners' insurance being written. Any variance from such rate~~,~~ including a variance based upon debit, shall be submitted or filed with the Insurance Commissioner.

SECTION 6. This act shall become effective November 1, 2022."

Passed the Senate the 27th day of April, 2022.

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Presiding Officer of the Senate

Passed the House of Representatives the ____ day of _____, 2022.

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Presiding Officer of the House of Representatives

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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 7. 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. Any policy that specifies a time limit covering damage to a roof due to wind or hail must include a provision allowing 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 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 more than twelve (12) months or health care provider more than ~~twenty-four (24)~~ 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. 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, 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 has been satisfied.

SECTION 8. This act shall become effective November 1, 2022.

Passed the House of Representatives the 23rd day of March, 2022.

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Presiding Officer of the House
of Representatives

Passed the Senate the ___ day of _____, 2022.

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Presiding Officer of the Senate