

1 **SENATE FLOOR VERSION**

2 February 27, 2025

3 SENATE BILL NO. 1050

By: Seifried

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7 An Act relating to the Unfair Claims Settlement
8 Practices Act; amending 36 O.S. 2021, Section 1250.5,
9 as last amended by Section 1, Chapter 214, O.S.L.
10 2023 (36 O.S. Supp. 2024, Section 1250.5), which
11 relates to acts by an insurer constituting unfair
12 claim settlement practice; decreasing allowable time
13 to file certain claim; and providing an effective
14 date.

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

16 SECTION 1. AMENDATORY 36 O.S. 2021, Section 1250.5, as
17 last amended by Section 1, Chapter 214, O.S.L. 2023 (36 O.S. Supp.
18 2024, Section 1250.5), is amended to read as follows:

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

24 1. Failing to fully disclose to first-party claimants,
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. Any policy
21 that specifies a time limit covering damage to a roof due to wind or
22 hail must allow the filing of claims after the first anniversary but
23 no later than twenty-four (24) months after the date of the loss, if
24 the damage is not evident without inspection;

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, hospital,
9 or person or entity licensed or otherwise authorized to provide
10 health care services were not medically necessary unless the health
11 insurer or administrator, as defined in Section 1442 of this title,
12 first obtains an opinion from any provider of health care licensed
13 by law and preceded by a medical examination or claim review, to the
14 effect that the services, procedures or supplies for which payment
15 is being denied were not medically necessary. In the event that
16 claims for mental health or substance use disorder treatments and
17 services are under review, the reviewing health care provider shall
18 have appropriate, qualified, and specialized credentials with
19 respect to the services and treatments. Upon written request of a
20 claimant, treating physician, hospital, or authorized person or
21 entity, the opinion shall be set forth in a written report, prepared
22 and signed by the reviewing physician. The report shall detail
23 which specific services, procedures, or supplies were not medically
24 necessary, in the opinion of the reviewing physician, and an

1 explanation of that conclusion. A copy of each report of a
2 reviewing physician shall be mailed by the health insurer, or
3 administrator, postage prepaid, to the claimant, treating physician,
4 hospital, or authorized person or entity requesting same within
5 fifteen (15) days after receipt of the written request. As used in
6 this paragraph, "physician" means a person holding a valid license
7 to practice medicine and surgery, osteopathic medicine, podiatric
8 medicine, dentistry, chiropractic, or optometry, pursuant to the
9 state licensing provisions of Title 59 of the Oklahoma Statutes;

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

13 12. Violating the provisions of the Health Care Fraud
14 Prevention Act;

15 13. Compelling, without just cause, policyholders to institute
16 suits to recover amounts due under its insurance policies or
17 insurance contracts by offering substantially less than the amounts
18 ultimately recovered in suits brought by them, when the
19 policyholders have made claims for amounts reasonably similar to the
20 amounts ultimately recovered;

21 14. Failing to maintain a complete record of all complaints
22 which it has received during the preceding three (3) years or since
23 the date of its last financial examination conducted or accepted by
24 the Commissioner, whichever time is longer. This record shall

1 indicate the total number of complaints, their classification by
2 line of insurance, the nature of each complaint, the disposition of
3 each complaint, and the time it took to process each complaint. For
4 the purposes of this paragraph, "complaint" means any written
5 communication primarily expressing a grievance;

6 15. Requesting a refund of all or a portion of a payment of a
7 claim made to a claimant more than ~~twelve (12)~~ two (2) months or a
8 health care provider more than ~~eighteen (18)~~ four (4) months after
9 the payment is made. This paragraph shall not apply:

- 10 a. if the payment was made because of fraud committed by
11 the claimant or health care provider, or
- 12 b. if the claimant or health care provider has otherwise
13 agreed to make a refund to the insurer for overpayment
14 of a claim;

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

- 20 a. the claim or payment was made because of fraud
21 committed by the claimant or health care provider,
- 22 b. the subscriber had a preexisting exclusion under the
23 policy related to the service provided, or

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1 c. the subscriber or employer failed to pay the
2 applicable premium and all grace periods and
3 extensions of coverage have expired;

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

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

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

1 this paragraph shall apply regardless of whether the minimum
2 deductible has been satisfied.

3 SECTION 2. This act shall become effective November 1, 2025.

4 COMMITTEE REPORT BY: COMMITTEE ON BUSINESS AND INSURANCE
5 February 27, 2025 - DO PASS

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