From the Desk of
Senator Dick Anderson

Oppose SB 174 – Unfair Claims Settlement Practices Act
Inherently Inconsistent with a Private Cause of Action

SB 174 takes the statutory provisions from the Unfair Claims Settlement Practices Act which is a broad regulatory statute meant to provide the Insurance Commissioner with the ability to investigate and remedy issues related to insurance claims and subject those provisions to a private right of action in two separate statutory schemes. The Unfair Claims Settlement Practices Act is a model established by the National Association of Insurance Commissioners that was clearly not meant to be used to sue insurers for claims handling.

Below are comments included in the NAIC model act that clearly state the act is ***inherently inconsistent with a private right of action and should be separate and distinct from the Unfair Trade Practices Act.***

Prefatory Note: By adopting this model act in June 1990, the NAIC separated issues regarding unfair claims settlement practices into a free-standing act apart from the NAIC Model Unfair Trade Practices Act. This change focuses more attention on unfair claims as a function of market conduct surveillance separate and apart from general unfair trade practices. By doing so, the NAIC is not recommending that states repeal their existing acts, but states may modify them for the purpose of capturing the substantive changes. However, for those states wishing to completely rewrite their comprehensive approach to unfair claims practices, this separation of unfair claims from unfair trade practices is recommended.
Drafting Note: A jurisdiction choosing to provide for a private cause of action should consider a different statutory scheme. This Act is inherently inconsistent with a private cause of action. This is merely a clarification of original intent and not indicative of any change of position. The NAIC has promulgated the Unfair Property/Casualty Claims Settlement Practices and the Unfair Life, Accident and Health Claims Settlement Practices Model Regulations pursuant to this Act.

Ask yourself – Do you think the following list of regulatory and administrative issues related to claims handling should be the subject of not only lawsuits but class action lawsuits?

746.230 Unfair claim settlement practices. (1) An insurer or other person may not commit or perform any of the following unfair claim settlement practices:

(a) Misrepresenting facts or policy provisions in settling claims;
(b) Failing to acknowledge and act promptly upon communications relating to claims;
(c) Failing to adopt and implement reasonable standards for the prompt investigation of claims;
d) Refusing to pay claims without conducting a reasonable investigation based on all available information;
(e) Failing to affirm or deny coverage of claims within a reasonable time after completed proof of loss statements have been submitted;
(f) Not attempting, in good faith, to promptly and equitably settle claims in which liability has become reasonably clear;
(g) Compelling claimants to initiate litigation to recover amounts due by offering substantially less than amounts ultimately recovered in actions brought by such claimants;
(h) Attempting to settle claims for less than the amount to which a reasonable person would believe a reasonable person was entitled after referring to written or printed advertising material accompanying or made part of an application;
(i) Attempting to settle claims on the basis of an application altered without notice to or consent of the applicant;
(j) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made;
(k) Delaying investigation or payment of claims by requiring a claimant or the claimant's physician, naturopathic physician, physician assistant or nurse practitioner to submit a preliminary claim report and then requiring subsequent submission of loss forms when both require essentially the same information;
(L) Failing to promptly settle claims under one coverage of a policy where liability has become reasonably clear in order to influence settlements under other coverages of the policy;

(m) Failing to promptly provide the proper explanation of the basis relied on in the insurance policy in relation to the facts or applicable law for the denial of a claim; or
(n) Any of the practices described in ORS 746.233.

(2) No insurer shall refuse, without just cause, to pay or settle claims arising under coverages provided by its policies with such frequency as to indicate a general business practice in this state, which general business practice is evidenced by:
(a) A substantial increase in the number of complaints against the insurer received by the Department of Consumer and Business Services;
(b) A substantial increase in the number of lawsuits filed against the insurer or its insureds by claimants; or
(c) Other relevant evidence. [1967 c.359 §588a; 1973 c.281 §1; 1989 c.594 §1; 2014 c.45 §79; 2015 c.59 §6; 2017 c.356 §101; 2019 c.284 §10]

746.233 Unfair claim settlement practices with respect to prior authorizations of health care items or services. (1) As used in this section, "prior authorization" has the meaning given that term in ORS 743B.001.

(2) An insurer offering a policy or certificate of health insurance may not, in making a determination on a health care provider or enrollee's request for prior authorization of a health care item or service, perform any of the following unfair claim settlement practices:
(a) Misrepresent facts of policy provisions;
(b) Fail to acknowledge and act upon communications relating to the request;
(c) Fail to adopt and implement reasonable standards for the prompt investigations of prior authorization requests;
(d) Make a determination without conducting a reasonable investigation based on all available information;
(e) Fail to act promptly, equitably and in good faith to approve the request for prior authorization that is medically necessary and covered under the terms of the policy;
(f) Require a provider or enrollee to submit substantially identical information more than one time in the course of making the determination; or
(g) If the request for prior authorization is denied, fail to promptly provide a complete and thorough explanation of the terms of the policy or certificate that the insurer relied upon and the factual or legal basis for the denial.

(3) An insurer may not engage in a pattern or practice of refusing, without just cause, to approve requests for prior authorization of items or services covered under its policies and certificates as demonstrated by:
(a) A substantial increase in the number of consumer complaints against the insurer received by the Department of Consumer and Business Services regarding denials of prior authorization;
(b) A substantial number of lawsuits filed by:
(A) A provider against the insurer or an insured based on the failure to approve a request for prior authorization for an item or service furnished by the provider; or
(B) A provider or enrollee against the insurer based on the failure to approve a prior authorization request for an item or service; or
(c) Other evidence that the department deems relevant.

(4) The department may adopt rules necessary to carry out the provisions of this section. [2019 c.284 §2]