

746.230¹

Unfair claim settlement practices

(1) No insurer or other person shall 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 claimants 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; **or**

(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.

(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.

(3)(a) No health maintenance organization, as defined in ORS [750.005 \(Definitions\)](#), shall unreasonably withhold the granting of participating provider status from a class of statutorily authorized health care providers for services rendered within the lawful scope of practice if the health care providers are licensed as such and reimbursement is for services mandated by statute.

(b) Any health maintenance organization that fails to comply with paragraph (a) of this subsection shall be subject to discipline under ORS [746.015 \(Discrimination\)](#).

(c) This subsection does not apply to group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Health Maintenance

Organization Act. [1967 c.359 §588a; 1973 c.281 §1; 1989 c.594 §1; 2014 c.45 §79]

Note: The amendments to [746.230 \(Unfair claim settlement practices\)](#) by section 6, chapter 59, Oregon Laws 2015, become operative January 1, 2017, and apply to health benefit plans in effect on or after January 1, 2017. See section 11, chapter 59, Oregon Laws 2015. The text that is operative on and after January 1, 2017, is set forth for the users convenience.

[746.230 \(Unfair claim settlement practices\)](#). (1) No insurer or other person shall 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 claimants 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; **or**
- (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.

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(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.