

ENROLLED HOUSE
BILL NO. 2634

By: Cox of the House

and

Henry of the Senate

An Act relating to insurance; amending 36 O.S. 1991, Section 321, as last amended by Section 37, Chapter 270, O.S.L. 1993 (36 O.S. Supp. 1993, Section 321), which relates to fees and licenses; providing for review of quarterly financial statements; amending 36 O.S. 1991, Sections 901.2, 902.2, as amended by Section 23, Chapter 349, O.S.L. 1993, 903 and 924.2, as amended by Section 24, Chapter 349, O.S.L. 1993 (36 O.S. Supp. 1993, Sections 902.2 and 924.2), which relate to insurance rating; defining terms; limiting application of certain factor considered in review of filings, providing for filing and approval of loss cost; amending 36 O.S. 1991, Section 1452, which relates to reports filed by third-party administrators; requiring that reports be subscribed and sworn to by certain individuals; providing penalty for failure to properly execute and file reports; amending 36 O.S. 1991, Section 3611.1, as last amended by Section 1, Chapter 59, O.S.L. 1993 (36 O.S. Supp. 1993, Section 3611.1), which relates to insurance contracts; requiring Commissioner to issue certain regulations; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 1991, Section 321, as last amended by Section 37, Chapter 270, O.S.L. 1993 (36 O.S. Supp. 1993, Section 321), is amended to read as follows:

Section 321. A. The Insurance Commissioner shall collect in advance the following fees and licenses:

1. For filing charter documents:

Original charter documents, articles of incorporation, bylaws, or record of organization of alien or foreign insurers, or certified copies thereof \$50.00

2. Certificate of Authority:

(a) Issuance:

Fraternal benefit societies, alien or foreign \$150.00

Hospital service and medical indemnity corporations, alien or foreign \$150.00

All other alien or foreign insurers\$150.00

(b) Renewal:

Fraternal benefit societies, alien or foreign \$150.00

Hospital service and medical indemnity corporations, alien or foreign \$150.00

All other alien or foreign insurers\$150.00

3. For filing appointment of Insurance Commissioner as agent for service of process \$10.00
4. Miscellaneous:
 - (a) Copies of records, per page\$0.40
 - (b) Amended charter documents, articles of incorporation or bylaws of domestic, alien or foreign insurers. \$50.00
 - (c) Certificate of Commissioner, under seal \$5.00
 - (d) For filing Merger and Acquisition Forms\$500.00
 - (e) For filing Variable Product Forms.....\$200.00
 - (f) For filing a Life, Accident and Health Policy\$50.00
 - (g) For filing an advertisement or rider application to a Life, Accident and Health Policy \$25.00
 - (h) Pending Company Review \$1,000.00
 - (i) Pending Company Admission Packet.....\$50.00

B. All fees and licenses not above dedicated, nor dedicated by Section 628 of this title, collected by the Insurance Commissioner as provided by this Code, shall be paid into the State Treasury weekly. The State Treasury is authorized and directed to deduct from said amount so paid a sum equal to one-tenth (1/10) of such payment and place the same to the credit of the General Revenue Fund of the state. The remainder of said amount so paid is hereby allocated and appropriated to the State Insurance Commissioner Revolving Fund and shall by the State Treasurer be placed to the credit of the State Insurance Commissioner Revolving Fund.

C. There shall be assessed an annual fee of Two Hundred Fifty Dollars (\$250.00) payable by each insurer, fraternal benefit society, hospital service and medical indemnity corporation, charitable and benevolent corporation, or United States surplus lines insurance companies licensed to do business in this state, to pay for the filing, processing, and reviewing of annual and quarterly financial statements by personnel of the Office of the State Insurance Commissioner.

SECTION 2. AMENDATORY 36 O.S. 1991, Section 901.2, is amended to read as follows:

Section 901.2 As used in this act unless the context otherwise requires:

1. "Act" means the Oklahoma Insurance Rating Act;
2. "Board" means the State Board for Property and Casualty Rates created pursuant to Section 331 et seq. of Title 36 of the Oklahoma Statutes;
3. "Commissioner" means the Insurance Commissioner of the State of Oklahoma or his designee;
4. "Department" means the Insurance Department of the State of Oklahoma; ~~and~~
5. "Rate" means the cost of insurance per exposure unit, whether expressed as a single number or as a prospective loss cost and an adjustment to account for the treatment of expenses, profit and variations in loss experience, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premiums:
 - a. "prospective loss cost", as used in this paragraph, means that portion of a rate that does not include provisions for expenses, other than loss adjustment expenses, or profit, and are based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time, and
 - b. "expenses", as used in this paragraph, means that portion of a rate attributable to acquisition, field

supervision, collection expenses, general expenses, taxes, licenses, and fees; and

6. "Rating organization" means any two or more insurers acting in cooperation or in concert for the purpose of making rates, rating plans or rating systems.

SECTION 3. AMENDATORY 36 O.S. 1991, Section 902.2, as amended by Section 23, Chapter 349, O.S.L. 1993 (36 O.S. Supp. 1993, Section 902.2), is amended to read as follows:

Section 902.2 A. The Board when reviewing a filing shall give due consideration to the following when, in its discretion, it determines that such factor or factors are applicable:

1. Past loss experience within and outside this state;
2. Prospective loss experience within and outside this state;
3. Physical hazards insured;
4. Safety and loss prevention programs;
5. Underwriting practices and judgment;
6. Catastrophe hazards;
7. Reasonable underwriting profit and contingencies;
8. Dividends, savings or unabsorbed premium deposits allowed or returned to policyholders;
9. Past expenses within and outside this state;
10. Prospective expenses within and outside this state;
11. Existence of classification rates for a given risk;
12. Investment income within and outside this state;
13. Rarity or peculiarity of the risks within and outside this state;
14. Differences In the case of workers' compensation rates, differences in the hazard levels of different geographical regions of the state based on Court of Criminal Appeals judicial districts;
15. All other relevant factors within and outside this state;
16. In the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business in this state for not less than the previous five (5) years; and
17. Whether existing rates continue to meet the standards of this article.

B. The Board shall determine the weight to be accorded each of the factors contained in subsection A of this section.

C. Past or prospective expenses within or outside this state pursuant to paragraphs 9 and 10 of subsection A of this section shall not include prohibited expenses for advertising or prohibited expenses for membership in organizations.

1. For the purpose of this subsection:

- a. "prohibited expenses for advertising" means the cost of advertising in any media the purpose of which is to influence legislation or to advocate support for or opposition to a candidate for public office;
- b. "prohibited expenses for advertising" shall not mean:
 - (1) any communication to customers and the public of information regarding an insurer's insurance products,
 - (2) any communication to customers and the public of safety, safety education or loss prevention information,
 - (3) periodic publications or reports to stockholders or members required by the certificate or bylaws of the insurer,
 - (4) any communication with customers and the public which provides instruction in the use of the insurer's products and services, or

- (5) any communication with customers and the public for giving notice or information required by law or otherwise necessary;
- c. "prohibited expenses for membership" means the cost of membership in any organization which conducts substantial efforts, including but not limited to prohibited expenses for advertising, the purpose of which is to influence legislation or to advocate support for or opposition to a candidate for public office; and
- d. "prohibited expenses for membership" shall not mean the cost of membership in rating organizations or other organizations the primary purpose of which is to provide statistical information on losses.

2. The Board shall promulgate rules and regulations for the implementation of this subsection.

SECTION 4. AMENDATORY 36 O.S. 1991, Section 903, is amended to read as follows:

Section 903. A. 1. Except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, every insurer governed by the provisions of this act shall file with the Board, either directly or through a licensed rating organization of which it is a member or subscriber, all rates and rating plans and classifications, class rates, rating schedules, loss cost and all other supplementary rate information and every modification of any of the foregoing, which it uses or proposes to use in this state except as otherwise provided in this section.

2. The Board shall send a notification of filing of rates to any person who annually requests, in writing, to be notified of filings pursuant to regulation of the Board.

3. The Attorney General shall be notified within ten (10) days, in writing, of each:

- a. filing of rates, whether for prior approval or for immediate use, and
- b. certification of completion of a filing.

4. The Attorney General shall be notified at least ten (10) days in advance, in writing, of each:

- a. meeting of the Board, and
- b. hearing conducted by the Board.

B. Rates, rating plans, classifications, schedules, loss cost and other information shall be deemed approved thirty (30) calendar days following certification of completion of the filing as provided in this act unless, within the thirty (30) calendar-day period:

1. The Board by majority vote, approves, disapproves or approves with modification, the filing at one of its scheduled meetings or hearings;

2. The Board orders a formal hearing on the filing; or

3. The Board or the Commissioner, if a quorum of the Board is not available at the next regularly scheduled meeting, extends this period for one additional thirty (30) calendar-day period.

C. Nothing in this act shall be construed to require any filing for approval of rates, rating plans, classifications, schedules, loss cost and other information approved by the Board prior to the effective date of this act.

D. Any formal hearing ordered by the Board shall be completed and a written order on the filing issued by the Board within ninety (90) calendar days from the date of the order setting the formal hearing, or the filing shall be deemed approved at the expiration of the ninety-day period.

E. 1. Rate filings on homeowner's insurance shall become effective when filed, or upon a future date specified in such filing, and shall remain effective unless the Board reviews and disapproves the filing because such rate is not in compliance with the standards set out in this act. Provided, if a rate filing is disapproved because it is excessive or unfairly discriminatory, the Board may order return of premium to the policyholders; plus interest thereon at an annual rate equal to the average United States Treasury Bill rate of the preceding calendar year as certified by the State Treasurer on the first regular business day in January of each year, plus four percentage points.

2. For purposes of this subsection, homeowner's insurance shall mean:

- a. insurance which combines, on an individual basis, property and liability insurance required to protect an individual's investment in his home or contents thereof, commonly called homeowner's or renter's insurance and specifically including insurance on a farm dwelling and attached or detached garage and their contents,
- b. dwelling fire insurance, or
- c. individual fire insurance on dwelling contents.

3. Any such rate shall remain in effect as provided in subsection F of this section.

F. Filed rates, whether made by an insurer or by a rating organization, and whether or not prior approval is required under the flex rating, file and use or automatic rate reduction system, shall be effective for a period of not more than four (4) years from the effective date of the insurer's or rating organization's rate filing unless otherwise changed by the Board, or unless superceded by a subsequent filing approved pursuant to the procedures set out herein. At the end of the four-year period, the rates expire, and for an insurer to continue to write the insurance coverage to which the expired rates applied, a new rate filing is required. All rates in effect on or before September 1, 1991, shall expire September 1, 1995.

G. Rates or risks which are not by general custom of the business, or because of rarity or peculiar characteristics, written according to normal classification or rating procedure and which cannot be practicably filed before they are used, may be used before being filed. The Board may make such examination as it may deem advisable to ascertain whether any such rates meet the requirements of this act.

H. Whenever it shall be made to appear to the Board, either from its own information or from complaint of any party alleging to be aggrieved thereby, that there are reasonable grounds to believe that the rates on any or on all risks or classes of risks or kinds of insurance within the scope of this article are not in accordance with the terms of this act, it shall be the duty of the Board to investigate and determine whether or not any or all of such rates meet the requirements of this act.

I. When investigating rates to determine whether or not they comply with the provisions of this act, the previously approved filing shall not be changed, altered, amended, or held in abeyance until after completion of the investigation and an opportunity for hearing in accordance with the provisions of this article. Following such hearing, the Board shall enter its order in accordance with the provisions of this act. The effective date of such order shall not be less than thirty (30) days nor more than sixty (60) days after the date of the order unless the Board

determines that, in the public interest, a shorter or longer period is appropriate; provided, the filer has adequate time to implement such rate change. Any such order shall apply prospectively only and shall not affect premiums collected on new or renewal policies issued prior to the effective date of this order.

J. Under such rules and regulations as it shall adopt, the Board may, by written order, suspend or modify the requirements of filing as to any kind of insurance, subdivision or combination thereof, or as to classes of risks, the rates for which cannot practicably be filed before they are used. Such orders, rules and regulations shall be made known to insurers and rating organizations affected thereby. The Board may make such examination as it may deem advisable to ascertain whether any rates affected by such order meet the standards set forth in this act. This subsection shall not apply to workers' compensation filings.

K. Any filing with respect to fidelity, surety or guaranty bonds shall, however, be deemed approved from the date of filing and shall thereafter be subject to the provisions of subsection F of this section.

L. If the Board finds that a filing does not meet the requirements of this act, it shall send to the insurer or rating organization which made such filing, written notice of disapproval of such filing, specifying therein in what respects it finds that such filing fails to meet the requirements of this act and stating that such filing shall not become effective to the extent disapproved.

M. If within thirty (30) days after a rate has become effective for homeowner's insurance the Board finds that such filing does not meet the requirements of this act, it shall send to the rating organization or insurer which made such filing, a written notice of disapproval of such filing, specifying therein in what respect it finds that such filing fails to meet the requirements of this act and stating when, within a reasonable period thereafter, such filing shall be deemed no longer effective. Any such notice shall apply prospectively only and shall not affect premiums collected on new or renewal policies issued prior to the effective date of this notice. If a rate filing is disapproved because it is excessive or unfairly discriminatory the Board may order return of premium to the policyholder; plus interest thereon at an annual rate equal to the average United States Treasury Bill rate of the preceding calendar year as certified by the State Treasurer on the first regular business day in January of each year, plus four percentage points.

SECTION 5. AMENDATORY 36 O.S. 1991, Section 924.2, as amended by Section 24, Chapter 349, O.S.L. 1993 (36 O.S. Supp. 1993, Section 924.2), is amended to read as follows:

Section 924.2 A. Any rate, schedule of rates or rating plan for workers' compensation insurance submitted to or filed with the State Board for Property and Casualty Rates, or fixed by the Board of Managers of the State Insurance Fund, and premiums, by whatever name, for workers' compensation for self-insureds except for group self-insured associations shall provide for an appropriate reduction in premium charges, by whatever name, for those eligible insured employers who have successfully participated in the occupational safety and health consultation, education and training program administered by the Commissioner of the Department of Labor pursuant to Section 414 of Title 40 of the Oklahoma Statutes.

B. All insurance companies writing workers' compensation insurance in this state, including the State Insurance Fund, and all self-insureds providing workers' compensation insurance except for group self-insured associations, shall allow an appropriate

reduction in premium charges to all eligible employers who qualify for the reduction pursuant to the provisions of this section.

C. Eligible employers shall be those employers:

1. Who are insured by an insurance company writing workers' compensation insurance in this state;

2. Who are self-insured; or

3. Who are insured by the State Insurance Fund.

D. In order to qualify for the reduction in workers' compensation insurance premium, an employer shall successfully participate annually in the occupational safety and health consultation, education and training program administered by the Department of Labor. Successful participation shall be defined as:

1. Undergoing a safety and health hazard survey of the workplace, including an evaluation of the employer's safety and health program and onsite interviews with employees by the Department's consultant;

2. Correcting all hazards identified during the onsite visit within a reasonable period of time as established by the Department;

3. Establishing an effective workplace safety and health program and implementing program provisions within a reasonable period of time as established by the Department. The program shall include:

a. demonstration of management commitment to worker safety and health,

b. procedures for identifying and controlling workplace hazards,

c. development and communication of safety plans, rules and work procedures, and

d. training for supervisors and employees in safe and healthful work practices;

4. Reducing by one-third (1/3) or more the extent to which the lost workday case rate, as measured by the Department of Labor, was above the national average for the industry at the time the employer elected to participate in the occupational safety and health consultation, education and training program, or maintaining a rate at or below the national average for the industry; and

5. Documenting a reduction in workers' compensation claims for the preceding year by showing one of the following:

a. a ten percent (10%) reduction in the dollar amount of claims,

b. a ten percent (10%) reduction in the severity of claims, or

c. no reported claims,

as a result of attending the occupational safety and health consultation, education and training program administered by the Department of Labor.

E. 1. Upon successful participation in the occupational safety and health consultation, education and training program as defined in subsection D of this section, an employer shall be issued a certificate by the Commissioner of the Department of Labor which shall be the basis of qualification for the reduction in workers' compensation insurance premium, by whatever name. The certificate shall qualify the employer for a premium reduction for a one-year period.

2. Upon issuance of a certificate to an employer, the Commissioner of the Department of Labor shall mail a copy of the certificate to the employer's insurer. Any insurer required by this section to allow an appropriate reduction in premium charges to a qualified employer which willfully fails to allow such reduction after receiving a copy of the certificate shall be subject, after

notice and hearing, to an administrative fine, imposed by the Insurance Commissioner, which shall be not less than Ten Thousand Dollars (\$10,000.00) or three times the amount of the premium reduction, whichever is greater. The Insurance Commissioner shall promulgate rules necessary to carry out the provisions of this paragraph.

F. The Insurance Commissioner, the Administrator of the Workers' Compensation Court and the State Insurance Fund Commissioner shall maintain records documenting reductions in workers' compensation insurance premiums granted pursuant to this section and shall make an annual report of such reductions to the President Pro Tempore of the Senate and the Speaker of the House of Representatives by ~~January~~ May 1 of each year. Insurers shall report such premium reductions in their annual statement.

G. The State Insurance Fund shall instruct its actuary to continually review the insurance premium credit program, developed and implemented pursuant to Section 142a of Title 85 of the Oklahoma Statutes, to determine if the program is detrimental to the financial stability of the Fund. If the actuary determines that the program contributes detrimentally to the financial stability of the Fund, the actuary shall immediately recommend to the State Insurance Fund Commissioner that the safety premium reduction cease for a one-year period.

SECTION 6. AMENDATORY 36 O.S. 1991, Section 1452, is amended to read as follows:

Section 1452. On or before June 1 of each year, all licensed administrators shall file an annual report prepared by a certified public accountant and which shall be subscribed and sworn to by the president and attested to by the secretary or other proper officers substantiating that the information contained in the report is true and factual concerning each of the plans they administer which are governed pursuant to the provisions of the Third-party Administrator Act. The report shall include the name and address of each fund and a statement of fund equity, paid claims by the covered unit, the accumulated year-to-date paid claims, and the year-to-date reserve status. Failure of any third-party administrator to execute and file such annual reports as required by this section shall constitute cause, after notice and hearing, for censure, suspension, or revocation of administrator licensure to transact business in this state, or a fine of not less than One Hundred Dollars (\$100.00) or more than One Thousand Dollars (\$1,000.00) for each occurrence, or both censure, suspension, or revocation and fine.

SECTION 7. AMENDATORY 36 O.S. 1991, Section 3611.1, as last amended by Section 1, Chapter 59, O.S.L. 1993 (36 O.S. Supp. 1993, Section 3611.1), is amended to read as follows:

Section 3611.1 A. As used in this section:

1. "Commissioner" means the Commissioner of Insurance;
2. "Medicare supplement policy" means a group or individual policy of accident and health insurance, or a subscriber contract of a nonprofit hospital service and medical indemnity corporation or a health maintenance organization which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. Such term does not include:

- a. a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for

members or former members, or combination thereof, of the labor organizations, or

- b. a policy or contract of any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:
 - (1) is composed of individuals all of whom are actively engaged in the same profession, trade or occupation,
 - (2) has been maintained in good faith for purposes other than obtaining insurance, and
 - (3) has been in existence for at least two (2) years prior to the date of its initial offering of such policy or plan to its members, or
- c. individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance; and

3. "Direct response Medicare supplement policy" means a policy of insurance which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare issued as a result of solicitation of individual insureds by mail or by mass media advertising.

B. The Commissioner shall issue reasonable regulations to establish minimum standards for benefit claims payment, marketing practices, compensation arrangements, and reporting practices for Medicare supplement policies. The Commissioner shall issue reasonable regulations to provide for an open enrollment period for those persons who qualify as disabled pursuant to federal Medicare guidelines.

C. A Medicare supplement policy may not deny a claim for losses incurred more than six (6) months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than "a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage".

D. A Medicare supplement policy shall be expected to return to the policyholder benefits which are reasonable in relation to the premium charged. The Commissioner shall issue regulations to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums for the period of coverage for which rates are computed and in accordance with accepted actuarial principles and practices.

E. 1. No Medicare supplement policy or certificate issued pursuant to a group Medicare supplement policy shall be delivered or issued for delivery in this state unless an outline of coverage is provided to the applicant at the time application is made.

2. The Commissioner shall prescribe by regulation the contents and a standard form of an informational brochure for persons eligible for Medicare which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. The Commissioner may require by regulation that the informational brochure be provided with the outline of coverage to any prospective insureds eligible for Medicare. With respect to direct response policies, the Commissioner may require that the prescribed brochure and outline of

coverage be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

3. The Commissioner may require notice provisions, designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all accident and health insurance policies sold to persons eligible for Medicare by reason of age, other than:

- a. Medicare supplement policies,
- b. disability income policies,
- c. basic, catastrophic, or major medical expense policies,
- d. single premium, nonrenewable policies, or
- e. other policies defined by regulation of the Commissioner.

4. The Commissioner may adopt from time to time, such reasonable regulations as are necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations promulgated thereunder, including but not limited to:

- a. requiring refunds or credits if the policies or certificates do not meet loss ratio requirements,
- b. establishing a uniform methodology for calculating and reporting loss ratios,
- c. assuring public access to policies, premiums and loss ratio information of issuers of Medicare supplement insurance, and
- d. establishing a policy for holding public hearings prior to approval of premium increases.

F. Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate, or attached thereto, stating that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. A direct response policy issued to persons eligible for Medicare shall have a notice prominently printed on the first page, or attached thereto, stating that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination, the applicant is not satisfied for any reason.

G. The Insurance Commissioner shall have the authority to employ actuaries, statisticians, accountants, auditors, investigators, or any other technicians as the Insurance Commissioner may deem necessary or beneficial to examine any Medicare supplement filings made by insurers or rating organizations and to examine such records of the insurers or rating organizations as may be deemed appropriate in conjunction with the Medicare supplement filing in order to determine that the rates or other filings are consistent with the terms, conditions, requirements and purposes of the Insurance Code, and to verify, validate and investigate the information upon which the insurer or rating organization relies to support such filing.

1. The Commissioner shall maintain a list of technicians who are proficient in the line of Medicare supplement insurance. If the Commissioner determines that it is necessary to utilize the services of such a technician, the Commissioner shall employ the next available technician in rotation on the list.

2. All reasonable expenses incurred in such filing review shall be paid by the insurer or rating organization making the filing.

SECTION 8. This act shall become effective September 1, 1994.

Passed the House of Representatives the 27th day of April, 1994.

Speaker of the House of
Representatives

Passed the Senate the 19th day of April, 1994.

President of the Senate