

ENROLLED SENATE  
BILL NO. 108

By: Robinson of the Senate

and

Cox of the House

An Act relating to insurance; amending 36 O.S. 1991, Sections 613, 1241, 1254, as renumbered by Section 20, Chapter 342, O.S.L. 1994, and as last amended by Section 1, Chapter 256, O.S.L. 1999, Section 60, Chapter 418, O.S.L. 1997, as last amended by Section 1, Chapter 333, O.S.L. 1999, Sections 61 and 66, Chapter 418, O.S.L. 1997, 1425.1, as last amended by Section 70, Chapter 418, O.S.L. 1997, and as renumbered by Section 127, Chapter 418, O.S.L. 1997, 1428, as last amended by Section 81, Chapter 418, O.S.L. 1997, 2122, 3639, Section 9, Chapter 248, O.S.L. 1998, 4101, Section 6, Chapter 331, O.S.L. 1999, 6125.1, 6212, as amended by Section 17, Chapter 246, O.S.L. 1996, 6217, as last amended by Section 1, Chapter 164, O.S.L. 1995, Section 2, Chapter 329, O.S.L. 1992, as last amended by Section 2, Chapter 304, O.S.L. 1998, Section 8, Chapter 211, O.S.L. 1994, as amended by Section 5, Chapter 304, O.S.L. 1998 (36 O.S. Supp. 1999, Sections 321, 362, 1250.5, 1424.11, 1424.12, 1424.17, 1426A, 1428, 4049, 6057.1, 6212, 6217, 6512, and 6522), which relate to the Insurance Commissioner and the Insurance Department, deposit requirements, applications for insurance, insurance agents and limited insurance representatives, continuing education, domestic stock and mutual insurers, cancellation of insurance, viatical settlements, the Health Care Freedom of Choice Act, prepaid funeral benefits, health insurance, and health reinsurance; providing for reciprocal taxes, fines, penalties, licenses, fees, deposits, and other obligations and prohibitions; deleting obsolete language; authorizing Insurance Commissioner to require greater deposits upon specified findings; prohibiting establishment of emergency response system; creating the Health Care Fraud Prevention Act and providing short title; defining terms; prohibiting discounted reimbursement and providing exception under specified circumstances; prohibiting transfer of specified information without authorization and notice; making violation of the Health Care Fraud Prevention Act an unfair claim settlement practice; requiring annual review of findings; increasing time to accept or reject applications for property and casualty insurance; authorizing employees who sell or rent

motor vehicles to sell motor vehicle insurance under manager's limited insurance license; authorizing placement of business with insurers prior to approval of appointment; excepting specified insurance agents and limited insurance representatives from continuing education requirement; making certain penalties discretionary rather than mandatory; requiring notice to insureds prior to cancellation of insurance; increasing time for notice of non-renewal of insurance; creating the Standard Nonforfeiture Law for Individual Deferred Annuities and providing short title; excepting reinsurance, specified group annuities, premium deposit funds, variable annuities, investment annuities, immediate annuities, specified deferred annuities, reversionary annuities, and annuity contracts issued outside this state; stating conditions for approval by Insurance Commissioner; stating conditions for termination of certain contracts; stating minimum values for annuity contracts; providing for minimum nonforfeiture amounts; requiring specified minimum present value at commencement of benefits; stating maturity date for specified purposes; requiring specified statement in specified contracts; providing for calculation of specified benefits under certain circumstances; stating minimum nonforfeiture benefits for certain contracts; authorizing election to comply with act; stating operative dates for specified purposes; requiring report by licensed viatical settlement providers and stating requirements; increasing maximum principal for prepaid funeral benefits; creating the Life Settlement Act; providing short title; defining terms; requiring licensing and providing procedure and fee therefor; providing for denial, revocation, suspension or nonrenewal of license; requiring approval of life settlement contracts and related forms by the Insurance Commissioner; providing procedure for approval and disapproval; requiring the filing of annual statements by a certain date; providing for examination of business and affairs of licensee or applicant for license; requiring certain disclosures; providing standards for evaluation or reasonable payments; requiring life settlement provider to obtain certain documents prior to entering into a life settlement contract; requiring a refund provision; requiring payment of proceeds of settlement into an escrow or trust account; providing requirements for escrow or trust account; providing for transfer of proceeds to owner; providing powers of Commissioner; declaring certain acts to be unfair life settlement practices and providing fines therefor; providing for deposit of fines; prohibiting life settlement business after certain date unless in compliance with the Life Settlement Act; stating minimum discounts; prohibiting viatical settlement brokers and providers from seeking or obtaining

compensation from viator without prior written agreement; expanding classes of policies permitted; defining term; modifying definitions; requiring reinsurance for basic and standard health benefit plans; authorizing examination of claim files by Insurance Commissioner; increasing maximum principal allowed for prepaid funeral plans; increasing term of licenses; making certain fees biennial; modifying requirements for continuing education; amending 74 O.S. 1991, Section 1332, as amended by Section 9, Chapter 367, O.S.L. 1992 (74 O.S. Supp. 1999, Section 1332), which relates to participation in certain insurance plans; increasing period of employment required for participation in certain disability plans; providing for codification; and providing an effective date.

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

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 349 of Title 36, unless there is created a duplication in numbering, reads as follows:

When, by the laws of any other state, any taxes, fines, penalties, licenses, fees, deposits of money or securities, or other obligations or prohibitions are imposed upon insurance companies of this or other states, or their agents, greater than are required by laws of this state, then the same obligations and prohibitions, of whatever kind, shall, in like manner for like purposes, be imposed upon all insurance companies of such states and their agents. All insurance companies of other nations shall be held to the same obligations and prohibitions that are imposed by the state where they have elected to make their deposit and establish their principal agency in the United States.

SECTION 2. AMENDATORY 36 O.S. 1991, Section 613, is amended to read as follows:

Section 613. A. ~~Any insurance company which~~ Except as provided in subsection C of this section, any insurer that incorporates or is authorized initially to transact the business of insurance in Oklahoma after the effective date of this act shall not be issued a certificate of authority by the Insurance Commissioner unless it has deposited in trust with the State Treasurer through the Insurance Commissioner's office cash or securities eligible for the investment of capital funds of domestic insurers under this Code in an amount not less than Three Hundred Thousand Dollars (\$300,000.00). The Insurance Commissioner may require a greater amount to be deposited in trust if the Insurance Commissioner finds that a greater amount is warranted for the protection of the policyholders of the insurer pursuant to rules promulgated by the Insurance Commissioner. Any amount over Three Hundred Thousand Dollars (\$300,000.00) must be documented and reasons stated by the Commissioner in writing for the excess deposit amount. The Commissioner will annually review those

insurers with deposits above Three Hundred Thousand Dollars (\$300,000.00) to determine whether such additional deposits remain justified.

B. The Insurance Commissioner shall not issue a certificate of authority to any insurer ~~which~~ that incorporated or was initially authorized to transact the business of insurance in Oklahoma prior to the effective date of this act unless it has deposited in trust with the State Treasurer through the Insurance Commissioner's office cash or securities eligible for the investment of capital funds of domestic insurers under this Code in an amount not less than the surplus in regard to policyholders, or net admitted assets (if a Lloyd's association) required pursuant to this Code to be maintained for authority to transact the kinds of insurance to be transacted, except that in the case of life and/or accident and health insurers the deposit shall be in the amount of One Hundred Thousand Dollars (\$100,000.00), ~~and except that:~~.

C. 1. As to domestic title insurers, the deposit shall be as required by Article 50 (Title Insurers).

2. As to foreign insurers, in lieu of such deposit or part thereof in this state, the Insurance Commissioner may accept the current certificate in proper form of the public official having supervision over insurers in any other state to the effect that a like deposit or part thereof by such insurer is being maintained in public custody in such state in trust for the purpose, among other reasonable purposes, of protection of all the insurer's policyholders or of all its policyholders and creditors.

3. As to alien insurers, other than title insurers, in lieu of such deposit or part thereof in this state, the Insurance Commissioner may accept the certificate of the official having supervision over insurance of another state in the United States, given under his hand and seal, that the insurer maintains within the United States by way of deposits with public depositories, or in trust institutions within the United States approved by such official, assets available for discharge of its United States insurance obligations, which assets shall be in amount not less than the outstanding liabilities of the insurer arising out of its insurance transactions in the United States, together with the largest deposit required by this Code to be made in this state by any type of domestic insurer transacting like kinds of insurance.

~~C.~~ D. Any securities deposited by insurers shall be issued to the Insurance Commissioner and the insurer and shall not be released by any company holding such security without the signatures of the Insurance Commissioner and the authorized ~~insurance company~~ insurer's personnel. Failure of any company holding such security to comply with this subsection may result, after hearing by the proper licensing authority, in a fine of not more than Twenty-five Thousand Dollars (\$25,000.00) per occurrence.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 650 of Title 36, unless there is created a duplication in numbering, reads as follows:

Insurers, nonprofit health service plans, and health maintenance organizations shall not establish or promote an emergency medical response, triage, or transportation system in competition with or in substitution of the Nine-One-One system. Insurers, nonprofit health service plans, and health maintenance organizations shall not use false or misleading language to discourage or prohibit access to the Nine-One-One system.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1219.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

Sections 4 through 6 of this act shall be known and may be cited as the "Health Care Fraud Prevention Act".

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1219.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Health Care Fraud Prevention Act:

1. "Accident and health insurance policy" means any policy, certificate, contract, agreement or other instrument that provides accident and health insurance, as defined in Section 703 of this title, to any person in this state;

2. "Health care provider" means a physician, hospital, ambulatory surgical center, pharmacy, pharmacist, laboratory, or any other state-licensed or state-recognized provider of health care services;

3. "Insured" means any person entitled to reimbursement for expenses of health care services and procedures under an accident and health insurance policy issued by an insurer;

4. "Insurer" means any entity that provides an accident and health insurance policy in this state, including but not limited to a licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a fraternal benefit society, a multiple employer welfare arrangement, or any other entity subject to regulation by the Insurance Commissioner;

5. "Preferred provider organization" means any entity defined as a "preferred provider organization (PPO)" in Section 6054 of this title; and

6. "Third-party administrator" means any person defined as an "administrator" in Section 1442 of this title.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1219.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An insurer or third-party administrator shall not reimburse a health care provider on a discounted fee basis for covered services that are provided to an insured unless:

1. The insurer or third-party administrator has contracted with either:

- a. the health care provider, or
- b. a preferred provider organization which has contracted with the health care provider;

2. The health care provider has agreed to provide health care services under the terms of the contract; and

3. The insurer or third-party administrator has agreed to provide coverage for those health care services under an accident and health insurance policy.

B. A party to a preferred provider contract, including a contract with a preferred provider organization, may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority and prior adequate notification of the other contracting parties.

SECTION 7. AMENDATORY 36 O.S. 1991, Section 1254, as renumbered by Section 20, Chapter 342, O.S.L. 1994, and as last amended by Section 1, Chapter 256, O.S.L. 1999 (36 O.S. Supp. 1999, 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:

1. Failing to fully disclose to first party claimants, benefits, coverages, or other provisions of any insurance policy or insurance contract when such 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

such a time limit is not complied with unless the failure to comply with such time limit prejudices an insurer's rights;

8. Requesting a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment;

9. Issuing checks or drafts in partial settlement of a loss or claim under a specified coverage which contain language which releases 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, such 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 such 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 subsection, 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 such policyholders have made claims for amounts reasonably similar to the amounts ultimately recovered;

~~13.~~ 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; or

~~14.~~ 15. Requesting a refund of all or a portion of a payment of a claim made to a claimant or health care provider more than twenty-four (24) 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.

SECTION 8. AMENDATORY 36 O.S. 1991, Section 1241, is amended to read as follows:

Section 1241. A property and casualty insurer shall, within ~~forty-five (45)~~ sixty (60) business days of taking an application, determine whether or not the applicant should be accepted or denied as an insured and shall give written notice to the agent of the acceptance or denial. If the applicant is denied as an insured, any premium monies paid, less any expenses incurred either by the agent or the insurer, shall be immediately returned to the proposed purchaser of the policy. Failure of the insurer to return premium monies to the applicant within ~~forty-five (45)~~ sixty (60) business days of the initial submission to the insurer, broker, or agent, shall result in the applicant recovering any interest and bank charges which the proposed insured has incurred because of the delay in return of the initial premium, less expenses incurred. In addition, if the insurer does not return the premium monies, less expenses, within the ~~forty-five-day~~ sixty-day period, the insurer shall remain liable for the insurance coverage and any claims pursuant thereto which the remaining premium monies would have purchased.

SECTION 9. AMENDATORY Section 60, Chapter 418, O.S.L. 1997, as last amended by Section 1, Chapter 333, O.S.L. 1999 (36 O.S. Supp. 1999, Section 1424.11), is amended to read as follows:

Section 1424.11 A. No person shall act as or hold himself or herself out to be an insurance agent, surplus lines insurance broker, limited insurance representative, managing general agent, consultant, or customer service representative unless duly licensed. Salaried employees in the office of an insurance agent, surplus lines insurance broker, limited insurance representative, managing general agent or consultant, who devote full time to clerical and administrative services, with incidental receiving of insurance applications and premiums in the office of the employer and who do not receive any commissions for the applications nor a compensation that is varied by the volume of applications or premiums taken or received, shall be exempt from any licensing requirement. Employees who sell motor vehicle insurance for a rental vehicle operation in connection with short-term renting or leasing of motor vehicles may do so under the limited insurance license of the branch manager of the location at which the vehicle is rented or the coverage is sold.

B. No insurance agent, surplus lines insurance broker, or limited insurance representative shall make application for,

procure, negotiate for, or place for others any policies for any lines of insurance for which he or she is not then qualified and duly licensed.

C. An insurance agent may receive qualification for a license in one or more of the following categories or lines of insurance:

1. Life insurance, including fraternal agents licensed pursuant to Section 2733.1 of this title;
2. Accident and health insurance, including fraternal agents licensed pursuant to Section 2733.1 of this title;
3. Personal property and casualty insurance;
4. Commercial property and casualty insurance;
5. Variable annuity contracts, including fraternal agents licensed pursuant to Section 2733.1 of this title; and
6. Title insurance.

D. A limited insurance representative may receive qualification for a license in one or more of the following categories:

1. As a ticket-selling agent of a common carrier who acts only with reference to the issuance of insurance on personal effects carried as baggage, in connection with the transportation provided by such common carrier;
2. To engage in the sale of only limited travel accident insurance;
3. To engage in the sale of motor vehicle insurance at a vehicle rental counter or at any other point of sale at which motor vehicle insurance is offered or sold in connection with the short-term renting or leasing of motor vehicles;
4. To engage in the sale of credit life insurance or credit accident and health insurance or both credit life insurance and credit accident and health insurance in connection with a credit transaction by which satisfaction of a debt in whole or in part is a benefit provided;
5. To engage in the sale of personal property floater insurance upon personal effects against loss or damage from any cause in connection with a credit transaction of not more than Five Thousand Dollars (\$5,000.00) by which satisfaction of the credit transaction debt in whole or in part is a benefit provided, and such personal effects are used as collateral on the debt;
6. To engage in the sale of nonfiling insurance relating to mortgages and security interests arising under the Uniform Commercial Code, Section 1-101 et seq. of Title 12A of the Oklahoma Statutes;

7. Prepaid legal liability insurance, which means the assumption of an enforceable contractual obligation to provide specified legal services or to reimburse policyholders for specified legal expenses, pursuant to the provisions of a group or individual policy;

8. Job loss insurance, which means the sale of involuntary unemployment insurance in connection with a credit transaction by which satisfaction of a debt in whole or in part is a benefit provided;

9. Crop hail and multiperil crop hail insurance; and

10. Prepaid dental insurance, provided the individual selling the prepaid dental insurance has been appointed by the prepaid dental plan organization to sell such insurance.

E. 1. An insurance agent or limited insurance representative may solicit applications for and issue travel accident policies or baggage insurance by means of mechanical vending machines supervised by the agent or representative only if the Insurance Commissioner shall determine that the form of policy to be sold is reasonably suited for sale and issuance through vending machines, that use of vending machines for the sale of said policies would be of convenience to the public, and that the type of vending machine to be used is reasonably suitable and practical for the sale and issuance of said policies. Policies so sold do not have to be countersigned.

2. The Commissioner shall issue to the insurance agent or limited insurance representative a special vending machine license for each such machine to be used. The license shall specify the name and address of the insurer and licensee, the kind of insurance and type of policy to be sold, and the place where the machine is to be in operation. The license shall expire, be renewable, and be suspended or revoked coincidentally with the insurance agent license or limited representative license of the licensee. The license fee for each vending machine shall be that stated in the provisions of Section 1425 of this title. Proof of existence of the license shall be displayed on or about each machine in such manner as the Commissioner may reasonably require.

SECTION 10. AMENDATORY Section 61, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 1999, Section 1424.12), is amended to read as follows:

Section 1424.12 A. An insurance agent may place only a kind or kinds of insurance for which the agent is licensed and appointed by an insurer. Such appointment by an insurer may be made within forty-five (45) days after the placement of business with said insurer. If an insurer accepts business from an agent, the insurer shall, within forty-five (45) days, appoint the agent through the proper procedure established by the Insurance Commissioner. In the event that an agent's appointments for one or more lines of insurance have been terminated, then the agent may elect to surrender the license as to that line or lines, and upon renewal the

Commissioner will issue a license that includes only those lines for which the agent has both a license and an appointment.

B. An insurance agent may place a kind or kinds of insurance for which the agent is not appointed by an insurer, only by placing the insurance through a licensed agent holding an appointment for that kind or kinds of insurance from an insurer. This subsection shall not be interpreted to permit an agent to solicit insurance in a line for which the agent is not licensed.

C. A limited insurance representative may place only a kind or kinds of insurance for which the representative is licensed and appointed by an insurer. In the event that a representative's appointments have all been terminated, then the representative's license will be deemed to have expired unless, within ten (10) days after the last termination, a new appointment has been secured.

D. A limited insurance representative may place a kind or kinds of insurance for which he or she is not appointed as a limited insurance representative only by placing the insurance through a licensed limited insurance representative holding an appointment for that kind or kinds of insurance from an insurer.

SECTION 11. AMENDATORY Section 66, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 1999, Section 1424.17), is amended to read as follows:

Section 1424.17 A. An insurance agent or limited insurance representative may represent as many insurers as may appoint the agent or representative in accordance with the provisions of the Insurance Agents Licensing Act. A company shall not pay any commission or fee to an agent or limited insurance representative unless and until ~~his~~ the appointment with that company has been approved by the Commissioner.

B. Such appointment by an insurer may be made forty-five (45) days after the placement of business with that insurer through the appropriate appointment process established by the Insurance Commissioner.

SECTION 12. AMENDATORY 36 O.S. 1991, Section 1425.1, as last amended by Section 70, Chapter 418, O.S.L. 1997, and as renumbered by Section 127, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 1999, Section 1426A), is amended to read as follows:

Section 1426A. A. 1. Each insurance agent shall, biennially, complete not less than fourteen (14) clock hours of continuing insurance education which shall cover subjects in the lines for which the agent is licensed. Such education may include a written or oral examination.

2. Each customer service representative shall, biennially, complete not less than ten (10) clock hours of continuing insurance education which shall cover subjects in the lines for which the licensee is authorized to conduct insurance-related business on behalf of the appointing agent, broker, or agency.

3. Licensees shall complete, in addition to the foregoing, two (2) clock hours of ethics course work in this same period.

B. 1. The Insurance Commissioner shall approve courses and providers of continuing education. The Insurance Department may use one or more of the following to review and provide a nonbinding recommendation to the Insurance Commissioner on approval or disapproval of courses and providers of continuing education:

- a. employees of the Insurance Commissioner,
- b. a continuing education advisory committee, or
- c. an independent service whose normal business activities include the review and approval of continuing education courses and providers. The Commissioner may negotiate agreements with such independent service to review documents and other materials submitted for approval of courses and providers and provide the Commissioner with its nonbinding recommendation. The Commissioner may require such independent service to collect the fee charged by the independent service for reviewing materials provided for review directly from the course providers.

The Insurance Commissioner has sole authority to approve courses and providers of continuing education. If the Insurance Commissioner uses one of the entities listed above to provide a nonbinding recommendation, he or she shall adopt or decline to adopt the recommendation within thirty (30) days of receipt of the recommendation. In the event the Insurance Commissioner takes no action within said thirty-day period, the recommendation made to the Commissioner will be deemed to have been adopted by the Commissioner.

2. Each insurance company shall be allowed to provide continuing education to insurance agents and customer service representatives as required by this section; provided that such continuing education meets the general standards for education otherwise established by the Insurance Commission.

3. An agent who, during the time period prior to renewal, successfully completes any one of the following courses or programs of instruction and equivalent classroom hours approved by the Insurance Commissioner shall be deemed to have met the biennial requirement for continuing education:

- a. any part of a life course curriculum totaling fifty (50) classroom hours, or a health course totaling twenty-six (26) classroom hours offered by the Life Underwriter Training Council,
- b. any part of the American College of Life Underwriters (CLU) diploma curriculum totaling thirty (30) classroom hours,

- c. any part of the Accredited Advisor in Insurance (AAI) program totaling twenty-five (25) classroom hours offered by the Insurance Institute of America,
- d. any part of the Chartered Property and Casualty Underwriter (CPCU) professional designation program totaling thirty (30) classroom hours offered by the American Institute of Property and Liability Underwriters, or
- e. any part of the Certified Insurance Counselor Program totaling twenty (20) classroom hours.

C. Each provider of continuing education shall, after approval by the Commissioner, submit an annual fee of Two Hundred Dollars (\$200.00) payable to the Insurance Commissioner which shall be deposited in the State Insurance Commissioner Revolving Fund, created in subsection G of Section 1425 of this title, for the purposes of fulfilling and accomplishing the conditions and purposes of the Insurance Agents Licensing Act and the Insurance Adjusters Licensing Act. Provided, public funded educational institutions shall be exempt from this subsection.

D. Failure of an insurance agent or customer service representative to comply with the requirements of this act may, after notice and opportunity for hearing, result in censure, suspension, nonrenewal of license or a civil penalty of up to Five Hundred Dollars (\$500.00) or by both such penalty and civil penalty. Said civil penalty may be enforced in the same manner in which civil judgments may be enforced. Any civil penalties collected under this act shall be deposited in the State Insurance Commissioner Revolving Fund.

E. Limited insurance representatives and nonresident agents who have successfully completed an equivalent or greater requirement as set out in subparagraph b of paragraph 2 of subsection A of Section 1424 of this title shall be exempt from the provisions of this section.

F. Agents and limited insurance representatives who are sixty-five (65) years of age or older and who have at least thirty (30) years of experience as agents or limited insurance representatives, and who do not write new business, shall be exempt from the provisions of this section.

G. The Commissioner shall adopt and promulgate such rules as are necessary for effective administration of this act.

SECTION 13. AMENDATORY 36 O.S. 1991, Section 1428, as last amended by Section 81, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 1999, Section 1428), is amended to read as follows:

Section 1428. A. The Insurance Commissioner or the independent hearing examiner ~~shall~~ may censure, suspend, or revoke, or refuse to issue, continue, or renew, any license issued or applied for pursuant to the provisions of the Insurance Agents Licensing Act if, after notice to the licensee and to the insurer represented, the

Commissioner or the independent hearing examiner finds as to the licensee any one or more of the following conditions:

1. Any materially untrue statement in the license application;
2. Any cause for which issuance of the license could have been refused had it existed and been known to the Commissioner at the time of issuance;
3. Any violation of or noncompliance with any insurance laws of this state, or any violation of any lawful rule or order of the Commissioner;
4. Obtaining or attempting to obtain any license through misrepresentation or fraud;
5. Improperly withholding, misappropriating, or converting to the licensee's own use any monies belonging to policyholders, insurers, beneficiaries, or others received in the course of the licensee's insurance business;
6. Misrepresentation of the terms of any actual or proposed insurance contract;
7. Conviction of or plea of guilty or nolo contendere to:
  - a. any felony, or
  - b. a misdemeanor involving moral turpitude or dishonesty;
8. The licensee has been found guilty of any unfair trade practice or fraud;
9. In the conduct of his or her affairs, the licensee has used fraudulent, coercive, or dishonest practices, or has shown himself or herself to be incompetent, untrustworthy, or financially irresponsible;
10. The licensee has forged the name of another person to an application for insurance; or
11. The applicant has been found to have been cheating on an examination for an insurance license.

B. If the action by the Commissioner or the independent hearing examiner is to deny renewal or to deny an application for a license, the Commissioner or independent hearing examiner shall notify the applicant or licensee and advise, in writing, the applicant or licensee of the reasons for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the Commissioner or independent hearing examiner within a reasonable time for a hearing before the Commissioner or independent hearing examiner to determine the reasonableness of the action of the Commissioner or independent hearing examiner.

C. The license of a legal entity may be suspended, revoked, or refused if the Commissioner or independent hearing examiner finds that a violation by an individual licensee was known or should have been known by one or more of the partners, officers, or managers acting on behalf of the agency and the violation was not reported to the Commissioner nor corrective action taken in relation to the violation.

D. In addition to any applicable denial, censure, suspension, or revocation of a license, any person violating the provisions of the Insurance Agents Licensing Act may be subject to a civil penalty of not less than One Hundred Dollars (\$100.00) nor more than One Thousand Dollars (\$1,000.00) for each occurrence. Said penalty may be enforced in the same manner in which civil judgments may be enforced.

E. Every licensee licensed pursuant to the provisions of the Insurance Agents Licensing Act shall keep at his or her place of business the usual and customary records pertaining to transactions authorized by his or her license. All records as to any particular transactions shall be kept available and open to the inspection of the Commissioner at any time during business hours during the three (3) years immediately following the date of completion of the transaction. The Commissioner may require a financial or market conduct examination during any investigation of a licensee. The cost of such examination shall be apportioned among all of the appointing insurers of the licensee.

F. Every licensee licensed pursuant to the provisions of the Insurance Agents Licensing Act shall notify the Commissioner of the conviction of or plea of guilty or nolo contendere to any felony or to a misdemeanor involving moral turpitude or dishonesty within thirty (30) days after the plea is taken and also within thirty (30) days of the entering of an order of judgment and sentencing and shall notify the Commissioner of any administrative action taken against his or her license in another state within thirty (30) days of the entering of the administrative order in that state.

G. For one (1) year after notification by the Commissioner of an alleged violation, or for two (2) years after the last day the person was licensed, whichever is the lesser period of time, the Commissioner shall retain jurisdiction as to any person who cancels his or her agent's license or allows said license to lapse, or otherwise ceases to be licensed, if the person while licensed as an agent allegedly violated any provision of this Code. Notice and opportunity for hearing shall be conducted in the same manner as if the person still maintained an agent's license. If the Commissioner or independent hearing examiner determines that a violation of the provisions of this Code occurred, any order issued by the Commissioner or independent hearing examiner pursuant to said determination may become a permanent record in the file of the person and may be used in any future request by the person for licensure or reinstatement.

H. Files pertaining to investigations or legal matters which contain information concerning a current and ongoing investigation of allegations of violations of this Code by a licensed agent shall

not be available for public inspection without proper judicial authorization; however, a licensed agent, under investigation for alleged violations of this Code, or against whom an action for alleged violations of this Code has been commenced, may view evidence and complaints pertaining to the investigation, other than privileged information, at reasonable times at the Commissioner's office. All qualification examination materials, booklets and answers for any license authorized to be issued by the Commissioner under any statute, shall not be available for public inspection.

SECTION 14. AMENDATORY 36 O.S. 1991, Section 2122, is amended to read as follows:

Section 2122. A. A domestic stock insurer shall not pay any ordinary cash dividend to stockholders except out of that part of its available surplus funds which is derived from realized net profits on its business. The restriction shall ~~not~~ apply to all extraordinary dividends, as defined in Section 1655 of this title, ~~which have been approved by the Commissioner.~~

B. A stock dividend may be paid out of any available surplus funds in excess of the aggregate amount of surplus loaned to the insurer pursuant to Section 2125 of this article.

C. A dividend otherwise proper may be payable out of the insurer's earned surplus even though its total surplus is then less than the aggregate of its past contributed surplus resulting from issuance of its capital stock at a price in excess of the par value thereof.

SECTION 15. AMENDATORY 36 O.S. 1991, Section 3639, is amended to read as follows:

Section 3639. A. The provisions of this section apply to commercial property insurance policies, commercial casualty insurance policies, and commercial fire insurance policies.

B. As used in this section:

1. "Renewal" or "to renew" means the issuance or offer of issuance by an insurer of a policy succeeding a policy previously issued and delivered by the same insurer or an insurer within the same group of insurers, or the issuance of a certificate or notice extending the term of an existing policy for a specified period beyond its expiration date;

2. "Nonpayment of premium" means the failure or inability of the named insured to discharge any obligation in connection with the payment of premiums on a policy of insurance subject to this section, whether such payments are payable directly to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit;

3. "Cancellation" means termination of a policy at a date other than its expiration date;

4. "Expiration date" means the date upon which coverage under a policy ends. It also means, for a policy written for a term longer than one (1) year or with no fixed expiration date, each annual anniversary date of such policy; and

5. "Nonrenewal" or "refusal to renew" means termination of a policy at its expiration date.

C. After coverage has been in effect for more than ~~forty-five (45)~~ sixty (60) business days or after the effective date of the renewal of a commercial property, commercial casualty or commercial fire insurance policy, a notice of cancellation shall not be issued by any licensed insurer or surplus or excess lines insurer unless it is based on at least one of the following reasons with at least ten (10) days notice to the insured:

1. Nonpayment of premium;

2. Discovery of fraud or material misrepresentation in the procurement of the insurance or with respect to any claims submitted thereunder;

3. Discovery of willful or reckless acts or omissions on the part of the named insured which increase any hazard insured against;

4. The occurrence of a change in the risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed;

5. A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof which substantially increases any hazard insured against;

6. A determination by the Commissioner that the continuation of the policy would place the insurer in violation of the insurance laws of this state;

7. Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured against; or

8. Loss of or substantial changes in applicable reinsurance.

D. An insurer may refuse to renew a policy if the insurer gives to the first-named insured at the address shown on the policy written notice that the insurer will not renew the policy. Such notice shall be given at least ~~forty-five (45)~~ sixty (60) days before the expiration date. If notice is given by mail, said notice shall be deemed to have been given on the day said notice is mailed. If the notice is mailed less than ~~forty-five (45)~~ sixty (60) days before expiration, coverage shall remain in effect until ~~forty-five (45)~~ sixty (60) days after notice is mailed. Earned premium for any period of coverage that extends beyond the expiration date shall be considered pro rata based upon the previous year's rate. For purposes of this section, the transfer of a policyholder between companies within the same insurance group is not a refusal to renew.

In addition, changing deductibles, changes in premium, changes in the amount of insurance, or reductions in policy limits or coverage are not refusals to renew.

Notice of nonrenewal shall not be required if the insurer or a company within the same insurance group has offered to issue a renewal policy or, if the named insured has obtained replacement coverage or has agreed in writing to obtain replacement coverage.

If an insurer provides the notice required by this subsection and thereafter the insurer extends the policy for ninety (90) days or less, an additional notice of nonrenewal is not required with respect to the extension.

E. An insurer shall give to the named insured at the mailing address shown on the policy, written notice of premium increase, change in deductible, reduction in limits or coverage at least forty-five (45) days prior to the expiration date of the policy. If the insurer fails to provide such notice, the premium, deductible, limits and coverage provided to the named insured prior to the change shall remain in effect until notice is given or until the effective date of replacement coverage obtained by the named insured, whichever first occurs. If notice is given by mail, said notice shall be deemed to have been given on the day said notice is mailed. If the insured elects not to renew, any earned premium for the period of extension of the terminated policy shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, the premium increase, if any, and other changes shall be effective the day following the prior policy's expiration or anniversary date.

This subsection shall not apply to:

1. Changes in a rate or plan filed with or approved by the State Board for Property and Casualty Rates and applicable to an entire class of business; or
2. Changes based upon the altered nature of extent of the risk insured; or
3. Changes in policy forms filed with or approved by the Insurance Commissioner and applicable to an entire class of business.

F. Proof of mailing of notice of cancellation, or of nonrenewal or of premium or coverage changes, to the named insured at the address shown in the policy, shall be sufficient proof of notice.

SECTION 16. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4030.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

Sections 16 through 27 of this act shall be known as the Standard Nonforfeiture Law for Individual Deferred Annuities.

SECTION 17. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4030.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

This act shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this state through an agent or other representative of the company issuing the contract.

SECTION 18. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4030.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. In the case of contracts issued on or after the effective date of this act except as provided in Section 25 of this act, no contract of annuity, except as stated in Section 25 of this act, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the Insurance Commissioner are at least as favorable to the contractholder, upon cessation of payment of considerations under the contract:

1. That upon cessation of payment of considerations under a contract, the company will grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in Sections 28, 29, 30, 31 and 33 of this act;

2. If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company will pay in lieu of a paid-up annuity benefit a cash surrender benefit of such amount as is specified in Sections 28, 29, 31 and 33 of this act. The company shall reserve the right to defer the payment of the cash surrender benefit for a period of six (6) months after demand therefor with surrender of the contract;

3. A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of the benefits; and

4. A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which the benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to

the company on the contract or any prior withdrawals from or partial surrenders of the contract.

B. Notwithstanding the requirements of this section, a deferred annuity contract may provide that if no considerations have been received under a contract for a period of two (2) full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from prior considerations paid would be less than Twenty Dollars (\$20.00) monthly, the company may at its option terminate the contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis on the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by this payment shall be relieved of any further obligation under the contract.

SECTION 19. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4030.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The minimum values as specified in Sections 28, 29, 30, 31 and 33 of this act, of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

B. With respect to contracts providing for flexible considerations, the minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at a rate of interest of three percent (3%) per annum of percentages of the net considerations (as hereinafter defined) paid prior to such time, decreased by the sum of:

1. Any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of three percent (3%) per annum; and

2. The amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount not less than zero and shall be equal to the corresponding gross considerations credited to the contract during that contract year less an annual contract charge of Thirty Dollars (\$30.00) and less a collection charge of One Dollar and twenty-five cents (\$1.25) per consideration credited to the contract during that contract year. The percentages of net considerations shall be sixty-five percent (65%) of the net consideration for the first contract year and eighty-seven and one-half percent (87.5%) of the net considerations for the second and later contract years. Notwithstanding the provisions of the preceding sentence, the percentage shall be sixty-five percent (65%) of the portion of the total net consideration for any renewal contract year which exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was sixty-five percent (65%).

C. With respect to contracts providing for fixed scheduled considerations, minimum nonforfeiture amounts shall be calculated on the assumption that considerations are paid annually in advance and shall be defined as for contracts with flexible considerations which are paid annually with two exceptions:

1. The portion of the net consideration for the first contract year to be accumulated shall be the sum of sixty-five percent (65%) of the net consideration for the first contract year plus twenty-two and one-half percent (22.5%) of the excess of the net consideration for the first contract year over the lesser of the net considerations for the second and third contract years; and

2. The annual contract charge shall be the lesser of Thirty Dollars (\$30.00) or ten percent (10%) of the gross annual consideration.

D. With respect to contracts providing for a single consideration, minimum nonforfeiture amounts shall be defined as for contracts with flexible considerations except that the percentage of the net consideration used to determine the minimum nonforfeiture amount shall be equal to ninety percent (90%) and the net consideration shall be the gross consideration less a contract charge of Seventy-five Dollars (\$75.00).

SECTION 20. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4030.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

SECTION 21. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4030.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

For contracts that provide cash surrender benefits, the cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit that would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture

amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

SECTION 22. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4030.8 of Title 36, unless there is created a duplication in numbering, reads as follows:

For contracts that do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine maturity value, and increased by any existing additional amounts credited by the company to the contract. For contracts that do not provide any death benefits prior to the commencement of any annuity payments, present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

SECTION 23. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4030.9 of Title 36, unless there is created a duplication in numbering, reads as follows:

For the purpose of determining the benefits calculated under Sections 29 and 30 of this act, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

SECTION 24. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4030.10 of Title 36, unless there is created a duplication in numbering, reads as follows:

A contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

SECTION 25. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4030.11 of Title 36, unless there is created a duplication in numbering, reads as follows:

Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated

with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

SECTION 26. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4030.12 of Title 36, unless there is created a duplication in numbering, reads as follows:

For a contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of Sections 28, 29, 30, 31, and 33 of this act, additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this act. The inclusion of such benefits shall not be required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

SECTION 27. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4030.13 of Title 36, unless there is created a duplication in numbering, reads as follows:

After the effective date of this act, a company may file with the Insurance Commissioner a written notice of its election to comply with the provisions of this act after a specified date before the second anniversary of the effective date of this act. After the filing of notice, then upon the specified date, which shall be the operative date of this act for that company, this act shall become operative with respect to annuity contracts thereafter issued by the company. If a company makes no election, the operative date of this act for the company shall be the second anniversary of the effective date of this act.

SECTION 28. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4046.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. On March 1 of each calendar year, each viatical settlement provider licensed in this state shall make a report containing the following information for the previous calendar year:

1. For each policy viaticated:
  - a. date viatical settlement entered into,

- b. life expectancy of viator at time of contract,
- c. face amount of policy, and
- d. amount paid by the viatical settlement provider to viaticate the policy;

2. For each viator that is deceased:

- a. date viatical settlement entered into,
- b. life expectancy of viator at time of contract,
- c. face amount of policy,
- d. amount paid by the viatical settlement provider to viaticate the policy,
- e. date of death of viator, and
- f. total insurance premiums paid by viatical settlement provider to maintain the policy in force;

3. Breakdown of applications received, accepted and rejected, by disease category;

4. Breakdown of policies viaticated by issuer and policy type;

5. Number of secondary market as compared to primary market transactions;

6. Portfolio size; and

7. Amount of outside borrowings.

SECTION 29. AMENDATORY Section 9, Chapter 248, O.S.L. 1998 (36 O.S. Supp. 1999, Section 4049), is amended to read as follows:

Section 4049. A. A viatical settlement provider entering into a viatical settlement contract with any person with a catastrophic or life threatening illness or condition shall first obtain:

1. A written statement from a licensed attending physician, as defined in Section 725.2 of Title 59 of the Oklahoma Statutes, that the person is of sound mind and under no constraint or undue influence; and

2. A witnessed document in which the person:

- a. consents to the viatical settlement contract,
- b. acknowledges the catastrophic or life threatening illness,
- c. represents a full and complete understanding of the viatical settlement contract,

- d. represents a full and complete understanding of the benefits of the life insurance policy,
- e. releases medical records, and
- f. acknowledges that the viatical settlement contract has been entered into freely and voluntarily.

The witness, as required in this paragraph, shall be a disinterested third party.

B. All medical information solicited or obtained by any licensee shall be subject to the applicable provisions of state law relating to confidentiality of medical information.

C. All viatical settlement contracts entered into in this state shall contain an unconditional refund provision extending at least thirty (30) days from the date of the contract, or fifteen (15) days from or after the receipt of the viatical settlement proceeds, whichever is less.

D. Immediately upon receipt from the viator of documents to effect the transfer of the insurance policy, the viatical settlement provider shall pay the proceeds of the settlement to an escrow or trust account managed by a trustee or escrow agent in a bank approved by the Commissioner, pending acknowledgment of the transfer by the issuer of the policy. The trustee or escrow agent shall be required to transfer the proceeds due to the viator immediately upon receipt of acknowledgment of the transfer from the insurer.

E. Failure to tender the viatical settlement by the date disclosed to the viator renders the contract null and void.

F. In order to assure that viators receive reasonable return for viaticating an insurance policy, the following shall be minimum discounts:

| <u>Insured's Life</u>                  | <u>Minimum Percentage of Face</u> |
|--|-----------------------------------|
| <u>Expectancy</u>                      | <u>Value Less Outstanding</u>     |
|  | <u>Loans Received by Viator</u>   |
| <u>Less than six (6) months</u>        | <u>80%</u>                        |
| <u>At least six (6) but less</u>       |                                   |
| <u>than twelve (12) months</u>         | <u>70%</u>                        |
| <u>At least twelve (12) but less</u>   |                                   |
| <u>than eighteen (18) months</u>       | <u>65%</u>                        |
| <u>At least eighteen (18) but less</u> |                                   |
| <u>than twenty-four (24) months</u>    | <u>60%</u>                        |

Twenty-four (24) months or more

50%

A viatical settlement broker or provider shall not, without the written agreement of the viator obtained prior to performing any services in connection with a viatical settlement, seek or obtain any compensation from the viator.

SECTION 30. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4085 of Title 36, unless there is created a duplication in numbering, reads as follows:

Sections 30 through 41 of this act shall constitute a part of the Insurance Code and shall be known and may be cited as the "Life Settlement Act".

SECTION 31. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4086 of Title 36, unless there is created a duplication in numbering, reads as follows:

For purposes of the Life Settlement Act:

1. "Person" means any natural or artificial entity including, but not limited to, individuals, partnerships, associations, trusts, or corporations;

2. "Life settlement" means an agreement that is solicited, negotiated, offered, entered into, delivered, or issued for delivery in this state under which a person pays compensation or anything of value that is less than the expected death benefit of a policy insuring the life of an individual who does not have a catastrophic or life-threatening illness or condition in return for the policy owner's or certificate holder's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the policy;

3. "Life settlement broker" means an individual, partnership, corporation or other entity who or which for another and for a fee, commission or other valuable consideration offers or advertises the availability of life settlements, introduces to life settlement providers, or offers or attempts to negotiate life settlements between an owner and one or more life settlement providers. Life settlement broker does not include an attorney, accountant, or financial planner retained to represent the insured whose compensation is not paid by the life settlement provider;

4. "Life settlement contract" means a written agreement entered into between a life settlement provider and a person owning a life insurance policy or who owns or is covered under a group policy insuring the life of a person who does not have a catastrophic or life-threatening illness or condition. The agreement shall establish the terms under which the life settlement provider will pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the policyowner's assignment, transfer, sale, devise, or bequest of death benefit or ownership of the insurance policy or certificate to the life settlement provider;

5. "Life settlement provider" means an individual, partnership, corporation, or other entity that enters into an agreement with a person owning a life insurance policy or who owns or is covered under a group policy insuring the life of a person who does not have a catastrophic or life-threatening illness or condition, under the terms of which the life settlement provider pays compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the policyowner's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the insurance policy or certificate to the life settlement provider. Life settlement provider does not include:

- a. any bank, savings bank, savings and loan association, credit union or other licensed lending institution which takes an assignment of a life insurance policy as collateral for a loan,
- b. the issuer of a life insurance policy providing accelerated benefits, or
- c. any natural person who enters into no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit;

6. "Owner" means the owner of a life insurance policy insuring the life of a person that does not have a catastrophic or life threatening illness or condition or the certificate holder who enters into an agreement under which the life settlement provider will pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the owner's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the insurance policy or certificate to the life settlement provider; and

7. "Commissioner" means the Insurance Commissioner of the State of Oklahoma.

SECTION 32. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4087 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. No individual, partnership, corporation, or other entity may act as a life settlement provider or enter into or solicit a life settlement contract without first having obtained a license from the Insurance Commissioner.

B. Application for a life settlement provider license shall be made to the Commissioner by the applicant on a form prescribed by the Commissioner, and the application shall be accompanied by a fee of Five Hundred Dollars (\$500.00).

C. Licenses may be renewed from year to year on the anniversary date upon payment of the annual renewal fee of Five Hundred Dollars

(\$500.00). Failure to pay the fee within the terms prescribed shall result in the automatic revocation of the license.

D. The applicant shall provide such information as the Commissioner may require on forms prepared by the Commissioner. The Commissioner shall have authority, at any time, to require the applicant to fully disclose the identity of all stockholders, partners, officers, and employees, and the Commissioners may, in the exercise of discretion, refuse to issue a license in the name of any firm, partnership, or corporation or any other entity if not satisfied that any officer, employee, stockholder, or partner thereof who may materially influence the applicant's conduct meets the standards of the Life Settlement Act.

E. A license issued to a firm, partnership, corporation, or other entity authorizes all members, officers, and designated employees to act as life settlement providers under the license, and all such persons must be named in the application and any supplements to the application.

F. Upon filing an application and payment of the license fee, the Commissioner shall investigate each applicant and may issue a license if the Commissioner finds that the applicant:

1. Has provided a detailed plan of operation;
2. Is competent and trustworthy and intends to act in good faith in the capacity for which licensure is sought;
3. Has a good business reputation and has had experience, training, or educating so as to be qualified in the business for which licensure is sought; and
4. If the applicant is a corporation, is incorporated under the laws of this state or is a foreign corporation authorized to transact business in this state.

G. The Commissioner shall not issue any license to any nonresident applicant, unless a written designation of an agent for service of process is filed and maintained with the Commissioner or the applicant has filed with the Commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the Commissioner.

SECTION 33. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4088 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Commissioner shall have the right to suspend, revoke, or refuse to renew the license of any life settlement provider or broker if the Commissioner finds that:

1. There was any misrepresentation in the application for the license;

2. The holder of the license has been guilty of fraudulent or dishonest practices, is subject to final administrative actions, or is otherwise shown to be untrustworthy or incompetent to act as a life settlement provider;

3. The licensee demonstrates a pattern of unreasonable payments to policyholders;

4. The licensee has been convicted of a felony or any misdemeanor of which criminal fraud is an element; or

5. The licensee has violated any of the provisions of the Life Settlement Act.

B. Before the Commissioner shall deny a license application or suspend, revoke or refuse to renew the license of a life settlement provider or broker, the Commissioner shall conduct a hearing in accordance with the Administrative Procedures Act.

SECTION 34. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4089 of Title 36, unless there is created a duplication in numbering, reads as follows:

No life settlement provider shall use any life settlement contract or related forms, including applications and advertisements, in this state unless it has been filed with and approved by the Commissioner. Any life settlement contract form filed with the Commissioner shall be deemed approved if it has not been disapproved within sixty (60) days of the filing. The Commissioner shall disapprove a life settlement contract or related forms if, in the Commissioner's opinion, the contract or any of the provisions are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the policyowner.

SECTION 35. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4090 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Each licensee shall file with the Commissioner on or before March 1 of each year an annual statement containing such information as the Commissioner may prescribe by rule.

B. The Commissioner may, when the Commissioner deems it reasonably necessary to protect the interest of the public, examine the business and affairs of any licensee or applicant for a license. The Commissioner shall have the authority to order any licensee or applicant to produce any records, books, files, or other information reasonably necessary to ascertain whether or not the licensee or applicant is acting or has acted in violation of the law or otherwise contrary to the interests of the public. The expenses incurred in conducting any examination shall be paid by the licensee or applicant.

C. Names and individual identification data for all insureds and owners shall be considered confidential information and shall not be disclosed by the Commissioner, unless required by law.

D. Records of all transactions of life settlement contracts shall be maintained by the licensee and shall be available to the Commissioner for inspection during reasonable business hours.

SECTION 36. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4091 of Title 36, unless there is created a duplication in numbering, reads as follows:

A life settlement provider shall disclose the following information to the owner no later than the date the life settlement contract is signed by all parties:

1. That possible alternatives to life settlement contracts for persons may exist including, but not limited to, nonforfeiture options offered by the issuer of the life insurance policy;

2. That some or all of the proceeds of the life settlement may be taxable and that assistance should be sought from a personal tax advisor;

3. That the life settlement could be subject to creditors' claims;

4. That receipt of a life settlement may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements, and that advice should be obtained from the appropriate agencies;

5. The policyowner's right to rescind a life settlement contract within thirty (30) days after it is executed by all parties or within fifteen (15) days from the receipt of the life settlement proceeds by the owner, whichever is less, as provided in subsection B of Section 9 of this act; and

6. The date by which the funds will be available to the owner and the source of the funds.

SECTION 37. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4092 of Title 36, unless there is created a duplication in numbering, reads as follows:

In order to assure reasonable return for selling an insurance policy to a life settlement provider or negotiating a settlement with a life settlement provider or broker, the following shall be the minimum percentage of face value less outstanding loans, based on attained age of the insured:

| <u>Attained Age</u> | <u>Minimum Percentage</u> |
|---------------------|---------------------------|
| 60-64 years of age  | 50%                       |
| 65-69 years of age  | 60%                       |
| 70-74 years of age  | 65%                       |
| 75-79 years of age  | 70%                       |

|                    |     |
|--------------------|-----|
| 80-84 years of age | 80% |
| 85 years and over  | 85% |

A life settlement broker or provider shall not, without the written agreement of the owner obtained prior to performing any services in connection with a life settlement, seek or obtain any compensation from the owner.

SECTION 38. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4093 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A life settlement provider entering into a life settlement contract with any person shall first obtain:

1. A written statement from a licensed attending physician, as defined in Section 725.2 of Title 59 of the Oklahoma Statutes, that the person is of sound mind and under no constraint or undue influence; and

2. A witnessed document in which the person:

- a. consents to the life settlement contract,
- b. represents a full and complete understanding of the life settlement contract,
- c. represents a full and complete understanding of the benefits of the life insurance policy, and
- d. acknowledges that the life settlement contract has been entered into freely and voluntarily.

The witness, as required in this paragraph, shall be a disinterested third party.

B. All life settlement contracts entered into in this state shall contain an unconditional refund provision extending at least thirty (30) days from the date of the contract, or fifteen (15) days from or after the receipt of the life settlement proceeds, whichever is less.

C. Immediately upon receipt from the owner of documents to effect the transfer of the insurance policy, the life settlement provider shall pay the proceeds of the settlement to an escrow or trust account managed by a trustee or escrow agent in a bank approved by the Commissioner, pending acknowledgement of the transfer by the issuer of the policy. The trustee or escrow agent shall be required to transfer the proceeds due to the owner immediately upon receipt of acknowledgement of the transfer from the insurer.

D. Failure to tender the life settlement by the date disclosed to the owner renders the contract null and void.

SECTION 39. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4094 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Commissioner shall have the authority to:

1. Promulgate rules implementing the Life Settlement Act;
2. Establish standards for evaluating reasonableness of payments under life settlements contracts. This authority includes, but is not limited to, regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a life insurance policy;
3. Establish appropriate licensing requirements and fees for agents and brokers; and
4. Require a penal bond in an amount to be set by the Commissioner.

SECTION 40. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4095 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Any of the following acts by a life settlement provider or broker constitutes an unfair life settlement practice:

1. Failing to fully disclose to an owner, benefits, coverages, or other provisions of any life settlement contract when such benefits, coverages or other provisions are pertinent to the contract;
2. Knowingly misrepresenting to an owner pertinent facts relating to the life settlement contract at issue;
3. Failing to adopt and implement reasonable standards for prompt payment of amounts arising under its life settlement contracts;
4. Not attempting in good faith to effectuate prompt, fair and equitable payment of amounts arising under its life settlement contracts;
5. Requesting an owner to sign a release that extends beyond the subject matter that gave rise to the life settlement contract;
6. Issuing checks or drafts in partial settlement of a loss or claim under a specified coverage which contains language which releases an insurer or its insured from its total liability;
7. Compelling, without just cause, a policyowner to institute a suit to recover an amount due under his or her insurance policy or insurance contract by offering substantially less than the amount ultimately recovered in a suit brought by him or her, when such policyholder has made claims for an amount reasonably similar to the amount ultimately recovered;

8. Failing to maintain a complete record of all complaints which the broker or provider has received during the preceding three (3) years or since the date of the last examination by the Commissioner, whichever time is shorter. This record shall indicate the total number of complaints, their classification, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For the purpose of this paragraph, "complaint" means any written communication primarily expressing a grievance;

9. Entering into a life settlement contract where the subject life insurance policy or certificate was issued by the life settlement provider; or

10. Offering or advertising the availability of life settlements or negotiating a life settlement contract with policyowners or certificate holders issued by the principal life settlement provider.

B. For any violation of this section, the Insurance Commissioner may, after notice and hearing, subject a life settlement provider or broker to a civil fine of not less than One Thousand Dollars (\$1,000.00) for a nonwillful violation or Five Thousand Dollars (\$5,000.00) for a willful violation for each occurrence. Such fine may be enforced in the same manner in which civil judgments may be enforced. Such fines shall be placed in the Insurance Commissioner's Revolving Fund.

SECTION 41. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4096 of Title 36, unless there is created a duplication in numbering, reads as follows:

No life settlement provider transacting business in this state shall continue to do so on or after November 1, 2000, unless the provider is in compliance with the Life Settlement Act.

SECTION 42. AMENDATORY 36 O.S. 1991, Section 4101, is amended to read as follows:

Section 4101. No policy of group life insurance shall be delivered in this state unless it conforms to one of the following descriptions:

1. A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

- a. The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof determined by conditions pertaining to their employment. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors and partners of one or more affiliated corporations, proprietors or

partnerships if the business of the employer and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership or contract, or otherwise. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include retired employees. No director of a corporate employer shall be eligible for insurance under the policy unless such a person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor or partner shall be eligible for insurance under the policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship. A policy issued to insure the employees of a public body may provide that the term "employee" shall include elected or appointed officials.

- b. The premium for the policy shall be paid by the policyholder, either wholly from the employer's funds or funds contributed by him, or partly from such funds and partly from funds contributed by the insured employees, or from funds contributed wholly by the insured employees. A policy on which part or all of the premium is to be derived from funds contributed by the insured employees may be placed in force only if at least seventy-five percent (75%) of the then eligible employees, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, elect to make the required contributions. A policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, or all except any as to whom evidence of insurability is not satisfactory to the insurer.
- c. The policy must cover at least ten employees as of date of issue.
- d. The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the employees or by the employer or trustee;

2. A policy issued to a creditor, who shall be deemed to be the policyholder, to insure debtors of the creditor. Credit unions and associations formed for the purpose of making loans to their members shall be deemed to be creditors within the meaning of this section. Policies issued to a creditor to insure debtors of the creditor are subject to the following requirements:

- a. The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or all of any class or classes thereof determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness. The policy may provide that the term "debtors" shall include the debtors of one or more subsidiary corporations, and the debtors of one or more affiliated corporations, proprietors or partnerships if the business of the policyholder and of such affiliated corporations, proprietors or partnerships is under common control through stock ownership, contract or otherwise.
- b. The premium for the policy shall be paid by the policyholder, either from the creditor's funds, or from charges collected from the insured debtors, or from both. A policy on which part or all of the premium is to be derived from the collection from the insured debtors of identifiable charges not required of uninsured debtors shall not include, in the class or classes of debtors eligible for insurance, debtors under obligation outstanding at its date of issue without evidence of individual insurability unless at least seventy-five percent (75%) of the then eligible debtors elect to pay the required charges. A policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.
- c. The policy may be issued only if the group of eligible debtors is then receiving new entrants at the rate of at least one hundred persons yearly, or may reasonably be expected to receive at least one hundred new entrants during the first policy year, and only if the policy reserves to the insurer the right to require evidence of individual insurability if less than seventy-five percent (75%) of the new entrants become insured.
- d. The amount of insurance on the life of any debtor shall at no time exceed the amount owed by him which is repayable to the creditor, or One Hundred Thousand Dollars (\$100,000.00), whichever is less, provided further, no company licensed to do business in this state shall issue in excess of One Hundred Thousand Dollars (\$100,000.00) group credit life insurance on one individual in the State of Oklahoma.
- e. The insurance shall be payable to the policyholder. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment-;i

3. A policy issued to a labor union, which shall be deemed the policyholder, to insure members of such union for the benefit of persons other than the union or any of its officials, representatives or agents, subject to the following requirements:

- a. The members eligible for insurance under the policy shall be all of the members of the union, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the union, or both.
- b. The premium for the policy shall be paid by the policyholder, either wholly from the union's funds, or partly from such funds and partly from funds contributed by the insured members specifically for their insurance, or from funds contributed wholly by the insured members. A policy on which part or all of the premium is to be derived from funds contributed by the insured members specifically for their insurance may be placed in force only if at least seventy-five percent (75%) of the then eligible members, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, elect to make the required contributions. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.
- c. The policy must cover at least ten members at date of issue.
- d. The amount of insurance under the policy must be based upon some plan precluding individual selection either by the members or by the union-;

4. A policy issued to the trustees of a fund established in this state by two or more employers in the same industry, provided a majority of the employees to be insured of each employer are located within this state, or to the trustees of a fund established by one or more labor unions, or by one or more employers in the same industry and one or more labor unions or by one or more employers and one or more labor unions whose members are in the same or related occupation or trades, or by an association of persons, licensed by the State of Oklahoma to engage in a recognized profession, which trustees shall be deemed the policyholder to insure employees of the employers or members of the unions or members of an association of persons, licensed by the State of Oklahoma to engage in a recognized profession, for the benefit of persons other than the employers or the unions, or the association of persons, licensed by the State of Oklahoma to engage in a recognized profession, subject to the following requirements:

- a. The persons eligible for insurance shall be all of the employees of the employers or all of the members of the union, or all the members of an association of

persons, licensed by the State of Oklahoma to engage in a recognized profession, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the unions, or to both, or pertaining to membership in the association of persons, licensed by the State of Oklahoma to engage in a recognized profession. The policy may provide that the term "employees" shall include the individual proprietor or partners if any employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include retired employees. No director of a corporate employer shall be eligible for insurance under the policy unless such person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor or a partner shall be eligible for insurance under the policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both if their duties are principally connected with such trusteeship, and that the term "members of an association" shall include employees of members.

- b. The premium for the policy shall be paid by the trustees wholly from funds contributed by the employer or employers of the insured persons, or by the union or unions, or by both, or by an association of persons, licensed by the State of Oklahoma to engage in a recognized profession, or from funds contributed wholly or in part by the insured persons. A policy on which part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance may be placed in force only if at least seventy-five percent (75%) of the then eligible persons, excluding any as to whom evidence of insurability is not satisfactory to the insurer, elect to make the required contributions. A policy issued to the trustees of a fund established by an association of persons, licensed by the State of Oklahoma to engage in a recognized profession, on which part or all the premium is to be derived from funds contributed by the insured persons specifically for their insurance, may be placed in force only if the total number of persons covered at the date of issue exceeds six hundred or seventy-five percent (75%) of the eligible persons, whichever is less, excluding any as to whom evidence of insurability is not satisfactory to the insurer, elect to make the required contribution. A policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, or all except any as

to whom evidence of individual insurability is not satisfactory to the insurer.

- c. The policy must cover at date of issue at least one hundred persons; and if the fund is established by the members of an association of employers the policy may be issued only if (a) either (i) the participating employers constitute at date of issue at least sixty percent (60%) of those employer members whose employees are not already covered by group life insurance or (ii) the total number of persons covered at date of issue exceeds six hundred; and (b) the policy shall not require that if a participating employer discontinues membership in the association, the insurance of his employees shall cease solely by reason of such discontinuance.
- d. The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the insured persons or by the policyholder, employers, or unions;

5. A policy issued to any nonprofit industrial association to insure the executives of employer members of a nonprofit industrial association, which is now and has been actively functioning for a period of not less than ten (10) years, such policy to be issued to such association which shall be deemed to be the employer for the purposes of this article, or to the association and executives of such employer members jointly and insuring only all of such executives for amounts of insurance based upon some plan which will preclude individual selection, for the benefit of persons other than such association, and the premium on which shall be paid by the employer members or the employer members and the executives of such employer members jointly;

6. A policy issued to a credit union which shall be deemed the policyholder, to insure eligible members for the benefit of someone other than the credit union or its officials and subject to the following requirements:

- a. The members eligible for insurance under the policy shall be all the members of the credit union or all of any class or classes thereof.
- b. The premiums for the policy shall be paid by the policyholder, either wholly from the credit union's funds, or partly from such funds and partly from funds contributed by the insured members specifically for their insurance. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.
- c. The amount of insurance under the policy may be based on the amount of the member's savings in the credit

union or upon some other plan precluding individual selection either by the members or by the credit union-;

7. A policy issued to a charitable, benevolent, educational or religious institution, or their agencies, to insure the members thereof for the purpose set forth in subsection D of Section 3604 of this title-;

8. A policy issued to an alumni association of an institution of higher education accredited by the Oklahoma State Regents for Higher Education, to insure the members thereof for the purpose set forth in subsection E of Section 3604 of this title-;

9. A policy to an association, which has a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, that insures at least ten members, employees, or employees of members of the association or its officers or trustees. The term "employees" as used in this paragraph shall include retired employees.

"Association" means, with respect to life insurance coverage offered, an association which:

- a. has been actively in existence for at least five (5) years,
- b. has been formed and maintained in good faith for purposes other than obtaining insurance,
- c. does not condition membership in the association on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee or association member,
- d. makes life insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such member or individuals eligible for coverage through a member,
- e. does not make life insurance coverage offered through the association available other than in connection with a member of the association, and
- f. meets such additional requirements as may be imposed under state law;

10. A policy issued to cover any other group subject to the following requirements:

- a. no such group life insurance policy shall be delivered in this state unless the Commissioner of Insurance finds that:
  - (1) the issuance of such group policy is not contrary to the best interest of the public,

- (2) the issuance of the group policy would result in economies of acquisition or administration, and
- (3) the benefits are reasonable in relation to the premiums charged, and
- b. the premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered person or from both; or

11. A policy issued to cover any other substantially similar group which, in the discretion of the Insurance Commissioner, may be subject to the issuance of a group life policy or contract.

SECTION 43. AMENDATORY Section 6, Chapter 331, O.S.L. 1999 (36 O.S. Supp. 1999, Section 6057.1), is amended to read as follows:

Section 6057.1 A. In order to enforce the provisions of the Health Care Freedom of Choice Act, the Insurance Commissioner may conduct an examination of insurers' and preferred provider organizations' claims files pursuant to the procedure set forth in Section 1250.4 of this title.

B. ~~The Insurance~~ Commissioner, upon finding an insurer in violation of any provision of the Health Care Freedom of Choice Act, may issue a cease and desist order to the insurer directing the insurer to stop such unlawful practices. If the insurer refuses or fails to comply with the order, the Commissioner shall have the authority to revoke or suspend the insurer's certificate of authority. The Commissioner shall use the authority specified in this subsection to the extent deemed necessary to obtain the insurer's compliance with the order. The Attorney General shall offer assistance if requested by the Commissioner to enforce the Commissioner's orders.

~~B.~~ C. Reasonable attorney fees shall be awarded to the Commissioner if judicial action is necessary for the enforcement of the orders. Such fees shall be based upon those prevailing in the community. Fees collected by the Commissioner without the assistance of the Attorney General shall be credited to the Insurance Commissioner's Revolving Fund. Fees collected by the Attorney General shall be credited to the Attorney General's Revolving Fund.

SECTION 44. AMENDATORY 36 O.S. 1991, Section 6125.1, is amended to read as follows:

Section 6125.1 The maximum amount of principal which an organization may legally receive from any one individual pursuant to a contract establishing a fund for prepaid funeral benefits pursuant to paragraph 2 of subsection B of Section 6125 of Title 36 of the Oklahoma Statutes shall be ~~Ten Thousand Dollars (\$10,000.00)~~ Fifteen Thousand Dollars (\$15,000.00).

SECTION 45. AMENDATORY 36 O.S. 1991, Section 6212, as amended by Section 17, Chapter 246, O.S.L. 1996 (36 O.S. Supp. 1999, Section 6212), is amended to read as follows:

Section 6212. A. The Insurance Commissioner shall collect a fee of Twenty Dollars (\$20.00) for an examination for an adjuster's license in any of the following classes of business. The fee for any combination of two or more examinations shall not exceed Forty Dollars (\$40.00). The classes of business are:

1. Motor vehicle physical damage;
2. Fire and allied lines;
3. Casualty;
4. Workers' compensation;
5. Crime and fidelity bonds; and
6. Crop/hail.

B. The Commissioner shall collect the following fees for an adjuster's license:

1. For a license in any single class of business, ~~each year, Fifteen Dollars (\$15.00)~~ every two (2) years, Thirty Dollars (\$30.00);

2. For a license in any combination of two or more classes of business, ~~each year, Twenty-five Dollars (\$25.00)~~ every two years, Fifty Dollars (\$50.00);

3. Public adjuster, ~~each year, Fifteen Dollars (\$15.00)~~ every two years, Thirty Dollars (\$30.00); and

4. Emergency adjuster, as provided for in Section 6218 of this title, each year, Fifteen Dollars (\$15.00).

C. The fees prescribed in this section for examinations shall accompany the application for an original license or a renewal of a license.

D. The fee for the original license or renewal license shall be collected in advance of issuance. Late application for renewal shall require a fee of double the amount of the original license fee.

E. The Commissioner may issue a duplicate license for any lost, stolen, or destroyed license issued pursuant to the provisions of the Insurance Adjusters Licensing Act if an affidavit is submitted by the licensee to the Commissioner concerning the facts of such loss, theft, or destruction. Said affidavit shall be in a form prescribed by the Commissioner. The fee for a duplicate license shall be Five Dollars (\$5.00).

SECTION 46. AMENDATORY 36 O.S. 1991, Section 6217, as last amended by Section 1, Chapter 164, O.S.L. 1995 (36 O.S. Supp. 1999, Section 6217), is amended to read as follows:

Section 6217. A. A license as an adjuster shall expire ~~one (1) year~~ two (2) years from the month of original issuance of the license or subsequent renewal of the license.

B. Any licensee applying for renewal of a license as an adjuster from January 1, ~~1996~~ 2000, through January 1, ~~1997~~ 2001, shall have completed not less than six (6) clock hours of continuing insurance education within the previous eighteen (18) months prior to renewal of the license. Beginning January 1, ~~1997~~ 2001, and each year thereafter, any licensee applying for renewal of a license as an adjuster shall have completed not less than ~~six (6)~~ twelve (12) clock hours of continuing insurance education within the previous ~~twelve (12)~~ twenty-four (24) months prior to renewal of the license. Such continuing education shall cover subjects in the classes of insurance for which the adjuster is licensed. Such continuing education shall not include a written or oral examination. The Insurance Commissioner shall approve courses and providers of continuing education for insurance adjusters as required by this section. For company or staff adjusters the Insurance Commissioner shall approve courses provided by the insurer employing the company or staff adjusters, including training related to the insurance contracts issued by the company employing the company or staff adjusters. Provided, a licensee who, during the allotted time prior to renewal, successfully completes any one of the following courses or programs of instruction and equivalent classroom hours shall be deemed to have met the requirements for continuing education:

1. Any part of the Life Underwriter Training Council Life Course curriculum totaling fifty (50) classroom hours, which may include the health course totaling twenty-six (26) classroom hours;

2. Any part of the American College CLU diploma curriculum totaling thirty (30) classroom hours;

3. Any part of the Insurance Institute of America's Accredited Advisor in Insurance (AAI) program totaling twenty-five (25) classroom hours;

4. Any part of the American Institute of Property and Liability Underwriters' Chartered Property Casualty Underwriter (CPCU) professional designation program totaling thirty (30) classroom hours;

5. Any part of the Certified Insurance Counselor program totaling twenty-five (25) classroom hours;

6. Any insurance-related course, approved by the Advisory Board and the Insurance Commissioner, taught by an accredited college or university or an area vocational-technical school per credit hour granted totaling fifteen (15) classroom hours;

7. Any course or program of instruction or seminar developed or sponsored by an authorized area vocational-technical school, an

insurer, recognized agents' association, or insurance trade association, or any independent program of instruction, if approved by the Advisory Board and the Insurance Commissioner, for the equivalency of the number of classroom hours assigned thereto by the Board and the Commissioner; and

8. Any correspondence course, approved by the Advisory Board and the Insurance Commissioner, for the equivalency of the number of classroom hours assigned thereto by the Commissioner.

C. Subject to the right of the Commissioner to suspend, revoke, or refuse to renew a license of an adjuster, any such license may be renewed by filing on the form prescribed by the Commissioner on or before the expiration date a written request by or on behalf of the licensee for such renewal and proof of completion of the continuing education requirement set forth in subsection B of this section, accompanied by payment of the renewal fee.

D. If the request, proof of compliance with the continuing education requirement and fee for renewal of a license as an adjuster are filed with the Commissioner prior to the expiration of the existing license, the licensee may continue to act pursuant to said license, unless revoked or suspended prior to the expiration date, until the issuance of a renewal license or until the expiration of ten (10) days after the Commissioner has refused to renew the license and has mailed notice of said refusal to the licensee. Any request for renewal filed after the date of expiration may be considered by the Commissioner as an application for a new license.

SECTION 47. AMENDATORY Section 2, Chapter 329, O.S.L. 1992, as last amended by Section 2, Chapter 304, O.S.L. 1998 (36 O.S. Supp. 1999, Section 6512), is amended to read as follows:

Section 6512. As used in the Small Employer Health Insurance Reform Act:

1. "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Insurance Commissioner that a small employer carrier is in compliance with the provisions of Section 6515 of this title, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans;

2. "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person;

3. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

4. "Basic health benefit plan" means a lower cost health benefit plan adopted by the state for small employer groups;

5. "Board" means the board of directors of the program established pursuant to Section & 6522 of this ~~act~~ title;

~~5.~~ 6. "Carrier" means any entity which provides health insurance in this state. For the purposes of the Small Employer Health Insurance Reform Act, carrier includes a licensed insurance company, not-for-profit hospital service or medical indemnity corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

~~6.~~ 7. "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of the Small Employer Health Insurance Reform Act. A small employer carrier shall not use case characteristics, other than age, gender, industry, geographic area, family composition and group size, without prior approval of the Insurance Commissioner;

~~7.~~ 8. "Class of business" means all or a separate grouping of small employers established pursuant to Section 6514 of ~~the Small Employer Health Insurance Reform Act~~ this title;

~~8.~~ 9. "Commissioner" means the Insurance Commissioner;

~~9.~~ 10. "Committee" means the Health Benefit Plan Committee created pursuant to Section 10 of this act;

~~10.~~ 11. "Control" (including the terms "controlling", "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact in the manner provided in Section 1654 of this title. The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect;

~~11.~~ 12. "Department" means the Insurance Department;

~~12.~~ 13. "Dependent" means a spouse, an unmarried child under the age of eighteen (18), an unmarried child who is a full-time

student under the age of twenty-three (23) and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent;

~~13.~~ 14. "Eligible employee" means an employee who works on a full-time basis and has a normal work week of twenty-four (24) or more hours. The term includes a sole proprietor, a partner of a partnership, and associates of a limited liability company, if the sole proprietor, partner or associate is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis;

~~14.~~ 15. "Established geographic service area" means a geographic area, as approved by the Commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage;

- ~~15.~~ 16.
- a. "Health benefit plan" means any hospital or medical policy or certificate; contract of insurance provided by a not-for-profit hospital service or medical indemnity plan; or prepaid health plan or health maintenance organization subscriber contract.
  - b. Health benefit plan does not include accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, any plan certified by the Oklahoma Basic Health Benefits Board, or automobile medical payment insurance.
  - c. "Health benefit plan" shall not include policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance, provided that the carrier offering such policies or certificates complies with the following:
    - (1) the carrier files on or before March 1 of each year a certification with the Commissioner that contains the statement and information described in division (2) of this subparagraph,
    - (2) the certification required in division (1) of this subparagraph shall contain the following:
      - (a) a statement from the carrier certifying that policies or certificates described in this subparagraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance, and
      - (b) a summary description of each policy or certificate described in this subparagraph, including the average annual premium rates

(or range of premium rates in cases where premiums vary by age, gender or other factors) charged for such policies and certificates in this state, and

- (3) in the case of a policy or certificate that is described in this subparagraph and that is offered for the first time in this state on or after the effective date of this act, the carrier files with the Commissioner the information and statement required in division (2) of this subparagraph at least thirty (30) days prior to the date such a policy or certificate is issued or delivered in this state;

~~16.~~ 17. "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

~~17.~~ 18. "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty-one (31) days. However, an eligible employee or dependent shall not be considered a late enrollee if:

- a. the individual meets each of the following:
  - (1) the individual was covered under qualifying previous coverage at the time of the initial enrollment,
  - (2) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse or divorce, and
  - (3) the individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage,
- b. the individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period, or
- c. a court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order;

~~18.~~ 19. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or

offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

~~19.~~ 20. "Plan of operation" means the plan of operation of the program established pursuant to Section § 6522 of this ~~act~~ title;

~~20.~~ 21. "Premium" means all monies paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan;

~~21.~~ 22. "Program" means the Oklahoma Small Employer Health Reinsurance Program created pursuant to Section § 6522 of this ~~act~~ title;

~~22.~~ 23. "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

- a. Medicare or Medicaid,
- b. an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan, or
- c. an individual health insurance policy, including coverage issued by a health maintenance organization, fraternal benefit society and those entities set forth in Section 2501 et seq. of Title 63 of the Oklahoma Statutes, that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that such policy has been in effect for a period of at least one (1) year;

~~23.~~ 24. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect;

~~24.~~ 25. "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to Section § 6522 of this ~~act~~ title;

~~25.~~ 26. "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Section 2501 et seq. of Title 63 of the Oklahoma Statutes to provide health care services to covered individuals;

~~26.~~ 27. "Risk-assuming carrier" means a small employer carrier whose application is approved by the Commissioner pursuant to Section 7 6521 of this ~~act~~ title;

~~27.~~ 28. "Small employer" means any person, firm, corporation, partnership, limited liability company or association that is

actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than fifty (50) eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state income taxation, shall be considered one employer; ~~and~~

~~28.~~ 29. "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state; and

30. "Standard health benefit plan" means the health benefit plan adopted by the state for small employers.

SECTION 48. AMENDATORY Section 8, Chapter 211, O.S.L. 1994, as amended by Section 5, Chapter 304, O.S.L. 1998 (36 O.S. Supp. 1999, Section 6522), is amended to read as follows:

Section 6522. A. A reinsuring carrier shall be subject to the provisions of this section.

B. There is hereby created a nonprofit entity to be known as the "Oklahoma Small Employer Health Reinsurance Program".

C. 1. The program shall operate subject to the supervision and control of the board. Subject to the provisions of paragraph 2 of this subsection, the board shall consist of eight (8) members appointed by the Insurance Commissioner plus the Commissioner, or his or her designated representative, who shall serve as an ex officio member of the board.

2. a. In selecting the members of the board, the Commissioner shall include representatives of small employers and small employer carriers and such other individuals determined to be qualified by the Commissioner. At least five members of the board shall be representatives of carriers and shall be selected from individuals nominated in this state pursuant to procedures and guidelines developed by the Commissioner.
- b. In the event that the program becomes eligible for additional financing pursuant to paragraph 3 of subsection L of this section, the board shall be expanded to include two additional members who shall be appointed by the Commissioner. In selecting the additional members of the board, the Commissioner shall choose individuals who represent organizations offering categories of health insurance not already represented on the board, including but not limited to excess or stoploss health insurance. The expansion of the board under this subsection shall continue for the period that the program continues to be eligible for additional financing pursuant to paragraph 3 of subsection L of this section.

3. The initial board members shall be appointed as follows: two of the members to serve a term of two (2) years; three of the members to serve a term of four (4) years; and three of the members to serve a term of six (6) years. Subsequent board members shall serve for a term of three (3) years. A board member's term shall continue until his or her successor is appointed.

4. A vacancy on the board shall be filled by the Commissioner. A board member may be removed by the Commissioner for cause.

D. Within sixty (60) days after ~~the effective date of this act~~ July 1, 1994, each small employer carrier shall make a filing with the Commissioner containing the carrier's net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

E. Within one hundred eighty (180) days after the appointment of the initial board, the board shall submit to the Commissioner a plan of operation and, thereafter, any amendments thereto necessary or suitable to ensure the fair, reasonable and equitable administration of the program. The Commissioner may, after notice and hearing, approve the plan of operation if the Commissioner determines it to be suitable to ensure the fair, reasonable and equitable administration of the program, and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the Commissioner.

F. If the board fails to submit a suitable plan of operation within one hundred eighty (180) days after its appointment, the Commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The Commissioner shall amend or rescind any plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the Commissioner.

G. The plan of operation shall:

1. Establish procedures for the handling and accounting of program assets and monies and for an annual fiscal reporting to the Commissioner;

2. Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

3. Establish procedures for reinsuring risks in accordance with the provisions of this section;

4. Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program;

5. Establish a methodology for applying the dollar thresholds contained in this section in the case of carriers that pay or reimburse health care providers through capitation or salary; or

6. Provide for any additional matters necessary for the implementation and administration of the program.

H. The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:

1. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this act, including the authority, with the approval of the Commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

2. Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;

3. Take any legal action necessary to avoid the payment of improper claims against the program;

4. Define the health benefit plans for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this act;

5. Establish rules, conditions and procedures for reinsuring risks under the program;

6. Establish actuarial functions as appropriate for the operation of the program;

7. Assess reinsuring carriers in accordance with the provisions of subsection L of this section, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

8. Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program; and

9. Unless otherwise prohibited by law, borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

I. A reinsuring carrier may reinsure with the program as provided for in this subsection:

1. With respect to a basic health benefit plans plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage ~~as described in paragraph 4 of this subsection~~ provided in a basic or standard health benefit plan;

2. A small employer carrier may reinsure an entire employer group within sixty (60) days following the commencement of the group's coverage under a health benefit plan;

3. A reinsuring carrier may reinsure an eligible employee or dependent of a small employer within a period of sixty (60) days following the commencement of coverage of the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty (60) days of the commencement of his or her coverage;

4. a. The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of Five Thousand Dollars (\$5,000.00) in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for ten percent (10%) of the next Fifty Thousand Dollars (\$50,000.00) of benefit payments during a calendar year, and the program shall reinsure the remainder. A reinsuring carrier's liability under this subparagraph shall not exceed a maximum limit of Ten Thousand Dollars (\$10,000.00) in any one (1) calendar year with respect to any reinsured individual.
- b. The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Department of Labor, Bureau of Labor Statistics, unless the board proposes and the Commissioner approves a lower adjustment factor;

5. A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan;

6. Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. Sec. 300c(c)(2)(A), and as such is subject to requirements that limit the amount of risk that may be ceded to the program that is more restrictive than those specified in paragraph 4 of this subsection, shall be reduced to reflect that portion of the risk above the amount set forth in paragraph 4 of this subsection that may not be ceded to the program, if any; and

7. A reinsuring carrier shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

J. 1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates which shall be multiplied by the factors set forth in paragraph 2 of this subsection to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the Commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention levels required under this act.

2. Premiums for the program shall be as follows:

- a. an eligible employee or dependent may be reinsured for a rate that is five (5) times the base reinsurance premium rate for the individual established pursuant to this paragraph, and
- b. an entire small employer group may be reinsured for a rate that is one and one-half (1 1/2) times the base reinsurance premium rate for the group established pursuant to this paragraph. However, in no event shall the reinsurance premium for any entire group be less than five (5) times the lesser of:
  - (1) the lowest base reinsurance rate applicable to any insured employee, or
  - (2) the lowest base reinsurance rate applicable to any insured dependent in the group.

3. The board periodically shall review the methodology established under paragraph 1 of this subsection, including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the Commissioner.

4. The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

K. If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the

small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in Section 6515 of ~~Title 36 of the Oklahoma Statutes~~ this title.

L. 1. Prior to March 1 of each year, the board shall determine and report to the Commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

2. Any net loss for the year shall be recouped by assessments of reinsuring carriers.

- a. The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers. The assessment formula shall be based on:
  - (1) each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers, and
  - (2) each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring carriers.
- b. The formula established pursuant to subparagraph a of this paragraph shall not result in any reinsuring carrier having an assessment share that is less than fifty percent (50%) nor more than one hundred fifty percent (150%) of an amount which is based on the proportion of the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers.
- c. The board may, with approval of the Commissioner, change the assessment formula established pursuant to subparagraph a of this paragraph from time to time as appropriate. The board may provide for the shares of the assessment base attributable to total premium and to the previous year's premium to vary during a transition period.
- d. Subject to the approval of the Commissioner, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. Sec. 300 et seq., to the

extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

3. a. Prior to March 1 of each year, the board shall determine and file with the Commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.
- b. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed five percent (5%) of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers, the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the Commissioner within ninety (90) days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file a report with the Commissioner within ninety (90) days following the end of the applicable calendar year, the Commissioner may evaluate the operations of the program and implement such amendments to the plan of operation the Commissioner deems necessary to reduce future losses and assessments.
- c. If assessments in each two (2) consecutive calendar years exceed five percent (5%) of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers, the program shall be eligible to receive additional financing as provided in Section 6523 of this title.

4. If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, "future losses" includes reserves for incurred but not reported claims.

5. Each reinsuring carrier's proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the reinsuring carriers with the board.

6. The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

7. A reinsuring carrier may seek from the Commissioner a deferment from all or part of an assessment imposed by the board.

The Commissioner may defer all or part of the assessment of a reinsuring carrier if the Commissioner determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition. If all or part of an assessment against a reinsuring carrier is deferred, the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The reinsuring carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessments.

M. Neither the participation in the program as reinsuring carriers, the establishment of rates, forms or procedures, nor any other joint or collective action required by this section and Section 6523 of this title shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.

N. The program shall be exempt from any and all taxes.

SECTION 49. AMENDATORY 74 O.S. 1991, Section 1332, as amended by Section 9, Chapter 367, O.S.L. 1992 (74 O.S. Supp. 1999, Section 1332), is amended to read as follows:

Section 1332. A. The State and Education Employees Group Insurance Board shall establish a Disability Insurance Program for state employees. The program shall consist of a long-term disability plan and a short-term disability plan. Participation in the program shall be limited to state employees who have been state employees for a period of not less than ~~six (6) months~~ one (1) month and who are eligible for enrollment in the Health Insurance Plan administered by the Board. No state employee shall be eligible to receive any benefits from the long-term disability program unless the state employee has used all of ~~his or her~~ the sick leave of the employee. The Board shall promulgate such rules ~~and regulations~~ as are necessary for adoption and administration of the Disability Insurance Program, including but not limited to benefit eligibility requirements, methods for computing benefit amounts, benefits amounts, and verification of medical and health status of employees applying for or receiving benefits. Provided, no preexisting condition limitation or waiting period shall be assessed against any state employee prior to or as a condition of receiving benefits for short- or long-term disability coverage under the Disability Insurance Program. As it pertains to preexisting conditions and waiting periods, the loss shall begin after the effective date of coverage and during the period that coverage is in force.

B. The Disability Insurance Program shall be funded from appropriations made by the Legislature. Employees shall not be required to make contributions to participate in the program.

C. Employee disability insurance coverage shall begin on March 1, 1986.

D. The Board shall establish a grievance procedure by which a three-member grievance panel established in the same manner as

specified in paragraph (f) of Section 1306 of this title shall act as an appeals body for complaints regarding the allowance and payment of claims, eligibility, and other matters. The grievance procedure provided by this subsection shall be the exclusive remedy available to persons having complaints against the insurer. Such grievance procedure shall be subject to the Oklahoma Administrative Procedures Act, ~~Sections 301 through 325 of Title 75 of the Oklahoma Statutes,~~ including provisions ~~thereof~~ for the review of agency decisions by the district court. The grievance panel shall schedule a hearing regarding the allowance and payment of claims, eligibility and other matters within sixty (60) days from the date the grievance panel receives a written request for a hearing. Upon written request to the grievance panel received not less than ten (10) days before the hearing date, the grievance panel shall cause a full stenographic record of the proceedings to be made by a licensed or certified court reporter at the insured employee's expense.

E. The Board may establish a claim processing division for claims administration or may contract for claims administration services with a private insurance carrier or a company that specializes in claims administration of any insurance that the Board may be directed to offer.

SECTION 50. This act shall become effective November 1, 2000.

Passed the Senate the 26th day of May, 2000.

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President of the Senate

Passed the House of Representatives the 26th day of May, 2000.

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Speaker of the House of Representatives

