

ENGROSSED SENATE AMENDMENT
TO
ENGROSSED HOUSE
BILL NO. 1341

By: Cox of the House

and

Wilkerson of the Senate

An Act relating to insurance; prohibiting disclosure of nonpublic personal information; * * * * eliminating certain filing requirements; eliminating deviation procedure; modifying prohibited actions relating to motor vehicle insurance; * * * * subsidiaries of insurers; modifying prohibition on offer or acquisition of voting security of domestic insurer; * * * * insurance policies and contracts; modifying instruments that must contain warning statement; * * * * Small Employer Health Insurance Reform Act; * * * * providing an effective date; and declaring an emergency.

AMENDMENT NO. 1. Page 1, strike the title, enacting clause and entire bill and insert

"[insurance - property and casualty insurance -
codification - repealer - effective date -
emergency]

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 307.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. No person shall disclose any nonpublic personal information contrary to the provisions of Title V of the Gramm-Leach-Bliley Act of 1999, Public Law No. 106-102.

B. The Insurance Commissioner may promulgate rules necessary to carry out the provisions of this section.

C. Nothing in this section shall be construed to create a private cause of action.

SECTION 2. AMENDATORY 36 O.S. 1991, Section 309.4, is amended to read as follows:

Section 309.4 A. All examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the company, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from such facts.

B. No later than thirty (30) days following completion of the examination, the examiner in charge shall file with the Insurance Department a verified written report of examination under oath. Upon receipt of the verified report, the Department shall transmit the report to the company examined, together with a notice which shall afford such company examined a reasonable opportunity of not more than twenty (20) days to make a written submission or written rebuttal with respect to any matters contained in the examination report.

C. Within twenty (20) days of the end of the period allowed for the receipt of written submissions or written rebuttals, the Insurance Commissioner shall fully consider and review the report, together with any written submissions or written rebuttals and any relevant portions of the examiners' workpapers and enter an order:

1. Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the Commissioner, the Commissioner may order the company to take any action the Commissioner considers necessary and appropriate to cure such violation;

2. Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining

additional data, documentation or information, and refiling pursuant to subsection A of this section; or

3. Calling for an investigatory hearing with notice pursuant to the Administrative Procedures Act to the company for purposes of obtaining additional documentation, data, information and testimony.

D. 1. All orders entered pursuant to paragraph 1 of subsection C of this section shall be accompanied by findings and conclusions resulting from the Commissioner's consideration and review of the examination report, relevant examiner workpapers and any written submissions or rebuttals. Any such order shall be considered a final administrative decision and may be appealed pursuant to the Administrative Procedures Act, and shall be served upon the company by certified mail, together with a copy of the adopted examination report. Within thirty (30) days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders. Upon proper order of the Commissioner, the company shall deliver by mail or otherwise, within thirty (30) days of the date of the order, a copy of the adopted report and related orders to all states and jurisdictions in which the company is licensed to transact the business of insurance.

2. Any hearing conducted pursuant to paragraph 3 of subsection C of this section by the Commissioner or authorized representative, shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the Commissioner's review of relevant workpapers or by the written submission or rebuttal of the company. Within thirty (30) days of the conclusion of any such hearing, the Commissioner shall enter an order pursuant to paragraph 1 of subsection C of this section.

3. The Commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The Commissioner or ~~his~~ a representative of the Commissioner may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation whether under the control of the Department, the company or other persons. The documents produced shall be included in the record, and testimony taken by the Commissioner or ~~his~~ representative of the Commissioner shall be under oath and preserved for the record.

4. Nothing contained in this section shall require the Department to disclose any information or records which would indicate or show the existence or content of any investigation or activity of a criminal justice agency.

5. The hearing shall proceed with the Commissioner or ~~his~~ a representative of the Commissioner posing questions to the persons subpoenaed. Thereafter the company and the Department may present testimony relevant to the investigation. The company and the Department shall be permitted to make closing statements and may be represented by counsel of their choice.

E. 1. Upon the adoption of the examination report under paragraph 1 of subsection C of this section, the Commissioner shall continue to hold the content of the examination report as private and confidential information for a period of two (2) days except to the extent provided in subsection B of this section and subsection F of Section ~~3~~ 309.3 of this ~~act~~ title. Thereafter, the Commissioner may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

2. Nothing contained in Sections ~~4~~ 309.1 through ~~7~~ 309.7 of this ~~act~~ title shall prevent or be construed as prohibiting the Commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any other state or

country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with Sections ~~4~~ 309.1 through ~~7~~ 309.7 of this ~~act~~ title.

3. In the event the Commissioner determines that regulatory action is appropriate as a result of any examination, ~~he~~ the Commissioner may initiate any proceedings or actions as provided by law.

F. All working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the Commissioner or any other person in the course of an examination made under Sections ~~4~~ 309.1 through ~~7~~ 309.7 of this ~~act~~ title shall be given confidential treatment and are not subject to subpoena and may not be made public by the Commissioner or any other person, except to the extent provided in subsection E of this section and subsection F of Section ~~3~~ 309.3 of this ~~act~~ title. Access may also be granted to the National Association of Insurance Commissioners. Such parties shall agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

SECTION 3. AMENDATORY 36 O.S. 1991, Section 311, as last amended by Section 13, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 2000, Section 311), is amended to read as follows:

Section 311. A. Each insurer authorized to do business under the provisions of this Code shall, annually, on or before the first day of March, file in the office of the Insurance Commissioner and with the National Association of Insurance Commissioners (NAIC), statements which shall exhibit its financial condition on the thirty-first day of December of the previous year and its business of that year. Annual statements shall be filed with the NAIC by

diskette or electronically as approved by the NAIC. For good cause shown, the Insurance Commissioner may extend the time within which such statements may be filed. The statements shall be in such general form and context as approved by the National Association of Insurance Commissioners for the kinds of insurance to be reported upon, and as supplemented for additional information required by the Insurance Commissioner by rule. In addition, the statements shall be prepared in accordance with the NAIC annual statement instruction handbooks and follow the accounting procedures and practices prescribed by the NAIC accounting practices and procedure manuals as supplemented by the Insurance Commissioner by rule. The assets and liabilities shall be computed pursuant to the most conservative method allowed by the laws of this state. Such statements shall be subscribed and sworn to by the president and secretary and other proper officers. And if the Insurance Commissioner finds that the facts warrant, and that all laws applicable to the insurer are fully complied with, the Commissioner shall issue to the company a license, or certificate of authority, subject to all requirements and conditions of the law, to transact business in this state, specifying in the certificate the particular kind or kinds of insurance it is authorized to transact, and the certificate shall expire on the first day of March next after its issue. If a new certificate of authority is neither issued nor denied by the first day of March, the insurer shall be deemed to possess a temporary certificate of authority for a period not to exceed six (6) months, until the new certificate is issued or specifically refused. The annual statement of an insurer of a foreign country shall embrace only its business and condition in the United States, and shall be subscribed and sworn to by its resident manager or principal representative in charge of its United States business, or other officer duly authorized. Any amendments and addendums to the annual statement subsequently filed with the Commissioner shall also be

filed with the National Association of Insurance Commissioners, and the insurer shall pay the applicable filing fees.

B. In the absence of actual malice, or gross negligence, members of the National Association of Insurance Commissioners, their duly authorized committees, subcommittees and task forces, their delegates, National Association of Insurance Commissioners' employees, and all others charged with the responsibility of collecting, reviewing, analyzing and disseminating the information developed from the filing of the annual statement shall be acting as agents of the Commissioner under the authority of this section and shall not be subject to civil liability for libel, slander or any other cause of action by virtue of their collection, review and analysis or disseminating of the data and information collected from the filings required under this section.

C. All financial analysis ratios and examination synopses pertaining to insurance companies, which are submitted to the Commissioner by the National Association of Insurance Commissioners' Insurance Regulatory Information System, are confidential records which shall not be available for public inspection and shall not be disclosed by the Commissioner except in receivership proceedings.

SECTION 4. AMENDATORY 36 O.S. 1991, Section 332, is amended to read as follows:

Section 332. A. The State Board for Property and Casualty Rates is hereby vested with the duty and authority of enforcing and administering all applicable provisions of the Insurance Code pertaining to the jurisdiction of the Board. The Board may make reasonable rules and regulations necessary for effectuating such provisions of this Code.

B. The Board shall have powers and authority expressly conferred upon it by or reasonably implied from the provisions of this Code. The Board shall have the power to approve, disapprove, or approve with modifications, filings submitted to it.

C. The Board may conduct such examinations and investigations of insurance matters, within the scope of its authority, as it may deem proper to secure information useful in the lawful administration of the applicable provisions of the Insurance Code.

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

1. The Commissioner shall maintain a list of technicians qualified pursuant to rules adopted by the Board who are proficient in the lines of insurance for which the Board approves rates. Upon request of the Commissioner or the Board, the Commissioner shall employ the next available technician in rotation on the list, proficient in the line or lines of insurance being reviewed. The Commissioner may deviate from the list when employing technicians for loss cost filings pursuant to Section 901.5 of this title.

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

E. The Commissioner shall employ for the Board examiners to ensure that the rates which have been approved by or filed with the Board are the rates which are being used by the insurer or by the insurers whose rating organization has had a rate approval or rate filing.

1. Any insurer examined pursuant to the provisions of this section shall pay all reasonable charges incurred in such examination, including the actual expense of the Commissioner or the expenses and compensation of ~~his~~ the authorized representative of the Commissioner and the expense and compensation of assistants and examiners employed therein.

2. All expenses incurred in such examination shall be verified by affidavit and a copy shall be filed and kept in the office of the Insurance Commissioner.

SECTION 5. AMENDATORY Section 2, Chapter 344, O.S.L. 1999 (36 O.S. Supp. 2000, Section 362), is amended to read as follows:

Section 362. A. There is hereby created in the State Treasury a revolving fund for the Insurance Commissioner to be designated the "Insurance Department Anti-Fraud Revolving Fund". The fund shall be a continuing fund, not subject to fiscal year limitations and shall consist of all monies received and collected by the Insurance Department pursuant to subsection B of this section and all other monies designated to the fund by law. All monies accruing to the credit of said fund are hereby appropriated and may be budgeted and expended by the Insurance Commissioner for the purposes of investigation of suspected insurance fraud and civil or administrative action in cases involving suspected insurance fraud. Expenditures from said fund shall be made upon warrants issued by the State Treasurer against claims filed as prescribed by law with the Director of State Finance for approval and payment.

B. ~~Each insurer licensed to do business in this state~~ The following shall pay an annual fee of ~~Five Hundred Dollars (\$500.00)~~ Six Hundred Dollars (\$600.00) to the Insurance Department which shall be payable quarterly in the amount of ~~One Hundred Twenty-five Dollars (\$125.00)~~ One Hundred Fifty Dollars (\$150.00): Life, accident and health insurers; property and casualty insurers; county

mutual fire insurers; mutual benefit associations; fraternal benefit societies; reciprocal insurers; motor service clubs; title insurers; nonprofit insurers; health maintenance organizations (HMOs); risk retention groups; surplus lines carriers; multiple employer welfare arrangements (MEWAs); trusts which write surety policies; prepaid dental plan organizations; third-party administrators; and accredited reinsurers. The payments shall be due on or before the last day of the month following each calendar quarter. ~~The first payment shall be made not later than July 30, 1999.~~ Within sixty (60) days after each calendar quarter, the Commissioner shall transfer:

1. Twenty-five percent (25%) of all monies collected by the Insurance Department pursuant to this section to the Attorney General's Insurance Fraud Unit Revolving Fund created in Section ~~7 19.3~~ of ~~this act~~ Title 74 of the Oklahoma Statutes, for use by the Attorney General in the investigation and prosecution of insurance fraud; and

2. Fifteen percent (15%) of all monies collected by the Insurance Department pursuant to this section to the OSBI Revolving Fund created in Section 150.19a of Title 74 of the Oklahoma Statutes, for use by the Oklahoma State Bureau of Investigation in the investigation of insurance fraud.

SECTION 6. AMENDATORY 36 O.S. 1991, Section 628, is amended to read as follows:

Section 628. When by or pursuant to the laws of any other state or foreign country any premium or income or other taxes, or any fees, fines, penalties, licenses, deposit requirements or other material obligations, prohibitions or restrictions are imposed upon Oklahoma insurers doing business, or that might seek to do business in such other state or country, or upon the agents of such insurers, which in the aggregate are in excess of such taxes, fees, fines, penalties, licenses, deposit requirements or other obligations,

prohibitions or restrictions directly imposed upon similar insurers or agents of such other state or foreign country under the statutes of this state, so long as such laws continue in force or are so applied, the same obligations, prohibitions and restrictions of whatever kind shall be imposed upon similar insurers or agents of such other state or foreign country doing business in Oklahoma. 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. Any tax, license or other obligation imposed by any city, county or other political subdivision of a state or foreign country on Oklahoma insurers or their agents shall be deemed to be imposed by such state or foreign country within the meaning of this section. The provisions of this section shall not apply to ad valorem taxes on real or personal property or to personal income taxes. Monies collected pursuant to this section shall be paid by the Insurance Commissioner to the State Treasury to the credit of the General Revenue Fund of the state.

SECTION 7. AMENDATORY 36 O.S. 1991, Section 903, as last amended by Section 35, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 2000, Section 903), is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Any such rate shall remain in effect ~~as provided in subsection F of this section~~ until amended or withdrawn by the insurer.

~~F. Filed rates, whether made by an insurer or by a rating organization, and whether or not prior approval is required under the flex rating, file and use, or automatic rate reduction system, shall be effective for a period to be determined by the Insurance Commissioner from the effective date of the insurer's or rating organization's rate filing unless otherwise changed by the Board, or unless superseded by a subsequent filing approved pursuant to the~~

~~procedures set out herein. The Commissioner shall adopt rules pursuant to the Administrative Procedures Act relative to the duration of the filing periods for each line of insurance, but in no event will the period be set at less than four (4) years. The Commissioner shall notify, in writing, each insurer of the durational filing period for each line of insurance. Nothing in this section will be deemed to require refiling of rates that are no longer in use. Prior to the imposition of penalties for failure to comply to the provisions of this section, the Commissioner shall give written notice to the insurer. The insurer shall have thirty (30) days following the receipt of notice to initiate a filing, withdraw, amend, or continue a filing rate. Upon failure to take action prior to the expiration of the thirty-day period, the insurer may be fined an amount not to exceed One Thousand Dollars (\$1,000.00).~~

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

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

~~I.~~ H. When investigating rates to determine whether or not they comply with the provisions of this act, the previously approved

filing shall not be changed, altered, amended, or held in abeyance until after completion of the investigation and an opportunity for hearing in accordance with the provisions of this article. Following such hearing, the Board shall enter its order in accordance with the provisions of this act. The effective date of such order shall not be less than thirty (30) days nor more than sixty (60) days after the date of the order unless the Board determines that, in the public interest, a shorter or longer period is appropriate; provided, the filer has adequate time to implement such rate change. Any such order shall apply prospectively only and shall not affect premiums collected on new or renewal policies issued prior to the effective date of this order.

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

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

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

that such filing shall not become effective to the extent disapproved.

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

SECTION 8. AMENDATORY 36 O.S. 1991, Section 929, is amended to read as follows:

Section 929. ~~A.~~ Except with regard to homeowner's insurance, every member of, or subscriber to, a licensed rating organization may adhere to the filings made on its behalf by such organization, except that any such member or subscriber may deviate from such filings as authorized herein if it has filed with the rating organization and with the Board, the deviation to be applied and information necessary to justify the deviation, provided such deviation, other than direct deviations as are authorized by this act, is approved by the Board. If approved, the deviation shall remain in force until such approval is withdrawn by the insurer with the approval of the Board when required. The Board shall approve

any such deviation requiring Board action unless it finds that the deviation to be applied would not be uniform in its application or would be inconsistent with the provisions of this act, but unless it approves the deviation within thirty (30) days it shall, within a reasonable time, grant a hearing to the applicant at the applicant's request.

~~B. Nothing in this act shall prevent an insurer, except a workers' compensation insurer, from reducing and immediately using a rate, which is reduced by no more than fifteen percent (15%) of the last formally approved rate, without filing a rate application with the Board. However, the insurer shall file notice of a rate decrease with the Board which shall approve or disapprove such rate reduction within thirty (30) calendar days of receipt of such notice. The insurer may increase such rate to the originally approved rate at any time, but shall, ten (10) days prior to making such increase, notify the Board of its intention. Such deviation shall become effective upon the date that notice is received by the Board.~~

SECTION 9. AMENDATORY 36 O.S. 1991, Section 941, is amended to read as follows:

Section 941. A. No insurance carrier who issues motor vehicle insurance policies in this state shall assign driving record points, cancel, refuse to issue or renew, or ~~increase the charge a higher~~ premium rate for any motor vehicle liability or collision insurance policy for the reason that the insured has been involved in a motor vehicle collision and was not at fault.

B. This section shall not apply to an insured who has been convicted of:

1. Homicide or assault arising out of the operation of any motor vehicle; or

2. A violation of ~~Sections~~ Section 11-902 or 761 of this title Title 47 of the Oklahoma Statutes as being impaired by or under the

influence of alcohol or intoxicating liquor or who was under the influence of any substance included in the Uniform Controlled Dangerous Substances Act.

C. The Insurance Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance business in this state of any insurance carrier violating the provisions of this section or may censure the insurer or impose a fine.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1219.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in this section:

1. "Direct contract" means a written agreement between the health care provider and the person directly purporting to offer discounts through the discount card which expressly states the intent of this agreement to be used for the purpose of offering discounts on health-related purchases to uninsured or noncovered persons.

2. "Discount card" means a card or any other purchasing mechanism or device, which is not insurance, that purports to offer discounts or access to discounts in health-related purchases from health care providers;

3. "Health care provider" means any person or entity licensed by this state to provide health care services including, but not limited to, physicians, hospitals, home health agencies, pharmacies, and dentists;

4. "Person" means an individual, corporation, business trust, estate, trust, partnership, association, joint venture, limited liability company, or any other government or commercial entity;

B. It shall be unlawful for any person to sell, market, promote, advertise or otherwise distribute any discount card where:

1. Any discount offered by such discount card is not specifically authorized by a separate direct contract between each health care provider and the person selling the discount card;

2. The discount card does not expressly state in bold and prominent type that such discount is not insurance; and

3. The discount or range of discounts offered by such discount card are misleading, deceptive or fraudulent, regardless of the literal wording used on such discount card.

C. The penalty for a person who violates the provisions of this section may include:

1. A full repayment of all funds collected from individuals which purchased or incurred expenses as a result of buying or using the discount card;

2. Payment to health care providers for services provided to any person who defaulted on payment of claims related to their use of the discount card;

3. An amount equal to One Hundred Dollars (\$100.00) per discount card sold, marketed, promoted, advertised or otherwise distributed within the State of Oklahoma, or Ten Thousand Dollars (\$10,000.00), whichever is greater;

4. Three times the amount of the actual damages, if any, sustained;

5. Reasonable attorney's fees;

6. Costs; and

7. Any other relief which the court deems proper.

SECTION 11. AMENDATORY 36 O.S. 1991, Section 1241, as amended by Section 8, Chapter 353, O.S.L. 2000 (36 O.S. Supp. 2000, Section 1241), is amended to read as follows:

Section 1241. A property and casualty insurer shall, within ~~sixty (60)~~ forty-five (45) 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 ~~sixty (60)~~ forty-five (45) 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 ~~sixty-day~~ forty-five-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 12. AMENDATORY 36 O.S. 1991, Section 1257, as last amended by Section 8, Chapter 342, O.S.L. 1994, and as renumbered by Section 20, Chapter 342, O.S.L. 1994 (36 O.S. Supp. 2000, Section 1250.8), is amended to read as follows:

Section 1250.8 A. If an insurance policy or insurance contract provides for the adjustment and settlement of first party motor vehicle total losses, on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods shall apply:

1. An insurer may elect to offer a replacement motor vehicle which is a specific comparable motor vehicle available to the insured, with all applicable taxes, license fees, and other fees incident to the transfer of evidence of ownership of the motor vehicle paid, at no cost to the insured other than any deductible provided in the policy. The offer and any rejection thereof shall be documented in the claim file; or

2. An insured may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a

comparable motor vehicle, including all applicable taxes, license fees and other fees incident to a transfer of evidence of ownership, or a comparable motor vehicle. Such cost may be determined by:

- a. the cost of a comparable motor vehicle in the local market area when a comparable motor vehicle is available in the local market area,
- b. one of two or more quotations obtained by an insurer from two or more qualified dealers located within the local market area when a comparable motor vehicle is not available in the local market area, or
- c. the cost of a comparable motor vehicle as quoted in the latest edition of the National Automobile Dealers Association Official Used Car Guide or monthly edition of any other nationally recognized published guidebook.

B. If a first party motor vehicle total loss is settled on a basis which deviates from the methods described in subsection A of this section, the deviation shall be supported by documentation giving particulars of the condition of the motor vehicle. Any deductions from such cost, including, but not limited to, deduction for salvage, shall be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to a first party claimant.

C. If liability for motor vehicle damages is reasonably clear, insurers shall not recommend that third party claimants make claims pursuant to the third party claimants' own policies solely to avoid paying claims pursuant to such insurer's insurance policy or insurance contract.

D. Insurers shall not require a claimant to travel unreasonably either to inspect a replacement motor vehicle, obtain a repair

estimate or have the motor vehicle repaired at a specific repair shop.

E. Insurers shall, upon the request of a claimant, include the deductible of a first party claimant, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with a first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses shall be made from a deductible recovery unless an outside attorney is retained to collect such recovery. The deduction shall then be made for only a pro rata share of the allocated loss adjustment expense.

F. If an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it reasonably may be expected that the damage can be repaired satisfactorily. An insurer shall give a copy of an estimate to a claimant and may furnish to the claimant the names of one or more conveniently located repair shops, if requested by the claimant.

G. If an amount claimed is reduced because of betterment or depreciation, all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

H. An insurer or its representative shall not require a claimant to obtain motor vehicle repairs at a specific repair facility. An insurer or its representative shall not require a claimant to obtain motor vehicle glass repair or replacement at a specific motor vehicle glass repair or replacement facility. An insurer shall fully and promptly pay for the cost of the motor vehicle repair services or products, less any applicable deductible amount payable according to the terms of the policy. The claimant shall be furnished an itemized priced statement of repairs by the repair facility at the time of acceptance of the repaired motor vehicle. Unless a cash settlement is made, if a claimant selects a

motor vehicle repair or motor vehicle glass repair or replacement facility, the insurer shall provide payment to the facility based on a competitive price, as established by that insurer through market surveys or by the insured through competitive bids at the insured's option, to determine a fair and reasonable market price for similar services. Reasonable deviation from this market price is allowed based on the facts in each case.

I. An insurer shall not use as a basis for cash settlement with a first party claimant an amount which is less than the amount which an insurer would pay if repairs were made, other than in total loss situations, unless such amount is agreed to by the insured.

J. An insurer shall not force a claimant to execute a full settlement release in order to settle a property damage claim involving a personal injury.

K. All payment or satisfaction of a claim for a motor vehicle which has been transferred by title to the insurer shall be paid by check or draft, payable on demand.

L. As used in this section, "total loss" means that the vehicle repair costs plus the salvage value of the vehicle meets or exceeds the actual cash value of the motor vehicle prior to the loss, as provided in used automobile dealer guidebooks.

SECTION 13. AMENDATORY 36 O.S. 1991, Section 1653, as last amended by Section 88, Chapter 418, O.S.L. 1997 (36 O.S. Supp. 2000, Section 1653), is amended to read as follows:

Section 1653. A. No person other than the issuer shall make a tender offer for, request or invite tenders of, or enter into any agreement to exchange, seek to acquire or acquire, in the open market or otherwise, any voting security of a domestic insurer or of any other person controlling a domestic insurer, ~~if such other person, either directly or through his or her affiliates, is substantially engaged in the business of insurance,~~ if, after the consummation of such action, such person would, directly or

indirectly, or by conversion or by exercise of any right to acquire, be in control of such insurer. No person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer unless, at the time any such offer, request, or invitation is made or any such agreement is entered into, or prior to the acquisition of such securities if no offer or agreement is involved, such person has filed with the Insurance Commissioner and has sent to such insurer, and such insurer has sent to its shareholders, a statement containing the information required by this section and such offer, request, invitation, agreement or acquisition has been approved by the Commissioner in the manner prescribed in subsection D of this section.

B. The statement to be filed with the Commissioner as required by subsection A of this section shall be made under oath or affirmation and shall contain the following information described in this subsection.

1. The name and address of each person, referred to in this section as the "acquiring party", by whom or on whose behalf the merger or other acquisition of control referred to in subsection A of this section is to be effected.

a. If such person is an individual:

- (1) his or her principal occupation and all offices and positions held during the past five (5) years,
- (2) any conviction of any felony or of a misdemeanor involving moral turpitude, dishonesty, or breach of trust, during his or her lifetime, and
- (3) any conviction of crimes other than minor traffic violations and any administrative discipline imposed during the past ten (10) years.

b. If such person is not an individual:

- (1) a report of the nature of its business operations during the past five (5) years or for such lesser period as such person and any predecessors thereof shall have been in existence,
- (2) any conviction of any felony or of a misdemeanor involving moral turpitude, dishonesty, or breach of trust, during its existence, and any administrative discipline imposed during the past ten (10) years,
- (3) an informative description of the business intended to be done by such person and such person's subsidiaries, and
- (4) a list of all individuals who are or who have been selected to become directors or executive officers of such person, or who perform or will perform functions appropriate to such positions. Such list shall include for each such individual the information required by subparagraph a of this paragraph.

2. The source, nature and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for any such purpose, and the identity of persons furnishing such consideration; provided, however, that where a source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing such statement so requests.

3. Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years for each such acquiring party, or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence, and similar unaudited information as of a

date not earlier than ninety (90) days prior to the filing of the statement. However, the Commissioner has the discretionary ability to waive the audit requirements set forth in this section based upon review of substantially similar financial disclosure statements submitted by the acquiring party.

4. Any plans or proposals which each acquiring party may have to liquidate such insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management.

5. The number of shares of any security referred to in subsection A of this section which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement, or acquisition referred to in subsection A of this section, including any requested documentary evidence of the same, and a statement as to the method by which the fairness of the proposal was arrived at.

6. The amount of each class of any security referred to in subsection A of this section which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party.

7. A full description of any contracts, arrangements or understandings with respect to any security referred to in subsection A of this section in which any acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies, including any required documentary evidence of the same. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

8. A description of the purchase of any security referred to in subsection A of this section during the twelve (12) calendar months

preceding the filing of the statement, by any acquiring party, including the dates of purchase, names of the purchasers, and consideration paid or agreed to be paid therefor.

9. Copies of all tender offers for, advertisements for, invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in subsection A of this section, and, if distributed, of additional soliciting material relating thereto.

10. Such additional information as the Commissioner may require or by rule prescribe as necessary or appropriate for the protection of policyholders and securityholders of the insurer or in the public interest.

C. 1. If the person required to file the statement referred to in subsection A of this section is a partnership, limited partnership, limited liability company, syndicate or other group or legal entity, the Commissioner may require that the information called for by subsection B of this section shall be given with respect to each partner or each member of such entity, syndicate or group, and each person who controls such partner or member. If any such partner, member or person is a corporation or the person required to file the statement referred to in subsection A of this section is a corporation, the Commissioner may require that the information called for by subsection B of this section be given with respect to such corporation, each officer and director of such corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent (10%) of the outstanding voting securities of such corporation.

2. If any material change occurs in the facts set forth in the statement filed with the Commissioner and sent to such insurer pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the Commissioner and sent to such

insurer within two (2) business days after the person learns of such change. Such insurer shall send such amendment to its shareholders.

3. If any offer, request, invitation, agreement or acquisition referred to in subsection A of this section is proposed to be made by means of a registration statement under the Securities Act of 1933, Public Law 22, or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, Public Law 291, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in subsection A of this section may utilize such documents in furnishing the information called for by that statement.

D. 1. The Commissioner shall approve any merger or other acquisition of control referred to in subsection A of this section unless, after a public hearing thereon, he or she finds that:

- a. after the change of control, the domestic insurer referred to in subsection A of this section would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed,
- b. the effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein,
- c. the financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders,
- d. the terms of the offer, request, invitation, agreement or acquisition referred to in subsection A of this section are unfair and unreasonable,
- e. the plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or

consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest, or

- f. the competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders or the public to permit the merger or other acquisition of control.

2. The public hearing referred to in paragraph 1 of this subsection shall be held within thirty (30) days after the statement required by subsection A of this section is filed, or after the information required by the Commissioner has been supplied, and at least twenty (20) days' notice thereof shall be given by the Commissioner to the person filing the statement, unless the notice is waived. Not less than fourteen (14) days' notice of the public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the Commissioner, unless the notice is waived in writing. The insurer shall give notice to its securityholders. The Commissioner shall make a determination within thirty (30) days after the conclusion of the hearing. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interests may be affected thereby shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments. All discovery proceedings shall be concluded not later than three (3) days prior to the commencement of the public hearing, except by consent.

3. The Commissioner may retain at the acquiring person's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the Commissioner's staff as may be reasonably

necessary to assist the Commissioner in reviewing the proposed acquisition of control.

E. The provisions of this section shall not apply to any offer, request, invitation, agreement or acquisition which the Commissioner by order shall exempt therefrom as not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or as otherwise not comprehended within the purposes of this section.

F. The courts of this state are hereby vested with jurisdiction over every person not resident, domiciled, or authorized to do business in this state who files a statement with the Commissioner under this section, and over all actions involving such person arising out of violations of this section. Each such person shall be deemed to have performed acts equivalent to and constituting an appointment by such a person of the Commissioner to be ~~his~~ the person's true and lawful agent upon whom may be served all lawful process in any action, suit or proceeding arising out of violations of this section. Copies of all such lawful process shall be served on the Commissioner in triplicate and transmitted by certified mail with return receipt requested by the Commissioner to such person at ~~his or her~~ the person's last-known address.

SECTION 14. AMENDATORY 36 O.S. 1991, Section 1905, is amended to read as follows:

Section 1905. The Insurance Commissioner may apply to the court for an order appointing ~~him~~ the Commissioner as receiver of and directing ~~him~~ the Commissioner to rehabilitate a domestic insurer upon one or more of the following grounds. That the insurer:

1. Is impaired or insolvent.
2. Is in a condition such that the continued operation would be hazardous to the policyholders, the creditors of the insurer, or the general public.

3. Has refused to submit its books, records, accounts or affairs to reasonable examination by the Insurance Commissioner.

~~3.~~ 4. Has failed to comply with an order of the Insurance Commissioner to make good an impairment of capital or surplus or both.

~~4.~~ 5. Has transferred or attempted to transfer substantially its entire property or business, or has entered into any transaction the effect of which is to merge substantially its entire property or business in that of any other insurer without having first obtained the written approval of the Insurance Commissioner.

~~5.~~ 6. Has willfully violated its charter or any law of this state.

~~6.~~ 7. Has an officer, director, or manager who has refused to be examined under oath concerning its affairs, for which purpose the Insurance Commissioner is hereby authorized to conduct and to enforce by all appropriate and available means any such examination under oath in any other state or territory of the United States, in which any such officer, director, or manager may then presently be, to the full extent permitted by the laws of such other state or territory, this special authorization considered.

~~7.~~ 8. Has been the subject of an application for the appointment of a receiver, trustee, custodian, or sequestrator of the insurer or its property otherwise pursuant to the provisions of this code, but only if such appointment has been made or is imminent and its effect is or would be to oust the courts of this state of jurisdiction hereunder.

~~8.~~ 9. Has consented to such an order through a majority of its directors, stockholders, members or subscribers.

~~9.~~ 10. Has failed to pay a final judgment rendered against it in this state upon any insurance contract issued or assumed by it, within thirty (30) days after the judgment became final or within thirty (30) days after the time for taking an appeal has expired, or

within thirty (30) days after dismissal of an appeal before final termination, whichever date is the later.

SECTION 15. AMENDATORY 36 O.S. 1991, Section 1906, is amended to read as follows:

Section 1906. The Insurance Commissioner may apply to the court for an order appointing ~~him~~ the Commissioner as receiver (if ~~his~~ the appointment of the Commissioner as receiver shall not be then in effect) and directing ~~him~~ the Commissioner to liquidate the business of a domestic insurer, foreign or of the United States branch of an alien insurer having trusteed assets in this State, regardless of whether or not there has been a prior order directing ~~him~~ the Commissioner to rehabilitate such insurer, upon any grounds specified in Section ~~1905~~ 1905 of this ~~article~~ title, or if such insurer:

1. Has ceased transacting business for a period of one (1) year, or

2. Is an insolvent insurer and has commenced voluntary liquidation or dissolution, or attempts to commence or prosecute any action or proceeding to liquidate its business or affairs, or to dissolve its corporate charter, or to procure the appointment of a receiver, trustee, custodian, or sequestrator under any law except this ~~code~~ Code.

3. Has failed, if a domestic insurer, to obtain from the Insurance Commissioner a certificate of authority to transact a business of insurance in Oklahoma for one of the immediately preceding five (5) years.

SECTION 16. AMENDATORY Section 31, Chapter 349, O.S.L. 1993 (36 O.S. Supp. 2000, Section 3613.1), is amended to read as follows:

Section 3613.1 Every insurance policy or application and every insurance claim form shall contain a statement that clearly indicates in substance the following: "WARNING: Any person who

knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony." The absence of such a statement shall not constitute a defense in any prosecution.

SECTION 17. AMENDATORY 36 O.S. 1991, Section 3623.1, is amended to read as follows:

Section 3623.1 ~~Nothing~~ Except as provided in this section, nothing in this Code shall be construed to prevent an insurer from charging and collecting in this state separate ~~initial membership fees and policy~~ fees in addition to premiums for insurance, and such fees shall not be considered premium within the definition of this Code, but shall be subject to premium tax as provided in this Code.

"Minimum premium charge" means the smallest acceptable premium for which an insurer will write a policy. This minimum charge is the amount necessary to cover fixed expenses, other than those expenses provided for in paragraph 1 of this subsection, in placing the policy on the books. A minimum premium charge includes, but is not limited to, minimum earned premium and minimum retained premium. A minimum premium charge shall be considered premium within the definition of this Code and shall be subject to premium tax as provided in this Code.

SECTION 18. AMENDATORY 36 O.S. 1991, Section 3636, as amended by Section 5, Chapter 294, O.S.L. 1994 (36 O.S. Supp. 2000, Section 3636), is amended to read as follows:

Section 3636. A. No policy insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any person arising out of the ownership, maintenance or use of a motor vehicle shall be issued, delivered, renewed, or extended in this state with respect to a motor vehicle registered or principally garaged in this state unless the policy includes the coverage described in subsection B of this section.

B. The policy referred to in subsection A of this section shall provide coverage therein or supplemental thereto for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles and hit-and-run motor vehicles because of bodily injury, sickness or disease, including death resulting therefrom. Coverage shall be not less than the amounts or limits prescribed for bodily injury or death for a policy meeting the requirements of Section 7-204 of Title 47 of the Oklahoma Statutes, as the same may be hereafter amended; provided, however, that increased limits of liability shall be offered and purchased if desired, not to exceed the limits provided in the policy of bodily injury liability of the insured. The uninsured motorist coverage shall be upon a form approved by the Insurance Commissioner as otherwise provided in the Insurance Code and may provide that the parties to the contract shall, upon demand of either, submit their differences to arbitration; provided, that if agreement by arbitration is not reached within three (3) months from date of demand, the insured may sue the tort-feasor.

C. For the purposes of this coverage the term "uninsured motor vehicle" shall include an insured motor vehicle where the liability insurer thereof is unable to make payment with respect to the legal liability of its insured within the limits specified therein because of insolvency. For the purposes of this coverage the term "uninsured motor vehicle" shall also include an insured motor vehicle, the liability limits of which are less than the amount of the claim of the person or persons making such claim, regardless of the amount of coverage of either of the parties in relation to each other.

D. An insurer's insolvency protection shall be applicable only to accidents occurring during a policy period in which its insured's uninsured motorist coverage is in effect where the liability insurer of the tort-feasor becomes insolvent within one (1) year after such

an accident. Nothing herein contained shall be construed to prevent any insurer from according insolvency protection under terms and conditions more favorable to its insured than is provided hereunder.

E. In the event of payment to any person under the coverage required by this section and subject to the terms and conditions of such coverage, the insurer making such payment shall, to the extent thereof, be entitled to the proceeds of any settlement or judgment resulting from the exercise of any rights of recovery of such person against any person or organization legally responsible for the bodily injury for which such payment is made, including the proceeds recoverable from the assets of the insolvent insurer. Provided, however, with respect to payments made by reason of the coverage described in subsection C of this section, the insurer making such payment shall not be entitled to any right of recovery against such tort-feasor in excess of the proceeds recovered from the assets of the insolvent insurer of said tort-feasor. Provided further, that any payment made by the insured tort-feasor shall not reduce or be a credit against the total liability limits as provided in the insured's own uninsured motorist coverage. Provided further, that if a tentative agreement to settle for liability limits has been reached with an insured tort-feasor, written notice shall be given by certified mail to the uninsured motorist coverage insurer by its insured. Such written notice shall include:

1. Written documentation of pecuniary losses incurred, including copies of all medical bills; and

2. Written authorization or a court order to obtain reports from all employers and medical providers. Within sixty (60) days of receipt of this written notice, the uninsured motorist coverage insurer may substitute its payment to the insured for the tentative settlement amount. The uninsured motorist coverage insurer shall then be entitled to the insured's right of recovery to the extent of such payment and any settlement under the uninsured motorist

coverage. If the uninsured motorist coverage insurer fails to pay the insured the amount of the tentative tort settlement within sixty (60) days, the uninsured motorist coverage insurer has no right to the proceeds of any settlement or judgment, as provided herein, for any amount paid under the uninsured motorist coverage.

F. A named insured or applicant shall have the right to reject uninsured motorist coverage in writing, and except that unless a named insured or applicant requests such coverage in writing, such coverage need not be provided in or supplemental to any renewal, reinstatement, substitute, amended or replacement policy where a named insured or applicant had rejected the coverage in connection with a policy previously issued to him by the same insurer.

G. Notwithstanding the provisions of this section, the following are the only instances in which a new form affecting uninsured motorist coverage shall be required:

1. When an insurer is notified of a change in or an additional named insured;

2. When there is an additional vehicle that is not a replacement vehicle; provided, a new form shall not be required for the addition, substitution or deletion of a vehicle from a commercial automobile liability policy covering a fleet of five (5) or more vehicles; or

3. When the amount of bodily injury liability coverage is amended. Provided, any change in premium alone shall not require the issuance of a new form.

After selection of limits, rejection, or exercise of the option not to purchase uninsured motorist coverage by a named insured or applicant for insurance, the insurer shall not be required to notify any insured in any renewal, reinstatement, substitute, amended or replacement policy as to the availability of such uninsured motorist coverage or such optional limits. Such selection, rejection, or exercise of the option not to purchase uninsured motorist coverage

by a named insured or an applicant shall be valid for all insureds under the policy and shall continue until a named insured requests in writing that the uninsured motorist coverage be added to an existing or future policy of insurance.

H. The offer of the coverage required by subsection B of this section shall be in the following form which shall be filed with and approved by the Insurance Commissioner. The form shall be provided to the proposed insured in writing separately from the application and shall read substantially as follows:

OKLAHOMA UNINSURED MOTORIST COVERAGE LAW

Oklahoma law gives you the right to buy Uninsured Motorist coverage in the same amount as your bodily injury liability coverage. THE LAW REQUIRES US TO ADVISE YOU OF THIS VALUABLE RIGHT FOR THE PROTECTION OF YOU, MEMBERS OF YOUR FAMILY, AND OTHER PEOPLE WHO MAY BE HURT WHILE RIDING IN YOUR INSURED VEHICLE. YOU SHOULD SERIOUSLY CONSIDER BUYING THIS COVERAGE IN THE SAME AMOUNT AS YOUR LIABILITY INSURANCE COVERAGE LIMIT.

Uninsured Motorist coverage, unless otherwise provided in your policy, pays for bodily injury damages to you, members of your family who live with you, and other people riding in your car who are injured by: (1) an uninsured motorist, (2) a hit-and-run motorist, or (3) an insured motorist who does not have enough liability insurance to pay for bodily injury damages to any insured person. Uninsured Motorist coverage, unless otherwise provided in your policy, protects you and family members who live with you while riding in any vehicle or while a pedestrian. THE COST OF THIS COVERAGE IS SMALL COMPARED WITH THE BENEFITS!

You may make one of four choices about Uninsured Motorist Coverage:

1. You may buy Uninsured Motorist coverage equal to your bodily injury liability coverage for \$_____ for _____ months.

2. You may buy Uninsured Motorist coverage in the amount of \$10,000.00 for each person injured, not to exceed \$20,000.00 for two or more persons injured in one occurrence (the smallest coverage which Oklahoma law allows) for \$_____ for ____ months.

3. You may buy Uninsured Motorist coverage in an amount less than your bodily injury liability coverage but more than the minimum levels.

4. You may reject Uninsured Motorist coverage.

Please indicate below what Uninsured Motorist coverage you want:

____ I want the same amount of Uninsured Motorist coverage as my bodily injury liability coverage.

____ I want minimum Uninsured Motorist coverage (\$10,000.00 per person/\$20,000.00 per occurrence).

____ I want Uninsured Motorist coverage in the following amount:
\$_____ per person/\$_____ per occurrence.

____ I want to reject Uninsured Motorist coverage.

Proposed Insured

THIS FORM IS NOT A PART OF YOUR POLICY AND DOES NOT PROVIDE COVERAGE.

~~I. To account for individual insurance company operational differences, for a one-year phase-in period beginning September 1, 1990, insurers may file for a deviation from the form described in subsection H of this section, to be used only for the insurer's policyholders as of September 1, 1990. The Insurance Commissioner shall approve the deviation only if the form includes substantially the same information as is included in subsection H of this section. In the deviated form, insurers may provide existing policyholders the option to maintain their current level of Uninsured Motorist coverage. Each existing policyholder shall receive the notice provided in subsection H of this section no later than the next policy renewal following the phase-in period. The Insurance~~

Commissioner shall approve a deviation to this form if the form includes substantially the same information.

SECTION 19. AMENDATORY 36 O.S. 1991, Section 3639, as amended by Section 15, Chapter 353, O.S.L. 2000 (36 O.S. Supp. 2000, 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 ~~sixty (60)~~ forty-five (45) 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 ~~sixty (60)~~ forty-five (45) 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 ~~sixty (60)~~ forty-five (45) days before expiration, coverage shall remain in effect until ~~sixty (60)~~

forty-five (45) 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 or filed pursuant to the Commercial Property and Casualty Competitive Loss Cost Rating Act 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 20. AMENDATORY Section 4, Chapter 273, O.S.L. 1997 (36 O.S. Supp. 2000, Section 4061), is amended to read as follows:

Section 4061. A. Beginning January 1, 1998, every life insurance company doing business in this state shall annually, and quarterly if required by the Insurance Commissioner, submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Insurance Commissioner by rule are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported accounts and comply with applicable laws of this state. The Commissioner by rule shall define the specifics of this opinion and add any other items deemed to be necessary to its scope.

B. 1. Beginning January 1, 1998, every life insurance company, except as exempted by or pursuant to rule, shall also annually, and quarterly if required by the Insurance Commissioner, include in the opinion required by subsection A of this section, an opinion of the same qualified actuary as to whether the reserves and related

actuarial items held in support of the policies and contracts specified by the Commissioner by rule, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

2. The Commissioner may provide by rule for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by this section.

C. Each opinion required by subsection B of this section shall be accompanied by a memorandum, in form and substance acceptable to the Commissioner as specified by rule, prepared to support each actuarial opinion. If the insurance company fails to provide a supporting memorandum at the request of the Commissioner within a period specified by rule, or the Commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the rules or is otherwise unacceptable to the Commissioner, the Commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the Commissioner.

D. Every opinion shall be governed by the following provisions:

1. The opinion shall be submitted with the annual statement and quarterly statement, if a quarterly statement is required by the Commissioner, reflecting the valuation of such reserve liabilities for each year ~~ending on or after December 31, 1997;~~

2. The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the Commissioner as specified by rule;

3. The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the Commissioner may by rule prescribe;

4. In the case of an opinion required to be submitted by a foreign or alien company, the Commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the Commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state;

5. Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurance company and the Commissioner, for any act, error, omission, decision or conduct with respect to the actuary's opinion; and

6. Disciplinary action by the Commissioner against the company or the qualified actuary shall be defined in rules by the Commissioner.

E. 1. Any memorandum in support of the opinion, and any other material provided by the company to the Commissioner in connection therewith, shall be kept confidential by the Commissioner and shall not be made public and shall not be subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or by rules promulgated hereunder; provided, however, that the memorandum or other material may otherwise be released by the Commissioner as follows:

- a. with the written consent of the company, or
- b. to the American Academy of Actuaries upon request stating that the memorandum or other material is

required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the Commissioner for preserving the confidentiality of the memorandum or other material.

2. Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before any governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall be no longer confidential.

F. For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in rules promulgated by the Insurance Commissioner.

SECTION 21. AMENDATORY Section 4, Chapter 244, O.S.L. 1995 (36 O.S. Supp. 2000, Section 4430), is amended to read as follows:

Section 4430. A. 1. An insurer may not charge a renewal premium rate for a long-term care insurance policy which exceeds by more than fifteen percent (15%) any premium charged for the policy during the preceding twelve (12) months.

2. Upon approval of the Insurance Commissioner, an insurer may charge a renewal premium exceeding the fifteen percent (15%) increase provided for in paragraph 1 of this subsection upon showing that a larger increase is necessary because of utilization of policy benefits in excess of the expected rate.

B. 1. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

2. For certificates issued or delivered on or after ~~the effective date of this act~~ November 1, 1995, under a group long-term care insurance policy as defined in Section 4424 of ~~Title 36 of the Oklahoma Statutes~~ this title, which policy was in force ~~at the time~~

~~this act became effective on November 1, 1995,~~ the provisions of this section shall not apply.

3. This section does not apply to policies or certificates issued or delivered on or after November 1, 2001.

SECTION 22. AMENDATORY 36 O.S. 1991, Section 4502, is amended to read as follows:

Section 4502. A. Each group accident and health policy shall contain in substance the following provisions:

1. A provision that, in the absence of fraud, all statements made by the policyholder or by any insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary.

2. A provision that the insurer will furnish to the policyholder, for delivery to each employee or member of the insured group, an individual certificate setting forth in summary form a statement of the essential features of the insurance coverage of such employee or member and to whom benefits are payable. If dependents or family members are included in the coverage additional certificates need not be issued for delivery to such dependents or family members.

3. A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

B. Each group health policy certificate subject to the provisions of the Federal Health Insurance Portability and Accountability Act, Public Law 104-191, (HIPAA) laws shall contain in substance the following provisions, which shall be in addition to the provisions required by subsection A of this section.

1. A provision that a health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition;

2. A provision that a health benefit plan shall not define a preexisting condition more restrictively than:

- a. a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage,
- b. pregnancy and genetic information shall not be considered preexisting conditions,
- c. a health benefit plan may exclude a preexisting condition for late enrollees for a period not to exceed eighteen (18) months from the date the individual enrolls for coverage,
- d. the period of any such preexisting condition exclusion shall be reduced by the aggregate of the periods of creditable coverage as defined in the Federal HIPAA laws,
- e. a period of creditable coverage shall not be counted if after such period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage,
- f. "enrollment date" means the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment, and
- g. "late enrollee" means a participant or beneficiary who enrolls under the plan other than during the first

period in which the individual is eligible to enroll under the plan or a special enrollment period;

3. A provision that individuals losing other coverage shall be permitted to enroll for coverage under the terms of the plan if each of the following conditions is met:

- a. the employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent,
- b. the employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer required such a statement at such time and provided the employee with notice of such requirement, and the consequences of such requirement, at such time,
- c. the employee's or dependent's coverage was under a COBRA continuation provision and the coverage under such provision was exhausted; or was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions toward such coverage were terminated, and
- d. under the terms of the plan, the employee requests such enrollment not later than thirty (30) days after the date of exhaustion of coverage;

4. A provision that for any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period, that

period shall not be taken into account in determining the continuous period of creditable coverage. "Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period;

5. A provision that preexisting condition exclusions will not apply to newborns, who, as the last day of the thirty-day period beginning with the date of birth, are covered under creditable coverage;

6. A provision that preexisting condition exclusions will not apply to a child who is adopted or placed for adoption before attaining eighteen (18) years of age;

7. A provision that dependents are eligible for a special enrollment period if the group health plan makes coverage available with respect to a dependent of an individual, and the individual is a participant under the plan, or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period, and a person becomes such a dependent of the individual through marriage, birth or adoption or placement for adoption. The special enrollment period shall apply to that person or, if not otherwise enrolled, the individual, the dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

a. The dependent special enrollment period shall be a period of not less than thirty (30) days and shall begin on the later of the date dependent coverage is

made available, or the date of the marriage, birth, or adoption or placement for adoption.

b. There is no waiting period if an individual seeks to enroll a dependent during the first thirty (30) days of such a dependent special enrollment period.

c. The coverage for the dependent shall become effective in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received, in the case of a dependent's birth, as of the date of such birth, in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption;

8. A provision that eligibility or continued eligibility of any individual will not be based on any of the following health-status-related factors in relation to the individual or a dependent of the individual: health status, medical condition, including both physical and mental illnesses, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence or disability.

a. Carriers are not required to provide particular benefits other than those provided under the terms of the plan or coverage.

b. Carriers may establish limitations or restrictions on the amount, level, extent, and nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage;

9. A provision that the group health plan is guaranteed renewable, except as provided pursuant to the federal provisions found in HIPAA, which are as follows:

a. nonpayment of premium,

- b. fraud,
- c. violation of participation and/or contribution rules,
- d. termination of coverage:

(1) in any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the large or small group market, coverage of such type may be discontinued by the issuer only if: the issuer provides notice to each plan sponsor provided coverage of this type in such market, and participants and beneficiaries covered under such coverage, of such discontinuation at least ninety (90) days prior to the date of the discontinuation of such coverage and makes available the option to purchase all or, in the case of the large group market, any other health insurance coverage currently being offered by the issuer to a group health plan in such market and in exercising the option to discontinue coverage of this type and in offering the option of coverage pursuant to this provision, the issuer acts uniformly without regard to the claims experience of those sponsors or any health-status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage,

(2) in any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the large or small group market, coverage of such type may be discontinued by the issuer only if: the issuer

provides notice to the Oklahoma Insurance Department and to each plan sponsor and participants and beneficiaries covered under such coverage of such discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of such coverage; and all health insurance issued or delivered for issuance in the state in such market or markets are discontinued and coverage under such health insurance coverage in such market or markets is not renewed, and

(3) in the case of a discontinuation under subparagraph 2 of this paragraph in a market, the issuer shall not provide for the issuance of any health insurance coverage in the market and in this state during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed,

e. movement outside the service area, and

f. association membership ceases; and

10. A provision that certification of creditable coverage will be issued individuals covered:

a. at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

b. in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

c. on the request on behalf of an individual made not later than twenty-four (24) months after the date of cessation of the coverage described in subparagraph a or b of this paragraph, whichever is later.

The certification described in this paragraph is a written certification of the period of creditable coverage of the individual under such plan and the coverage, if any, under such COBRA continuation provision, and the waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under such plan.

SECTION 23. AMENDATORY Section 3, Chapter 304, O.S.L. 1992, as last amended by Section 1, Chapter 304, O.S.L. 1998 (36 O.S. Supp. 2000, Section 4509.2), is amended to read as follows:

Section 4509.2 A. When an insured individual or a dependent who was covered by group insurance pursuant to the provisions of the Health Insurance Portability and Accountability Act of 1996, 29 U.S.C.A., Section 1181 et seq., gains employment with an employer who provides for health insurance through a group plan, the succeeding group carrier shall accept the insured individual and dependents of the insured individual who were covered under the prior coverage and shall not apply limitations or exclusions based on preexisting conditions or apply waiting-period requirements for the insured individual or the dependents of the insured individual beyond the time when any surviving exclusion or waiting period with the prior carrier would have been fulfilled. The insured individual and any dependents of such individual must apply for the new coverage within sixty-three (63) days following the date of termination of prior creditable coverage.

B. When an insured individual or dependent who was covered by individual insurance pursuant to the provisions of the Health Insurance Portability and Accountability Act of 1996, 29 U.S.C.A., Section 1181 et seq., gains employment with an employer who provides for health insurance through a group plan, the succeeding group carrier shall accept the insured individual and dependents of the insured individual who were covered under the prior coverage and shall not apply limitations or exclusions based on preexisting

conditions or apply waiting-period requirements for the insured individual or the dependents of the insured individual beyond the time when any surviving exclusion or waiting period with the prior carrier would have been fulfilled. The insured individual and any dependents of such individual must apply for the new coverage within sixty-three (63) days following the date of termination of prior creditable coverage.

C. Insurance carriers receiving an application for individual insurance may underwrite the risk or decline coverage based on the underwriting guidelines of the insurance carrier. Upon denial of coverage, insurance carriers shall advise the applicant of the existence of, and how to apply for coverage under, the Health Insurance High Risk Pool.

D. When there is a lapse in the coverage of the insured individual or a dependent of the insured individual provided for by subsections A, B, and C of this section for any reason other than a probationary period or similar waiting period imposed pursuant to personnel policies of an employer, the provisions of subsections A, B, and C of this section shall not apply to the person whose coverage lapsed.

E. When an individual employee who was covered under a group health insurance plan terminates employment with an employer and gains employment with another employer who provides for health insurance through a group plan, the carrier of the succeeding employer shall not apply preexisting conditions limitations or exclusions of preexisting conditions or apply waiting-period requirements for the individual employee or his dependents covered under the group plan of the previous employer beyond the time when any surviving exclusion or waiting period with the prior carrier would have been fulfilled, provided the individual employee applies for the new coverage within thirty-one (31) days following the date of eligibility for participation in the plan in accordance with the

employment or personnel policies of the employer of such participation.

F. When there is a lapse in the coverage of the individual employee provided for by subsection E of this section for any reason other than a probationary period or similar waiting period imposed by the employment or personnel policies of the employer, the provisions of subsection E of this section shall not apply.

SECTION 24. AMENDATORY 36 O.S. 1991, Section 4804, is amended to read as follows:

Section 4804. No insurance company shall, knowingly, issue any fire insurance policy upon property within this state for an amount which, with any existing insurance thereon, exceeds the fair value of the property, ~~nor for a longer term than five years.~~ If buildings insured against loss by fire, and situated within this state, are totally destroyed by fire, the company shall not be liable beyond the actual value of the insured property at the time of the loss or damage, and if it shall appear that the insured has paid premiums on an amount in excess of said actual value, the assured shall be reimbursed the proportionate excess of premiums paid on the difference between the amount named in the policy and said actual value, with interest at six per centum per annum from the date of issue.

SECTION 25. AMENDATORY Section 2, Chapter 329, O.S.L. 1992, as last amended by Section 47, Chapter 353, O.S.L. 2000 (36 O.S. Supp. 2000, 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 title;

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;

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, and family composition and group size, without prior approval of the Insurance Commissioner. Group size shall not be used as a case characteristic;

8. "Class of business" means all or a separate grouping of small employers established pursuant to Section 6514 of this title. Group size shall not be used as a class of business;

9. "Commissioner" means the Insurance Commissioner;

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

~~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;

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

~~13.~~ 12. "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;

~~14.~~ 13. "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;

~~15.~~ 14. "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;

~~16.~~ 15. 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;

~~17.~~ 16. "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;

~~18.~~ 17. "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;

~~19.~~ 18. "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;

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

~~21.~~ 20. "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;

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

~~23.~~ 22. "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;

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

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

~~26.~~ 25. "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;

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

~~28.~~ 27. "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;

~~29.~~ 28. "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.~~ 29. "Standard health benefit plan" means the health benefit plan adopted by the state for small employers.

SECTION 26. AMENDATORY Section 4, Chapter 329, O.S.L. 1992 (36 O.S. Supp. 2000, Section 6514), is amended to read as follows:

Section 6514. A. A small employer carrier may establish a class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

1. The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers;

2. The small employer carrier has acquired a class of business from another small employer carrier; or

3. The small employer carrier provides coverage to one or more association groups that meet the requirements of an association as set forth in Section 4501 of this title.

B. A small employer carrier may establish up to nine separate classes of business under subsection A of this section.

C. The Insurance Commissioner may establish rules to provide for a period of transition in order for a small employer carrier to come into compliance with subsection B of this section in the instance of acquisition of an additional class of business from another small employer carrier.

D. The Commissioner may approve the establishment of additional classes of business upon application to the Commissioner and a finding by the Commissioner that such action would enhance the efficiency and fairness of the small employer marketplace.

E. A small employer carrier shall offer each product currently marketed to all classes of business established pursuant to this section.

SECTION 27. AMENDATORY Section 13, Chapter 211, O.S.L. 1994, as amended by Section 6, Chapter 304, O.S.L. 1998 (36 O.S. Supp. 2000, Section 6527), is amended to read as follows:

Section 6527. A. Each small employer carrier shall actively market health benefit plan coverage to all eligible small employers in this state.

B. 1. Except as provided in paragraph 2 of this subsection, no small employer carrier or agent shall, directly or indirectly, engage in the following activities:

- a. encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, group size, occupation or geographic location of the small employer, or
- b. encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, group size, occupation or geographic location of the small employer.

2. The provisions of paragraph 1 of this subsection shall not apply with respect to information provided by a small employer carrier or agent to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

C. 1. Except as provided in paragraph 2 of this subsection, no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, group size, occupation or geographic location of the small employer.

2. Paragraph 1 of this subsection shall not apply with respect to a compensation arrangement that provides compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the small employer.

3. A small employer carrier shall not implement, directly or indirectly, agent commission schedules that vary the level of agent commissions based on the size of the group or otherwise reduce access to small employer health benefit plans.

4. Notwithstanding paragraph 3 of this subsection, a small employer carrier may:

- a. vary agent commission amounts or percentages based on group size if the variation in the commission amounts or percentages are inversely related to the size of the group, or
- b. vary agent commission amounts or percentages based on the cumulative premium paid by a single small employer over a specific period if the variation in the commission amounts or percentages are inversely related to the cumulative premium paid during the period.

D. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent, if any, for the sale of any health benefit plan.

E. No small employer carrier may terminate, fail to renew or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation, group size, or geographic location of the small employers placed by the agent with the small employer carrier.

F. No small employer carrier or agent may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

G. Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial. The reasons for denial shall be limited to minimum participation requirements and minimum contribution requirements.

H. The Insurance Commissioner may promulgate rules setting forth additional standards to provide for the fair marketing and

broad availability of health benefit plans to small employers in this state.

I. 1. A violation of this section by a small employer carrier or an agent shall be an unfair trade practice under ~~Section 1204 et seq. of Title 36 of the Oklahoma Statutes~~ Article 12 of this title.

2. If a small employer carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

SECTION 28. AMENDATORY 40 O.S. 1991, Section 4-508, as last amended by Section 3, Chapter 348, O.S.L. 2000 (40 O.S. Supp. 2000, Section 4-508), is amended to read as follows:

Section 4-508. INFORMATION TO BE KEPT CONFIDENTIAL - DISCLOSURE.

A. Except as otherwise provided by law, information obtained from any employing unit or individual pursuant to the administration of the Employment Security Act of 1980, and determinations as to the benefit rights of any individual shall be kept confidential and shall not be disclosed or be open to public inspection in any manner revealing the individual's or employing unit's identity. Any claimant or employer or agent of such person as authorized in writing shall be supplied with information from the records of the Commission, to the extent necessary for the proper presentation of the claim or complaint in any proceeding under the Employment Security Act of 1980, Section 1-101 et seq. of this title, with respect thereto.

B. Upon receipt of written request by any employer who maintains a Supplemental Unemployment Benefit (SUB) Plan, the Commission or its designated representative may release to such employer information regarding weekly benefit amounts paid its

workers during a specified temporary layoff period, provided such Supplemental Unemployment Benefit (SUB) Plan requires benefit payment information before Supplemental Unemployment Benefits can be paid to such workers. Any information disclosed under this provision shall be utilized solely for the purpose outlined herein and shall be held strictly confidential by the employer.

C. The provisions of this section shall not prevent the Commission from disclosing the following information and no liability whatsoever, civil or criminal, shall attach to any member of the Commission or any employee thereof for any error or omission in the disclosure of such information:

1. The delivery to taxpayer or claimant a copy of any report or other paper filed by the taxpayer or claimant pursuant to the Employment Security Act of 1980;

2. The disclosure of information to any person for a purpose as authorized by the taxpayer or claimant pursuant to a waiver of confidentiality. The waiver shall be in writing and shall be notarized;

3. The Oklahoma Department of Commerce may have access to data obtained pursuant to the Oklahoma Employment Security Act of 1980 pursuant to rules promulgated by the Oklahoma Employment Security Commission. The information obtained shall be held confidential by the Department and any of its agents and shall not be disclosed or be open to public inspection. The Oklahoma Department of Commerce, however, may release aggregated data, either by industry or county, provided that such aggregation meets disclosure requirements of the Oklahoma Employment Security Commission;

4. The publication of statistics so classified as to prevent the identification of a particular report and the items thereof;

5. The disclosing of information or evidence to the Attorney General or any district attorney when the information or evidence is to be used by the officials or other parties to the proceedings to

prosecute or defend allegations of violations of the Employment Security Act of 1980. The information disclosed to the Attorney General or any district attorney shall be kept confidential by them and not be disclosed except when presented to a court in a prosecution of a violation of Section 1-101 et seq. of this title, and a violation by the Attorney General or district attorney by otherwise releasing the information shall be a felony;

6. The furnishing, at the discretion of the Commission, of any information disclosed by the records or files to any official person or body of this state, any other state or of the United States who is concerned with the administration of assessment of any similar tax in this state, any other state or the United States;

7. The furnishing of information to other state agencies for the limited purpose of aiding in the collection of debts owed by individuals to the requesting agencies;

8. The release to officials, employees, and agents of the Oklahoma Department of Transportation of information required for use in federally mandated regional transportation planning, which is performed as a part of their official duties;

9. The release to officials, employees and agents of the State Treasurer's office of information required to verify or evaluate the effectiveness of the Oklahoma Small Business Linked Deposit Program on job creation;

10. The release to officials, employees, and agents of the Attorney General, the State Insurance Fund, the Department of Labor, ~~and~~ the Workers' Compensation Court, and the Insurance Department for use in investigation of workers' compensation fraud;

11. The release to employees of the Oklahoma State Bureau of Investigation or release to employees of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control for use in criminal investigations and the location of missing persons or fugitives from justice;

12. The release to officials, employees, and agents of the Center of International Trade, Oklahoma State University, of information required for the development of International Trade for employers doing business in the State of Oklahoma;

13. The release to officials, employees, and agents of the Oklahoma State Regents for Higher Education of information required for use in the default prevention efforts and/or collection of defaulted student loans guaranteed by the Oklahoma Guaranteed Student Loan Program. Any information disclosed under this provision shall be utilized solely for the purpose outlined herein and shall be held strictly confidential by the Oklahoma State Regents for Higher Education;

14. The release to officials, employees, and agents of the Center for Economic and Management Research of the University of Oklahoma, of information required to identify economic trends. The information obtained shall be kept confidential by the University and any of its agents and shall not be disclosed or be open to public inspection. The University of Oklahoma may release aggregated data, provided that such aggregation meets disclosure requirements of the Commission;

15. The release to officials, employees, and agents of the Office of State Finance of information required to identify economic trends. The information obtained shall be kept confidential by the Office of State Finance and any of its agents and shall not be disclosed or be open to public inspection. The Office of State Finance may release aggregate data, provided that such aggregation meets disclosure requirements of the Commission; ~~or~~

16. The release to officials, employees, and agents of the Department of Mental Health and Substance Abuse Services of information required to evaluate the effectiveness of mental health and substance abuse treatment and state or local programs utilized to divert persons from inpatient treatment. The information

obtained shall be kept confidential by the Department, its employees and any of its agents and shall not be disclosed or be open to public inspection. The Department of Mental Health and Substance Abuse Services, however, may release aggregated data, either by treatment facility, program or larger aggregate units, provided that such aggregation meets disclosure requirements of the Oklahoma Employment Security Commission; or

17. The release to officials, employees, and agents of the Attorney General, the Oklahoma State Bureau of Investigation, and the Insurance Department for use in the investigation of insurance fraud.

D. All subpoenas or court orders for production of documents must provide a minimum of twenty (20) days from the date it is served for the Commission to produce the documents. If the date on which production of the documents is required is less than twenty (20) days from the date of service, the subpoena or order shall be considered void on its face as an undue burden or hardship on the Commission.

E. Should any of the disclosures provided for in this section require more than casual or incidental staff time, the Commission may charge the cost of such staff time to the party requesting the information.

F. It is further provided that the provisions of this section shall be strictly interpreted and shall not be construed as permitting the disclosure of any other information contained in the records and files of the Commission.

SECTION 29. AMENDATORY 59 O.S. 1991, Section 1311.1, as amended by Section 3, Chapter 186, O.S.L. 1994 (59 O.S. Supp. 2000, Section 1311.1), is amended to read as follows:

Section 1311.1 A. Hearings shall be held in the Insurance Commissioner's offices or at such other place as the Commissioner may deem convenient.

B. The Commissioner shall appoint an ~~assistant~~ independent hearing examiner to preside at the hearing to sit in the capacity of a quasi-judicial officer.

C. All hearings will be public and held in accordance with, and governed by, Article II of the Administrative Procedures Act, Section 308a et seq. of Title 75 of the Oklahoma Statutes.

D. If at a hearing the person presiding determines that a license which was suspended prior to the hearing pursuant to Section 1311 of this title shall be revoked or suspended, the period of revocation or suspension shall be deemed to have begun on the date the license was suspended pending the hearing.

E. The Commissioner, upon written request reasonably made by the licensed bail bondsman affected by the hearing, and at such bail bondsman's expense, shall cause a full stenographic record of the proceedings to be made by a competent court reporter.

F. The ordinary fees and costs of such hearing examiner may be assessed by the hearing examiner against the respondent, unless the respondent is the prevailing party.

SECTION 30. REPEALER Section 1, Chapter 353, O.S.L. 2000 (36 O.S. Supp. 2000, Section 349), is hereby repealed.

SECTION 31. This act shall become effective July 1, 2001.

SECTION 32. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval."

and when title is restored amend title
to conform

Passed the Senate the 17th day of April, 2001.

Presiding Officer of the Senate

Passed the House of Representatives the ____ day of _____,
2001.

Presiding Officer of the House
of Representatives