STATE OF OKLAHOMA

2nd Session of the 49th Legislature (2004)

HOUSE BILL HB2385: Cox

AS INTRODUCED

An Act relating to insurance; amending 36 O.S. 2001, Sections 311, as last amended by Section 1, Chapter 150, O.S.L. 2003 and 321, as amended by Section 3, Chapter 307, O.S.L. 2002 (36 O.S. Supp. 2003, Sections 311 and 321), which relate to the Insurance Department; providing conditions for renewal of license or certificate of authority; adding certain entities and contracts to fee list; exempting certain filings from fees; requiring domestic insurers to keep certain information current; defining term; amending 36 O.S. 2001, Sections 629 and 630, which relate to authorization of insurance companies; changing term insurer to insurance company; amending 36 O.S. 2001, Section 903, which relates to rating organizations; modifying definition of homeowner's insurance to exclude certain dwellings; amending 36 O.S. 2001, Section 1250.2, as amended by Section 53, Chapter 197, O.S.L. 2003 (36 O.S. Supp. 2003, Section 1250.2), which relates to the Unfair Claims Settlement Practices Act; modifying definition of Insurer to include certain organizations; amending 36 O.S. 2001, Sections 1435.6, as amended by Section 13, Chapter 307, O.S.L. 2002 and 1435.13 (36 O.S. Supp. 2003, Section 1435.6), which relate to the Oklahoma Producer Licensing Act; allowing for retesting after thirty days; prohibiting waiver of fees; allowing for revocation of license if censured or placed on probation in other jurisdiction; amending 36 O.S. 2001, Section 1450, which relates to the Third-party Administrator Act; requiring partners in entity to be licensed; requiring notification of termination; amending 36 O.S. 2001, Section 1902, which relates to rehabilitation and liquidation; requiring adoption of certain court rules to assign certain judicial proceedings; amending 36 O.S. 2001, Sections 6532, as amended by Section 1, Chapter 439, O.S.L. 2002, 6534, as amended by Section 2, Chapter 439, O.S.L. 2002 and 6542, as amended by Section 7, Chapter 439, O.S.L. 2002 (36 O.S. Supp. 2003, Sections 6532, 6534 and 6542), which relate to the Health Insurance High Risk Pool Act; modifying definition of federally defined eligible individual; modifying eligibility requirements to include certain individuals; expanding eligibility for coverage to certain persons; providing exemption from preexisting conditions limitation for certain persons; repealing 36 O.S. 2001, Section 1435.38, which relates to the Oklahoma Producer Licensing Act; providing for codification; providing an effective date; and declaring an emergency.

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

SECTION 1. AMENDATORY 36 O.S. 2001, Section 311, as last amended by Section 1, Chapter 150, O.S.L. 2003 (36 O.S. Supp. 2003, Section 311), is amended to read as follows:

Section 311. A. 1. All insurers authorized to do business under the provisions of this Code shall, annually, on or before the first day of March, file with the National Association of Insurance Commissioners (NAIC), statements which shall exhibit the financial condition of insurers on the thirty-first day of December of the previous year and its business of that year. Annual statements shall be filed electronically as approved by the NAIC, along with applicable fees. Domestic insurers shall file a printed annual financial statement along with all supplement filings in the office of the Insurance Commissioner annually on or before the first day of March.

2. Foreign insurers shall file an Affidavit of Filing and Financial Statement Attestation annually on or before the first day of March. The Insurance Commissioner may require foreign insurers to file the annual financial statement in a printed format. Such document required by the Insurance Commissioner shall be due annually on or before the first day of March.

3. 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, including any supplemental filings described in the NAIC annual instruction handbook, 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~~ <u>The license or certificate of authority to transact the business of insurance in this state shall be renewed unless</u> the Insurance Commissioner finds that the facts <u>do not</u> warrant <u>renewal</u>, and that ~~all laws applicable to the insurer are~~ <u>the insurer has not</u> fully complied with <u>all laws applicable to the insurer. Upon initial licensure</u>, 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 2. AMENDATORY 36 O.S. 2001, Section 321, as amended by Section 3, Chapter 307, O.S.L. 2002 (36 O.S. Supp. 2003, Section 321), is amended to read as follows:

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

1. For filing charter documents:

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

2. Certificate of Authority:

(a) Issuance:

Fraternal benefit societies, alien or foreign...................................$150.00

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

All other alien or foreign insurers.........$150.00

(b) Renewal:

Fraternal benefit societies, alien or

foreign....................................$150.00

Hospital service and medical indemnity

corporations, alien or foreign..............$150.00

All other alien or foreign insurers.........$150.00

3. For filing appointment of Insurance

Commissioner as agent for service of process......$10.00

4. Miscellaneous:

(a) Copies of records, per page...................$0.40

(b) Amended charter documents, articles

of incorporation or bylaws of domestic,

alien or foreign insurers or health

maintenance organizations...................$50.00

(c) Certificate of Commissioner, under seal...... $5.00

(d) For filing Merger and Acquisition

Forms.................................... $1,000.00

(e) For filing Variable Product Forms...........$200.00

(f) For filing a Life, Accident and Health

Policy and Health Maintenance

Organization contract.......................$50.00

(g) For filing an advertisement or rider

application to a Life, Accident and

Health Policy and Health Maintenance

Organization contract.......................$25.00

(h) Pending Company Review....................$1,000.00

(i) ~~Pending Company Admission Packet.............$50.00~~

~~(j)~~ For filing a Viatical Settlement

Contract or Life Settlement $50.00

~~(k)~~ (j) For filing an advertisement for

Viatical Settlement or Life

Settlement..................................$25.00

~~(l)~~ (k) For filing application for Viatical

Settlement or Life Settlement Contract.......$25.00

~~(m)~~ (l) Miscellaneous form filing...................$25.00

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

C. There shall be assessed an annual fee of Five Hundred Dollars ($500.00) payable by each insurer, health maintenance organization, fraternal benefit society, hospital service and medical indemnity corporation, charitable and benevolent corporation, or United States surplus lines insurance companies licensed to do business in this state, to pay for the filing, processing, and reviewing of annual and quarterly financial statements by personnel of the Office of the State Insurance Commissioner.

D. Filings required as part of a health maintenance organization application for a certificate of authority shall not be subject to the fees set out in this section except for the original charter documents, issuance of certificate of authority, and pending company review fees.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 615.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

All domestic insurers are required to keep biographical information current. A domestic insurer is required to provide Biographical Affidavits within thirty (30) days of any change in officers, directors, key management or any person acquiring ten

percent (10%) or more controlling interest in a domestic insurer. The information shall be on the National Association of Insurance Commissioners (NAIC) UCAA Biographical Affidavit Form. The Biographical Affidavit is to be certified by an independent third party that has conducted a comprehensive review of the background of the applicant and has indicated that the Biographical Affidavit has no inaccurate or conflicting information and is accepted as the Business Character Report. As used in this section, "independent third party" is one that has no affiliation with the applicant and is in the business of providing background checks or investigations. The Business Character Report must be current and shall not be older than one (1) year.

SECTION 4. AMENDATORY 36 O.S. 2001, Section 629, is amended to read as follows:

Section 629. A. Every ~~insurer~~ insurance company transacting ~~insurance~~ business in this state whose premium tax, paid with respect to the previous calendar year's premiums, was One Thousand Dollars ($1,000.00) or more, shall make an estimate each year as provided herein and remit with each estimate a prepayment of its annual premium tax for the current calendar year equal to one-fourth (1/4) of its annual premium tax paid with respect to the previous calendar year's premiums. Estimates, with remittance, shall be made on or before April 1, June 15, September 15 and December 15, respectively.

B. All sums prepaid by an ~~insurer~~ insurance company shall be allowed as credits against its annual return for premium tax payable on or before the first day of March. If sums prepaid exceed the ~~insurer's~~ insurance company's annual premium tax payable on or before the first day of March, the excess shall be refunded or shall be allowed as credits against subsequent prepayments of the tax as the ~~insurer~~ insurance company shall elect on the annual return for premium tax filed for the year by the ~~insurer~~ insurance company with

respect to which such excess prepayments were made. Provided, in the case of an ~~insurer~~ insurance company which has made prepayments of its premium tax in excess of its annual premium tax payable, the part of the excess prepayments as has not been credited against subsequent prepayments of the tax shall be refunded to the ~~insurer~~ insurance company upon application within one hundred eighty (180) days after application is made.

SECTION 5. AMENDATORY 36 O.S. 2001, Section 630, is amended to read as follows:

Section 630. Failure to make such payments timely shall subject the ~~insurer~~ insurance company to a penalty of ten percent (10%) of the tax due and said tax and penalty shall be further subject to interest at the rate of six percent (6%) per annum, from the date said payment should have been paid, until the tax, penalty and interest are paid.

SECTION 6. AMENDATORY 36 O.S. 2001, 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~~ insurance company 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 <u>or her</u> home or contents thereof, commonly called homeowner's or renter's insurance and specifically including insurance on ~~a farm dwelling and~~ <u>an</u> 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 until amended or withdrawn by the insurer.

F. 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.

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.

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.

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.

J. Any filing with respect to fidelity, surety or guaranty bonds shall, however, be deemed approved from the date of filing.

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.

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 7. AMENDATORY 36 O.S. 2001, Section 1250.2, as amended by Section 53, Chapter 197, O.S.L. 2003 (36 O.S. Supp. 2003, Section 1250.2), is amended to read as follows:

Section 1250.2 As used in the Unfair Claims Settlement Practices Act:

1. "Agent" means any individual, corporation, association, partnership, or other legal entity authorized to represent an insurer with respect to a claim;

2. "Claimant" means either a first party claimant, a third party claimant, or both, and includes such claimant's designated legal representatives and includes a member of the claimant's immediate family designated by the claimant;

3. "Commissioner" means the Insurance Commissioner;

4. "First party claimant" means an individual, corporation, association, partnership, or other legal entity, including a subscriber under any plan providing health services, asserting a right to payment pursuant to an insurance policy or insurance contract for an occurrence of contingency or loss covered by such policy or contract;

5. "Insurance policy or insurance contract" means any contract of insurance, certificate, indemnity, medical or hospital service, suretyship, annuity, subscriber certificate or any evidence of coverage of a health maintenance organization issued, proposed for issuance, or intended for issuance by any entity subject to this Code;

6. "Insurer" means a person licensed by the Commissioner to issue or who issues any insurance policy or insurance contract in this state, including the State Insurance Fund <u>and also includes health maintenance organizations</u>;

7. "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

8. "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim; and

9. "Third party claimant" means any individual, corporation, association, partnership, or other legal entity asserting a claim against any individual, corporation, association, partnership, or other legal entity insured under an insurance policy or insurance contract.

SECTION 8. AMENDATORY 36 O.S. 2001, Section 1435.6, as amended by Section 13, Chapter 307, O.S.L. 2002 (36 O.S. Supp. 2003, Section 1435.6), is amended to read as follows:

Section 1435.6 A. A resident individual applying for an insurance producer license shall pass a written examination unless exempt pursuant to Section 1435.10 of this title. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer and the insurance laws and regulations of this state. Examinations required by this section shall be developed and conducted under rules and regulations prescribed by the Insurance Commissioner.

B. The Insurance Commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and collecting the nonrefundable fee set forth in Section 1435.23 of this title.

C. Each individual applying for an examination shall remit a nonrefundable fee as prescribed by the Insurance Commissioner as set forth in Section 1435.23 of this title.

D. After completion and filing of the application with the Insurance Commissioner, except as provided in Section 1435.10 of this title, the Commissioner shall subject each applicant for license as an insurance agent, insurance consultant, limited insurance representative, or customer service representative to an examination approved by the Commissioner as to competence to act as a licensee, which each applicant shall personally take and pass to the satisfaction of the Commissioner. The Commissioner may accept examinations administered by a testing service as satisfying the examination requirements of persons seeking license as agents, solicitors, counselors, or adjusters under this Code. The Commissioner may negotiate agreements with such testing services to include performance of examination development, test scheduling, examination site arrangements, test administration, grading, reporting, and analysis. The Commissioner may require such testing services to correspond directly with the applicants with regard to

the administration of such examinations and that such testing services collect fees for administering such examinations directly from the applicants. The Commissioner may stipulate that any agreements with such testing services provide for the administration of examinations in specific locales and at specified frequencies. The Commissioner shall retain the authority to establish the scope and type of all examinations.

E. If the applicant is a legal entity, the examination shall be taken by each individual who is to act for the entity as a licensee.

F. Each examination for a license shall be approved for use by the Commissioner and shall reasonably test the knowledge of the applicant as to the lines of insurance, policies, and transactions to be handled pursuant to the license applied for, the duties and responsibilities of the licensee, and the pertinent insurance laws of this state.

G. Examination for licensing shall be at such reasonable times and places as are designated by the Commissioner.

H. The Commissioner or testing service shall give, conduct, and grade all examinations in a fair and impartial manner and without discrimination among individuals examined.

I. The applicant shall pass the examination with a grade determined by the Commissioner to indicate satisfactory knowledge and understanding of the line or lines of insurance for which the applicant seeks qualification. Within ten (10) days after the examination, the Commissioner shall inform the applicant and the appointing insurer, when applicable, as to whether or not the applicant has passed. Formal evidence of licensing shall be issued by the Commissioner to the licensee within a reasonable time.

J. An applicant who has failed to pass the first examination for the license applied for may take a second examination within thirty (30) days following the first examination. Examination fees for subsequent examinations shall not be waived.

K. An applicant who has failed to pass the first two examinations for the license applied for shall not be permitted to take a subsequent examination until the expiration of ~~six (6) months~~ thirty (30) days after the last previous examination. ~~A current application, company appointments, and applicable fees shall be submitted with each request to take a subsequent examination.~~ Examination fees for subsequent examinations shall not be waived.

SECTION 9. AMENDATORY 36 O.S. 2001, Section 1435.13, is amended to read as follows:

Section 1435.13 A. The Insurance Commissioner may place on probation, censure, suspend, revoke or refuse to issue or renew a license issued pursuant to the Oklahoma Producer Licensing Act or may levy a civil penalty in accordance with subsection D of this section or any combination of actions, for any one or more of the following causes:

1. Providing incorrect, misleading, incomplete or materially untrue information in the license application;

2. Violating any insurance laws, or violating any regulation, subpoena or order of the Insurance Commissioner or of another state’s Insurance Commissioner;

3. Obtaining or attempting to obtain a license through misrepresentation or fraud;

4. Improperly withholding, misappropriating or converting any monies or properties received in the course of doing insurance business;

5. Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

6. Having been convicted of a felony;

7. Having admitted or been found to have committed any insurance unfair trade practice or fraud;

8. Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness or financial

irresponsibility in the conduct of business in this state or elsewhere;

9. Having an insurance producer license, or its equivalent, denied, suspended<u>, censured, placed on probation</u> or revoked in any other state, province, district or territory;

10. Forging another's name to an application for insurance or to any document related to an insurance transaction;

11. Improperly using notes or any other reference material to complete an examination for an insurance license;

12. Knowingly accepting insurance business from an individual who is not licensed;

13. Failing to comply with an administrative or court order imposing a child support obligation; or

14. Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax.

B. In the event that the action by the Insurance Commissioner is to nonrenew or to deny an application for a license, the Insurance Commissioner shall notify the applicant or licensee and advise the applicant or licensee, in writing, of the reason for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the Insurance Commissioner within thirty (30) days of the date of notification of said notification by the Insurance Commissioner for a hearing before the Insurance Commissioner or an independent hearing examiner to determine the reasonableness of the Insurance Commissioner's action. The hearing shall be heard within a reasonable time period and shall be held pursuant to the Oklahoma Administrative Procedures Act.

C. The license of a business entity may be suspended, revoked or refused if the Insurance Commissioner finds, after opportunity for hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership or corporation and the

violation was neither reported to the Insurance Commissioner nor corrective action taken.

D. In addition to or in lieu of any applicable denial, probation, censure, suspension or revocation of a license, a person may, after opportunity for hearing, be subject to a civil fine of not less than One Hundred Dollars ($100.00) nor more than One Thousand Dollars ($1,000.00) for each occurrence. Said penalty may be enforced in the same manner in which civil judgments may be enforced.

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

F. The Insurance Commissioner shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by the Oklahoma Producer Licensing Act and Title 36 of the Oklahoma Statutes against any person who is under investigation for or charged with a violation of the Oklahoma Producer Licensing Act or Title 36 of the Oklahoma Statutes even if the person's license or registration has been surrendered or has lapsed by operation of law.

G. Files pertaining to investigations or legal matters which contain information concurring a current and ongoing investigation of allegations of violations of the Oklahoma Insurance Code by a licensed agent shall not be available for public inspection without

proper judicial authorization; however, a licensee under investigation for alleged violations of the Oklahoma Insurance Code, or against whom an action for alleged violations of the Oklahoma Insurance Code has been commenced, may view evidence and complaints pertaining to the investigation, other than privileged information, at reasonable times at the Commissioner's office. All qualification examination materials, booklets and answers for any license authorized to be issued by the Commissioner under any statute shall not be available for public inspection.

H. The Commissioner shall promptly notify all appointing insurers, where applicable, and the licensee regarding any censure, suspension, revocation or termination of license by the Commissioner.

I. Upon suspension, revocation or termination of the license of a resident or nonresident of this state, the Commissioner shall notify the Central Office of the National Association of Insurance Commissioners, or its appropriate nonprofit affiliates and the Insurance Commissioner of each state for whom the Commissioner has executed a certificate of licensure status.

J. Any licensee who ceases to maintain residency in this state shall deliver the licensee's insurance license to the Commissioner by personal delivery or by mail with return receipt requested within ten (10) days after terminating residency.

K. The Commissioner may issue a duplicate license for any lost, stolen or destroyed license issued pursuant to this act upon an affidavit of the licensee prescribed by the Commissioner concerning the facts of such loss, theft or destruction.

SECTION 10. AMENDATORY 36 O.S. 2001, Section 1450, is amended to read as follows:

Section 1450. A. No person shall act as or present himself or herself to be an administrator, as defined by the provisions of the Third-party Administrator Act, in this state, unless the person

holds a valid license as an administrator which is issued by the Insurance Commissioner.

B. In the case of a partnership which has been licensed, each general partner and each other individual acting for the partnership, and in the case of any entity which has been licensed, each individual acting for the entity as a third-party administrator shall be named in the license and shall qualify therefore as though an individual licensee. The Commissioner shall charge a full additional license fee and a separate license shall be issued for each individual so named in such a license. The entity shall notify the Commissioner within fifteen (15) days if any individual licensed on its behalf has been terminated, or is no longer associated with or employed by the entity.

C. An application for an administrator's license shall be in a form prescribed by the Commissioner and shall be accompanied by a fee of One Hundred Dollars ($100.00). This fee shall not be refundable if the application is denied or refused for any reason by either the applicant or the Commissioner.

~~C.~~ D. The administrator's license shall continue in force no longer than twelve (12) months from the original month of issuance. Upon filing a renewal form prescribed by the Commissioner, accompanied by a fee of One Hundred Dollars ($100.00), the license may be renewed annually for a one-year term. Late application for renewal of a license shall require a fee of double the amount of the original license fee. The administrator shall submit, together with the application for renewal, a list of the names and addresses of the persons with whom the administrator has contracted in accordance with Section 1443 of this title. The Commissioner shall hold this information confidential except as provided in Section 1443 of this title.

~~D.~~ E. The administrator's license shall be issued or renewed by the Commissioner unless, after notice and opportunity for hearing,

the Commissioner determines that the administrator is not competent, trustworthy, or financially responsible, or has had any insurance license denied for cause by any state, has been convicted or has pleaded guilty or nolo contendere to any felony or to a misdemeanor involving moral turpitude or dishonesty.

~~E.~~ F. After notice and opportunity for hearing, and upon determining that the administrator has violated any of the provisions of the Oklahoma Insurance Code or upon finding reasons for which the issuance or nonrenewal of such license could have been denied, the Commissioner may either suspend or revoke an administrator's license or assess a civil penalty of not more than Five Thousand Dollars ($5,000.00) for each occurrence. The payment of the penalty may be enforced in the same manner as civil judgments may be enforced.

~~F.~~ G. Any person who is acting as or presenting himself or herself to be an administrator without a valid license shall be subject, upon conviction, to a fine of not less than One Thousand Dollars ($1,000.00) nor more than Ten Thousand Dollars ($10,000.00) for each occurrence. This fine shall be in addition to any other penalties which may be imposed for violations of the Oklahoma Insurance Code or other laws of this state.

~~G.~~ H. Except as provided for in subsections E and F of this section, any person convicted of violating any provisions of the Third-party Administrator Act shall be guilty of a misdemeanor and shall be subject to a fine of not more than One Thousand Dollars ($1,000.00).

~~H.~~ I. Any fees imposed pursuant to the provisions of this section and any civil penalties imposed pursuant to an administrative hearing order for violation of the provisions of the Third-party Administrator Act shall be deposited in the State Insurance Commissioner Revolving Fund.

SECTION 11. AMENDATORY 36 O.S. 2001, Section 1902, is amended to read as follows:

Section 1902. A. The district court is vested with exclusive original jurisdiction of delinquency proceedings pursuant to the provisions of this article, and is authorized to make all necessary and proper orders to carry out the purposes of this article.

B. Except as to claims against the estate, nothing in this article shall deprive a party in interest of any contractual right to pursue arbitration of any dispute under any law. Where an insurer subject to this article is a party to an arbitration proceeding, the venue of such arbitration proceeding shall be in Oklahoma County.

C. In addition to grounds otherwise provided by law, the following persons are subject to the personal jurisdiction of the district court:

1. Current and former agents and brokers of the insurer;

2. Policy holders and reinsurers of the insurer;

3. Current and former officers, directors, managers, trustees, organizers, promoters, and any other persons in control of the insurer; and

4. Any third party administrator for an insurer and any person that maintains information for an insurer.

D. Notwithstanding any other provision in this article, this section shall not confer jurisdiction on the district court to resolve coverage disputes between guaranty associations and those asserting claims against an association resulting from the initiation of a delinquency proceeding under this article except to the extent that the guaranty association has otherwise expressly consented to such jurisdiction pursuant to a plan of rehabilitation or liquidation that resolves its obligations to covered policyholders.

E. The determination of any dispute with respect to the statutory obligations of any guaranty association by a court or administrative agency or body with jurisdiction in the state of domicile of the guaranty association shall be binding and conclusive as to the parties in a delinquency proceeding initiated in the district court, including, without limitation, the policyholders of the insurer.

F. The venue of delinquency proceedings against any insurer shall be in Oklahoma County. <u>The judges in a judicial district that includes Oklahoma County shall adopt local court rules assigning all delinquency proceedings against insurers to a judge who shall hear all delinquency proceedings against insurers in this state. The judges may adopt local court rules providing for the transfer of cases between judges which will facilitate final disposition of delinquency proceedings against insurers.</u>

G. No person other than the Insurance Commissioner, his attorney, or the Attorney General representing the Insurance Commissioner shall appear in the courts of this state requesting the appointment of a receiver or otherwise commence delinquency proceedings to take over, liquidate, rehabilitate, reorganize, or conserve an insurer and no court shall entertain a petition for the commencement of such proceedings unless the same has been filed in the name of the state on the relation of the Insurance Commissioner.

H. An appeal shall lie to the Supreme Court from an order granting or refusing rehabilitation, liquidation, or conservation, and from every other order in delinquency proceedings having the character of a final order as to the particular portion of the proceedings embraced therein.

SECTION 12. AMENDATORY 36 O.S. 2001, Section 6532, as amended by Section 1, Chapter 439, O.S.L. 2002 (36 O.S. Supp. 2003, Section 6532), is amended to read as follows:

Section 6532. As used in the Health Insurance High Risk Pool Act:

1. "Agent" means any person who is licensed to sell health insurance in this state;

2. “Primary plan” means the comprehensive health insurance benefit plan adopted by the Board of Directors of the Health Insurance High Risk Pool which meets all requirements of federal law as a plan required to be offered by the Pool;

3. "Board" means the Board of Directors of the Health Insurance High Risk Pool;

4. "Church plan" has the meaning given such term under Section 3(33) of the Employee Retirement Income Security Act of 1974;

5. "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

a. a group health plan,

b. health insurance coverage,

c. Part A or B of Title XVIII of the Social Security Act,

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 of such act,

e. Chapter 55 of Title 10, U.S. Code,

f. a medical care program of the Indian Health Service or of a tribal organization,

g. a state health benefits risk pool,

h. a health plan offered under Chapter 89 of Title 5, U.S. Code,

i. a public health plan as defined in federal regulations, or

j. a health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);

6. "Federally defined eligible individual" means an individual:

a. for whom, as of the date on which the individual seeks coverage under the Health Insurance High Risk Pool Act, the aggregate of the periods of creditable coverage, as defined in Section 1D of the Employee Retirement Income Security Act of 1974, is eighteen (18) or more months,

b. whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in conjunction with any such plan,

c. who is not eligible for coverage under a group health plan, part A or B of Title XVIII of the Social Security Act, or a state plan under Title XIX of such Act or any successor program and who does not have other health insurance coverage,

d. with respect to whom the most recent coverage under a COBRA continuation provision or under a similar state program, elected such coverage, and

e. who has exhausted such continuation coverage under such provision or program, if the individual elected the continuation coverage described in this paragraph of this section; however, if the individual is eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986, the requirement for exhaustion of any available COBRA or state continuation benefits is waived;

7. "Governmental plan" has the same meaning given such term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan;

8. "Group health benefit plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides

medical care as defined in Section 3N of the Employee Retirement Income Security Act of 1974 and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise;

9. "Health insurance" means any individual or group hospital or medical expense-incurred policy or health care benefits plan or contract. The term does not include any policy governing short-term accidents only, a fixed-indemnity policy, a limited benefit policy, a specified accident policy, a specified disease policy, a Medicare supplement policy, a long-term care policy, medical payment or personal injury coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance, a disability policy, or workers' compensation;

10. "Insurer" means any individual, corporation, association, partnership, fraternal benefit society, or any other entity engaged in the health insurance business, except insurance agents and brokers. This term shall also include not-for-profit hospital service and medical indemnity plans, health maintenance organizations, preferred provider organizations, prepaid health plans, the State and Education Employees Group Health Insurance Plan, and any reinsurer reinsuring health insurance in this state, which shall be designated as engaged in the business of insurance for the purposes of Section 6531 et seq. of this title;

11. "Medical care" means amounts paid for:

a. the diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

b. transportation primarily for and essential to medical care referred to in ~~paragraph 1~~ subparagraph a of this ~~section~~ paragraph, and

c. insurance covering medical care referred to in ~~paragraphs 1 and 2~~ <u>subparagraphs a and b</u> of this ~~section~~ <u>paragraph</u>;

12. "Medicare" means coverage under Parts A and B of Title XVIII of the Social Security Act (Public Law 74-271, 42 U.S.C., Section 1395 et seq., as amended);

13. "Pool" means the Health Insurance High Risk Pool;

14. "Physician" means a doctor of medicine and surgery, doctor of osteopathic medicine, doctor of chiropractic, doctor of podiatric medicine, doctor of optometry, and, for purposes of oral and maxillofacial surgery only, a doctor of dentistry, each duly licensed by this state;

15. "Plan" means any of the comprehensive health insurance benefit plans as adopted by the Board of Directors of the Health Insurance High Risk Pool, or by rule;

16. “Alternative plan” means any of the comprehensive health insurance benefit plans adopted by the Board of Directors of the Health Insurance High Risk Pool other than the primary plan; and

17. "Reinsurer" means any insurer as defined in Section 103 of this title from whom any person providing health insurance to Oklahoma insureds procures insurance for itself as the insurer, with respect to all or part of the health insurance risk of the person.

SECTION 13. AMENDATORY 36 O.S. 2001, Section 6534, as amended by Section 2, Chapter 439, O.S.L. 2002 (36 O.S. Supp. 2003, Section 6534), is amended to read as follows:

Section 6534. A. Except as otherwise provided in this section, any person who maintains a primary residence in this state for at least one (1) year<u>, or who is legally domiciled in this state on the date of application and who is eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986,</u> or is a federally defined eligible individual shall be

eligible for coverage under any of the plans of the Health Insurance High Risk Pool including:

1. The spouse of the insured; and

2. Any dependent unmarried child of the insured, from the moment of birth. Such coverage shall terminate at the end of the premium period in which the child marries, ceases to be a dependent of the insured, or attains the age of nineteen (19) years, whichever occurs first. However, if the child is a full-time student at an accredited institution of higher learning, the coverage may continue while the child remains unmarried and a full-time student, but not beyond the premium period in which the child reaches the age of twenty-three (23) years.

B. 1. No person is eligible for coverage under any of the Pool plans unless such person has been rejected by at least two insurers for coverage substantially similar to the primary plan coverage. As used in this paragraph, rejection includes an offer of coverage with a material underwriting restriction or an offer of coverage at a rate equal to or greater than the primary Pool plan rates. No person is eligible for coverage under any of the plans if such person has, on the date of issue of coverage under any of the plans, coverage equivalent to the primary plan under another health insurance contract or policy. This paragraph shall not apply to federally defined eligible individuals or an individual who is eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986.

2. No person who is currently receiving, or is entitled to receive, health care benefits under any federal or state program providing financial assistance or preventive and rehabilitative social services is eligible for coverage under any of the plans.

3. No person who is covered under any of the plans and who terminates coverage is again eligible for coverage unless twelve (12) months has elapsed since the coverage was terminated; provided,

however, this provision shall not apply to an applicant who is a federally defined eligible individual. The Board of Directors of the Health Insurance High Risk Pool may waive the twelve-month waiting period under circumstances to be determined by the Board.

4. No person on whose behalf any of the plans have paid out an aggregate from any or all offered plans of Five Hundred Thousand Dollars ($500,000.00) in covered benefits is eligible for coverage under any of the plans.

5. No inmate incarcerated in any state penal institution or confined to any narcotic detention, treatment, and rehabilitation facility shall be eligible for coverage under any of the plans; provided, however, this provision shall not apply with respect to an applicant who is a federally defined eligible individual.

C. The Board may establish an annual enrollment cap if the Board determines it is necessary to limit costs to the plans. However, federally defined eligible individuals shall be guaranteed access to the Pool without regard to any enrollment caps that are set for nonfederally defined eligible individuals.

D. The coverage of any person who ceases to meet the eligibility requirements of this section may be terminated at the end of the month in which an individual no longer meets the eligibility requirements.

SECTION 14. AMENDATORY 36 O.S. 2001, Section 6542, as amended by Section 7, Chapter 439, O.S.L. 2002 (36 O.S. Supp. 2003, Section 6542), is amended to read as follows:

Section 6542. A. 1. The primary plan shall offer as the basic option an annually renewable policy with coverage as specified in this section for each eligible person, except, that if an eligible person is also eligible for Medicare coverage, the plan shall not pay or reimburse any person for expenses paid by Medicare.

2. Any person whose health insurance is involuntarily terminated for any reason other than nonpayment of premium or fraud

may apply for coverage under any of the plans offered by the Board. If such coverage is applied for within sixty-three (63) days after the involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage shall be the date of termination of the previous coverage.

3. The primary plan shall provide that, upon the death, annulment of marriage or divorce of the individual in whose name the contract was issued, every other person covered in the contract may elect within sixty-three (63) days to continue coverage under a continuation or conversion policy.

4. No coverage provided to a person who is eligible for Medicare benefits shall be issued as a Medicare supplement policy.

B. The primary plan shall offer comprehensive coverage to every eligible person who is not eligible for Medicare. Comprehensive coverage offered under the primary plan shall pay an eligible person's covered expenses, subject to the limits on the deductible and coinsurance payments authorized under subsection E of this section up to a lifetime limit of Five Hundred Thousand Dollars ($500,000.00) per covered individual. The maximum limit under this paragraph shall not be altered by the Board of Directors of the Health Insurance High Risk Pool, and no actuarially equivalent benefit may be substituted by the Board.

C. Except for a health maintenance organization and prepaid health plan or preferred provider organization utilized by the Board or a covered person, the usual customary charges for the following services and articles, when prescribed by a physician, shall be covered expenses in the primary plan:

1. Hospital services;

2. Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental, which are rendered by a physician or by others at the direction of a physician;

3. Drugs requiring a physician's prescription;

4. Services of a licensed skilled nursing facility for eligible individuals, ineligible for Medicare, for not more than one hundred eighty (180) calendar days during a policy year, if the services are the type which would qualify as reimbursable services under Medicare;

5. Services of a home health agency, if the services are of a type which would qualify as reimbursable services under Medicare;

6. Use of radium or other radioactive materials;

7. Oxygen;

8. Anesthetics;

9. Prosthesis, other than dental prosthesis;

10. Rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;

11. Diagnostic x-rays and laboratory tests;

12. Oral surgery for partially or completely erupted, impacted teeth and oral surgery with respect to the tissues of the mouth when not performed in connection with the extraction or repair of teeth;

13. Services of a physical therapist;

14. Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

15. Processing of blood including, but not limited to, collecting, testing, fractioning, and distributing blood; and

16. Services for the treatment of alcohol and drug abuse, but the plan shall be required to make a fifty percent (50%) co-payment and the payment of the plan shall not exceed Four Thousand Dollars ($4,000.00).

Usual and customary charges shall not exceed the reimbursement rate for charges as set by the State and Education Employees Group Insurance Board.

D. 1. Covered expenses in the primary plan shall not include the following:

a. any charge for treatment for cosmetic purposes, other than for repair or treatment of an injury or congenital bodily defect to restore normal bodily functions,

b. any charge for care which is primarily for custodial or domiciliary purposes which do not qualify as eligible services under Medicaid,

c. any charge for confinement in a private room to the extent that such charge is in excess of the charge by the institution for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician,

d. that part of any charge for services or articles rendered or provided by a physician or other health care personnel which exceeds the prevailing charge in the locality where the service is provided, or any charge for services or articles not medically necessary,

e. any charge for services or articles the provision of which is not within the authorized scope of practice of the institution or individual providing the service or articles,

f. any expense incurred prior to the effective date of the coverage under the plan for the person on whose behalf the expense was incurred,

g. any charge for routine physical examinations in excess of one every twenty-four (24) months,

h. any charge for the services of blood donors and any fee for the failure to replace the first three (3) pints of blood provided to an eligible person annually, and

i. any charge for personal services or supplies provided by a hospital or nursing home, or any other nonmedical or nonprescribed services or supplies.

2. The primary plan may provide an option for a person to have coverage for the expenses set out in paragraph 1 of this subsection or any benefits payable under any other health insurance policy or plan, commensurate with the deductible and coinsurance selected.

E. 1. The primary plan shall provide for a choice of annual deductibles per person covered for major medical expenses in the amounts of Five Hundred Dollars ($500.00), One Thousand Dollars ($1,000.00), One Thousand Five Hundred Dollars ($1,500.00), Two Thousand Dollars ($2,000.00), Five Thousand Dollars ($5,000.00) and Seven Thousand Five Hundred Dollars ($7,500.00), plus the additional benefits payable at each level of deductible; provided, if two individual members of a family satisfy the applicable deductible, no other members of the family shall be required to meet deductibles for the remainder of that calendar year.

2. The schedule of premiums and deductibles shall be established by the Board.

3. Rates for coverage issued by the Pool may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing coverage.

4. Separate schedules of premium rates based on age may apply for individual risks.

5. Rates are subject to approval by the Insurance Commissioner.

6. Standard risk rates for coverages issued by the Pool shall be established by the Board, subject to the approval of the Insurance Commissioner, using reasonable actuarial techniques, and shall reflect anticipated experiences and expenses of such coverage for standard risks.

7. a. The rating plan established by the Board shall initially provide for rates equal to one hundred

twenty-five percent (125%) of the average standard risk rates of the five largest insurers doing business in the state.

b. Any change to the initial rates shall be based on experience of the plans and shall reflect reasonably anticipated losses and expenses. The rates shall not increase more than five percent (5%) annually with a maximum rate not to exceed one hundred fifty percent (150%) of the average standard risk rates.

8. a. A Pool policy may contain provisions under which coverage is excluded during a period of twelve (12) months following the effective date of coverage with respect to a given covered person's preexisting condition, as long as:

(1) the condition manifested itself within a period of six (6) months before the effective date of coverage, or

(2) medical advice or treatment for the condition was recommended or received within a period of six (6) months before the effective date of coverage. The provisions of this paragraph shall not apply to a person who is a federally defined eligible individual.

b. The Board shall waive the twelve-month period if the person had continuous coverage under another policy with respect to the given condition within a period of six (6) months before the effective date of coverage under the Pool plan. The Board shall also waive any preexisting waiting periods for an applicant who is a federally defined eligible individual.

c. In the case of an individual who is eligible for the credit for health insurance costs under Section 35 of

the Internal Revenue Code of 1986, the preexisting conditions limitation will not apply only if the individual maintained creditable health insurance coverage for an aggregate period of three (3) months as of the date on which the individual seeks to enroll in coverage under the Pool plan, not counting any period prior to a sixty-three-day break in coverage.

9. a. No amounts paid or payable by Medicare or any other governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may be made or recognized as claims under such policy, or be recognized as or towards satisfaction of applicable deductibles or out-of-pocket maximums, or to reduce the limits of benefits available.

   b. The Board shall have a cause of action against a covered person for any benefits paid to a covered person which should not have been claimed or recognized as claims because of the provisions of this paragraph, or because otherwise not covered.

SECTION 15. REPEALER 36 O.S. 2001, Section 1435.38, is hereby repealed.

SECTION 16. This act shall become effective July 1, 2004.

SECTION 17. 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.

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