

**COMMITTEE AMENDMENT**  
HOUSE OF REPRESENTATIVES  
State of Oklahoma

SPEAKER:

CHAIR:

I move to amend SB2119 \_\_\_\_\_  
Of the printed Bill  
Page \_\_\_\_\_ Section \_\_\_\_\_ Lines \_\_\_\_\_  
Of the Engrossed Bill

By striking the Title, the Enacting Clause, the entire bill, and by inserting in lieu thereof the following language:

**AMEND TITLE TO CONFORM TO AMENDMENTS**

Adopted: \_\_\_\_\_

Amendment submitted by: Ron Peterson

\_\_\_\_\_

\_\_\_\_\_  
Reading Clerk

1 STATE OF OKLAHOMA

2 2nd Session of the 51st Legislature (2008)

3 PROPOSED COMMITTEE SUBSTITUTE  
4 FOR ENGROSSED

5 SENATE BILL NO. 2119

By: Sparks of the Senate

and

Peterson (Ron) of the House

7  
8  
9  
10 PROPOSED COMMITTEE SUBSTITUTE

11 ( Insurance - Health Insurance High Risk Pool Act -  
12 Health Insurance Competitive Loss Rating Act -  
13 Insurance Commissioner - codification - effective  
14 date -

emergency )

15  
16  
17  
18 BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

19 SECTION 1. AMENDATORY 36 O.S. 2001, Section 6534, as  
20 last amended by Section 19, Chapter 274, O.S.L. 2004 (36 O.S. Supp.  
21 2007, Section 6534), is amended to read as follows:

22 Section 6534. A. Except as otherwise provided in this section,  
23 any person who maintains a primary residence in this state for at  
24 least one (1) year, or who is legally domiciled in this state on the

1 date of application and who is eligible for the credit for health  
2 insurance costs under Section 35 of the Internal Revenue Code of  
3 1986, or is a federally defined eligible individual shall be  
4 eligible for coverage under any of the plans of the Health Insurance  
5 High Risk Pool including:

6 1. The spouse of the insured; and

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

16 B. 1. No person is eligible for coverage under any of the Pool  
17 plans unless such person has been rejected by at least two insurers  
18 for coverage substantially similar to the primary plan coverage. As  
19 used in this paragraph, rejection includes an offer of coverage with  
20 a material underwriting restriction or an offer of coverage at a  
21 rate equal to or greater than the primary Pool plan rates. No  
22 person is eligible for coverage under any of the plans if such  
23 person has, on the date of issue of coverage under any of the plans,  
24 coverage equivalent to the primary plan under another health

1 insurance contract or policy. This paragraph shall not apply to  
2 federally defined eligible individuals or an individual who is  
3 eligible for the credit for health insurance costs under Section 35  
4 of the Internal Revenue Code of 1986.

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

9 3. No person who is covered under any of the plans and who  
10 terminates coverage is again eligible for coverage unless twelve  
11 (12) months has elapsed since the coverage was terminated; provided,  
12 however, this provision shall not apply to an applicant who is a  
13 federally defined eligible individual. The Board of Directors of  
14 the Health Insurance High Risk Pool may waive the twelve-month  
15 waiting period under circumstances to be determined by the Board.

16 4. No person on whose behalf any of the plans have paid out an  
17 aggregate from any or all offered plans of ~~Five Hundred Thousand~~  
18 ~~Dollars (\$500,000.00)~~ One Million Dollars (\$1,000,000.00) in covered  
19 benefits is eligible for coverage under any of the plans.

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

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

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

10 SECTION 2. AMENDATORY 36 O.S. 2001, Section 6537, is  
11 amended to read as follows:

12 Section 6537. The Health Insurance High Risk Pool may:

13 1. Exercise powers granted to insurers under the laws of this  
14 state;

15 2. Sue or be sued; ~~provided, individual members of the Board~~  
16 ~~while acting in good faith within the course of their duties under~~  
17 ~~the provisions of the Health Insurance High Risk Pool Act shall not~~  
18 ~~be personally liable for actions taken by the Board;~~

19 3. In addition to imposing assessments under Section 6536 of  
20 this title, levy interim assessments against insurers and reinsurers  
21 to ensure the financial ability of the plan to cover claims,  
22 expenses and administrative expenses incurred or estimated to be  
23 incurred in the operation of the plan prior to the end of a calendar  
24 year. Any interim assessment shall be due and payable within thirty

1 (30) days of the receipt of the assessment notice by the insurer.  
2 Interim assessments shall be credited against the insurer's and  
3 reinsurer's annual assessment; and

4 4. Request the Insurance Commissioner to check the reports,  
5 records, books and papers of the Insurance Department to determine  
6 the financial condition of an insurer for purposes of Section 6540  
7 of this title.

8 SECTION 3. AMENDATORY 36 O.S. 2001, Section 6538, as  
9 amended by Section 5, Chapter 439, O.S.L. 2002 (36 O.S. Supp. 2007,  
10 Section 6538), is amended to read as follows:

11 Section 6538. A. The Board of Directors of the Health  
12 Insurance High Risk Pool shall select an administering insurer who  
13 shall be an insurer as defined in this act, through a competitive  
14 bidding process, to administer the plan. The Board shall evaluate  
15 the bids submitted under this subsection based on criteria  
16 established by the Board, which criteria shall include, but not be  
17 limited to, the following:

18 1. The administering insurer's proven ability to handle large  
19 group accident and health insurance policies and claims;

20 2. The efficiency of the administering insurer's claims-paying  
21 procedures; and

22 3. An estimate of total charges for administering the plan.

23 B. The administering insurer shall serve for a period of ~~two~~  
24 ~~(2)~~ up to five (5) years. At least one (1) year prior to the

1 expiration of each ~~two-year~~ contract period of service by an  
2 administering insurer, the Board shall invite all reasonably  
3 interested potential administering insurers, including the current  
4 administering insurer, to submit bids to serve as the administering  
5 insurer for the succeeding ~~two-year~~ contract period. The selection  
6 of the administering insurer for the succeeding ~~two-year~~ contract  
7 period shall be made at least six (6) months prior to the end of the  
8 current ~~two-year~~ contract period. The Board may terminate the  
9 service of the administering insurer at any time if the Board  
10 determines that the administering insurer has failed to perform  
11 their duties effectively according to the contract established or  
12 for other good cause as determined by the Board. In this case, the  
13 Board will accept bids from other potential administering insurers  
14 to serve the remainder of the vacated term.

15 C. The Board may select more than one administering insurer to  
16 perform the different functions involved in administering the plan.

17 D. The administering insurer shall:

18 1. Perform all eligibility and administrative claims-payment  
19 functions relating to the plan;

20 2. Pay an agent's referral fee as established by the Board to  
21 each agent who refers an applicant to the plan, if the applicant is  
22 accepted. The selling or marketing of the plan shall not be limited  
23 to the administering insurer or its agents. The referral fees shall  
24

1 be paid by the administering insurer from moneys received as  
2 premiums for the plan;

3 3. Establish a premium billing procedure for collection of  
4 premiums from persons insured under the plan;

5 4. Perform all necessary functions to assure timely payment of  
6 benefits to covered persons under the plan, including, but not  
7 limited to, the following:

8 a. making available information relating to the proper  
9 manner of submitting a claim for benefits under the  
10 plan and distributing forms upon which submissions  
11 shall be made,

12 b. evaluating the eligibility of each claim for payment  
13 under the plan, and

14 c. notifying each claimant within thirty (30) days after  
15 receiving a properly completed and executed proof of  
16 loss, whether the claim is accepted, rejected, or  
17 compromised;

18 5. Submit regular reports to the Board regarding the operation  
19 of the plan. The frequency, content, and form of the reports shall  
20 be determined by the Board;

21 6. Following the close of each calendar year, determine net  
22 premiums, reinsurance premiums less administrative expenses  
23 allowance, the expense of administration pertaining to the  
24 reinsurance operations of the Pool, and the incurred losses for the

1 year, and report this information to the Board and to the Insurance  
2 Commissioner;

3 7. Pay claims expenses from the premium payments received from,  
4 or on behalf of, covered persons under the plan. If the payments by  
5 the administering insurer for claims expenses exceed the portion of  
6 premiums allocated by the Board for the payment of claims expenses,  
7 the Board shall provide through assessment the additional funds  
8 necessary for payment of claims expenses; and

9 8. Conduct bill review to check for appropriate coding,  
10 duplication, excessive charges and billing errors.

11 E. 1. The administering insurer shall be paid, as provided in  
12 the contract of the Pool, for direct and indirect expenses incurred  
13 in administering the Pool.

14 2. As used in this subsection, the term "direct and indirect  
15 expenses" includes the portion of the audited administrative costs,  
16 printing expenses, claims administration expenses, management  
17 expenses, building overhead expenses and other actual operating and  
18 administrative expenses of the administering insurer which are  
19 approved by the Board as allocable to the administration of the plan  
20 and included in the bid specifications.

21 SECTION 4. AMENDATORY Section 6, Chapter 439, O.S.L.  
22 2002 (36 O.S. Supp. 2007, Section 6538.1), is amended to read as  
23 follows:

24

1 Section 6538.1 A. The Board of Directors of the Health  
2 Insurance High Risk Pool shall select a case manager or managers  
3 through a competitive bidding process, to provide case management  
4 services for the Pool. The Board shall evaluate the bids submitted  
5 under this subsection based on criteria established by the Board,  
6 which criteria shall include, but not be limited to, the following:

7 1. The case manager or managers' proven ability to handle large  
8 group accident and health insurance case management and its  
9 understanding of health care delivery systems;

10 2. The cost savings attributed to the case manager or managers'  
11 services; and

12 3. An estimate of total charges for providing case management  
13 services to the Pool.

14 B. The case manager or managers shall serve for a period of ~~two~~  
15 ~~(2)~~ up to five (5) years beginning January 1, ~~2003~~ 2009. Prior to  
16 the expiration of each ~~two-year~~ contract period of service by a case  
17 manager, the Board shall invite all reasonably interested potential  
18 case managers, including the current case manager or managers, to  
19 submit bids to serve as a case manager for the succeeding ~~two-year~~  
20 contract period. The selection of the case manager or managers for  
21 the succeeding ~~two-year~~ contract period shall be made at least four  
22 (4) months prior to the end of the current ~~two-year~~ contract period.  
23 The Board may terminate the service of a case manager at any time if  
24 the Board determines that the case manager has failed to perform the

1 duties effectively according to the contract established or for  
2 other good cause as determined by the Board. In this case, the  
3 Board will accept bids from other potential case managers to serve  
4 the remainder of the vacated term.

5 C. A case manager's duties shall include:

6 1. Assessing, planning, implementing, coordinating, monitoring  
7 and evaluating the options and services required to meet a member's  
8 health needs;

9 2. Performance of utilization review, to include concurrent  
10 review of inpatient skilled and rehabilitation services, emergency  
11 room retrospective review for appropriateness, frequency, and/or  
12 chronic disease indicators;

13 3. Authorization processes based upon nationally recognized  
14 criteria for elective inpatient and outpatient services;

15 4. Multidisciplinary complex case management for high risk  
16 pregnancy, transplants, neonates, and other complex cases; and

17 5. Providing other cost-containment measures as adopted by the  
18 Board.

19 D. 1. The case manager shall be paid, as provided in the  
20 contract of the Pool, for direct and indirect expenses incurred in  
21 providing case management service for the Pool.

22 2. As used in this subsection, the term "direct and indirect  
23 expenses" includes the portion of the printing expenses, case  
24 management expenses, management expenses, building overhead expenses

1 and other actual operating and administrative expenses of the case  
2 manager which are approved by the Board as allocable to case  
3 management of the plan and included in the bid specifications.

4 E. ~~The Health Insurance High Risk~~ Pool may provide financial  
5 incentives to the case manager or managers based upon savings and  
6 outcomes attributed to such case manager or managers.

7 F. All information and data relating to the Pool which is  
8 collected, created or received by the case manager during the course  
9 of its contractual engagement with the Pool shall be the property of  
10 the Pool.

11 SECTION 5. AMENDATORY 36 O.S. 2001, Section 6542, as  
12 last amended by Section 20, Chapter 274, O.S.L. 2004 (36 O.S. Supp.  
13 2007, Section 6542), is amended to read as follows:

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

19 2. Any person whose health insurance is involuntarily  
20 terminated for any reason other than nonpayment of premium or fraud  
21 may apply for coverage under any of the plans offered by the Board  
22 of Directors of the Health Insurance High Risk Pool. If such  
23 coverage is applied for within sixty-three (63) days after the  
24 involuntary termination and if premiums are paid for the entire

1 period of coverage, the effective date of the coverage shall be the  
2 date of termination of the previous coverage.

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

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

10 B. The primary plan shall offer comprehensive coverage to every  
11 eligible person who is not eligible for Medicare. Comprehensive  
12 coverage offered under the primary plan shall pay an eligible  
13 person's covered expenses, subject to the limits on the deductible  
14 and coinsurance payments authorized under subsection E of this  
15 section up to a lifetime limit of ~~Five Hundred Thousand Dollars~~  
16 ~~(\$500,000.00)~~ One Million Dollars (\$1,000,000.00) per covered  
17 individual. The maximum limit under this paragraph shall not be  
18 altered by the Board of Directors of the Health Insurance High Risk  
19 Pool, and no actuarially equivalent benefit may be substituted by  
20 the Board.

21 C. Except for a health maintenance organization and prepaid  
22 health plan or preferred provider organization utilized by the Board  
23 or a covered person, the usual customary charges for the following  
24

1 services and articles, when prescribed by a physician, shall be  
2 covered expenses in the primary plan:

3 1. Hospital services;

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

8 3. Drugs requiring a physician's prescription;

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

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

16 6. Use of radium or other radioactive materials;

17 7. Oxygen;

18 8. Anesthetics;

19 9. Prosthesis, other than dental prosthesis;

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

22 11. Diagnostic x-rays and laboratory tests;

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

4 13. Services of a physical therapist;

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

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

9 16. Services for the treatment of alcohol and drug abuse, but  
10 the plan shall be required to make a fifty percent (50%) co-payment  
11 and the payment of the plan shall not exceed Four Thousand Dollars  
12 (\$4,000.00).

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

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

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

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

- 1 c. any charge for confinement in a private room to the  
2 extent that such charge is in excess of the charge by  
3 the institution for its most common semiprivate room,  
4 unless a private room is prescribed as medically  
5 necessary by a physician,
- 6 d. that part of any charge for services or articles  
7 rendered or provided by a physician or other health  
8 care personnel which exceeds the prevailing charge in  
9 the locality where the service is provided, or any  
10 charge for services or articles not medically  
11 necessary,
- 12 e. any charge for services or articles the provision of  
13 which is not within the authorized scope of practice  
14 of the institution or individual providing the service  
15 or articles,
- 16 f. any expense incurred prior to the effective date of  
17 the coverage under the plan for the person on whose  
18 behalf the expense was incurred,
- 19 g. any charge for routine physical examinations in excess  
20 of one every twenty-four (24) months,
- 21 h. any charge for the services of blood donors and any  
22 fee for the failure to replace the first three (3)  
23 pints of blood provided to an eligible person  
24 annually, and

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

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

8           E.  1.  The primary plan shall provide for a choice of annual  
9 deductibles per person covered for major medical expenses in the  
10 amounts of Five Hundred Dollars (\$500.00), One Thousand Dollars  
11 (\$1,000.00), One Thousand Five Hundred Dollars (\$1,500.00), Two  
12 Thousand Dollars (\$2,000.00), Five Thousand Dollars (\$5,000.00) and  
13 Seven Thousand Five Hundred Dollars (\$7,500.00), plus the additional  
14 benefits payable at each level of deductible; provided, if two  
15 individual members of a family satisfy the applicable deductible, no  
16 other members of the family shall be required to meet deductibles  
17 for the remainder of that calendar year.

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

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

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

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

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

7 7. a. The rating plan established by the Board shall  
8 initially provide for rates equal to one hundred  
9 twenty-five percent (125%) of the average standard  
10 risk rates of the five largest insurers doing business  
11 in the state.

12 b. Any change to the initial rates shall be based on  
13 experience of the plans and shall reflect reasonably  
14 anticipated losses and expenses. The rates shall not  
15 increase more than five percent (5%) annually with a  
16 maximum rate not to exceed one hundred fifty percent  
17 (150%) of the average standard risk rates.

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

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

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

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

17 c. In the case of an individual who is eligible for the  
18 credit for health insurance costs under Section 35 of  
19 the Internal Revenue Code of 1986, the preexisting  
20 conditions limitation will not apply if the individual  
21 maintained creditable health insurance coverage for an  
22 aggregate period of three (3) months as of the date on  
23 which the individual seeks to enroll in coverage under  
24

1 the Pool plan, not counting any period prior to a  
2 sixty-three-day break in coverage.

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

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

16 SECTION 6. NEW LAW A new section of law to be codified  
17 in the Oklahoma Statutes as Section 4413 of Title 36, unless there  
18 is created a duplication in numbering, reads as follows:

19 A. This act shall constitute a part of the Oklahoma Insurance  
20 Code and shall be known and may be cited as the "Health Insurance  
21 Competitive Loss Rating Act".

22 B. The purposes of the Health Insurance Competitive Loss Rating  
23 Act are:

- 1        1. To promote price competition among insurers so as to provide
- 2 rates that are responsive to competitive market conditions;
- 3        2. To protect policyholders and the public against the adverse
- 4 effects of excessive, inadequate or unfairly discriminatory rates;
- 5        3. To prohibit unlawful price-fixing agreements and other
- 6 anticompetitive behavior by insurers;
- 7        4. To provide regulatory procedures for the maintenance of
- 8 appropriate data reporting systems;
- 9        5. To provide regulatory controls in the absence of a
- 10 competitive marketplace; and
- 11        6. To authorize essential cooperative action among insurers in
- 12 the ratemaking process and to regulate such activity to prevent
- 13 practices that substantially lessen competition or create a
- 14 monopoly.

15        SECTION 7.        NEW LAW        A new section of law to be codified  
16 in the Oklahoma Statutes as Section 4414 of Title 36, unless there  
17 is created a duplication in numbering, reads as follows:

18        The Health Insurance Competitive Loss Rating Act applies to all  
19 forms of health insurance written in this state by insurers licensed  
20 in this state.

21        SECTION 8.        NEW LAW        A new section of law to be codified  
22 in the Oklahoma Statutes as Section 4415 of Title 36, unless there  
23 is created a duplication in numbering, reads as follows:

24

1       A. A competitive market is presumed to exist for a line of  
2 insurance unless the Insurance Commissioner, after a hearing, issues  
3 an order stating that a reasonable degree of competition does not  
4 exist in the market. The burden of proof in any hearing shall be  
5 placed on the party or parties advocating the position that  
6 competition does not exist. Any ruling that a market is not  
7 competitive shall identify the factors causing the market not to be  
8 competitive. Such order shall expire no later than one (1) year  
9 after issue unless rescinded earlier by the Commissioner or unless  
10 the Commissioner renews the rule after a hearing and a finding as to  
11 the continued lack of a reasonable degree of competition. Any  
12 ruling that renews the finding that competition does not exist shall  
13 also identify the factors that cause the market to continue not to  
14 be competitive.

15       B. In determining whether a reasonable degree of competition  
16 exists within a line of insurance, the Commissioner shall consider  
17 the following factors:

- 18       1. The number of insurers actively engaged in writing coverage;
- 19       2. Market shares of the leading writers and the changes in  
20 market shares over a reasonable period of time;
- 21       3. Existence of financial or economic barriers that could  
22 prevent new firms from entering the market;
- 23       4. Measures of market concentration and changes of market  
24 concentration over time;

1 5. Whether long-term profitability for insurers in the market  
2 is reasonable in relation to industries of comparable business risk;  
3 and

4 6. The relationship of insurers' costs to revenue over a  
5 reasonable period of time.

6 SECTION 9. NEW LAW A new section of law to be codified  
7 in the Oklahoma Statutes as Section 4416 of Title 36, unless there  
8 is created a duplication in numbering, reads as follows:

9 A. A rate may not be excessive, inadequate or unfairly  
10 discriminatory.

11 1. No rate in a competitive market may be determined to be  
12 excessive unless the rate has increased the previous calendar year  
13 more than fifty percent (50%) above the inflation rate as calculated  
14 using the Consumer Price Index (CPI-U) published by the United  
15 States Bureau of Labor Statistics. A rate in a noncompetitive  
16 market may be determined to be excessive if it is likely to produce  
17 a profit that is unreasonably high for the insurance provided.

18 2. A rate may not be determined to be inadequate unless:

19 a. the rate is clearly insufficient to sustain projected  
20 losses, expenses and special assessments, and

21 b. the rate is unreasonably low and use of the rate by  
22 the insurer has tended or, if continued, will tend to  
23 create a monopoly in the market.

24

1           3. Unfair discrimination may be determined to exist if, after  
2 allowing for practical limitations, price differentials fail to  
3 reflect equitably the differences in expected losses and expenses.  
4 A rate may not be determined to be unfairly discriminatory because  
5 different premiums result for policyholders with like loss exposures  
6 but different expense levels, or like expenses but different loss  
7 exposures, or if it averaged broadly among persons insured within a  
8 group, franchise or blanket policy or a mass-marketed plan. No rate  
9 in a competitive market shall be considered unfairly discriminatory  
10 unless it classifies risk on the basis of race, color, creed, or  
11 national origin.

12           B. In determining whether rates in a noncompetitive market are  
13 excessive, inadequate, or unfairly discriminatory, due consideration  
14 may be given to:

15           1. Past and prospective loss experience within and outside this  
16 state, in accordance with accepted actuarial principles;

17           2. A reasonable margin for underwriting profit and  
18 contingencies;

19           3. Loadings for leveling premium rates over time for dividends,  
20 savings or unabsorbed premium deposits allowed or returned by  
21 insurers to their policyholders, members or subscribers;

22           4. Past and prospective expenses both countrywide and those  
23 specially applicable to this state; and  
24

1           5. Provisions for special assessments and to all other relevant  
2 factors including judgment within and outside this state.

3           SECTION 10.       NEW LAW       A new section of law to be codified  
4 in the Oklahoma Statutes as Section 4417 of Title 36, unless there  
5 is created a duplication in numbering, reads as follows:

6           A. If the Insurance Commissioner determines that competition  
7 does not exist in a market and issues a ruling to that effect  
8 pursuant to Section 8 of this act, the rates applicable to insurance  
9 sold in that market shall be regulated in accordance with the  
10 provisions of the Health Insurance Competitive Loss Rating Act that  
11 are applicable to noncompetitive markets.

12          B. Any rate in effect at the time the Commissioner determines  
13 that competition does not exist pursuant to the Health Insurance  
14 Competitive Loss Rating Act shall be deemed to be in compliance with  
15 the laws of this state unless disapproved pursuant to the procedures  
16 and rating standards contained in Sections 11 through 14 of this act  
17 that are applicable to noncompetitive markets.

18          C. Any insurer having a rate filing in effect at the time the  
19 Commissioner determines that competition does not exist pursuant to  
20 Section 8 of this act may be required to furnish supporting  
21 information within thirty (30) days of a written request by the  
22 Commissioner.

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1 SECTION 11. NEW LAW A new section of law to be codified  
2 in the Oklahoma Statutes as Section 4418 of Title 36, unless there  
3 is created a duplication in numbering, reads as follows:

4 A. Every insurer shall file with the Insurance Commissioner all  
5 rates and supplementary rate information to be used in this state no  
6 later than thirty (30) days after the effective date; provided, that  
7 the rates and supplementary rate information need not be filed for  
8 commercial risks, which by general custom are not written according  
9 to manual rules or rating plans.

10 B. In a noncompetitive market, every insurer shall file with  
11 the Commissioner all rates, supplementary rate information and  
12 supporting information at least thirty (30) days before the proposed  
13 effective date. The Commissioner may give written notice, within  
14 thirty (30) days of receipt of the filing, that the Commissioner  
15 needs additional time, not to exceed thirty (30) days from the date  
16 of the notice to consider the filing. Upon written application of  
17 the insurer, the Commissioner may authorize rates to be effective  
18 before the expiration of the waiting period or an extension thereof.  
19 A filing shall be deemed to meet the requirements of the Health  
20 Insurance Competitive Loss Rating Act and to become effective unless  
21 disapproved pursuant to Title 36 of the Oklahoma Statutes by the  
22 Commissioner before the expiration of the waiting period or an  
23 extension thereof.

24 In a noncompetitive market, the filing shall be deemed in

1 compliance with the filing provision of this section unless the  
2 Commissioner informs the insurer within ten (10) days after receipt  
3 of the filings as to what supplementary rate information or  
4 supporting information is required to complete the filing.

5 C. Every insurer shall file with the Commissioner, except as to  
6 rates for those lines of insurance exempted from the provisions of  
7 the Health Insurance Competitive Loss Rating Act by the Commissioner  
8 under subsections E and F of this section, all rates, supplementary  
9 rate information and any changes and amendments which it proposes to  
10 use. An insurer may file its rates by either filing its final rates  
11 or by filing a multiplier and, if applicable, an expense constant  
12 adjustment to be applied to prospective loss costs that have been  
13 filed by an advisory organization as permitted by this title. Such  
14 loss cost multiplier filing and expense constant filings made by  
15 insurers shall remain in effect until amended or withdrawn by the  
16 insurer. Every filing shall state the effective date.

17 D. Under rules as may be adopted, the Commissioner may, by  
18 written order, suspend or modify the requirement of filing as to any  
19 kind of insurance, subdivision or combination thereof, or as to  
20 classes of risks.

21 E. Notwithstanding any other provision of the Health Insurance  
22 Competitive Loss Rating Act, upon the written consent of the insured  
23 in a separate written document, a rate in excess of that determined  
24

1 in accordance with the other provisions of the Health Insurance  
2 Competitive Loss Rating Act may be used on a specific risk.

3 F. A filing and any supporting information required to be filed  
4 shall be open to public inspection once the filing becomes effective  
5 except information marked confidential, trade secret, or proprietary  
6 by the insurer or filer. The insurer or filer shall have the burden  
7 of asserting to the Commissioner that a filing and supporting  
8 information are confidential, upon the request of the Commissioner.  
9 The Commissioner may disapprove the insurer's request for  
10 confidential filing status.

11 SECTION 12. NEW LAW A new section of law to be codified  
12 in the Oklahoma Statutes as Section 4419 of Title 36, unless there  
13 is created a duplication in numbering, reads as follows:

14 A. 1. The Insurance Commissioner shall disapprove a rate in a  
15 competitive market only if the Commissioner finds, pursuant to  
16 subsection B of this section, that the rate is inadequate, excessive  
17 or unfairly discriminatory pursuant to the provisions of the Health  
18 Insurance Competitive Loss Rating Act.

19 2. The Commissioner may disapprove a rate for use in a  
20 noncompetitive market only if the Commissioner finds, pursuant to  
21 subsection B of this section, that the rate is excessive, inadequate  
22 or unfairly discriminatory under this section.

23 B. 1. Prior to the expiration of a waiting period or an  
24 extension thereof, made pursuant to subsection B of Section 11 of

1 this act, the Commissioner may disapprove, by written order, rates  
2 filed pursuant to subsection B of Section 11 of this act with a  
3 hearing. The order shall specify in what respects the filing fails  
4 to meet the requirements of this act. Any insurer whose rates are  
5 disapproved pursuant to this section shall be given a hearing upon  
6 written request made within thirty (30) days of disapproval.

7 2. If, at any time, the Commissioner finds that a rate  
8 applicable to insurance sold in a noncompetitive market does not  
9 comply with the standards set forth in Section 8 of this act, the  
10 Commissioner may, after a hearing held upon not less than twenty  
11 (20) days' written notice, issue an order pursuant to subsection C  
12 of this section, disapproving such rate. The hearing notice shall  
13 be sent to every insurer and advisory organization that adopted the  
14 rate and shall specify the matters to be considered at the hearing.  
15 The disapproval order shall not affect any contract or policy made  
16 or issued prior to the effective date set forth in the order.

17 3. If, at any time, the Commissioner finds that a rate  
18 applicable to insurance sold in a competitive market is inadequate  
19 or unfairly discriminatory under Section 8 of this act, the  
20 Commissioner may issue an order pursuant to subsection C of this  
21 section disapproving the rate. The order shall not affect any  
22 contract or policy made or issued prior to the effective date set  
23 forth in the order.

24

1 C. If the Commissioner disapproves a rate pursuant to  
2 subsection B of this section, the Commissioner shall issue an order  
3 within thirty (30) days of the close of the hearing specifying in  
4 what respects the rate fails to meet the requirements of the Health  
5 Insurance Competitive Loss Rating Act. The order shall state an  
6 effective date no sooner than thirty (30) business days after the  
7 date of the order when the use of the rate shall be discontinued.  
8 This order shall not affect any policy made before the effective  
9 date of the order.

10 D. An order of disapproval may be appealed to the district  
11 court within sixty (60) days of written receipt of the  
12 Commissioner's notice of disapproval. The insurer may implement the  
13 disapproved rate upon notification to the court, in which case any  
14 excess of the disapproved rate over a rate previously in effect  
15 shall be placed in a reserve established by the insurer. The court  
16 shall have control over the disbursement of funds from such reserve.  
17 The funds shall be distributed as determined by the court in its  
18 final order except that de minimus refunds to policyholders shall  
19 not be required.

20 E. All determinations made by the Commissioner under this  
21 section shall be on the basis of findings of fact and conclusions of  
22 law.

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1           SECTION 13.           NEW LAW           A new section of law to be codified  
2 in the Oklahoma Statutes as Section 4420 of Title 36, unless there  
3 is created a duplication in numbering, reads as follows:

4           A. Every advisory organization and every insurer subject to the  
5 Health Insurance Competitive Loss Rating Act which makes its own  
6 rates shall provide within this state reasonable means whereby any  
7 insured aggrieved by the application of its rating system may, upon  
8 that insured's written request, be heard in person or through the  
9 insured's authorized representative to review the manner in which  
10 such rating system has been applied in connection with the insurance  
11 afforded the aggrieved insurer.

12           B. An insurer or any party affected by the action of an  
13 advisory organization may, within thirty (30) days after written  
14 notice of that action, make application, in writing, for an appeal  
15 to the Commissioner, setting forth the basis for the appeal and the  
16 grounds to be relied upon by the applicant.

17           C. Within thirty (30) days, the Commissioner shall review the  
18 application and, if the Commissioner finds that the application is  
19 made in good faith and that it sets forth on its face grounds which  
20 reasonably justify holding a hearing, the Commissioner shall conduct  
21 a hearing held not less than ten (10) days after written notice to  
22 the applicant and to the advisory organization or insurer. The  
23 Commissioner, after a hearing, shall affirm or reverse the action of  
24 the advisory organization or insurer.

1 SECTION 14. NEW LAW A new section of law to be codified  
2 in the Oklahoma Statutes as Section 4420.1 of Title 36, unless there  
3 is created a duplication in numbering, reads as follows:

4 Every advisory organization shall file with the Commissioner for  
5 approval every statistical plan, all prospective loss costs,  
6 provisions for special assessments and all supplementary rating  
7 information and every change or amendment or modification of any of  
8 the foregoing proposed for use in this state at least thirty (30)  
9 days prior to its effective date. Such filings will be deemed  
10 approved unless disapproved within the waiting period.

11 SECTION 15. NEW LAW A new section of law to be codified  
12 in the Oklahoma Statutes as Section 6545 of Title 36, unless there  
13 is created a duplication in numbering, reads as follows:

14 A. No applicant or participant in any plan adopted by the Board  
15 of Directors of the Health Insurance High Risk Pool may file a civil  
16 action against the Health Insurance High Risk Pool unless the party  
17 commencing the action has first filed a grievance and received a  
18 final decision thereon in accordance with the procedures authorized  
19 under Section 6536 of Title 36 of the Oklahoma Statutes. Any such  
20 civil action shall be commenced within six (6) months of the Board's  
21 final decision. Venue of any such action shall be in Oklahoma  
22 County.

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1 B. The Board, the individual members of the Board, and any  
2 employee, agent or independent contractor acting on behalf of the  
3 Pool shall not be liable for any obligations of the Pool.

4 C. No action taken in the administration of the Pool  
5 established under the Health Insurance High Risk Pool Act shall be  
6 the basis of any legal action, civil or criminal liability or  
7 penalty against the Board, against any individual member of the  
8 Board, against any agent, employee or independent contractor of the  
9 Pool or the Board, or against any member insurer of the Pool, either  
10 jointly or severally.

11 SECTION 16. This act shall become effective July 1, 2008.

12 SECTION 17. It being immediately necessary for the preservation  
13 of the public peace, health and safety, an emergency is hereby  
14 declared to exist, by reason whereof this act shall take effect and  
15 be in full force from and after its passage and approval.

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