

1 ENGROSSED SENATE
2 BILL NO. 2119

By: Sparks of the Senate

and

Peterson (Ron) of the House

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6 [insurance - Health Insurance High Risk Pool Act -
7 Health Insurance Competitive Loss Rating Act -
8 Insurance Commissioner - codification - effective
9 date -
10 emergency]

11
12 BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

13 SECTION 1. AMENDATORY 36 O.S. 2001, Section 6534, as
14 last amended by Section 19, Chapter 274, O.S.L. 2004 (36 O.S. Supp.
15 2007, Section 6534), is amended to read as follows:

16 Section 6534. A. Except as otherwise provided in this section,
17 any person who maintains a primary residence in this state for at
18 least one (1) year, or who is legally domiciled in this state on the
19 date of application and who is eligible for the credit for health
20 insurance costs under Section 35 of the Internal Revenue Code of
21 1986, or is a federally defined eligible individual shall be
22 eligible for coverage under any of the plans of the Health Insurance
23 High Risk Pool including:

24 1. The spouse of the insured; and

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

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

23 2. No person who is currently receiving, or is entitled to
24 receive, health care benefits under any federal or state program

1 providing financial assistance or preventive and rehabilitative
2 social services is eligible for coverage under any of the plans.

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

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

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

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

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

5 SECTION 2. AMENDATORY 36 O.S. 2001, Section 6542, as
6 last amended by Section 20, Chapter 274, O.S.L. 2004 (36 O.S. Supp.
7 2007, Section 6542), is amended to read as follows:

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

13 2. Any person whose health insurance is involuntarily
14 terminated for any reason other than nonpayment of premium or fraud
15 may apply for coverage under any of the plans offered by the Board.
16 If such coverage is applied for within sixty-three (63) days after
17 the involuntary termination and if premiums are paid for the entire
18 period of coverage, the effective date of the coverage shall be the
19 date of termination of the previous coverage.

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

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

3 B. The primary plan shall offer comprehensive coverage to every
4 eligible person who is not eligible for Medicare. Comprehensive
5 coverage offered under the primary plan shall pay an eligible
6 person's covered expenses, subject to the limits on the deductible
7 and coinsurance payments authorized under subsection E of this
8 section up to a lifetime limit of ~~Five Hundred Thousand Dollars~~
9 ~~(\$500,000.00)~~ One Million Dollars (\$1,000,000.00) per covered
10 individual. The maximum limit under this paragraph shall not be
11 altered by the Board of Directors of the Health Insurance High Risk
12 Pool, and no actuarially equivalent benefit may be substituted by
13 the Board.

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

19 1. Hospital services;

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

24 3. Drugs requiring a physician's prescription;

- 1 4. Services of a licensed skilled nursing facility for eligible
2 individuals, ineligible for Medicare, for not more than one hundred
3 eighty (180) calendar days during a policy year, if the services are
4 the type which would qualify as reimbursable services under
5 Medicare;
- 6 5. Services of a home health agency, if the services are of a
7 type which would qualify as reimbursable services under Medicare;
- 8 6. Use of radium or other radioactive materials;
- 9 7. Oxygen;
- 10 8. Anesthetics;
- 11 9. Prosthesis, other than dental prosthesis;
- 12 10. Rental or purchase, as appropriate, of durable medical
13 equipment, other than eyeglasses and hearing aids;
- 14 11. Diagnostic x-rays and laboratory tests;
- 15 12. Oral surgery for partially or completely erupted, impacted
16 teeth and oral surgery with respect to the tissues of the mouth when
17 not performed in connection with the extraction or repair of teeth;
- 18 13. Services of a physical therapist;
- 19 14. Transportation provided by a licensed ambulance service to
20 the nearest facility qualified to treat the condition;
- 21 15. Processing of blood including, but not limited to,
22 collecting, testing, fractioning, and distributing blood; and
- 23 16. Services for the treatment of alcohol and drug abuse, but
24 the plan shall be required to make a fifty percent (50%) co-payment

1 and the payment of the plan shall not exceed Four Thousand Dollars
2 (\$4,000.00).

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

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

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

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

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

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

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

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

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

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

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

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

23 E. 1. The primary plan shall provide for a choice of annual
24 deductibles per person covered for major medical expenses in the

1 amounts of Five Hundred Dollars (\$500.00), One Thousand Dollars
2 (\$1,000.00), One Thousand Five Hundred Dollars (\$1,500.00), Two
3 Thousand Dollars (\$2,000.00), Five Thousand Dollars (\$5,000.00) and
4 Seven Thousand Five Hundred Dollars (\$7,500.00), plus the additional
5 benefits payable at each level of deductible; provided, if two
6 individual members of a family satisfy the applicable deductible, no
7 other members of the family shall be required to meet deductibles
8 for the remainder of that calendar year.

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

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

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

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

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

22 7. a. The rating plan established by the Board shall
23 initially provide for rates equal to one hundred
24 twenty-five percent (125%) of the average standard

1 risk rates of the five largest insurers doing business
2 in the state.

3 b. Any change to the initial rates shall be based on
4 experience of the plans and shall reflect reasonably
5 anticipated losses and expenses. The rates shall not
6 increase more than five percent (5%) annually with a
7 maximum rate not to exceed one hundred fifty percent
8 (150%) of the average standard risk rates.

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

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

17 (2) medical advice or treatment for the condition was
18 recommended or received within a period of six
19 (6) months before the effective date of coverage.

20 The provisions of this paragraph shall not apply
21 to a person who is a federally defined eligible
22 individual.

23 b. The Board shall waive the twelve-month period if the
24 person had continuous coverage under another policy

1 with respect to the given condition within a period of
2 six (6) months before the effective date of coverage
3 under the Pool plan. The Board shall also waive any
4 preexisting waiting periods for an applicant who is a
5 federally defined eligible individual.

6 c. In the case of an individual who is eligible for the
7 credit for health insurance costs under Section 35 of
8 the Internal Revenue Code of 1986, the preexisting
9 conditions limitation will not apply if the individual
10 maintained creditable health insurance coverage for an
11 aggregate period of three (3) months as of the date on
12 which the individual seeks to enroll in coverage under
13 the Pool plan, not counting any period prior to a
14 sixty-three-day break in coverage.

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

23 b. The Board shall have a cause of action against a
24 covered person for any benefits paid to a covered

1 person which should not have been claimed or
2 recognized as claims because of the provisions of this
3 paragraph, or because otherwise not covered.

4 SECTION 3. NEW LAW A new section of law to be codified
5 in the Oklahoma Statutes as Section 4413 of Title 36, unless there
6 is created a duplication in numbering, reads as follows:

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

10 B. The purposes of the Health Insurance Competitive Loss Rating
11 Act are:

12 1. To promote price competition among insurers so as to provide
13 rates that are responsive to competitive market conditions;

14 2. To protect policyholders and the public against the adverse
15 effects of excessive, inadequate or unfairly discriminatory rates;

16 3. To prohibit unlawful price-fixing agreements and other
17 anticompetitive behavior by insurers;

18 4. To provide regulatory procedures for the maintenance of
19 appropriate data reporting systems;

20 5. To provide regulatory controls in the absence of a
21 competitive marketplace; and

22 6. To authorize essential cooperative action among insurers in
23 the ratemaking process and to regulate such activity to prevent
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1 practices that substantially lessen competition or create a
2 monopoly.

3 SECTION 4. NEW LAW A new section of law to be codified
4 in the Oklahoma Statutes as Section 4414 of Title 36, unless there
5 is created a duplication in numbering, reads as follows:

6 The Health Insurance Competitive Loss Rating Act applies to all
7 forms of health insurance written in this state by insurers licensed
8 in this state.

9 SECTION 5. NEW LAW A new section of law to be codified
10 in the Oklahoma Statutes as Section 4415 of Title 36, unless there
11 is created a duplication in numbering, reads as follows:

12 A. A competitive market is presumed to exist for a line of
13 insurance unless the Insurance Commissioner, after a hearing, issues
14 an order stating that a reasonable degree of competition does not
15 exist in the market. The burden of proof in any hearing shall be
16 placed on the party or parties advocating the position that
17 competition does not exist. Any ruling that a market is not
18 competitive shall identify the factors causing the market not to be
19 competitive. Such order shall expire no later than one (1) year
20 after issue unless rescinded earlier by the Commissioner or unless
21 the Commissioner renews the rule after a hearing and a finding as to
22 the continued lack of a reasonable degree of competition. Any
23 ruling that renews the finding that competition does not exist shall

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1 also identify the factors that cause the market to continue not to
2 be competitive.

3 B. In determining whether a reasonable degree of competition
4 exists within a line of insurance, the Commissioner shall consider
5 the following factors:

6 1. The number of insurers actively engaged in writing coverage;

7 2. Market shares of the leading writers and the changes in
8 market shares over a reasonable period of time;

9 3. Existence of financial or economic barriers that could
10 prevent new firms from entering the market;

11 4. Measures of market concentration and changes of market
12 concentration over time;

13 5. Whether long-term profitability for insurers in the market
14 is reasonable in relation to industries of comparable business risk;
15 and

16 6. The relationship of insurers' costs to revenue over a
17 reasonable period of time.

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

21 A. A rate may not be excessive, inadequate or unfairly
22 discriminatory.

23 1. No rate in a competitive market may be determined to be
24 excessive unless the rate has increased the previous calendar year

1 more than fifty percent (50%) above the inflation rate as calculated
2 using the Consumer Price Index (CPI-U) published by the United
3 States Bureau of Labor Statistics. A rate in a noncompetitive
4 market may be determined to be excessive if it is likely to produce
5 a profit that is unreasonably high for the insurance provided.

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

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

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

12 3. Unfair discrimination may be determined to exist if, after
13 allowing for practical limitations, price differentials fail to
14 reflect equitably the differences in expected losses and expenses.

15 A rate may not be determined to be unfairly discriminatory because
16 different premiums result for policyholders with like loss exposures
17 but different expense levels, or like expenses but different loss
18 exposures, or if it averaged broadly among persons insured within a
19 group, franchise or blanket policy or a mass-marketed plan. No rate
20 in a competitive market shall be considered unfairly discriminatory
21 unless it classifies risk on the basis of race, color, creed, or
22 national origin.

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

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

6 2. A reasonable margin for underwriting profit and
7 contingencies;

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

11 4. Past and prospective expenses both countrywide and those
12 specially applicable to this state; and

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

15 SECTION 7. NEW LAW A new section of law to be codified
16 in the Oklahoma Statutes as Section 4417 of Title 36, unless there
17 is created a duplication in numbering, reads as follows:

18 A. If the Insurance Commissioner determines that competition
19 does not exist in a market and issues a ruling to that effect
20 pursuant to Section 5 of this act, the rates applicable to insurance
21 sold in that market shall be regulated in accordance with the
22 provisions of the Health Insurance Competitive Loss Rating Act that
23 are applicable to noncompetitive markets.

1 B. Any rate in effect at the time the Commissioner determines
2 that competition does not exist pursuant to the Health Insurance
3 Competitive Loss Rating Act shall be deemed to be in compliance with
4 the laws of this state unless disapproved pursuant to the procedures
5 and rating standards contained in Sections 8 through 11 of this act
6 that are applicable to noncompetitive markets.

7 C. Any insurer having a rate filing in effect at the time the
8 Commissioner determines that competition does not exist pursuant to
9 Section 5 of this act may be required to furnish supporting
10 information within thirty (30) days of a written request by the
11 Commissioner.

12 SECTION 8. NEW LAW A new section of law to be codified
13 in the Oklahoma Statutes as Section 4418 of Title 36, unless there
14 is created a duplication in numbering, reads as follows:

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

21 B. In a noncompetitive market, every insurer shall file with
22 the Commissioner all rates, supplementary rate information and
23 supporting information at least thirty (30) days before the proposed
24 effective date. The Commissioner may give written notice, within

1 thirty (30) days of receipt of the filing, that the Commissioner
2 needs additional time, not to exceed thirty (30) days from the date
3 of the notice to consider the filing. Upon written application of
4 the insurer, the Commissioner may authorize rates to be effective
5 before the expiration of the waiting period or an extension thereof.
6 A filing shall be deemed to meet the requirements of the Health
7 Insurance Competitive Loss Rating Act and to become effective unless
8 disapproved pursuant to this title by the Commissioner before the
9 expiration of the waiting period or an extension thereof.
10 In a noncompetitive market, the filing shall be deemed in compliance
11 with the filing provision of this section unless the Commissioner
12 informs the insurer within ten (10) days after receipt of the
13 filings as to what supplementary rate information or supporting
14 information is required to complete the filing.

15 C. Every insurer shall file with the Commissioner, except as to
16 rates for those lines of insurance exempted from the provisions of
17 the Health Insurance Competitive Loss Rating Act by the Commissioner
18 under subsections E and F of this section, all rates, supplementary
19 rate information and any changes and amendments which it proposes to
20 use. An insurer may file its rates by either filing its final rates
21 or by filing a multiplier and, if applicable, an expense constant
22 adjustment to be applied to prospective loss costs that have been
23 filed by an advisory organization as permitted by this title. Such
24 loss cost multiplier filing and expense constant filings made by

1 insurers shall remain in effect until amended or withdrawn by the
2 insurer. Every filing shall state the effective date.

3 D. Under rules as may be adopted, the Commissioner may, by
4 written order, suspend or modify the requirement of filing as to any
5 kind of insurance, subdivision or combination thereof, or as to
6 classes of risks.

7 E. Notwithstanding any other provision of the Health Insurance
8 Competitive Loss Rating Act, upon the written consent of the insured
9 in a separate written document, a rate in excess of that determined
10 in accordance with the other provisions of the Health Insurance
11 Competitive Loss Rating Act may be used on a specific risk.

12 F. A filing and any supporting information required to be filed
13 shall be open to public inspection once the filing becomes effective
14 except information marked confidential, trade secret, or proprietary
15 by the insurer or filer. The insurer or filer shall have the burden
16 of asserting to the Commissioner that a filing and supporting
17 information are confidential, upon the request of the Commissioner.
18 The Commissioner may disapprove of the insurer's request for
19 confidential filing status.

20 SECTION 9. NEW LAW A new section of law to be codified
21 in the Oklahoma Statutes as Section 4419 of Title 36, unless there
22 is created a duplication in numbering, reads as follows:

23 A. 1. The Insurance Commissioner shall disapprove a rate in a
24 competitive market only if the Commissioner finds, pursuant to

1 subsection B of this section, that the rate is inadequate, excessive
2 or unfairly discriminatory pursuant to the provisions of the Health
3 Insurance Competitive Loss Rating Act.

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

8 B. 1. Prior to the expiration of a waiting period or an
9 extension thereof, made pursuant to subsection B of Section 8 of
10 this act, the Commissioner may disapprove, by written order, rates
11 filed pursuant to subsection B of Section 8 of this act with a
12 hearing. The order shall specify in what respects the filing fails
13 to meet the requirements of this act. Any insurer whose rates are
14 disapproved pursuant to this section shall be given a hearing upon
15 written request made within thirty (30) days of disapproval.

16 2. If, at any time, the Commissioner finds that a rate
17 applicable to insurance sold in a noncompetitive market does not
18 comply with the standards set forth in Section 5 of this act, the
19 Commissioner may, after a hearing held upon not less than twenty
20 (20) days' written notice, issue an order pursuant to subsection C
21 of this section, disapproving such rate. The hearing notice shall
22 be sent to every insurer and advisory organization that adopted the
23 rate and shall specify the matters to be considered at the hearing.

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1 The disapproval order shall not affect any contract or policy made
2 or issued prior to the effective date set forth in the order.

3 3. If, at any time, the Commissioner finds that a rate
4 applicable to insurance sold in a competitive market is inadequate
5 or unfairly discriminatory under Section 5 of this act, the
6 Commissioner may issue an order pursuant to subsection C of this
7 section disapproving the rate. The order shall not affect any
8 contract or policy made or issued prior to the effective date set
9 forth in the order.

10 C. If the Commissioner disapproves a rate pursuant to
11 subsection B of this section, the Commissioner shall issue an order
12 within thirty (30) days of the close of the hearing specifying in
13 what respects the rate fails to meet the requirements of the Health
14 Insurance Competitive Loss Rating Act. The order shall state an
15 effective date no sooner than thirty (30) business days after the
16 date of the order when the use of the rate shall be discontinued.
17 This order shall not affect any policy made before the effective
18 date of the order.

19 D. An order of disapproval may be appealed to the district
20 court upon sixty (60) days of written receipt of the Commissioner's
21 notice of disapproval. The insurer may implement the disapproved
22 rate upon notification to the court, in which case any excess of the
23 disapproved rate over a rate previously in effect shall be placed in
24 a reserve established by the insurer. The court shall have control

1 over the disbursement of funds from such reserve. The funds shall
2 be distributed as determined by the court in its final order except
3 that de minimus refunds to policyholders shall not be required.

4 E. All determinations made by the Commissioner under this
5 section shall be on the basis of findings of fact and conclusions of
6 law.

7 SECTION 10. NEW LAW A new section of law to be codified
8 in the Oklahoma Statutes as Section 4420 of Title 36, unless there
9 is created a duplication in numbering, reads as follows:

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

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

23 C. Within thirty (30) days, the Commissioner shall review the
24 application and, if the Commissioner finds that the application is

1 made in good faith and that it sets forth on its face grounds which
2 reasonably justify holding a hearing, the Commissioner shall conduct
3 a hearing held not less than ten (10) days after written notice to
4 the applicant and to the advisory organization or insurer. The
5 Commissioner, after a hearing, shall affirm or reverse the action of
6 the advisory organization or insurer.

7 SECTION 11. NEW LAW A new section of law to be codified
8 in the Oklahoma Statutes as Section 4420.1 of Title 36, unless there
9 is created a duplication in numbering, reads as follows:

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

17 SECTION 12. This act shall become effective July 1, 2008.

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

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1 Passed the Senate the 10th day of March, 2008.

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3 _____
4 Presiding Officer of the Senate
5

6
7 Passed the House of Representatives the ____ day of _____,
8 2008.

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10 _____
11 Presiding Officer of the House
12 of Representatives
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