STATE OF OKLAHOMA

2nd Session of the 52nd Legislature (2010)

COMMITTEE SUBSTITUTE
FOR ENGROSSED
SENATE BILL NO. 2054 By: Brown of the Senate

and

Sullivan of the House

COMMITTEE SUBSTITUTE

An Act relating to insurance; authorizing the Insurance Commissioner to require certain documents to be filed electronically; authorizing the Commissioner to promulgate certain rules; amending 36 O.S. 2001, Section 306, which relates to records; clarifying confidentiality of certain information; amending Section 1, Chapter 432, O.S.L. 2009 (36 O.S. Supp. 2009, Section 307.3), which relates to the State Insurance Commissioner Revolving Fund; correcting statutory cite; amending Section 19, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2009, Section 311A.17), which relates to the Oklahoma Annual Financial Report Act; modifying date; updating statutory cites; amending 36 O.S. 2001, Section 619, which relates to discretionary revocation or suspension; correcting statutory cite; amending 36 O.S. 2001, Section 628, which relates to retaliatory actions; eliminating deposit of certain fund to the General Revenue Fund; amending Section 75, Chapter 264, O.S.L. 2006, as amended by Section 1, Chapter 177, O.S.L. 2009 (36 O.S. Supp. 2009, Section 924.4), which relates to an affidavit of exempt status; eliminating requirement that certain affidavit be mailed; amending Section 4, Chapter 127, O.S.L. 2003 (36 O.S. Supp. 2009, Section 953), which relates to the Use of Credit Information in Personal Insurance Act; clarifying language; making language gender neutral; amending 36 O.S. 2001, Section 997, as

amended by Section 26, Chapter 264, O.S.L. 2006 (36 O.S. Supp. 2009, Section 997), which relates to commercial special risks; eliminating category of special risks; amending 36 O.S. 2001, Sections 1101, 1102, 1103, 1104, 1105, 1106, as amended by Section 1, Chapter 94, O.S.L. 2006, 1107, 1108, 1109, as amended by Section 27, Chapter 264, O.S.L. 2006, 1115, as amended by Section 9, Chapter 432, O.S.L. 2009, 1116, as amended by Section 10, Chapter 432, O.S.L. 2009, 1118 and 1120 (36 O.S. Supp. 2009, Sections 1106, 1109, 1115 and 1116), which relate to unauthorized insurers; creating the Unauthorized Insurers and Surplus Lines Insurance Act; providing certain contract in violation of statute to be voidable; providing how certain actions by certain insurer shall be deemed; exempting certain insurer from applicability; allowing attorney fees for certain insurers; permitting certain insurers to procure coverage through stated conditions; modifying report filing requirement; making language gender neutral; providing certain coverage from certain insurers to be valid and enforceable; requiring report of insurance coverage by certain insurers; penalizing failure to pay tax after accepting coverage from a certain insurer; requiring immediate mailing of legal process; allowing inspection of policy records issued by certain insurers; amending Section 8, Chapter 125, O.S.L. 2007 (36 O.S. Supp. 2009, Section 1204.1), which relates to information made available to policyholders; requiring advisory board or advisory organization to make certain information available to policyholders; amending 36 O.S. 2001, Section 1250.4, which relates to Unfair Claims Settlement Practices Act; modifying time period for certain persons to respond to the Commissioner; amending 36 O.S. 2001, Section 1452, as last amended by Section 16, Chapter 125, O.S.L. 2007 (36 O.S. Supp. 2009, Section 1452), which relates to third-party administrators; requiring annual report to be reviewed by a certified public accountant; amending 36 O.S. 2001, Section 1464, which relates to the Oklahoma Life, Accident and Health Insurance Broker Act; allowing a nonresident broker applicant to receive a license in this state if certain conditions are met; amending 36 O.S. 2001, Section 3614.1, which relates to the Genetic Nondiscrimination in Insurance Act; modifying

definitions; adding definitions; prohibiting certain actions by insurers on the basis of genetic information; allowing an insurer to take certain actions in certain conditions; eliminating certain penalties; allowing an insurer to use the results of a genetic test in making certain determinations; allowing an insurer to request certain test if certain specified conditions are met; prohibiting an insurer from using genetic information for underwriting purposes or prior to enrollment; providing that the obtaining of certain information is not considered a violation of certain requirement; amending 36 O.S. 2001, Section 5103, which relates to the Reinsurance Intermediary Act; requiring applicants designate agent for service of process upon certain insurers; amending 36 O.S. 2001, Sections 6060, as last amended by Section 23, Chapter 184, O.S.L. 2008, 6060.2, 6060.3, as amended by Section 5, Chapter 464, O.S.L. 2003, Section 1, Chapter 397, O.S.L. 2004, 6060.4, as last amended by Section 65, Chapter 264, O.S.L. 2006, Section 1, Chapter 351, O.S.L. 2008, 6060.5, as amended by Section 7, Chapter 464, O.S.L. 2003, 6060.6, 6060.7, as amended by Section 1, Chapter 30, O.S.L. 2002, 6060.8, as amended by Section 8, Chapter 464, O.S.L. 2003, 6060.8a, 6060.9, 6060.10 and 6060.11 (36 O.S. Supp. 2009, Sections 6060, 6060.3, 6060.3a, 6060.4, 6060.4a, 6060.5, 6060.7 and 6060.8), which relate to health benefits; modifying definition of health benefit plans; modifying statutory cite; allowing any health benefit plan to provide benefits for other forms of mental health or substance use disorder benefits subject to certain limitations; specifying that treatment limitations applicable to certain benefits shall be no more restrictive than other limitations applied to all medical and surgical benefits; amending 36 O.S. 2001, Sections 6512, as amended by Section 50, Chapter 176, O.S.L. 2009, 6515, 6522 and 6526 (36 O.S. Supp. 2009, Section 6512), which relate to the Small Employer Health Insurance Reform Act; modifying definitions; deleting requirement relating to certain premium rates; eliminating the Oklahoma Small Employer Health Reinsurance Program; requiring the board to develop certain plan and to submit the plan to the Commissioner within specified time period; specifying details of the plan; clarifying statutory cites;

amending 36 O.S. 2001, Sections 6608, as amended by Section 53, Chapter 176, O.S.L. 2009, 6609, as amended by Section 27, Chapter 184, O.S.L. 2008, 6615, as last amended by Section 24, Chapter 432, O.S.L. 2009 and 6620, as last amended by Section 9, Chapter 189, O.S.L. 2009 (36 O.S. Supp. 2009, Sections 6608, 6609, 6615 and 6620), which relate to the Service Warranty Insurance Act; eliminating reference to specified fee; requiring certain entity to file an audited financial statement; increasing amount of license fee; modifying date when certain annual statement is filed; requiring statement to show certain gross written premiums or assessments; correcting statutory cite; amending Section 11, Chapter 390, O.S.L. 2003, as amended by Section 54, Chapter 176, O.S.L. 2009 and Section 12, Chapter 390, O.S.L. 2003, as amended by Section 55, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2009, Sections 6810 and 6811), which relate to the Medical Professional Liability Insurance Closed Claim Reports Act; making the Medical Professional Liability Insurance Closed Claim Reports Act applicable to all medical professional liability claims in this state; specifying time period for filing of certain reports; amending Section 4, Chapter 64, O.S.L. 2002 and Section 5, Chapter 64, O.S.L. 2002 (40 O.S. Supp. 2009, Sections 600.4 and 600.5), which relate to the Oklahoma Professional Employer Organization Recognition and Registration Act; allowing a PEO to use a qualified assurance organization to provide certain services; defining term; providing procedures for approval as an assurance organization; specifying term of registration of a PEO; modifying renewal requirements; allowing for certain electronic filings; requiring the Commissioner to maintain list of approved assurance organizations; authorizing the Commissioner to promulgate rules; clarifying authority of Commissioner as it relates to the Oklahoma Professional Employer Organization Recognition and Registration Act; providing for initial and annual renewal fees for a PEO Group; amending 59 O.S. 2001, Sections 1305, as amended by Section 5, Chapter 204, O.S.L. 2003, 1306, as last amended by Section 1, Chapter 196, O.S.L. 2009, 1310, 1314, as amended by Section 25, Chapter 432, O.S.L. 2009, 1315, 1316, as last amended by Section 58, Chapter 176, O.S.L. 2009, 1317, as last amended by

Section 30, Chapter 184, O.S.L. 2008 and 1322 (59 O.S. Supp. 2009, Sections 1305, 1306, 1314, 1316 and 1317), which relate to bail bondsman; providing fee for duplicate license; clarifying language; adding cause for denial of bail bondsman license; modifying amount of certain civil penalty; requiring the Commissioner to suspend the appointment of bail agents if certain line of authority is surrendered, suspended or revoked; allowing the Commissioner to cancel a bail surety appointment under certain circumstances; requiring a bondsman to file copy of certain document with the Insurance Commissioner within specified time period; allowing the Commissioner to waive the filing requirement; repealing 11 O.S. 2001, Section 29-205, which relates to filing of certain ordinances with the Insurance Commissioner; repealing 36 O.S. 2001, Sections 6520, 6521, as amended by Section 30, Chapter 125, O.S.L. 2007, 6523 and 6525 (36 O.S. Supp. 2009, Section 6521), which relate to the Small Employer Health Insurance Reform Act; repealing 36 O.S. 2001, Section 6608, as amended by Section 4, Chapter 189, O.S.L. 2009 (36 O.S. Supp. 2009, Section 6608), which is a duplicate section relating to the Service Warranty Iaznsurance Act; providing for codification; and providing an effective date.

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

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 122 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Commissioner shall have the authority to require any entity obligated to submit or file documents with the Insurance Department to file the documents electronically.

B. The documents referred to in subsection A of this section include, but are not limited to, forms for compliance, rate filings, or annual, quarterly, or other financial statements.

C. The Commissioner may promulgate reasonable and necessary rules concerning the implementation of this section.

SECTION 2. AMENDATORY 36 O.S. 2001, Section 306, is amended to read as follows:

Section 306. A. The records, books, and papers pertaining to the official transactions, filings, examinations, investigations, and proceedings of the Insurance Department shall be maintained by the Department until disposition thereof has been approved by the Archives and Records Commission. These records, books, and papers shall be public records of the state. However, reports of examinations of insurers shall be filed and made public only as provided in Section 309.4 of this title. Open and ongoing investigative and disciplinary files shall not be made public until their completion or unless they are ordered to be made public by the proper judicial official. Files of the claims division of the ~~Commissioner's~~ office of the Commissioner, including but not limited to complaints and requests for assistance from insureds, and insurance agency and company records, shall not be public records and shall not be disclosed except in connection with disciplinary proceedings by the Commissioner. Final market conduct orders shall be open public records.

B. Any document or other information generated by the Insurance Department or received by the Insurance Department from a governmental agency or any other public body of any kind, including an insurance guaranty fund or risk pool board, that has a protection from disclosure under any statute or evidentiary privilege from disclosure, while in the possession of the body that generated or received the information, shall retain its confidential character while in the possession of the Insurance Department. The Insurance Department may require that any agency or public body providing a document or other information, if it expects the information to be treated confidentially by the Insurance Department, to also provide simultaneously an express reference to the claimed protection from disclosure.

C. A court shall quash any subpoena commanding the disclosure of confidential information or closed records of the Insurance Department absent a showing of justification for ~~such~~ the disclosure.

SECTION 3. AMENDATORY Section 1, Chapter 432, O.S.L. 2009 (36 O.S. Supp. 2009, Section 307.3), is amended to read as follows:

Section 307.3 A. Effective July 1, 2009, there is hereby created in the State Treasury a revolving fund for the Insurance Commissioner called the State Insurance Commissioner Revolving Fund.

The revolving fund shall be used to fund the operations of the Office of the Insurance Commissioner.

1. Notwithstanding any other law to the contrary, the revolving fund shall consist of and consolidate all funds that are or have been paid or collected by the Insurance Commissioner pursuant to the laws of this state and the rules of the Insurance Department except that the revolving fund shall not include:

a. premium taxes,

b. monies transferred to the Attorney General's Insurance Fraud Unit Revolving Fund pursuant to Section 362 of this title, and

c. funds paid to and collected pursuant to the Oklahoma Certified Real Estate Appraisers Act, ~~Section~~ Sections 858-700 ~~et seq.~~ through 858-732 of Title ~~36~~ 59 of the Oklahoma Statutes.

2. The revolving fund shall be a continuing fund, not subject to fiscal year limitations. Expenditures from the revolving fund shall be made pursuant to the laws of this state and the statutes relating to the Insurance Department. Warrants for expenditures from the revolving fund shall be drawn by the State Treasurer, based on claims signed by an authorized employee or employees of the Insurance Department and filed with the Director of State Finance.

B. All funds collected by the Insurance Commissioner shall be paid into the State Treasury weekly.

C. ~~The~~ After the effective date of this act, the State Treasury is authorized and directed to deduct from the funds paid ~~into~~ or collected by the Insurance Commissioner ~~Revolving Fund after the effective date of this section~~ a sum equal to seventy-six and one half percent (76.5%) of ~~such~~ the payment and place the same to the credit of the General Revenue Fund of the state. The State Treasurer shall place to the credit of the State Insurance Commissioner Revolving Fund the remainder of ~~said~~ the funds so paid and collected ~~shall by the State Treasurer be placed to the credit of the State Insurance Commissioner Revolving Fund~~ by the Insurance Commissioner.

SECTION 4. AMENDATORY Section 19, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2009, Section 311A.17), is amended to read as follows:

Section 311A.17 A. Upon written application of any insurer, the Insurance Commissioner may grant an exemption from compliance with any and all provisions of the Oklahoma Annual Financial Report Act if the Commissioner finds, upon review of the application, that compliance with the Oklahoma Annual Financial Report Act would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten (10) days from a denial of the written request of an insurer for an exemption from the Oklahoma Annual Financial Report Act, the insurer may request in writing a

hearing on its application for an exemption. The hearing shall be held in accordance with the Administrative Procedures Act and the laws and rules of the Insurance Department.

B. Domestic insurers retaining a certified public accountant who qualify as independent on the effective date of the Oklahoma Annual Financial Report Act shall comply with the Oklahoma Annual Financial Report Act for the year ending December 31, 2010, and each year thereafter unless the Commissioner permits otherwise.

C. Domestic insurers not retaining a certified public accountant on the effective date of the Oklahoma Annual Financial Report Act who qualifies as independent may meet the following schedule for compliance unless the Commissioner permits otherwise:

1. As of December 31, 2010, file with the Commissioner an audited financial report; and

2. For the year ending December 31, ~~2011~~ 2010, and each year thereafter, such insurers shall file with the Commissioner all reports and communication required by the Oklahoma Annual Financial Report Act.

D. Foreign insurers shall comply with the Oklahoma Annual Financial Report Act for the year ending December 31, ~~2011~~ 2010, and each year thereafter, unless the Commissioner permits otherwise.

E. The requirements of subsection D of Section ~~9~~ 311A.7 of this ~~act~~ title shall be in effect for audits of the year beginning January 1, 2010, and thereafter.

F. The requirements of Section ~~16~~ 311A.14 of this ~~act~~ title are to be in effect January 1, 2010. An insurer or group of insurers that is not required to have independent audit committee members or only a majority of independent audit committee members, as opposed to a supermajority, because the total written and assumed premium is below the threshold and subsequently becomes subject to one of the independence requirements due to changes in premium shall have one (1) year following the year the threshold is exceeded, but not earlier than January 1, 2010, to comply with the independence requirements. An insurer acquired as a result of a business combination shall have one (1) calendar year following the date of acquisition or combination to comply with the independence requirements.

G. The requirements of Section ~~18~~ 311A.16 of this ~~act~~ title are effective beginning with the reporting period ending December 31, 2010, and each year thereafter. An insurer or group of insurers that are not required to file a report because the total written premium is below the threshold and subsequently becomes subject to the reporting requirements shall have two (2) years following the year the threshold is exceeded, but not earlier than December 31, 2010, to file a report. Likewise, an insurer acquired in a business combination shall have two (2) calendar years following the date of acquisition or combination to comply with the reporting requirements.

SECTION 5. AMENDATORY 36 O.S. 2001, Section 619, is amended to read as follows:

Section 619. A. The Insurance Commissioner may after opportunity for a hearing refuse to renew, or may revoke or suspend an insurer's certificate of authority, in addition to other grounds in this Code, if the insurer:

1. Violates any provision of this Code other than those as to which refusal, suspension, or revocation is mandatory;

2. Knowingly fails to comply with any lawful rule or order of the Insurance Commissioner;

3. Is found by the Insurance Commissioner to be in unsound condition or in such condition as to render its further transaction of insurance in this state hazardous to its policyholders or to the people of this state;

4. Without reasonable cause compels claimants under its policies to accept less than the amount due them or to bring suit against it to secure full payment;

5. Refuses to be examined or to produce its accounts, records, and files for examination by the Insurance Commissioner when required;

6. Fails to pay any final judgment rendered against it in this state within thirty (30) days after the judgment becomes final; or

7. Is affiliated with and under the same general management or interlocking directorate or ownership as another insurer which

transacts direct insurance in this state without having a certificate of authority therefor, except as permitted to a surplus line insurer ~~under Article 11~~ pursuant to Sections 1101 through 1120 of this title ~~(Unauthorized Insurers)~~.

B. In addition to or in lieu of any applicable revocation or suspension of an insurer's certificate of authority, any insurer who knowingly and willfully violates this Code may be subject to a civil penalty of not more than Five Thousand Dollars ($5,000.00) for each occurrence.

C. In addition to or in lieu of any sanction, the Commissioner may require an insurer to restrict its insurance writings, obtain additional contributions to surplus, withdraw from the state, reinsure all or part of its business, increase capital, surplus, deposits or any other account for the security of policyholders or creditors, or provide independent actuarial review.

SECTION 6. AMENDATORY 36 O.S. 2001, Section 628, is amended to read as follows:

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

penalties, licenses, deposit requirements or other obligations, prohibitions or restrictions directly imposed upon similar insurers or agents of such other state or foreign country under the statutes of this state, so long as such laws continue in force or are so applied, the same obligations, prohibitions and restrictions of whatever kind shall be imposed upon similar insurers or agents of such other state or foreign country doing business in Oklahoma. All insurance companies of other nations shall be held to the same obligations and prohibitions that are imposed by the state where they have elected to make their deposit and establish their principal agency in the United States. Any tax, license or other obligation imposed by any city, county or other political subdivision of a state or foreign country on Oklahoma insurers or their agents shall be deemed to be imposed by such state or foreign country within the meaning of this section. The provisions of this section shall not apply to ad valorem taxes on real or personal property or to personal income taxes. ~~Monies collected pursuant to this section shall be paid by the Insurance Commissioner to the State Treasury to the credit of the General Revenue Fund of the state.~~

SECTION 7. AMENDATORY Section 75, Chapter 264, O.S.L. 2006, as amended by Section 1, Chapter 177, O.S.L. 2009 (36 O.S. Supp. 2009, Section 924.4), is amended to read as follows:

Section 924.4 A. Any person who is not required to be covered under a workers' compensation insurance policy or other plan for the payment of workers' compensation may execute an Affidavit of Exempt Status ~~Under~~ under the Workers' Compensation Act. The affidavit shall be a form prescribed by the Insurance Commissioner. The affidavit shall be available on the ~~Insurance Department's~~ web site~~,~~ ~~or shall be mailed to any person upon request and payment by the requestor of a nonrefundable processing fee in an amount to be set by the Commissioner by rule not to exceed Two Dollars and fifty cents ($2.50)~~ of the Insurance Department.

B. Execution of the affidavit shall establish a rebuttable presumption that the executor is not an employee for purposes of the Workers' Compensation Act and that an individual or company possessing the affidavit is in compliance and therefore shall not be responsible for workers' compensation claims made by the executor.

C. Except as otherwise provided in Section 11 of Title 85 of the Oklahoma Statutes, the execution of an affidavit shall not affect the rights or coverage of any employee of the individual executing the affidavit.

D. 1. Knowingly providing false information on a notarized Affidavit of Exempt Status Under the Workers' Compensation Act shall constitute a misdemeanor punishable by a fine not to exceed One Thousand Dollars ($1,000.00).

2. Affidavits shall conspicuously state on the front thereof in at least ten-point, bold-faced print that it is a crime to falsify information on the form.

3. The Insurance Commissioner shall immediately notify the Workers' Compensation Fraud Unit in the Office of the Attorney General of any violations or suspected violations of this section. The Commissioner shall cooperate with the Fraud Unit in any investigation involving affidavits executed pursuant to this section.

E. Application fees collected pursuant to this section shall be deposited in the State Treasury to the credit of the State Insurance Commissioner’s Revolving Fund.

SECTION 8. AMENDATORY Section 4, Chapter 127, O.S.L. 2003 (36 O.S. Supp. 2009, Section 953), is amended to read as follows:

Section 953. An insurer authorized to do business in this state that uses credit information to underwrite or rate risks, shall not:

1. Use an insurance score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status, or nationality of the consumer as a factor;

2. Deny, cancel or fail to renew a policy of personal insurance solely on the basis of credit information, without consideration of any other applicable underwriting factor independent of credit

information and not expressly prohibited by paragraph 1 of this section;

3. Base ~~an insured's~~ renewal rates for personal insurance of an insured solely upon credit information, without consideration of any other applicable factor independent of credit information;

4. Take ~~an~~ adverse action against a consumer solely because ~~he or she~~ the consumer does not have a credit card account, without consideration of any other applicable factor independent of credit information;

5. Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance, unless the insurer does one of the following:

a. treats the consumer as otherwise approved by the Insurance Commissioner, if the insurer presents information that ~~such~~ an absence or inability relates to the risk for the insurer,

b. treats the consumer as if the applicant or insured had neutral credit information, as defined by the insurer, or

c. excludes the use of credit information as a factor and use only other underwriting criteria;

6. Take an adverse action against a consumer based on credit information, unless an insurer obtains and uses a credit report

issued or an insurance score calculated within ninety (90) days from the date the policy is first written or renewal is issued;

7. Use credit information unless not later than every thirty-six (36) months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report. Regardless of the requirements of this subsection:

a. at annual renewal, upon the request of a consumer or the ~~consumer's~~ agent of the consumer, the insurer shall reunderwrite and rerate the policy based upon a current credit report or insurance score. An insurer need not recalculate the insurance score or obtain the updated credit report of a consumer more frequently than once in a twelve-month period,

b. the insurer shall have the discretion to obtain current credit information upon any renewal before the thirty-six (36) months, if consistent with its underwriting guidelines, and

c. no insurer need obtain current credit information for an insured, despite the requirements of paragraph 7 of this section, if one of the following applies:

(1) the insurer is treating the consumer as otherwise approved by the Commissioner,

(2) the insured is in the most favorably priced tier of the insurer, within a group of affiliated insurers. However, the insurer shall have the discretion to order ~~such~~ a report, if consistent with its underwriting guidelines,

(3) credit was not used for underwriting or rating ~~such~~ the insured when the policy was initially written. However, the insurer shall have the discretion to use credit for underwriting or rating ~~such~~ the insured upon renewal, if consistent with its underwriting guidelines, or

(4) the insurer reevaluates the insured beginning no later than thirty-six (36) months after inception and thereafter based upon other underwriting or rating factors, excluding credit information; and

8. Use the following as a negative factor in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy of personal insurance:

a. credit inquiries not initiated by the consumer or inquiries requested by the consumer for ~~his or her own~~ the credit information of the consumer,

b. inquiries relating to insurance coverage, if so identified on a ~~consumer's~~ credit report of the consumer,

c. collection accounts with a medical industry code, if so identified on the ~~consumer's~~ credit report of the consumer,

d. multiple lender inquiries, if coded by the consumer reporting agency on the ~~consumer's~~ credit report of the consumer as being from the home mortgage industry and made within thirty (30) days of one another, unless only one inquiry is considered, and

e. multiple lender inquiries, if coded by the consumer reporting agency on the ~~consumer's~~ credit report of the consumer as being from the automobile lending industry and made within thirty (30) days of one another, unless only one inquiry is considered.

SECTION 9. AMENDATORY 36 O.S. 2001, Section 997, as amended by Section 26, Chapter 264, O.S.L. 2006 (36 O.S. Supp. 2009, Section 997), is amended to read as follows:

Section 997. Commercial Special Risks.

A. The following categories of commercial lines risks, excluding employer's liability line, workers' compensation and excess workers' compensation, are special risks and are exempted from the filing and review requirements set forth in Section 987 of this title:

1. Risks which are written on an excess or umbrella basis;

2. ~~Those commercial lines insurance risks, or portions thereof which are not rated according to manuals, rating plans, or schedules including "a" rates;~~

~~3.~~ Commercial lines insurance risks which produce a minimum annual premium total of Ten Thousand Dollars ($10,000.00); and

~~4.~~ 3. Specifically designated special risks, including:

a. risks insured under the provisions of the Highly Protected Risks Rating Plan,

b. all commercial insurance aviation risks,

c. all credit insurance risks,

d. all boiler ~~and~~, machinery or equipment breakdown risks,

e. all inland marine risks,

f. all fidelity and surety risks, and

g. any other risk that the Commissioner determines to fall within the special risk category.

B. Underwriting files, premiums, loss and expense statistics, financial and other records with regard to special risks written by an insurer shall be maintained by the insurer and shall be subject to examination by the Commissioner.

SECTION 10. AMENDATORY 36 O.S. 2001, Section 1101, is amended to read as follows:

Section 1101. A. Sections 1101 through 1121 of this title shall be known and may be cited as the "Unauthorized Insurers and Surplus Lines Insurance Act".

B. No person in Oklahoma shall in any manner:

1. Represent or assist any insurer not then duly authorized to transact insurance in Oklahoma, in the soliciting, procuring, placing, or maintenance of any insurance coverage upon or with relation to any subject of insurance resident, located, or to be performed in Oklahoma.

2. Inspect or examine any risk or collect or receive any premium on behalf of ~~such~~ the insurer.

~~B.~~ C. Any person transacting insurance in violation of this section shall be liable to the insured for the performance of any contract between the insured and the insurer resulting from ~~such~~ the transaction.

~~C.~~ D. This section shall not apply as to reinsurance, to surplus line insurance lawfully procured pursuant to this article, to transactions exempt under Section 606 of Article 6 (Authorization of Insurers and General Qualifications), or to professional services of an adjuster or attorney-at-law from time to time with respect to claims under policies lawfully solicited, issued, and delivered outside of Oklahoma.

~~D.~~ E. The investigation and adjustment of any claim in this state arising under an insurance contract issued by an unauthorized

insurer shall not be deemed to constitute the transacting of insurance in this state.

~~E.~~ F. Insurance companies not licensed in the State of Oklahoma shall not contract with the trustees of any fund which will insure residents in this state without the previous written approval of the ~~State~~ Insurance Commissioner.

SECTION 11. AMENDATORY 36 O.S. 2001, Section 1102, is amended to read as follows:

Section 1102. A contract of insurance effectuated by ~~an unauthorized~~ a surplus lines insurer in violation of this Code shall be voidable except at the instance of the insurer.

SECTION 12. AMENDATORY 36 O.S. 2001, Section 1103, is amended to read as follows:

Section 1103. A. Delivery, effectuation, or solicitation of any insurance contract, by mail or otherwise, within this state by ~~an unauthorized~~ a surplus lines insurer, or the performance within this state of any other service or transaction connected with ~~such~~ the insurance by or on behalf of ~~such~~ the insurer, shall be deemed to constitute an appointment by the insurer of the Insurance Commissioner and the Commissioner's successors in office as its attorney, upon whom may be served all lawful process issued within this state in any action or proceeding against ~~such~~ the insurer arising out of any such contract or transaction.

B. ~~Such service~~ Service of process shall be made by delivering to and leaving with the Insurance Commissioner three copies thereof. At time of service the plaintiff shall pay Twenty Dollars ($20.00) to the Insurance Commissioner, taxable as costs in the action. The Insurance Commissioner shall mail by registered mail one of the copies of the process to the defendant at its principal place of business as last known to the Insurance Commissioner, and shall keep a record of all process so served.

C. Service of process in any ~~such~~ action or proceeding, in addition to the manner provided herein, shall also be valid if served upon any person within this state who, in this state on behalf of ~~such~~ the insurer, is soliciting insurance, or making, issuing, or delivering any insurance policy, or collecting or receiving any premium, membership fee, assessment, or other consideration for insurance.

D. Service of process upon ~~such~~ an insurer in accordance with this section shall be as valid and effective as if served upon a defendant personally present in this state.

E. Means provided in this section for service of process upon ~~such~~ the insurer shall not be deemed to prevent service of process upon the insurer by any other lawful means.

F. An insurer which has been so served with process shall have the right to appear in and defend ~~such~~ the action and employ

attorneys and other persons in this state to assist in its defense or settlement.

SECTION 13. AMENDATORY 36 O.S. 2001, Section 1104, is amended to read as follows:

Section 1104. Sections 1103 and 1105 of this article shall not apply to surplus line insurance lawfully effectuated under this article, or to reinsurance, nor to any action or proceeding against ~~an unauthorized~~ a surplus lines insurer arising out of:

1. Ocean marine and foreign trade insurance,

2. Insurance on subjects located, resident, or to be performed wholly outside this state, or on vehicles or aircraft owned and principally garaged outside this state,

3. Insurance on property or operations of railroads engaged in interstate commerce, or

4. Insurance on aircraft or cargo of ~~such~~ the aircraft, or against liability, other than employers' liability, arising out of the ownership, maintenance, or use of ~~such~~ the aircraft, where the policy or contract contains a provision designating the Insurance Commissioner as its attorney for the acceptance of service of lawful process in any action or proceeding instituted by or on behalf of an insured or beneficiary arising out of any ~~such~~ policy, or where the insurer enters a general appearance in any ~~such~~ action.

SECTION 14. AMENDATORY 36 O.S. 2001, Section 1105, is amended to read as follows:

Section 1105. In any action against ~~an unauthorized~~ a surplus lines insurer pursuant to ~~section~~ Section 1103 of this article, if the insurer has failed for thirty (30) days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract of insurance, and it appears to the court that ~~such~~ the refusal was vexatious and without reasonable cause, the court may allow to the plaintiff a reasonable ~~attorney's~~ attorney fee and include ~~such~~ the fee in any judgment that may be rendered in ~~such~~ the action. ~~Such~~ The fee shall not exceed one-third (1/3) of the amount which the court or jury finds the plaintiff is entitled to recover against the insurer, but in no event shall ~~such~~ a fee be less than One Hundred Dollars ($100.00). Failure of an insurer to defend any ~~such~~ action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

SECTION 15. AMENDATORY 36 O.S. 2001, Section 1106, as amended by Section 1, Chapter 94, O.S.L. 2006 (36 O.S. Supp. 2009, Section 1106), is amended to read as follows:

Section 1106. If insurance required to protect the interest of the assured cannot be procured from authorized insurers after direct inquiry to ~~such~~ authorized insurers, ~~such~~ the insurance, hereinafter designated as "surplus line", may be procured from ~~unauthorized~~ surplus lines insurers subject to the following conditions:

1. The ~~unauthorized~~ surplus lines insurer ~~must~~ shall have a certificate of approval from the Commissioner, and meet all relevant statutory requirements, including the following:

a. the insurer is financially stable, and

b. the insurer is controlled by persons possessing competence, experience and integrity, and

c. the insurer, if a foreign insurer, posts a special deposit in an amount to be determined by the Commissioner, or

d. the insurer, if an alien insurer, is listed on the National Association of Insurance Commissioners Non-Admitted Insurers Quarterly Listing.

The Commissioner may withdraw a certificate of approval or refuse to renew a certificate upon finding that the insurer no longer meets the criteria for approval set out herein;

2. The insurance ~~must~~ shall be procured through a licensed surplus line broker, hereinafter in this article referred to as the "broker"; and

3. The broker shall file the appropriate affidavit as required by Section 1107 of this title.

SECTION 16. AMENDATORY 36 O.S. 2001, Section 1107, is amended to read as follows:

Section 1107. A. After procuring any surplus line insurance, the broker shall execute and file with the Insurance Commissioner

~~his~~ a report ~~thereof in duplicate and~~ under oath, setting forth facts from which it may be determined whether the requirements of Section 1106 of this title have been met, and in addition thereto the following:

1. Name and address of the insurer, and name and address of the person named in the policy pursuant to Section 1118 of this title to whom the Insurance Commissioner shall send copies of legal process;

2. Number of the policy issued;

3. Name and address of the insured;

4. Nature and amount of liability assumed by the insurer;

5. Premium, and any membership, application, policy or registration fees; and

6. Other information reasonably required by the Insurance Commissioner.

B. The Insurance Commissioner shall prescribe and furnish the required report form. The Insurance Commissioner shall have the authority to grant approval to the surplus line broker for the master bordereau style reporting of surplus line activity on a quarterly basis.

C. Failure to file the report shall result, after notice and hearing, in censure, suspension, or revocation of license or a fine of up to Five Hundred Dollars ($500.00) for each occurrence or by both such fine and licensure penalty.

D. The brokers' affidavits and report shall be submitted on or before the end of each month following each calendar quarter.

SECTION 17. AMENDATORY 36 O.S. 2001, Section 1108, is amended to read as follows:

Section 1108. A. If after a hearing thereon the Insurance Commissioner finds that a particular insurance coverage or type, class, or kind of coverage is not readily procurable from authorized insurers, he may by order declare ~~such~~ the coverage or coverages to be recognized surplus lines until the Insurance Commissioner's further order. The broker's affidavit provided for in Section 1107 of this article shall not be required as to coverages while so recognized. Before holding any ~~such~~ hearing the Commissioner shall give notice to admitted insurers authorized to write such lines of insurance, to rating organizations licensed to make rates for such lines of insurance and to other interested persons in the manner provided by Article 3 of this Code.

B. Any ~~such~~ order shall be subject to modification, and the Insurance Commissioner shall so modify as to any coverage found by ~~him~~ the Commissioner to be no longer entitled to ~~such~~ recognition after a hearing held upon ~~his own~~ the initiative of the Commissioner or upon request of any insurance agent, surplus line broker, broker, insurer, rating or advisory organization, or other person.

SECTION 18. AMENDATORY 36 O.S. 2001, Section 1109, as amended by Section 27, Chapter 264, O.S.L. 2006 (36 O.S. Supp. 2009, Section 1109), is amended to read as follows:

Section 1109. A. Insurance contracts procured as surplus line coverage from ~~unauthorized~~ surplus lines insurers in accordance with this article shall be fully valid and enforceable as to all parties, and shall be given recognition in all matters and respects to the same effect as like contracts issued by authorized insurers.

B. Insurance contracts procured as surplus line coverage shall contain in bold-face type notification stamped by the broker or ~~unauthorized~~ surplus lines insurer on the declaration page of the policy that ~~such~~ the contracts are not subject to the protection of any guaranty association in the event of liquidation or receivership of the insurer.

SECTION 19. AMENDATORY 36 O.S. 2001, Section 1115, as amended by Section 9, Chapter 432, O.S.L. 2009 (36 O.S. Supp. 2009, Section 1115), is amended to read as follows:

Section 1115. A. On or before the end of each month following each calendar quarter, each surplus line broker shall remit to the State Treasurer through the Insurance Commissioner a tax on the premiums, exclusive of sums collected to cover federal and state taxes and examination fees, on surplus line insurance subject to tax transacted by the broker for the period covered by the report. ~~Such~~ The tax shall be at the rate of six percent (6%) of the gross

premiums less premiums returned on account of cancellation or reduction of premium, and shall exclude gross premiums and returned premiums upon business exempted from surplus line provisions pursuant to Section 1119 of this title.

B. Except as provided in subsection C of this section, for the purpose of determining the surplus line tax, the total premium charged for surplus line insurance placed in a single transaction with one underwriter or group of underwriters, whether in one or more policies, shall be allocated to this state in such proportion as the total premium on the insured properties or operations in this state, computed on the exposure in this state on the basis of any single standard rating method in use in all states or countries where ~~such~~ the insurance applies, bears to the total premium so computed in all ~~such~~ the states or countries. Policies sold to federally recognized Indian tribes shall be reported as provided in Section 1107 of this title; however, ~~such~~ these policies shall be exempt from the surplus line tax to the extent that the Insurance Commissioner can identify that coverage is for risks which are wholly owned by a tribe and located within Indian Country, as defined in Section 1151 of Title 18 of the United States Code.

C. The surplus line tax on insurance on motor transit operations conducted between this and other states shall be paid on the total premium charged on all surplus line insurance less:

1. The portion of the premium determined as provided in subsection B of this section charged for operations in other states taxing ~~such~~ the premium of an insured maintaining its headquarters office in this state; or

2. The premium for operations outside of this state of an insured maintaining its headquarters office outside of this state and branch office in this state.

D. Every person, association, or legal entity procuring or accepting any insurance coverage from ~~an unauthorized~~ a surplus lines insurer, upon, covering, or relating to a subject of insurance resident or having a situs in the this state, or any ~~such~~ insurance coverage which is to be performed in whole or part in this state, except ~~such~~ coverages as are lawfully obtained through a licensed surplus line broker in this state, shall report, within thirty (30) days next succeeding the issuance of evidence of coverage, the purchase of ~~such~~ the coverages of insurance to the Insurance Commissioner, on forms prescribed by the Commissioner, and at the same time shall remit to the Insurance Commissioner a tax in the amount of six percent (6%) of the annual premium agreed to be paid, or paid, for ~~such~~ the insurance. ~~Such~~ The insurance coverages, providing for the payment of retrospective premiums, or coverages on which the premiums are not determinable at the time of issuance, shall be reported to the Insurance Commissioner, by the insured, within thirty (30) days next succeeding the date ~~such~~ the coverages

are issued and the tax payable on ~~such~~ the coverages shall be remitted, by the insured, to the Insurance Commissioner within thirty (30) days next succeeding the date ~~such~~ the premiums can be determined. The tax on renewal premiums shall be paid by the insured in accordance with this section, in like manner as provided for payment of the original premium tax, within thirty (30) days next succeeding the date ~~such~~ the premiums can be determined.

SECTION 20. AMENDATORY 36 O.S. 2001, Section 1116, as amended by Section 10, Chapter 432, O.S.L. 2009 (36 O.S. Supp. 2009, Section 1116), is amended to read as follows:

Section 1116. A. Any surplus line broker who fails to remit the surplus line tax provided for by Section 1115 of this title for more than sixty (60) days after it is due shall be liable to a civil penalty of not to exceed Twenty-five Dollars ($25.00) for each additional day of delinquency. The Insurance Commissioner shall collect the tax by distraint and shall recover the penalty by an action in the name of the State of Oklahoma. The Commissioner may request the Attorney General to appear in the name of the state by relation of the Commissioner.

B. If any person, association or legal entity procuring or accepting any insurance coverage from ~~an unauthorized~~ a surplus lines insurer, otherwise than through a licensed surplus line broker in this state, fails to remit the surplus line tax provided for by subsection D of Section 1115 of this title, ~~such~~ the person,

association or legal entity shall, in addition to ~~said~~ the tax, be liable to a civil penalty in an amount equal to one percent (1%) of the premiums paid or agreed to be paid for ~~such~~ the policy or policies of insurance for each calendar month of delinquency or a civil penalty in the amount of Twenty-five Dollars ($25.00) whichever shall be the greater. The Insurance Commissioner shall collect the tax by distraint and shall recover the civil penalty in an action in the name of the State of Oklahoma. The Commissioner may request the Attorney General to appear in the name of the state by relation of the Commissioner.

SECTION 21. AMENDATORY 36 O.S. 2001, Section 1118, is amended to read as follows:

Section 1118. A. Every ~~unauthorized~~ surplus lines insurer issuing or delivering a surplus line policy through a surplus line broker in this state shall conclusively be deemed thereby to have irrevocably appointed the Insurance Commissioner as its attorney for acceptance of service of all legal process, other than a subpoena, issued in this state in any action or proceeding under or arising out of ~~such~~ the policy, and service of ~~such~~ process upon the Insurance Commissioner shall be lawful personal service upon ~~such~~ the insurer.

B. Each surplus line policy shall contain a provision stating the substance of subsection A of this section, and designating the

person to whom the Insurance Commissioner shall mail process as provided in subsection C of this section.

C. Triplicate copies of legal process against such an insurer shall be served upon the Insurance Commissioner, and at time of service the plaintiff shall pay to the Insurance Commissioner Twenty Dollars ($20.00), taxable as costs in the action. The Insurance Commissioner shall ~~forthwith~~ immediately mail one copy of the process so served to the person designated by the insurer in the policy for the purpose, by mail with return receipt requested. The insurer shall have forty (40) days after the date of mailing within which to plead, answer, or otherwise defend the action.

SECTION 22. AMENDATORY 36 O.S. 2001, Section 1120, is amended to read as follows:

Section 1120. Upon request of the Insurance Commissioner any person in Oklahoma who is the insured under any policy issued by ~~an unauthorized~~ a surplus lines insurer upon a subject of insurance resident, located, or to be performed in Oklahoma at the time the policy was issued, shall produce for examination all policies and other documents evidencing and relating to the insurance, and shall disclose the amount of the gross premiums paid or agreed to be paid for the insurance, through whom the insurance was procured, and such other information relative to the placing of ~~such~~ the insurance as may reasonably be required.

SECTION 23. AMENDATORY Section 8, Chapter 125, O.S.L. 2007 (36 O.S. Supp. 2009, Section 1204.1), is amended to read as follows:

Section 1204.1 Property and casualty insurers and advisory board or advisory organizations shall make loss runs or claims history available to current and former policyholders within thirty (30) days upon a written request by the policyholder.

SECTION 24. AMENDATORY 36 O.S. 2001, Section 1250.4, is amended to read as follows:

Section 1250.4 A. An insurer's claim files, other than the claim files of the State Insurance Fund, shall be subject to examination by the Insurance Commissioner or by duly appointed designees. Such files shall contain all notes and work papers pertaining to a claim in such detail that pertinent events and the dates of such events can be reconstructed. In addition, the Insurance Commissioner, authorized employees and examiners shall have access to any of an insurer's files that may relate to a particular complaint under investigation or to an inquiry or examination by the Insurance Department.

B. Every agent, adjuster, administrator, insurance company representative, or insurer, other than the State Insurance Fund and its representatives, upon receipt of any inquiry from the Commissioner ~~concerning a claim or a problem involving premium monies~~ shall, within ~~twenty (20)~~ thirty (30) days ~~after receipt of~~

~~such~~ from the date of the inquiry, furnish the Commissioner with an adequate response to the inquiry.

C. Every insurer, upon receipt of any pertinent written communication including but not limited to e-mail or other forms of written electronic communication, or documentation by the insurer of a verbal communication from a claimant which reasonably suggests that a response is expected, shall, within thirty (30) days after receipt thereof, furnish the claimant with an adequate response to the communication.

D. Any violation by an insurer of this section shall subject the insurer to discipline including a civil penalty of not less than One Hundred Dollars ($100.00) nor more than Five Thousand Dollars ($5,000.00).

SECTION 25. AMENDATORY 36 O.S. 2001, Section 1452, as last amended by Section 16, Chapter 125, O.S.L. 2007 (36 O.S. Supp. 2009, Section 1452), is amended to read as follows:

Section 1452. On or before June 1 of each year, all licensed administrators shall file an annual report for the previous calendar year ~~prepared by~~. The report shall have been reviewed by a certified public accountant~~,~~ who shall be independent of the administrator~~, and which~~. The report shall be subscribed and sworn to by the president and attested to by the secretary or other proper officers substantiating that the information contained in the report is true and factual concerning each of the plans they administer

which are governed pursuant to the provisions of the Third-party Administrator Act. The report shall include the name and address of each fund and a statement of fund equity, paid claims by the covered unit, the accumulated year-to-date paid claims, and the year-to-date reserve status. Failure of any third-party administrator to execute and file ~~such~~ the annual reports as required by this section shall constitute cause, after notice and opportunity for hearing, for censure, suspension, or revocation of administrator licensure to transact business in this state, or a civil penalty of not less than One Hundred Dollars ($100.00) or more than One Thousand Dollars ($1,000.00) for each occurrence, or both censure, suspension, or revocation and civil penalty.

SECTION 26. AMENDATORY 36 O.S. 2001, Section 1464, is amended to read as follows:

Section 1464. A. 1. To be licensed as a resident life or accident and health insurance broker, an individual or legal entity shall have been a licensed resident ~~or nonresident insurance~~ agent or agency in this state continuously for at least two (2) years immediately prior to application and such agent's license shall remain in effect in order to maintain the broker's license. A nonresident life or accident and health insurance broker applicant may receive a license in this state if they are licensed and in good standing in their home state, and if the home state of the applicant

awards nonresident licenses to residents of this state on the same basis.

2. Any applicant for a broker's license shall have no Oklahoma Insurance Code violations or record with the Insurance Commissioner or an insurance regulatory body of another state and shall not have been convicted, or pleaded guilty or nolo contendere to any felony or to a misdemeanor involving moral turpitude or dishonesty.

3. The fee for a life or accident and health insurance broker's license shall be Fifty Dollars ($50.00). The license may be renewed each year for the same fee. Late application for renewal of a license shall require a fee of double the amount of the original current license fee. The fees shall be placed in the State Insurance Commissioner Revolving Fund.

B. 1. Every applicant for a life or accident and health insurance broker's license shall file with the Commissioner and, upon approval of the application, maintain in force while licensed and for at least two (2) years following termination of the license, evidence satisfactory to the Commissioner of an errors and omissions policy covering the individual applicant in an amount of not less than One Hundred Thousand Dollars ($100,000.00) annual aggregate for all claims made during the policy period, or covering the applicant under a blanket liability policy insuring other life or accident and health insurance agents or brokers in an amount of not less than

Five Hundred Thousand Dollars ($500,000.00) annual aggregate for all claims made during the policy period.

2. Such policy shall be issued by an insurance company authorized to do business in this state, shall be continuous in form, and shall provide coverage acceptable to the Commissioner for errors and omissions of the life or accident and health insurance broker. The policy carrier shall notify the Commissioner of any lapse or termination of errors and omissions coverage.

3. Failure to maintain a policy in force shall result in automatic termination of licensure, and the license shall be returned by its lawful custodian to the Commissioner for further cancellation.

C. 1. Every applicant shall also provide a bond in favor of the people of Oklahoma executed by an authorized surety company and payable to any party injured under the term of the bond.

2. The bond shall be continuous in form and in the amount of Five Thousand Dollars ($5,000.00) total aggregate liability, or more if the Commissioner deems it necessary. The bond shall be conditioned upon full accounting and due payments to the person or company entitled thereto as an incident of life or accident and health insurance transactions and funds brought into the life or accident and health insurance broker's possession under his or her license.

3. ~~Said~~ The bond shall remain in force and effect until the surety is released from liability by the Commissioner or until the bond is canceled by the surety. The surety may cancel the bond and be released from further liability thereunder upon thirty (30) days of written notice, in advance, to the Commissioner. Said cancellation shall not affect any liability incurred or accrued thereunder before the termination of the thirty-day period. Upon receipt of any notice of cancellation, the Commissioner shall immediately notify the licensee.

4. ~~Said~~ The license shall automatically terminate upon there being no bond in force, and the license shall be returned by its lawful custodian to the Commissioner for further cancellation.

D. Life or accident and health insurance brokers shall be subject to the same violations, fines, and penalties as stated in Section 1428 of this title. Violations of the provisions of the Oklahoma Life, Accident and Health Insurance Broker Act may result, after notice and hearing, in censure, suspension, or revocation of license or a civil penalty of not less than One Hundred Dollars ($100.00), nor more than One Thousand Dollars ($1,000.00), or a combination thereof for each occurrence.

SECTION 27. AMENDATORY 36 O.S. 2001, Section 3614.1, is amended to read as follows:

Section 3614.1 A. This section shall be known and may be cited as the "Genetic Nondiscrimination in Insurance Act".

B. For purposes of the Genetic Nondiscrimination ~~In~~ in Insurance Act:

1. "Accident and health insurance" means accident and health insurance as ~~such term is~~ defined in Section 703 of ~~Title 36 of the Oklahoma Statutes~~ this title, but shall not include disability income or long-term care insurance;

2. ~~"DNA" means deoxyribonucleic acid~~ "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual;

3. "Genetic information" means, with respect to any individual, information ~~derived from the results of a genetic test. Genetic information shall not include family history, the results of a routine physical examination or test, the results of a chemical, blood or urine analysis, the results of a test to determine drug use, the results of a test for the presence of the human immunodeficiency virus, or the results of any other test commonly accepted in clinical practice at the time it is ordered by the insurer~~ about the genetic tests of an individual, the genetic tests of family members of an individual, and the manifestation of a disease or disorder in family members of the individual. Genetic information includes, but is not limited to, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services,

by an individual or any family member of the individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by a pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. Genetic information shall not include information about the sex or age of any individual;

4. "Genetic services" mean a genetic test, genetic education, or genetic counseling, including, but not limited to, obtaining, interpreting, or assessing genetic information;

5. "Genetic test" means ~~a laboratory test~~ an analysis of the human DNA, RNA, ~~or~~ chromosomes ~~of an individual for the purpose of identifying the presence or absence of inherited alterations in the DNA, RNA, or chromosomes that cause a predisposition for a clinically recognized disease or disorder~~, proteins, or metabolites that detect genotypes, mutations or chromosomal changes. "Genetic test" shall not ~~include:~~

~~a. a routine physical examination or a routine test performed as a part of a physical examination,~~

~~b. a chemical, blood, or urine analysis,~~

~~c. a test to determine drug use,~~

~~d. a test for the presence of the human immunodeficiency virus, or~~

~~e.~~ ~~any other test commonly accepted in clinical practice at the time it is ordered by the insurer~~ mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved;

~~5.~~ 6. "Insurer" means any individual, corporation, association, partnership, insurance support organization, fraternal benefit society, insurance ~~agent~~ producer, third-party ~~administration~~ administrator, self-insurer, or any other legal entity engaged in the business of insurance which is licensed to do business in or incorporated or domesticated or domiciled in or under the statutes of this state, or actually engaged in business in this state, regardless of where the contract of insurance is written or plan is administered or where the corporation is incorporated, that issues accident and health policies or plans or that administers any other type of health insurance policy containing medical provisions including, but not limited to, any nonprofit hospital service and indemnity and medical service and indemnity corporation, health maintenance organizations, preferred provider organizations, prepaid

health plans and the State and Education Employees Group Health Insurance Plan. Insurer shall not include insurers issuing life, disability income, or long-term care insurance;

~~6.~~ 7. "Policy" or "policy form" means any policy, contract, plan or agreement of accident and health insurance, or subscriber certificates of medical care corporations, health care corporations, hospital service associations, or health care maintenance organizations, delivered or issued for delivery in this state by any insurer; any certificate, contract or policy issued by a fraternal benefit society; any certificate issued pursuant to a group insurance policy delivered or issued for delivery in this state; and any evidence of coverage issued by a health maintenance organization. Policy or policy form shall not include life, disability income, and long-term care insurance policies; and

~~7. "RNA" means ribonucleic acid~~

8. “Underwriting purposes” means:

a. rules for, or determination of, eligibility, including but not limited to enrollment and continued eligibility, for benefits under the policy,

b. the computation of premium or contribution amounts under the policy,

c. the application of any preexisting condition exclusion under the policy, and

d. other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

C. No insurer offering an individual or group accident and health insurance policy shall~~, for the purpose of determining eligibility of any individual for any insurance coverage, establishing premiums, limiting coverage, renewing coverage, terminating coverage or any other underwriting decision in connection with the offer, sale or renewal or continuation of a policy, except to the extent and in the same fashion as an insurer limits coverage, or increases premiums for loss caused or contributed to by other medical conditions presenting an increased degree of risk~~:

1. ~~Require or request, directly or indirectly, any individual or a member of the individual's family to obtain a genetic test~~ Deny or condition the issuance or effectiveness of the policy or certificate, including but not limited to the imposition of any exclusion of benefits under the policy based on a preexisting condition, on the basis of the genetic information with respect to any individual; and

2. ~~Condition the provision of the policy upon a requirement that an individual take a genetic test~~ Discriminate in the pricing of the policy or certificate, including but not limited to the

adjustment of premium rates, of an individual on the basis of the genetic information with respect to any individual.

D. Nothing in subsection C of this section shall be construed to limit ~~an insurer's right to decline an application or enrollment request for a policy, charge a higher rate or premium for such a policy, or place a limitation on coverage under such a policy,~~ the ability of an insurer, to the extent otherwise permitted under this title, from:

1. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group on the basis of manifestations of any condition, disease or disorder of an insured or applicant; or

2. Increasing the premium for any policy or certificate issued to an individual based on the manifestation of a condition, disease or disorder of an individual who is covered under the policy. The manifestation of a disease or disorder in one individual shall not also be used as genetic information about other group members and to further increase the premium for the group.

E. ~~1. Any violation of subsections C and D of this section by an insurer shall be deemed an unfair practice pursuant to Section 1201 et seq. of Title 36 of the Oklahoma Statutes.~~

~~2. In addition, any individual who is damaged by an insurer's violation of this section may recover in a court of competent jurisdiction equitable relief, which may include a retroactive~~

~~order, directing the insurer to provide insurance coverage to the damaged individual under the same terms and conditions as would have applied had the violation not occurred~~ An insurer shall not request or require an individual or a family member of an individual to undergo a genetic test.

F. ~~Notwithstanding any language in this section to the contrary, this section shall not apply to an insurer or to an individual or third party dealing with an insurer in the ordinary course of underwriting, conducting, or administering the business of life, disability income, or long term care insurance~~ Subsection E of this section shall not be construed to preclude an insurer from obtaining and using the results of a genetic test in making a determination regarding payment, as defined for the purposes of applying the regulations promulgated under part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time, and consistent with subsection C of this section.

G. In accordance with subsection F of this section, an insurer may request only the minimum amount of information necessary to accomplish the intended purpose.

H. Notwithstanding subsection E of this section, an insurer may request, but shall not require, that an individual or a family member of an individual undergo a genetic test if each of the following conditions is met:

1. The request is made pursuant to research that complies with part 46 of Title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research;

2. The insurer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of the minor child, to whom the request is made that:

a. compliance with the request is voluntary, and

b. noncompliance shall have no effect on enrollment status or premium or contribution amounts;

3. No genetic information collected or acquired pursuant to the Genetic Nondiscrimination in Insurance Act shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate;

4. The insurer notifies the Secretary of Health and Human Services in writing that the insurer is conducting activities pursuant to the exception provided for under this subsection, including but not limited to a description of the activities conducted; and

5. The insurer complies with other conditions as the Secretary of Health and Human Services may by regulation require for activities conducted pursuant to this subsection.

I. An insurer shall not request, require, or purchase genetic information for underwriting purposes.

J. An insurer shall not request, require, or purchase genetic information with respect to any individual prior to the enrollment of the individual under the policy in connection with the enrollment.

K. If an insurer obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, the request, requirement, or purchase shall not be considered a violation of subsection J of this section if the request, requirement, or purchase is not in violation of subsection I of this section.

SECTION 28. AMENDATORY 36 O.S. 2001, Section 5103, is amended to read as follows:

Section 5103. A. No person, firm, association or corporation shall act as an RB in this state if the RB maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation:

1. In this state, unless ~~such~~ the RB is a licensed producer in this state; or

2. In another state, unless ~~such~~ the RB is a licensed producer in this state or another state having a law substantially similar to this law or ~~such~~ the RB is licensed in this state as a nonresident reinsurance intermediary.

B. No person, firm, association or corporation shall act as an RM:

1. For a reinsurer domiciled in this state, unless ~~such~~ the RM is a licensed producer in this state;

2. In this state, if the RM maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation in this state, unless ~~such~~ the RM is a licensed producer in this state; or

3. In another state for a nondomestic insurer, unless ~~such~~ the RM is a licensed producer in this state or another state having a law substantially similar to this law or ~~such~~ the person is licensed in this state as a nonresident reinsurance intermediary.

C. The Insurance Commissioner may require an RM subject to the provisions of subsection B of this section to:

1. File a bond in an amount from an insurer acceptable to the Commissioner for the protection of the reinsurer; and

2. Maintain an errors and omissions policy in an amount acceptable to the Commissioner.

D. 1. The Commissioner may issue a reinsurance intermediary license to any person, firm, association or corporation who has complied with the requirements of the Reinsurance Intermediary Act. Any ~~such~~ the license issued to a firm or association shall authorize all the members of the firm or association and any designated employees to act as reinsurance intermediaries pursuant to the

license, and all such persons shall be named in the application and any supplements thereto. Any ~~such~~ the license issued to a corporation shall authorize all of the officers, and any designated employees and directors thereof to act as reinsurance intermediaries on behalf of the corporation, and all such persons shall be named in the application and any supplements thereto.

2. If the applicant for a reinsurance intermediary license is a nonresident, the applicant, as a condition precedent to receiving or holding a license, shall designate the Commissioner as agent for service of process in the manner, and with the same legal effect, provided for by the Reinsurance Intermediary Act for designation of service of process upon ~~unauthorized~~ surplus lines insurers; and also shall furnish the Commissioner with the name and address of a resident of this state upon whom notices or orders of the Commissioner or process affecting ~~such~~ the nonresident reinsurance intermediary may be served. ~~Such~~ The licensee shall promptly notify the Commissioner in writing of every change in its designated agent for service of process, and such change shall not become effective until acknowledged by the Commissioner.

E. The Commissioner may refuse to issue a reinsurance intermediary license if, in the judgment of the Commissioner, the applicant, any one named on the application, or any member, principal, officer or director of the applicant, or that any controlling person of such applicant, is not trustworthy to act as a

reinsurance intermediary, or that any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of such license. Upon written request therefor, the Commissioner shall furnish a summary of the basis for refusal to issue a license, which document shall be privileged and not subject to the Oklahoma Open Records Act.

F. Licensed attorneys-at-law of this state when acting in their professional capacity as attorneys shall be exempt from this section.

G. Licenses issued by the Commissioner pursuant to this section shall be issued for a period of twenty-four (24) months. The license shall not be issued unless the application for the license is accompanied by a license fee of One Hundred Dollars ($100.00). The license shall not be renewed unless the renewal application for the license is accompanied by a renewal fee of One Hundred Dollars ($100.00).

SECTION 29. AMENDATORY 36 O.S. 2001, Section 6060, as last amended by Section 23, Chapter 184, O.S.L. 2008 (36 O.S. Supp. 2009, Section 6060), is amended to read as follows:

Section 6060. A. All ~~individual and group health insurance policies providing coverage on an expense incurred basis, and all individual and group service or indemnity type contracts issued by a nonprofit corporation, including the Oklahoma State and Education Employees Group Insurance Board, which provide coverage for a female~~

~~thirty-five (35) years old or older in this state, except for policies that provide coverage for specified disease or other limited benefit coverage,~~ health benefit plans shall include the coverage specified by this section for a mammography screening ~~in a reimbursement amount not to exceed One Hundred Fifteen Dollars ($115.00)~~ for the presence of occult breast cancer. Such coverage shall not:

1. Be subject to the policy deductible, co-payments and co-insurance limits of the plan; or

2. Require that a female undergo a mammography screening at a specified time as a condition of payment.

B. 1. Any female thirty-five (35) through thirty-nine (39) years of age shall be entitled pursuant to the provisions of this section to coverage for a mammography screening once every five (5) years.

2. Any female forty (40) years of age or older shall be entitled pursuant to the provisions of this section to coverage for an annual mammography screening.

C. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

SECTION 30. AMENDATORY 36 O.S. 2001, Section 6060.2, is amended to read as follows:

Section 6060.2 A. 1. ~~For policies, contracts or agreements issued or renewed on and after November 1, 1996, any individual or group health insurance policy, contract or agreement providing coverage on an expense incurred basis; any policy, contract or agreement issued for individual or group coverage by a not-for-profit hospital service and indemnity and medical service and indemnity corporation; contracts issued by health benefit plans including, but not limited to, health maintenance organizations, preferred provider organizations, health services corporations, physician sponsored networks, or physician hospital organizations; medical coverage provided by self-insureds that includes coverage for physician services in a physician's office, including coverage through private third-party payors; coverage provided through the State and Education Employees Group Insurance Board; and every policy, contract, or agreement which provides medical, major medical or similar comprehensive type coverage, group or blanket accident and health coverage, or medical expense, surgical, medical equipment, medical supplies, or drug prescription benefits~~ Every health benefit plan issued or renewed on or after November 1, 1996, shall, subject to the terms of the policy contract or agreement, include coverage for the following equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes, when medically necessary and when recommended or

prescribed by a physician or other licensed health care provider legally authorized to prescribe under the laws of this state:

a. blood glucose monitors,

b. blood glucose monitors to the legally blind,

c. test strips for glucose monitors,

d. visual reading and urine testing strips,

e. insulin,

f. injection aids,

g. cartridges for the legally blind,

h. syringes,

i. insulin pumps and appurtenances thereto,

j. insulin infusion devices,

k. oral agents for controlling blood sugar, and

l. podiatric appliances for prevention of complications associated with diabetes.

2. The State Board of Health shall develop and annually update, by rule, a list of additional diabetes equipment, related supplies and health care provider services that are medically necessary for the treatment of diabetes, for which coverage shall also be included, subject to the terms of the policy, contract, or agreement, if ~~such~~ the equipment and supplies have been approved by the federal Food and Drug Administration (FDA). ~~Such additional~~ Additional FDA-approved diabetes equipment and related supplies, and health care provider services shall be determined in consultation

with a national diabetes association affiliated with this state, and at least three (3) medical directors of health benefit plans, to be selected by the State Department of Health.

3. All policies specified in this section shall also include coverage for:

a. podiatric health care provider services as are deemed medically necessary to prevent complications from diabetes, and

b. diabetes self-management training. As used in this subparagraph, "diabetes self-management training" means instruction in an inpatient or outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. Diabetes self-management training shall comply with standards developed by the State Board of Health in consultation with a national diabetes association affiliated with this state and at least three (3) medical directors of health benefit plans selected by the State Department of Health. ~~Such coverage~~ Coverage for diabetes self-management training, including medical nutrition therapy relating to diet, caloric intake, and diabetes management, but excluding programs the only purpose of

which are weight reduction, shall be limited to the following:

(1) visits medically necessary upon the diagnosis of diabetes,

(2) a physician diagnosis which represents a significant change in the ~~patient's~~ symptoms or condition of the patient making medically necessary changes in the ~~patient's~~ self-management of the patient, and

(3) visits when reeducation or refresher training is medically necessary;

provided, however, payment for the coverage required for diabetes self-management training pursuant to the provisions of this section shall be required only upon certification by the health care provider providing the training that the patient has successfully completed diabetes self-management training.

4. Diabetes self-management training shall be supervised by a licensed physician or other licensed health care provider legally authorized to prescribe under the laws of this state. Diabetes self-management training may be provided by the physician or other appropriately registered, certified, or licensed health care professional as part of an office visit for diabetes diagnosis or treatment. Training provided by appropriately registered,

certified, or licensed health care professionals may be provided in group settings where practicable.

5. Coverage for diabetes self-management training and training related to medical nutrition therapy, when provided by a registered, certified, or licensed health care professional, shall also include home visits when medically necessary and shall include instruction in medical nutrition therapy only by a licensed registered dietician or licensed certified nutritionist when authorized by the ~~patient's~~ supervising physician of the patient when medically necessary.

6. ~~Such coverage~~ Coverage may be subject to the same annual deductibles or coinsurance as may be deemed appropriate and as are consistent with those established for other covered benefits within a given policy.

B. 1. Health benefit plans shall not reduce or eliminate coverage due to the requirements of this section.

2. Enforcement of the provisions of this act shall be performed by the Insurance Department and the State Department of Health.

~~3. The provisions of this section shall not apply to:~~

~~a. health benefit plans designed only for issuance to subscribers eligible for coverage under Title XVIII of the Social Security Act or any similar coverage under a state or federal government plan,~~

~~b. a health benefit plan which covers persons employed in more than one state where the benefit structure was~~

~~the subject of collective bargaining affecting persons employed in more than one state, and~~

~~c. agreements, contracts, or policies that provide coverage for a specified disease or other limited benefit coverage.~~

C. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

SECTION 31. AMENDATORY 36 O.S. 2001, Section 6060.3, as amended by Section 5, Chapter 464, O.S.L. 2003 (36 O.S. Supp. 2009, Section 6060.3), is amended to read as follows:

Section 6060.3 A. Every health benefit plan ~~contract~~ issued, amended, renewed or delivered in this state on or after July 1, 1996, that provides maternity benefits shall provide for coverage of:

1. A minimum of forty-eight (48) hours of inpatient care at a hospital, or a birthing center licensed as a hospital, following a vaginal delivery, for the mother and newborn infant after childbirth, except as otherwise provided in this section;

2. A minimum of ninety-six (96) hours of inpatient care at a hospital following a delivery by caesarean section for the mother and newborn infant after childbirth, except as otherwise provided in this section; and

3. a. Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. The coverage shall provide for one home visit within forty-eight (48) hours of childbirth by a licensed health care provider whose scope of practice includes providing postpartum care. Visits shall include, at a minimum:

(1) physical assessment of the mother and the newborn infant,

(2) parent education, to include, but not be limited to:

(a) the recommended childhood immunization schedule,

(b) the importance of childhood immunizations, and

(c) resources for obtaining childhood immunizations,

(3) training or assistance with breast or bottle feeding, and

(4) the performance of any medically necessary and appropriate clinical tests.

b. At the ~~mother's~~ discretion <u>of the mother</u>, visits may occur at the facility of the plan or the provider.

B. Inpatient care shall include, at a minimum:

1. Physical assessment of the mother and the newborn infant;

2. Parent education, to include, but not be limited to:

a. the recommended childhood immunization schedule,

b. the importance of childhood immunizations, and

c. resources for obtaining childhood immunizations;

3. Training or assistance with breast or bottle feeding; and

4. The performance of any medically necessary and appropriate clinical tests.

C. A plan may limit coverage to a shorter length of hospital inpatient stay for services related to maternity and newborn infant care provided that:

1. In the sole medical discretion or judgment of the attending physician licensed by the Oklahoma State Board of Medical Licensure and Supervision or the State Board of Osteopathic Examiners or the certified nurse midwife licensed by the Oklahoma Board of Nursing providing care to the mother and to the newborn infant, it is determined prior to discharge that an earlier discharge of the mother and newborn infant is appropriate and meets medical criteria contained in the most current treatment standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon:

a. evaluation of the antepartum, intrapartum and postpartum course of the mother and newborn infant,

b. the gestational age, birth weight and clinical condition of the newborn infant,

c. the demonstrated ability of the mother to care for the newborn infant postdischarge, and

d. the availability of postdischarge follow-up to verify the condition of the newborn infant in the first forty-eight (48) hours after delivery.

A plan shall adopt these guidelines by July 1, 1996; and

2. The plan covers one home visit, within forty-eight (48) hours of discharge, by a licensed health care provider whose scope of practice includes providing postpartum care. ~~Such~~ The visits shall include, at a minimum:

a. physical assessment of the mother and the newborn infant,

b. parent education, to include, but not be limited to:

(1) the recommended childhood immunization schedule,

(2) the importance of childhood immunizations, and

(3) resources for obtaining childhood immunizations,

c. training or assistance with breast or bottle feeding, and

d. the performance of any medically necessary and clinical tests.

At the mother's discretion, visits may occur at the facility of the plan or the provider.

D. The plan shall include, but is not limited to, notice of the coverage required by this section in the ~~plan's~~ evidence of coverage of the plan, and shall provide additional written notice of the coverage to the insured or an enrollee during the course of the ~~insured's or enrollee's~~ prenatal care of the insured or enrollee.

E. In the event the coverage required by this section is provided under a contract that is subject to a capitated or global rate, the plan shall be required to provide supplementary reimbursement to providers for any additional services required by that coverage if it is not included in the capitation or global rate.

F. No health benefit plan subject to the provisions of this section shall terminate the services of, reduce capitation payments for, refuse payment for services, or otherwise discipline a licensed health care provider who orders care consistent with the provisions of this section.

G. As used in this section, "health benefit plan" means ~~individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as~~

~~exempt under federal ERISA provisions~~ any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

H. The Insurance Commissioner shall promulgate any rules necessary to implement the provisions of this section.

SECTION 32. AMENDATORY Section 1, Chapter 397, O.S.L. 2004 (36 O.S. Supp. 2009, Section 6060.3a), is amended to read as follows:

Section 6060.3a A. Any health benefit plan, including the State and Education Employees Group Health Insurance plan, that is offered, issued or renewed in this state on or after January 1, 2005, that provides medical and surgical benefits shall provide coverage for routine annual obstetrical/gynecological examinations.

B. The benefit required to be provided by this section shall in no way diminish or limit diagnostic benefits otherwise allowable under a health benefit plan.

C. Nothing in this section shall be construed as requiring such routine annual examination to be performed by an obstetrician, gynecologist, or obstetrician/gynecologist.

D. As used in this section, "health benefit plan" means ~~group hospital or medical insurance coverage, a not for profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance plan, and coverage provided by a Multiple Employer Welfare Arrangement~~

~~(MEWA) or employee self-insured plan except as exempt under federal ERISA provisions. The term shall not include short term, accident, fixed indemnity or specified disease policies, disability income contracts, limited benefit or credit disability insurance, workers' compensation insurance coverage, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self insurance~~ any plan or arrangement as defined in subsection C of Section 6060.4 of this title, except that the term "health benefit plan" does not include policies or certificates issued to individuals or groups with fewer than fifty employees.

E. The provisions of this section shall not apply to policies or certificates issued to individuals or groups with fewer than fifty employees.

SECTION 33. AMENDATORY 36 O.S. 2001, Section 6060.4, as last amended by Section 65, Chapter 264, O.S.L. 2006 (36 O.S. Supp. 2009, Section 6060.4), is amended to read as follows:

Section 6060.4 A. A health benefit plan delivered, issued for delivery or renewed in this state on or after January 1, 1998, that provides benefits for the dependents of an insured individual shall provide coverage for each child of the insured, from birth through the date ~~such~~ the child is eighteen (18) years of age for:

1. Immunization against:

a. diphtheria,

b. hepatitis B,

c. measles,

d. mumps,

e. pertussis,

f. polio,

g. rubella,

h. tetanus,

i. varicella,

j. haemophilus influenzae type B, and

k. hepatitis A; and

2. Any other immunization subsequently required for children by the State Board of Health.

B. Benefits required pursuant to subsection A of this section shall not be subject to a deductible, co-payment, or coinsurance requirement.

C. 1. For purposes of this section, "health benefit plan" means a plan that:

a. provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, and

b. is offered by any insurance company, group hospital service corporation, the State and Education Employees Group Insurance Board, or health maintenance

organization that delivers or issues for delivery an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an evidence of coverage, or, to the extent permitted by the Employee Retirement Income Security Act of 1974, 29 U.S.C., Section 1001 et seq., by a multiple employer welfare arrangement as defined in Section 3 of the Employee Retirement Income Security Act of 1974, or any other analogous benefit arrangement, whether the payment is fixed or by indemnity.

2. The term "health benefit plan" shall not include:

a. a plan that provides coverage:

(1) only for a specified disease or diseases or under an individual limited benefit policy,

(2) only for accidental death or dismemberment,

(3) for ~~wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury~~ dental or vision care, ~~or~~

(4) a hospital confinement indemnity policy,

(5) disability income insurance or a combination of accident-only and disability income insurance, or

(6) as a supplement to liability insurance,

b. a Medicare supplemental policy as defined by Section 1882(g)(1) of the Social Security Act (42 U.S.C., Section 1395ss),

c. worker's compensation insurance coverage,

d. medical payment insurance issued as part of a motor vehicle insurance policy,

e. a long-term care policy, including a nursing home fixed indemnity policy, unless a determination is made that the policy provides benefit coverage so comprehensive that the policy meets the definition of a health benefit plan, or

f. short-term health insurance issued on a nonrenewable basis with a duration of six (6) months or less.

SECTION 34. AMENDATORY Section 1, Chapter 351, O.S.L. 2008 (36 O.S. Supp. 2009, Section 6060.4a), is amended to read as follows:

Section 6060.4a A. No health benefit plan, including, but not limited to, the State and Education Employees Group Health Insurance Plan, that is offered, issued or renewed in the state on or after January 1, 2009, shall exclude otherwise allowable claims which occur in conjunction with the arrest or pretrial detention of the policyholder prior to adjudication of guilt and sentencing to incarceration of ~~such~~ the policyholder. The reimbursement rate for

out-of-network claims for these services shall be set at the current Medicare rate.

B. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

SECTION 35. AMENDATORY 36 O.S. 2001, Section 6060.5, as amended by Section 7, Chapter 464, O.S.L. 2003 (36 O.S. Supp. 2009, Section 6060.5), is amended to read as follows:

Section 6060.5 A. This section shall be known and may be cited as the "Oklahoma Breast Cancer Patient Protection Act".

B. Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 1998, that provides medical and surgical benefits with respect to the treatment of breast cancer and other breast conditions shall ensure that coverage is provided for not less than forty-eight (48) hours of inpatient care following a mastectomy and not less than twenty-four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer.

C. Nothing in this section shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

D. Any plan subject to subsection B of this section shall also provide coverage for reconstructive breast surgery performed as a

result of a partial or total mastectomy. Because breasts are a paired organ, any such reconstructive breast surgery shall include coverage for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed, provided that the reconstructive surgery and any adjustments made to the nondiseased breast must occur within twenty-four (24) months of reconstruction of the diseased breast.

E. In implementing the requirements of this section, a health benefit plan may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required pursuant to subsections B and D of this section.

F. A health benefit plan shall provide notice to each insured or enrollee under ~~such~~ the plan regarding the coverage required by this section in the ~~plan's~~ evidence of coverage of the plan, and shall provide additional written notice of the coverage to the insured or enrollee as follows:

1. In the next mailing made by the plan to the employee;

2. As part of any yearly informational packet sent to the enrollee; or

3. Not later than December 1, 1997;

whichever is earlier.

G. As used in this act, "health benefit plan" means any plan or arrangement as defined in subsection ~~G~~ C of Section ~~6060.3~~ 6060.4 of this title.

H. The Insurance Commissioner shall promulgate any rules necessary to implement the provisions of this section.

SECTION 36. AMENDATORY 36 O.S. 2001, Section 6060.6, is amended to read as follows:

Section 6060.6 A. Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 1999, that provides hospitalization benefits shall provide coverage for anesthesia expenses including anesthesia practitioner expenses for the administration of the anesthesia, and hospital and ambulatory surgical center expenses associated with any medically necessary dental procedure when provided to a covered person who is:

1. Severely disabled; or

2. a. A minor eight (8) years of age or under, and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care, or

b. A minor four (4) years of age or under, who in the judgment of the practitioner treating the child, is not of sufficient emotional development to undergo a medically necessary dental procedure without the use of anesthesia.

B. A health benefit plan may require prior authorization for either inpatient or outpatient hospitalization for dental care in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

C. Coverage provided for in subsection A of this section shall be subject to the same annual deductibles, copayments or coinsurance limits as established for all other covered benefits under the health benefit plan.

D. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of ~~Title 36 of the Oklahoma Statutes~~ this title.

SECTION 37. AMENDATORY 36 O.S. 2001, Section 6060.7, as amended by Section 1, Chapter 30, O.S.L. 2002 (36 O.S. Supp. 2009, Section 6060.7), is amended to read as follows:

Section 6060.7 A. 1. Any ~~group health insurance or~~ health benefit plan ~~agreement, contract or policy, including the State and Education Employees Group Insurance Board and any indemnity plan, not for profit hospital or medical service or indemnity contract, prepaid or managed care plan or provider agreement, and Multiple Employer Welfare Arrangement (MEWA) or employer self insured plan, except as exempt under federal ERISA provisions,~~ that is offered, issued, or renewed on or after the effective date of this act shall provide coverage for audiological services and hearing aids for children up to eighteen (18) years of age.

2. Such coverage:

a. shall only apply to hearing aids that are prescribed, filled and dispensed by a licensed audiologist, and

b. may limit the hearing aid benefit payable for each hearing-impaired ear to every forty-eight (48) months; provided, however, ~~such~~ coverage may provide for up to four additional ear molds per year for children up to two (2) years of age.

B. Nothing in this section shall be construed to extend the practice or privileges of any health care provider beyond that provided in the laws governing the ~~provider's~~ practice and privileges of the provider.

C. ~~This requirement shall not apply to agreements, contracts or policies that provide coverage for a specified disease or other limited benefit coverage, or groups with fifty or fewer employees~~ As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

SECTION 38. AMENDATORY 36 O.S. 2001, Section 6060.8, as amended by Section 8, Chapter 464, O.S.L. 2003 (36 O.S. Supp. 2009, Section 6060.8), is amended to read as follows:

Section 6060.8 A. Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 2000, that provides coverage to men forty (40) years of age or older in this

state shall offer coverage for annual screening for the early detection of prostate cancer in men over the age of fifty (50) years and in men over the age of forty (40) years who are in high-risk categories. The coverage shall not be subject to policy deductibles. The coverage shall not exceed the actual cost of the prostate cancer screening up to a maximum of Sixty-five Dollars ($65.00) per screening.

B. The benefit required to be provided by subsection A of this section shall in no way diminish or limit diagnostic benefits otherwise allowable under a health benefit plan.

C. The prostate cancer screening coverage shall be offered as follows:

1. The screening shall be performed by a qualified medical professional including, but not limited to, a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner, or physician assistant;

2. The screening shall consist, at a minimum, of the following tests:

a. a prostate-specific antigen blood test, and

b. a digital rectal examination;

3. At least one screening per year shall be covered for any man fifty (50) years of age or older; and

4. At least one screening per year shall be covered for any man from forty (40) to fifty (50) years of age who is at increased risk of developing prostate cancer as determined by a physician.

D. As used in this section, "health benefit plan" means ~~group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self insured plan except as exempt under federal ERISA provisions. The term shall not include short-term, accident, fixed indemnity, or specified disease policies, disability income contracts, limited benefit or credit disability insurance, workers' compensation insurance coverage, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance~~ any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

SECTION 39. AMENDATORY 36 O.S. 2001, Section 6060.8a, is amended to read as follows:

Section 6060.8a A. Any health benefit plan, including the State and Education Employees Group Health Insurance Plan, that is offered, issued or renewed in this state on or after January 1,

2002, which provides medical and surgical benefits, shall offer coverage for colorectal cancer examinations and laboratory tests for cancer for any nonsymptomatic covered individual, in accordance with standard, accepted published medical practice guidelines for colorectal cancer screening, who is:

1. At least fifty (50) years of age; or

2. Less than fifty (50) years of age and at high risk for colorectal cancer according to the standard, accepted published medical practice guidelines.

B. The coverage provided for by this section shall be subject to the same annual deductibles, co-payments or coinsurance limits as established for other covered benefits under the health plan.

C. To minimize costs for nonsymptomatic screening, third-party reimbursement may be at the existing Medicaid rate which shall be payment in full.

D. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection ~~D~~ C of Section ~~6060.8~~ 6060.4 of ~~Title 36 of the Oklahoma Statutes~~ this title; provided, however, the provisions of this section shall not apply to policies or certificates issued to individuals or to groups with fifty (50) or fewer employees, or to plans offered under the state Medicaid program.

SECTION 40. AMENDATORY 36 O.S. 2001, Section 6060.9, is amended to read as follows:

Section 6060.9 A. Any health benefit plan, including the State and Education Employees Group Health Insurance Plan, that is offered, issued, or renewed in this state on or after January 1, 2001, that provides medical and surgical benefits with respect to the treatment of cancer and other conditions treated by chemotherapy or radiation therapy shall provide coverage for wigs or other scalp prostheses necessary for the comfort and dignity of the covered person.

B. The coverage provided for by this section shall be subject to the same annual deductibles, copayments, or coinsurance limits as established for all other covered benefits under the health benefit plan not to exceed One Hundred Fifty Dollars ($150.00) annually.

C. A health benefit plan shall provide notice to each insured or enrollee under ~~such~~ the plan regarding the coverage required by this section in the ~~plan's~~ evidence of coverage of the plan and shall provide additional written notice of the coverage to the insured or enrollee as follows:

1. In the next mailing made by the plan to the insured or enrolled employee;

2. As part of any yearly informational packet sent to the enrollee; or

3. Not later than December 1, 2000;

whichever is earlier.

D. As used in this act, "health benefit plan" means any plan or arrangement as defined in subsection ~~D~~ C of Section ~~6060.8~~ 6060.4 of ~~Title 36 of the Oklahoma Statutes~~ this title. However, this section shall not apply to policies or certificates issued to individuals or groups with fifty (50) or fewer employees or plans offered under the State Medicaid Program.

E. The Insurance Commissioner shall promulgate any rules necessary to implement the provisions of this section.

SECTION 41. AMENDATORY 36 O.S. 2001, Section 6060.10, is amended to read as follows:

Section 6060.10 As used in this act:

1. "Base period" means the period of coverage pursuant to the issuance or renewal of a health benefit plan that is required to provide benefits pursuant to the provisions of Section ~~2~~ 6060.11 of this ~~act~~ title;

2. a. "Health benefit plan" means~~:~~

~~(1) group hospital or medical insurance coverages,~~

~~(2) not for profit hospital or medical service or indemnity plans,~~

~~(3) prepaid health plans,~~

~~(4) health maintenance organizations,~~

~~(5) preferred provider plans,~~

~~(6) the State and Education Employees Group Insurance Plan,~~

~~(7) Multiple Employer Welfare Arrangements (MEWA), or~~

~~(8) employer self insured plans that are not exempt pursuant to the federal Employee Retirement Income Security Act (ERISA) provisions~~ any plan or arrangement as defined in subsection C of Section 6060.4 of this title, except as provided in subparagraph b of this paragraph.

b. The term "health benefit plan" shall not include individual plans~~; plans that only provide coverage for a specified disease, accidental death, or dismemberment for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury or as a supplement to liability insurance; Medicare supplemental policies as defined in Section 1882(g)(1) of the federal Social Security Act (42 U.S.C., Section 1395ss); workers' compensation insurance coverages; medical payment insurance issued as a part of a motor vehicle insurance policy; or long term care policies including nursing home fixed indemnity policies, unless the Insurance Commissioner determines that the policy provides comprehensive benefit coverage sufficient to meet the definition of a health benefit plan~~;

3. "Severe mental illness" means any of the following biologically based mental illnesses for which the diagnostic criteria are prescribed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

a. schizophrenia,

b. bipolar disorder (manic-depressive illness),

c. major depressive disorder,

d. panic disorder,

e. obsessive-compulsive disorder, and

f. schizoaffective disorder; and

4. "Small employer" means any person, firm, corporation, partnership, limited liability company, association, or other legal entity that is actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar year, employed no more than fifty (50) employees who work on a full-time basis, which means an employee has a normal work week of twenty-four (24) or more hours.

SECTION 42. AMENDATORY 36 O.S. 2001, Section 6060.11, is amended to read as follows:

Section 6060.11 A. Subject to the limitations set forth in this section and Sections ~~3~~ 6060.12 and ~~4~~ 6060.13 of this ~~act~~ title, any health benefit plan that is offered, issued, or renewed in this state on or after the effective date of this act shall provide benefits for treatment of severe mental illness.

B. ~~The provisions of subsection A of this section shall pertain to all aspects of any health benefit plan that is offered, issued, or renewed in this state~~ Subject to the limitations set forth in this section and Sections 6060.12 and 6060.13 of this title, any health benefit plan offered, issued, or issued for delivery in this state on or after the effective date of this act may provide benefits for other forms of mental health or substance use disorder benefits.

C. 1. Benefits for mental health disorders, including, but not limited to those required by subsection A of this section, and for substance use disorder as provided in subsection B of this section shall be equal to benefits for treatment of and shall be subject to the same preauthorization and utilization review mechanisms and other terms and conditions as all other physical diseases and disorders, including, but not limited to:

~~1. Coverage~~

a. coverage of inpatient hospital services for either twenty-six (26) days or the limit for other covered illnesses, whichever is greater~~;~~,

~~2. Coverage~~

b. coverage of outpatient services~~;~~,

~~3. Coverage~~

c. coverage of medication~~;~~,

~~4. Maximum~~

d. maximum lifetime benefits~~;~~,

~~5. Co payments;~~

e. copayments,

~~6. Coverage~~

f. coverage of home health visits~~;~~,

~~7. Individual~~

g. individual and family deductibles~~;~~, and

~~8. Co insurance~~

h. coinsurance.

2. Treatment limitations applicable to mental health or substance use disorder benefits shall be no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan. There shall be no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

~~C.~~ D. The provisions of ~~subsection A of~~ this section shall not apply to coverage provided by a health benefit plan for a small employer.

SECTION 43. AMENDATORY 36 O.S. 2001, Section 6512, as amended by Section 50, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2009, Section 6512), is amended to read as follows:

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

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

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

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

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

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

6. "Carrier" means any entity which provides health insurance in this state. For the purposes of the Small Employer Health

Insurance Reform Act, carrier includes a licensed insurance company, not-for-profit hospital service or medical indemnity corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

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

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

9. "Commissioner" means the Insurance Commissioner;

10. "Control" ~~(including the terms~~, "controlling", "controlled by" ~~and~~ or "under common control with"~~)~~ means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership

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

11. "Department" means the Insurance Department;

12. "Dependent" means a spouse, an unmarried child under the age of eighteen (18), an unmarried child who is a full-time student under the age of twenty-three (23) and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent;

13. "Eligible employee" means an employee who works on a full-time basis or, at the option of the employer, an employee who works on a part-time basis with a normal work week of twenty-four (24) or more hours. The term includes a sole proprietor, a partner of a partnership, and associates of a limited liability company, if the sole proprietor, partner or associate is included as an employee

under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis;

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

15. a. "Health benefit plan" means any hospital or medical policy or certificate; contract of insurance provided by a not-for-profit hospital service or medical indemnity plan; or prepaid health plan or health maintenance organization subscriber contract.

b. Health benefit plan does not include accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, ~~worker's~~ workers' compensation or similar insurance, ~~any plan certified by the Oklahoma Basic Health Benefits Board,~~ or automobile medical payment insurance.

c. "Health benefit plan" shall not include policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance, provided that the carrier offering ~~such~~ those policies or certificates complies with the following:

(1) the carrier files on or before March 1 of each year a certification with the Commissioner that contains the statement and information described in division (2) of this subparagraph,

(2) the certification required in division (1) of this subparagraph shall contain the following:

(a) a statement from the carrier certifying that policies or certificates described in this subparagraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance, and

(b) a summary description of each policy or certificate described in this subparagraph, including the average annual premium rates ~~(~~or range of premium rates in cases where premiums vary by age, gender or other factors~~)~~ charged for such policies and certificates in this state, and

(3) in the case of a policy or certificate that is described in this subparagraph and that is offered for the first time in this state on or after the effective date of this act, the carrier

files with the Commissioner the information and statement required in division (2) of this subparagraph at least thirty (30) days prior to the date ~~such~~ a policy or certificate is issued or delivered in this state;

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

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

a. the individual meets each of the following:

(1) the individual was covered under qualifying previous coverage at the time of the initial enrollment,

(2) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary

termination of the qualifying previous coverage, death of a spouse or divorce, and

(3) the individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage,

b. the individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period, or

c. a court has ordered coverage be provided for a spouse or minor or dependent child under a ~~covered employee's~~ health benefit plan of a covered employee and request for enrollment is made within thirty (30) days after issuance of the court order;

18. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

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

~~20.~~ "Premium" means all monies paid by a small employer and eligible employees as a condition of receiving coverage from a small

employer carrier, including any fees or other contributions associated with the health benefit plan;

~~21.~~ 20. "Program" means the Oklahoma Small Employer Health Reinsurance Program created pursuant to Section 6522 of this title;

~~22.~~ 21. "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

a. Medicare or Medicaid,

b. an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan, or

c. an individual health insurance policy, including coverage issued by a health maintenance organization, fraternal benefit society and those entities set forth in ~~Section 2501 et seq. of Title 63 of the Oklahoma Statutes~~ Sections 6901 through 6936 of this title, that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that ~~such~~ the policy has been in effect for a period of at least one (1) year;

~~23.~~ 22. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect;

~~24.~~ 23. "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to Section 6522 of this title;

~~25.~~ 24. "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to ~~Section 2501 et seq. of Title 63 of the Oklahoma Statutes~~ Sections 6901 through 6963 of this title to provide health care services to covered individuals;

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

~~27.~~ 25. "Small employer" means any person, firm, corporation, partnership, limited liability company or association that is actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than fifty (50) eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state income taxation, shall be considered one employer; and

~~28.~~ 26. "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state~~; and~~

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

SECTION 44. AMENDATORY 36 O.S. 2001, Section 6515, is amended to read as follows:

Section 6515. A. Premium rates for health benefit plans subject to the Small Employer Health Insurance Reform Act shall be subject to the following provisions:

1. The rate manual developed for use by a small employer carrier shall be filed and approved by the Insurance Commissioner prior to use. Any changes to the rate manual shall be filed and approved by the Insurance Commissioner prior to use. Every filing shall be made not less than thirty (30) days prior to the date the small employer carrier intends to implement the rates. The rate manual so filed shall be deemed approved upon expiration of the thirty-day waiting period unless, prior to the end of the period, it has been affirmatively approved or disapproved by order of the Commissioner. Approval of a rate manual by the Commissioner shall constitute a waiver of any unexpired portion of the thirty-day waiting period. The Commissioner may extend the period to approve or disapprove a rate manual by not more than an additional thirty (30) days by giving notice of such extension before expiration of

the initial thirty-day period. At the expiration of an extended period, the rate filing shall be deemed approved unless otherwise approved or disapproved by the Commissioner. The Commissioner may at any time, after notice and for cause shown, withdraw approval of a filed rate;

2. A small employer health benefit plan shall not be delivered or issued for delivery unless the policy form or certificate form can be expected to return to policyholders and certificate holders in the form of aggregate benefits provided under the policy form or certificate form at least sixty percent (60%) of the aggregate amount of premiums earned. The rate of return shall be estimated for the entire period for which rates are computed to provide coverage. The rate of return shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period in accordance with accepted actuarial principles and practices;

3. The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%);

4. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged

to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate;

5. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

a. the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that ~~such~~ the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers,

b. any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from

the ~~small employer carrier's~~ rate manual for the class of business of the small employer carrier, and

c. any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the ~~small employer carrier's~~ rate manual for the class of business of the small employer carrier;

6. Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any ~~such~~ adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer;

7. ~~Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to Section 6523 of this title;~~

~~8.~~ A small employer carrier may utilize industry as a case characteristic in establishing premium rates; provided, the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than fifteen percent (15%);

~~9.~~ 8. In the case of health benefit plans issued prior to the effective date of the Small Employer Health Insurance Reform Act, a premium rate for a rating period may exceed the ranges set forth in

paragraphs 3 and 4 of this subsection for a period of three (3) years following the effective date of the Small Employer Health Insurance Reform Act. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

a. the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that ~~such~~ the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers, and

b. any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the ~~carrier's~~ rate manual of the carrier for the class of business;

~~10.~~ 9. Small employer carriers shall:

a. apply rating factors, including case characteristics, consistently with respect to all small employers in a

class of business. Rating factors shall produce premiums for identical groups within the same class of business which differ only by amounts attributable to plan design and do not reflect differences due to claims experience, health status and duration of coverage, and

b. treat all health benefit plans issued or renewed in the same calendar month as having the same rating period;

~~11.~~ 10. For the purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs;

~~12.~~ 11. The Insurance Commissioner may establish rules to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of the Small Employer Health Insurance Reform Act, including:

a. assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to claims experience, health status or duration of coverage, and

b. prescribing the manner in which case characteristics may be used by small employer carriers.

B. A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless ~~such~~ the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage.

C. The Commissioner may suspend for a specified period the application of paragraph 3 of subsection A of this section as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the Commissioner either that the suspension is reasonably necessary in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

SECTION 45. AMENDATORY 36 O.S. 2001, Section 6522, is amended to read as follows:

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

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

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

2. a. In selecting the members of the board, the Commissioner shall include representatives of small employers and small employer carriers and such other individuals determined to be qualified by the Commissioner. At least five members of the board shall be representatives of carriers and shall be selected from individuals nominated in this state pursuant to procedures and guidelines developed by the Commissioner.

b. In the event that the program becomes eligible for additional financing pursuant to paragraph 3 of subsection L of this section, the board shall be expanded to include two additional members who shall be appointed by the Commissioner. In selecting the additional members of the board, the Commissioner shall choose individuals who represent organizations

offering categories of health insurance not already represented on the board, including but not limited to excess or stoploss health insurance. The expansion of the board under this subsection shall continue for the period that the program continues to be eligible for additional financing pursuant to paragraph 3 of subsection L of this section.

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

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

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

~~E. Within one hundred eighty (180) days after the appointment of the initial board, the board shall submit to the Commissioner a plan of operation and, thereafter, any amendments thereto necessary or suitable to ensure the fair, reasonable and equitable~~

~~administration of the program. The Commissioner may, after notice and hearing, approve the plan of operation if the Commissioner determines it to be suitable to ensure the fair, reasonable and equitable administration of the program, and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the Commissioner.~~

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

~~G. The plan of operation shall:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~4. a. The program shall not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of Five Thousand Dollars ($5,000.00) in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for ten percent (10%) of the next Fifty Thousand Dollars~~

~~($50,000.00) of benefit payments during a calendar year, and the program shall reinsure the remainder. A reinsuring carrier's liability under this subparagraph shall not exceed a maximum limit of Ten Thousand Dollars ($10,000.00) in any one (1) calendar year with respect to any reinsured individual.~~

~~b. The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Department of Labor, Bureau of Labor Statistics, unless the board proposes and the Commissioner approves a lower adjustment factor;~~

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

~~6. Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. Sec. 300e(c)(2)(A), and as such is subject to requirements that limit the amount of risk that may be ceded to the program that is more restrictive than those specified in paragraph 4 of this~~

~~subsection, shall be reduced to reflect that portion of the risk above the amount set forth in paragraph 4 of this subsection that may not be ceded to the program, if any; and~~

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

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

~~2. Premiums for the program shall be as follows:~~

~~a. an eligible employee or dependent may be reinsured for a rate that is five (5) times the base reinsurance premium rate for the individual established pursuant to this paragraph, and~~

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

~~(1) the lowest base reinsurance rate applicable to any insured employee, or~~

~~(2) the lowest base reinsurance rate applicable to any insured dependent in the group.~~

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

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

~~K. If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in Section 6515 of this title.~~

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

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

~~a. The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers. The assessment formula shall be based on:~~

~~(1) each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers, and~~

~~(2) each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued~~

~~for delivery during the calendar year to small employers in this state by reinsuring carriers.~~

~~b. The formula established pursuant to subparagraph a of this paragraph shall not result in any reinsuring carrier having an assessment share that is less than fifty percent (50%) nor more than one hundred fifty percent (150%) of an amount which is based on the proportion of the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers.~~

~~c. The board may, with approval of the Commissioner, change the assessment formula established pursuant to subparagraph a of this paragraph from time to time as appropriate. The board may provide for the shares of the assessment base attributable to total premium and to the previous year's premium to vary during a transition period.~~

~~d. Subject to the approval of the Commissioner, the board shall make an adjustment to the assessment formula for~~

~~reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. Sec. 300 et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.~~

~~3. a. Prior to March 1 of each year, the board shall determine and file with the Commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.~~

~~b. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed five percent (5%) of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers, the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the Commissioner within ninety (90) days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged,~~

~~the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file a report with the Commissioner within ninety (90) days following the end of the applicable calendar year, the Commissioner may evaluate the operations of the program and implement such amendments to the plan of operation the Commissioner deems necessary to reduce future losses and assessments.~~

~~c. If assessments in each two (2) consecutive calendar years exceed five percent (5%) of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers, the program shall be eligible to receive additional financing as provided in Section 6523 of this title.~~

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

~~5. Each reinsuring carrier's proportion of the assessment shall be determined annually by the board based on annual statements and~~

~~other reports deemed necessary by the board and filed by the reinsuring carriers with the board.~~

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

~~7. A reinsuring carrier may seek from the Commissioner a deferment from all or part of an assessment imposed by the board. The Commissioner may defer all or part of the assessment of a reinsuring carrier if the Commissioner determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition. If all or part of an assessment against a reinsuring carrier is deferred, the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The reinsuring carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessments.~~

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

~~N. The program shall be exempt from any and all taxes~~ Upon the effective date of this act, the board shall develop a plan to wind up business of the Oklahoma Employer Health Reinsurance Program.

E. The board shall submit the plan to the Insurance Commissioner for approval within one hundred twenty (120) days of the effective date of this act.

F. The plan shall include, but not be limited to, an accounting of the funds and expenses of the Oklahoma Small Employer Health Reinsurance Program and a detailed description of the method of reimbursement of any funds or monies from the initial assessment to any reinsuring carriers.

SECTION 46. AMENDATORY 36 O.S. 2001, Section 6526, is amended to read as follows:

Section 6526. The Insurance Commissioner may promulgate rules in accordance with Article I of the Administrative Procedures Act, ~~Section~~ Sections 250.2 ~~et seq.~~ through 323 of Title 75 of the Oklahoma Statutes, for the implementation and administration of the Small Employer Health Insurance Reform Act.

SECTION 47. AMENDATORY 36 O.S. 2001, Section 6608, as amended by Section 53, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2009, Section 6608), is amended to read as follows:

Section 6608. A. An application for license as a service warranty association shall be made to, and filed with, the Insurance

Commissioner on printed forms as prescribed and furnished by the Insurance Commissioner.

B. In addition to information relative to its qualifications as required under Section 6605 of this title, the Commissioner may require that the application show:

1. The location of the home office of the applicant;

2. The name and residence address of each director or officer of the applicant; and

3. ~~Such other~~ Other pertinent information as may be required by the Commissioner.

C. The Commissioner may require that the application, when filed, be accompanied by:

1. A copy of the articles of incorporation of the applicant, certified by the public official having custody of the original, and a copy of the bylaws of the applicant, certified by the chief executive officer of the applicant;

2. A copy of the most recent financial statement of the applicant, verified under oath of at least two of its principal officers; and

3. A license fee ~~in the amount of Two Hundred Dollars ($200.00)~~ as required pursuant to Section 6604 of this title.

D. Upon completion of the application for license, the Commissioner shall examine the application and make such further investigation of the applicant as the Commissioner deems advisable.

If the Commissioner finds that the applicant is qualified, the Commissioner shall issue to the applicant a license as a service warranty association. If the Commissioner does not find the applicant to be qualified the Commissioner shall refuse to issue the license and shall give the applicant written notice of ~~such~~ the refusal, setting forth the grounds ~~therefor~~ of the refusal.

E. 1. Any entity that claims one or more of the exclusions from the definition of service warranty provided in paragraph 14 of Section 6602 of this title shall file audited financial statements and other information as requested by the Commissioner by May 1, 2010, to document and verify that the ~~entity's~~ contracts of the entity are not included within the definition of service warranty.

2. Any entity that fails to meet the May 1, 2010, deadline or that begins claiming an exclusion exemption provided by paragraph 14 of Section 6602 of this title after May 1, 2010, shall file audited financial statements and other information as requested by the Commissioner prior to conducting or continuing business in this state.

3. Any entity approved for an exclusion provided by paragraph 14 of Section 6602 of this title may be required by the Commissioner to provide subsequent audited financial statements and other information ascertained by the Commissioner to be necessary to determine continued qualification for an exclusion provided by paragraph 14 of Section 6602 of this title.

4. Other information as requested by the Commissioner may include, but is not limited to, ~~audited financial statements,~~ SEC filings, audited financial statements of affiliates, and organizational data and organizational charts.

SECTION 48. AMENDATORY 36 O.S. 2001, Section 6609, as amended by Section 27, Chapter 184, O.S.L. 2008 (36 O.S. Supp. 2009, Section 6609), is amended to read as follows:

Section 6609. Each license issued to a service warranty association shall expire on November 1 following the date of issuance. If the association is then qualified ~~therefor~~ under the provisions of the Service Warranty Insurance Act, its license may be renewed annually, upon its request, and upon payment to the Insurance Commissioner of the license fee in the amount of ~~Two Hundred Dollars ($200.00)~~ Four Hundred Dollars ($400.00) in advance for each such license year.

SECTION 49. AMENDATORY 36 O.S. 2001, Section 6615, as last amended by Section 24, Chapter 432, O.S.L. 2009 (36 O.S. Supp. 2009, Section 6615), is amended to read as follows:

Section 6615. A. In addition to the license fees provided in the Service Warranty Insurance Act for service warranty associations each ~~such~~ service warranty association and insurer shall, annually on or before the ~~last~~ first day of ~~February~~ May, file with the Insurance Commissioner its annual statement in the form prescribed by the Commissioner showing all gross written premiums or

assessments received by it in connection with the issuance of service warranties in this state during the preceding calendar year and other relevant financial information as deemed necessary by the Commissioner, using accounting principles which will enable the Commissioner to ascertain whether the financial requirements set forth in Section 6607 of this title have been satisfied.

B. The Commissioner may levy a fine of up to One Hundred Dollars ($100.00) a day for each day an association neglects to file the annual statement in the form and within the time provided by the Service Warranty Insurance Act.

C. In addition to an annual statement, the Commissioner may require of licensees, under oath and in the form prescribed by it, quarterly statements or special reports which the Commissioner deems necessary for the proper supervision of licensees under the Service Warranty Insurance Act.

D. Premiums and assessments received by associations and insurers for service warranties shall not be subject to the premium tax provided for in Section 624 of this title, but shall be subject to an administrative fee of equal to two percent (2%) of the gross premium received on the sale of all service contracts issued in this state during the preceding calendar quarter. Said fees shall be paid quarterly to the Insurance Commissioner. However, licensed associations, licensed insurers and entities with applications for licensure as a service warranty association pending with the

Department that have contractual liability insurance in place as of March 31, 2009, from an insurer which satisfies the requirements of ~~subsection~~ subsections B and C of Section 6607 of this title and which covers one hundred percent (100%) of the claims exposure of the association or insurer on all contracts written may elect to pay an annual administrative fee of Three Thousand Dollars ($3,000.00) in lieu of the two-percent administrative fee.

SECTION 50. AMENDATORY 36 O.S. 2001, Section 6620, as last amended by Section 9, Chapter 189, O.S.L. 2009 (36 O.S. Supp. 2009, Section 6620), is amended to read as follows:

Section 6620. Along with the annual statement filed pursuant to Section ~~6618~~ 6615 of this title, each service warranty association or insurer shall provide the name and business address of each sales representative utilized by it in this state.

SECTION 51. AMENDATORY Section 11, Chapter 390, O.S.L. 2003, as amended by Section 54, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2009, Section 6810), is amended to read as follows:

Section 6810. A. Sections 6810 through 6820 of this title shall be known and may be cited as the "Medical Professional Liability Insurance Closed Claim Reports Act".

B. The Medical Professional Liability Insurance Closed Claim Reports Act shall apply to all medical professional liability claims in this state, regardless of whether or how the claims are covered by medical professional liability insurance.

C. As used in the Medical Professional Liability Insurance Closed Claim Reports Act:

1. "Claim" means:

a. a demand for monetary damages for injury or death caused by medical malpractice, or

b. a voluntary indemnity payment for injury or death caused by medical malpractice;

2. "Claimant" means a person, including an estate of a decedent, who is seeking or has sought monetary damages for injury or death caused by medical malpractice;

3. "Closed claim" means a claim that has been settled or otherwise disposed of by the insuring entity, self-insurer, facility, or provider. A claim may be closed with or without an indemnity payment to a claimant;

4. "Commissioner" means the Insurance Commissioner;

5. "Companion claims" means separate claims involving the same incident of medical malpractice made against other providers or facilities;

6. "Economic damages" means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, loss of use of property, cost of replacement or repair, cost of obtaining substitute domestic services, and loss of business or employment opportunities;

7. "Health care facility" or "facility" means a clinic, diagnostic center, hospital, laboratory, mental health center, nursing home, office, surgical facility, treatment facility, or similar place where a health care provider provides health care to patients;

8. "Health care provider" or "provider" means:

a. a person licensed to provide health care or related services, including an acupuncturist, doctor of medicine or osteopathy, a dentist, a nurse, an optometrist, a podiatric physician and surgeon, a chiropractor, a physical therapist, a psychologist, a pharmacist, an optician, a physician's assistant, a midwife, an osteopathic physician's assistant, a nurse practitioner, or a physician's trained mobile intensive care paramedic. If the person is deceased, this includes the estate or personal representative of the person, or

b. an employee or agent of a person described in subparagraph a of this paragraph, acting in the course and scope of the employment of the employee. If the employee or agent is deceased, this includes the estate or personal representative of the employee;

9. "Insuring entity" means:

a. an authorized insurer,

b. a captive insurer,

c. a joint underwriting association,

d. a patient compensation fund,

e. a risk retention group, or

f. an unauthorized insurer that provides surplus lines coverage;

10. "Medical malpractice" means an actual or alleged negligent act, error, or omission in providing or failing to provide health care services;

11. "Noneconomic damages" means subjective, nonmonetary losses, including pain, suffering, inconvenience, mental anguish, disability or disfigurement incurred by the injured party, emotional distress, loss of society and companionship, loss of consortium, humiliation and injury to reputation, and destruction of the parent-child relationship; and

12. "Self-insurer" means any health care provider, facility, or other individual or entity that assumes operational or financial risk for claims of medical professional liability.

SECTION 52. AMENDATORY Section 12, Chapter 390, O.S.L. 2003, as amended by Section 55, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2009, Section 6811), is amended to read as follows:

Section 6811. A. ~~Not later than the tenth day after the last day of the calendar quarter in which~~ When a claim for recovery under a medical professional liability insurance policy is closed, the

insurer shall file with the Insurance Department a closed claim report not later than April 1 of the same calendar year if the claim is closed prior to April 1, and if the claim is closed after April 1, then the closed claim report shall be filed by April 1 of the subsequent calendar year. These reports ~~must~~ shall include data for all claims closed in the preceding calendar year and any adjustments to data reported in prior years.

B. Any violation by an insurer of the Medical Professional Liability Insurance Closed Claim Reports Act shall subject the insurer to discipline including a civil penalty of not less than Five Thousand Dollars ($5,000.00).

C. Every insuring entity or self-insurer that provides medical professional liability insurance to any facility or provider in this state ~~must~~ shall report each medical professional liability closed claim to the Insurance Commissioner.

D. A closed claim that is covered under a primary policy and one or more excess policies shall be reported only by the insuring entity that issued the primary policy. The insuring entity that issued the primary policy shall report the total amount, if any, paid with respect to the closed claim, including any amount paid under an excess policy, any amount paid by the facility or provider, and any amount paid by any other person on behalf of the facility or provider.

E. If a claim is not covered by an insuring entity or self-insurer, the facility or provider named in the claim ~~must~~ shall report it to the Commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties. Instances in which a claim may not be covered by an insuring entity or self-insurer include situations in which:

1. The facility or provider did not buy insurance or maintained a self-insured retention that was larger than the final judgment or settlement;

2. The claim was denied by an insuring entity or self-insurer because it did not fall within the scope of the insurance coverage agreement; or

3. The annual aggregate coverage limits had been exhausted by other claim payments.

F. If a claim is covered by an insuring entity or self-insurer that fails to report the claim to the Commissioner, the facility or provider named in the claim ~~must~~ shall report it to the Commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties.

1. If a facility or provider is insured by a risk retention group and the risk retention group refuses to report closed claims and asserts that the federal Liability Risk Retention Act (95 Stat. 949; 15 U.S.C. Sec. 3901 et seq.) preempts state law, the facility or provider ~~must~~ shall report all data required by the Medical

Professional Liability Insurance Closed Claim Reports Act on behalf of the risk retention group.

2. If a facility or provider is insured by an unauthorized insurer and the unauthorized insurer refuses to report closed claims and asserts a federal exemption or other jurisdictional preemption, the facility or provider ~~must~~ shall report all data required by the Medical Professional Liability Insurance Closed Claim Reports Act on behalf of the unauthorized insurer.

3. If a facility or provider is insured by a captive insurer and the captive insurer refuses to report closed claims and asserts a federal exemption or other jurisdictional preemption, the facility or provider ~~must~~ shall report all data required by the Medical Professional Liability Insurance Closed Claim Reports Act on behalf of the captive insurer.

SECTION 53. AMENDATORY Section 4, Chapter 64, O.S.L. 2002 (40 O.S. Supp. 2009, Section 600.4), is amended to read as follows:

Section 600.4 A. Registration required. Except as otherwise provided in the Oklahoma Professional Employer Organization Recognition and Registration Act, no person shall, unless ~~such~~ the person is registered as a PEO or PEO Group under the Oklahoma Professional Employer Organization Recognition and Registration Act, provide, advertise, or otherwise hold itself out as providing professional employer services in this state.

B. Registration information.

1. Each PEO or PEO Group required to be registered under the Oklahoma Professional Employer Organization Recognition and Registration Act shall provide the Commissioner with information required by the Commissioner on forms prescribed by the Commissioner. Pursuant to paragraph 2 of this subsection, a PEO or PEO Group may use a qualified assurance organization as approved by the Commissioner to provide services related to the registration of the PEO or PEO Group. A PEO or PEO Group may authorize an assurance organization to act on behalf of the PEO or PEO Group in complying with the registration requirements set forth in the Oklahoma Professional Employer Organization Recognition and Registration Act, including, but not limited to, electronic filings of information and payment of registration fees. At a minimum, PEOs, PEO Groups or an approved assurance organization acting on behalf of the PEO or PEO Group, shall provide the following information:

~~1. The~~

a. the name or names under which the PEO or PEO Group conducts business~~;~~,

~~2. The~~

b. the address of the principal place of business of the PEO or PEO Group and the address of each office it maintains in this state~~;~~,

~~3. The~~

c. the PEO's or PEO Group's taxpayer or employer identification number~~;~~,

~~4. A~~

d. a list by jurisdiction of each name under which the PEO or PEO Group has operated in the preceding five (5) years, including any alternative names, names of predecessors and, if known, successor business entities~~;~~,

~~5. A~~

e. a statement of ownership, which shall include the name and evidence of the business experience of any person that, individually or acting in concert with one or more other persons, owns or controls, directly or indirectly, twenty-five percent (25%) or more of the equity interests of the PEO~~;~~ or PEO Group,

~~6. A~~

f. a statement of management, which shall include the name and evidence of the business experience of any person who serves as president, chief executive officer, or otherwise has the authority to act as senior executive officer of the PEO~~;~~ or PEO Group, and

~~7. A~~

g. a financial statement setting forth the financial condition of the PEO or PEO Group, as of a date not

earlier than one hundred eighty (180) days prior to the date submitted to the Commissioner, prepared in accordance with generally accepted accounting principles, and audited or reviewed by an independent certified public accountant licensed to practice in the jurisdiction in which such accountant is located. A PEO Group may submit combined or consolidated audited or reviewed financial statements to meet the requirements of this section.

2. The financial statement required by subparagraph g of paragraph 1 of this subsection may be dated as of a date that is not earlier than three hundred sixty-five (365) days before the date on which the application is submitted in the event the PEO or PEO Group provides the following:

a. evidence that is acceptable to the Commissioner that it is licensed or registered in good standing in another state with equal or greater requirements than the requirements of the Oklahoma Professional Employer Organization Recognition and Registration Act,

b. quarterly financial statements of management for each calendar quarter as of the most recent audit that demonstrate continuing financial operations acceptable to the Commissioner, and

c. the certification of an independent Certified Public Accountant that as of the end of the most recent calendar quarter, the PEO or PEO Group has paid all of its state and federal payroll taxes, health and workers' compensation premiums, and contributions to employee retirement plans in a timely and appropriate manner.

3. For purposes of the Oklahoma Professional Employer Organization Recognition and Registration Act, "assurance organization" means an independent entity approved by the Commissioner to certify the qualifications of a PEO or PEO Group for registration under this section and Section 600.6 of this title and any related requirements and procedures. To be considered for approval as an independent and qualified assurance organization, the assurance organization shall submit a written request for approval to the Commissioner. The written request shall include, but not be limited to, the following:

a. evidence that the assurance organization is independent and has an established national program for the accreditation and financial assurance of PEOs and PEO Groups based on requirements similar to the requirements of the Oklahoma Professional Employer Organization Recognition and Registration Act, and any rules promulgated for the implementation of the

Oklahoma Professional Employer Organization Recognition and Registration Act,

b. evidence that the assurance organization has documented qualifications, standards, procedures, and financial assurance acceptable to the Commissioner and is licensed or otherwise approved by one or more states to certify the qualifications of PEOs or PEO Groups,

c. an agreement to provide information, compliance monitoring services, and a level of financial assurance as deemed acceptable by the Commissioner,

d. an agreement to provide the Commissioner with an application that has been executed by each PEO or PEO Group requesting alternative registration under this section and Section 600.6 of this title and related requirements and procedures in a form approved by the Commissioner. The application shall:

(1) authorize the assurance organization to share with the Commissioner any application and compliance reporting information required under the Oklahoma Professional Employer Organization Recognition and Registration Act that has been provided to the assurance organization by the PEO or PEO Group,

(2) authorize the Commissioner to accept information shared by the assurance organization for registration or renewal of registration of the PEO or PEO Group as if the information was provided directly to the Commissioner by the PEO or PEO Group,

(3) provide the certification of the PEO or PEO Group that the information provided by the assurance organization to the Commissioner is true and complete and that the PEO or PEO Group is in full and complete compliance with all requirements of the Oklahoma Professional Employer Organization Recognition and Registration Act, and

(4) provide the certification of the assurance organization that the PEO or PEO Group is in compliance with the standards and procedures of the assurance organization which are similar to the requirements of the Oklahoma Professional Employer Organization Recognition and Registration Act and is qualified for registration or renewal of registration under the Oklahoma Professional Employer Organization Recognition and Registration Act,

e. an agreement to provide written notice to the Commissioner within two (2) business days of determination by the assurance organization of the failure of a PEO or PEO Group to meet the qualifications for registration under the Oklahoma Professional Employer Organization Recognition and Registration Act or determination by the assurance organization of the failure of the PEO or PEO Group to meet the qualifications for accreditation or certification by the assurance organization, and

f. an agreement to share with the Commissioner in a timely manner the information and supporting documentation provided to the assurance organization by the PEO or PEO Group similar to the information and documentation required for registration or renewal of registration under the Oklahoma Professional Employer Organization Recognition and Registration Act.

C. Initial registration.

1. Each PEO or PEO Group operating within this state as of November 1, 2002, shall complete its initial registration not later than one hundred eighty (180) days after the end of the PEO's or PEO Group's first fiscal year ending after November 1, 2002.

2. Each PEO or PEO Group not operating within this state as of November 1, 2002, shall complete its initial registration prior to

commencement of operations within this state. A registration is valid for a term of one (1) year.

D. Renewal. ~~Within one hundred eighty (180) days after the end of a registrant's fiscal year, such registrant shall renew its registration by notifying the Commissioner of any changes in the information provided in such registrant's most recent registration or renewal~~ A registration expires one (1) year following the registration unless it is renewed pursuant to this subsection. Before expiration of the registration, a registrant may renew the registration for an additional one-year term if the registrant:

1. Remains in good standing and otherwise is entitled to be registered pursuant to the Oklahoma Professional Employer Organization Recognition and Registration Act;

2. Files with the Commissioner a renewal application on a form prescribed by the Commissioner; and

3. Pays to the Commissioner a renewal fee as provided for in Section 600.5 of this title.

E. Group registration. Any two or more PEOs held under common control of any other person or persons acting in concert may be registered as a PEO Group. A PEO Group may satisfy any reporting and financial requirements of this registration law on a consolidated basis.

F. Electronic filing and compliance. A PEO, PEO Group or an approved independent and qualified assurance organization as

provided for in subsection B of this section may electronically submit filings in conformance with Sections 15-101 through 15-121 of Title 12A of the Oklahoma Statutes. Electronically submitted filings include, but are not limited to, applications, documents, reports, and other filings required under the Oklahoma Uniform Electronic Transactions Act.

G. De minimis exemption.

1. A PEO is exempt from the registration requirements payable under the Oklahoma Professional Employer Organization Recognition and Registration Act if such PEO:

a. submits a properly executed request for exemption on a form provided by the Department,

b. is domiciled outside this state and is licensed or registered as a professional employer organization in another state that has the same or greater requirements as the Oklahoma Professional Employer Organization Recognition and Registration Act,

c. does not maintain an office in this state or solicit in any manner clients located or domiciled within this state, and

d. does not have more than twenty-five covered employees employed or domiciled in this state; and

2. An exemption of a professional employer organization from the registration requirements under the Oklahoma Professional

Employer Organization Recognition and Registration Act shall be valid for one (1) year, subject to renewal.

~~G.~~ H. List. The Commissioner shall maintain a list of professional employer organizations registered or exempted under ~~this~~ the Oklahoma Professional Employer Organization Recognition and Registration Act and a list of approved assurance organizations.

~~H.~~ I. Forms. The Commissioner may prescribe forms necessary to promote the efficient administration of this section.

J. The Commissioner is authorized to promulgate reasonable rules necessary for the administration and implementation of this section.

K. Nothing in this section shall limit or change the authority of the Commissioner to register or terminate registration of a PEO or PEO Group or to investigate or enforce any provision of the Oklahoma Professional Employer Organization Recognition and Registration Act.

SECTION 54. AMENDATORY Section 5, Chapter 64, O.S.L. 2002 (40 O.S. Supp. 2009, Section 600.5), is amended to read as follows:

Section 600.5 A. Initial registration. Upon filing an initial registration statement under the Oklahoma Professional Employer Organization Recognition and Registration Act, a PEO shall pay an initial registration fee of Five Hundred Dollars ($500.00).

B. Initial Group Registration. Upon filing an initial Group registration statement pursuant to the Oklahoma Professional Employer Organization Recognition and Registration Act, the PEO Group shall pay an initial registration fee of Five Hundred Dollars ($500.00) per member of the PEO Group.

C. Renewal. Upon each annual renewal of a registration statement filed under the Oklahoma Professional Employer Organization Recognition and Registration Act, a PEO shall pay a renewal fee of Two Hundred Fifty Dollars ($250.00).

~~C.~~ D. Renewal. Upon each annual renewal of a Group registration statement filed under the Oklahoma Professional Employer Organization Recognition and Registration Act, a PEO Group shall pay a renewal fee of Two Hundred Fifty Dollars ($250.00) per member of the PEO Group.

E. Exemption. Each PEO exempt from registration under the terms of this subsection shall pay an exemption fee in the amount of Two Hundred Fifty Dollars ($250.00) upon initial application for exemption and upon each annual renewal of ~~such~~ the exemption.

SECTION 55. AMENDATORY 59 O.S. 2001, Section 1305, as amended by Section 5, Chapter 204, O.S.L. 2003 (59 O.S. Supp. 2009, Section 1305), is amended to read as follows:

Section 1305. A. The application for license to serve as a bail bondsman ~~must~~ shall affirmatively show that the applicant:

1. Is a person who has reached the age of twenty-one (21) years;

2. Is of good character and reputation;

3. Has not been previously convicted of, or pled guilty or nolo contendere to, any felony, or to a misdemeanor involving moral turpitude or dishonesty;

4. Is a citizen of the United States;

5. Has been a bona fide resident of the state for at least one (1) year;

6. Will actively engage in the bail bond business;

7. Has knowledge or experience, or has received instruction in the bail bond business; and

8. Has a high school diploma or its equivalent; provided, however, the provisions of this paragraph shall apply only to initial applications for license submitted on or after November 1, 1997, and shall not apply to renewal applications for license.

B. The applicant shall apply in writing on forms prepared and supplied by the Insurance Commissioner, and the Commissioner may propound any reasonable interrogatories to an applicant for a license pursuant to ~~Section~~ Sections 1301 ~~et seq.~~ through 1340 of this title, or on any renewal thereof, relating to qualifications, residence, prospective place of business and any other matters which, in the opinion of the Commissioner, are deemed necessary or expedient in order to protect the public and ascertain the

qualifications of the applicant. The Commissioner may also conduct any reasonable inquiry or investigation relative to the determination of the ~~applicant's~~ fitness of the applicant to be licensed or to continue to be licensed including, but not limited to, requiring a national criminal history record check as defined by Section 150.9 of Title 74 of the Oklahoma Statutes.

C. An applicant shall furnish to the Commissioner a license fee of Two Hundred Fifty Dollars ($250.00) with the application, a complete set of the ~~applicant's~~ fingerprints of the applicant and two recent credential-size full face photographs of the applicant. The ~~applicant's~~ fingerprints of the applicant shall be certified by an authorized law enforcement officer. The applicant shall provide with the application an investigative fee of One Hundred Dollars ($100.00) with which the Commissioner will conduct an investigation of the applicant. All fees shall be nonrefundable.

D. Failure of the applicant to secure approval of the Commissioner shall not preclude the applicant from reapplying, but a second application shall not be considered by the Commissioner within three (3) months after denial of the last application.

E. The fee for a duplicate pocket license shall be Twenty-five Dollars ($25.00).

SECTION 56. AMENDATORY 59 O.S. 2001, Section 1306, as last amended by Section 1, Chapter 196, O.S.L. 2009 (59 O.S. Supp. 2009, Section 1306), is amended to read as follows:

Section 1306. A. 1. An applicant for a cash bondsman license shall meet all requirements set forth in Section 1305 of this title with exception of residence.

2. In addition to the requirements prescribed in Section 1305 of this title, an applicant for a professional bondsman license shall submit to the Insurance Commissioner financial statements prepared by an accounting firm or individual holding a permit to practice public accounting in this state in accordance with generally accepted principles of accounting procedures setting forth the total assets of the bondsman less liabilities and debts as follows: For all applications made prior to ~~the effective date of this act~~ November 1, 2006, and the subsequent renewals of a license issued upon ~~such~~ the application when continuously maintained in effect as required by law, the statement shall show a net worth of at least Fifty Thousand Dollars ($50,000.00). For all applications made on and after ~~the effective date of this act~~ November 1, 2006, and the subsequent renewals of a license issued upon ~~such~~ the application when continuously maintained in effect as required by law, or for the renewal or reinstatement of any license that is expired pursuant to subsection D of Section 1309 of this title, suspended or revoked, the statement shall show a net worth of at least One Hundred Fifty Thousand Dollars ($150,000.00), ~~said~~ the statements to be current as of a date not earlier than ninety (90)

days prior to submission of the application and the statement shall be attested to by an unqualified opinion of the accountant.

3. Professional bondsman applicants shall make a deposit with the Insurance Commissioner in the same manner as required of domestic insurance companies of an amount to be determined by the Commissioner. For all applications made prior to ~~the effective date of this act~~ November 1, 1996, and the subsequent renewals of a license issued upon ~~such~~ the application when continuously maintained in effect as required by law, the deposit shall not be less than Twenty Thousand Dollars ($20,000.00). For all applications made on and after ~~the effective date of this act~~ November 1, 1996, and the subsequent renewals of a license issued upon ~~such~~ the application when continuously maintained in effect as required by law, or for the renewal or reinstatement of any license that is expired pursuant to subsection D of Section 1309 of this title, suspended or revoked, the deposit shall not be less than Fifty Thousand Dollars ($50,000.00). ~~Such~~ The deposits shall be subject to all laws, rules and regulations as deposits by domestic insurance companies but in no instance shall a professional bondsman write bonds which equal more than ten times the amount of the deposit which ~~such~~ the bondsman has submitted to the Commissioner. In addition, a professional bondsman may make the deposit by purchasing an annuity through a licensed domestic insurance company in the State of Oklahoma. The annuity shall be in the name of the

bondsman as owner with legal assignment to the Insurance Commissioner. The assignment form shall be approved by the Commissioner. If a bondsman exceeds the above limitation, the bondsman shall be notified by the Commissioner by mail with return receipt requested that the excess shall be reduced or the deposit increased within ten (10) days of notification, or the license of the bondsman shall be suspended immediately after the ten-day period, pending a hearing on the matter.

4. The deposit ~~herein~~ provided for in this section shall constitute a reserve available to meet sums due on forfeiture of any bonds or recognizance executed by ~~such~~ the bondsman.

5. Any deposit made by a professional bondsman pursuant to this section shall be released and returned by the Commissioner to the professional bondsman only upon extinguishment of all liability on outstanding bonds. Provided, however, the Commissioner shall have the authority to review specific financial circumstances and history of a professional bondsman, on a case-by-case basis, and may release a portion of the deposit if warranted. The Commissioner may promulgate rules to effectuate the provisions of this paragraph.

6. No release of deposits to a professional bondsman shall be made by the Commissioner except upon written application and the written order of the Commissioner. The Commissioner shall have no liability for any such release to a professional bondsman provided the release was made in good faith.

B. The deposit provided in this section shall be held in safekeeping by the Insurance Commissioner and shall only be used if a bondsman fails to pay an order and judgment of forfeiture after being properly notified or shall be used if the license of a professional bondsman has been revoked. The deposit shall be held in the name of the Insurance Commissioner and the bondsman. The bondsman shall execute an assignment of the deposit to the Insurance Commissioner for the payment of unpaid bond forfeitures.

C. Currently licensed professional bondsmen may maintain their aggregate liability limits upon presentation of documented proof that they have previously been granted a limitation greater than the requirements of subsection A of this section.

D. Notwithstanding any other provision of ~~Section~~ Sections 1301 ~~et seq.~~ through 1340 of this title, the license of a professional bondsman is transferable upon the death or legal or physical incapacitation of the bondsman to the ~~bondsman's~~ spouse of the bondsman, or to such other transferee as the professional bondsman may designate in writing, and the transferee may elect to act as a professional bondsman until the expiration of the license or for a period of one hundred eighty (180) days, whichever is greater, if the following conditions are met:

1. The transferee ~~must~~ shall hold a valid license as a surety bondsman in this state; and

2. The asset and deposit requirements set forth in this section continue to be met.

SECTION 57. AMENDATORY 59 O.S. 2001, Section 1310, is amended to read as follows:

Section 1310. A. The Insurance Commissioner may deny, censure, suspend, revoke, or refuse to renew any license issued under ~~Section~~ Sections 1301 ~~et seq.~~ through 1340 of this title for any of the following causes:

1. For any cause for which issuance of the license could have been refused;

2. Violation of any laws of this state or any lawful rule, regulation, or order of the Commissioner relating to bail;

3. Material misstatement, misrepresentation, or fraud in obtaining the license;

4. Misappropriation, conversion, or unlawful withholding of monies or property belonging to insurers, insureds, or others received in the conduct of business under the license;

5. Conviction of, or having entered a plea of guilty or nolo contendere to, any felony or to a misdemeanor involving moral turpitude or dishonesty;

6. Fraudulent or dishonest practices in conducting business under the license;

7. Failure to comply with, or violation of any proper order, rule, or regulation of the Commissioner;

8. Recommending any particular attorney-at-law to handle a case in which the bail bondsman has caused a bond to be issued under the terms of ~~Section~~ Sections 1301 ~~et seq.~~ through 1340 of this title;

9. When, in the judgment of the Commissioner, the licensee has, in the conduct of affairs under the license, demonstrated incompetency, or untrustworthiness, or conduct or practices rendering the licensee unfit to carry on the bail bond business or making continuance in the business detrimental to the public interest, or that the licensee is no longer in good faith carrying on the bail bond business, or that the licensee is guilty of rebating, or offering to rebate, or dividing with someone other than a licensed bail bondsman, or offering to divide commissions in the case of limited surety agents, or premiums in the case of professional bondsmen, and for this conduct is found by the Commissioner to be a source of detriment, injury, or loss to the public;

10. For any materially untrue statement in the license application;

11. Misrepresentation of the terms of any actual or proposed bond;

12. For forging the name of another to a bond or application for bond;

13. Cheating on an examination for licensure;

14. Soliciting business in or about any place where prisoners are confined, arraigned, or in custody;

15. For paying a fee or rebate, or giving or promising anything of value to a jailer, trustee, police officer, law enforcement officer, or other officer of the law, or any other person who has power to arrest or hold in custody, or to any public official or public employee in order to secure a settlement, compromise, remission, or reduction of the amount of any bail bond or estreatment thereof, or to secure delay or other advantage. This shall not apply to a jailer, police officer, or officer of the law who is not on duty and who assists in the apprehension of a defendant;

16. For paying a fee or rebating or giving anything of value to an attorney in bail bond matters, except in defense of an action on a bond;

17. For paying a fee or rebating or giving or promising anything of value to the principal or anyone in the ~~principal's~~ behalf of the principal;

18. Participating in the capacity of an attorney at a trial or hearing for one on whose bond the licensee is surety;

19. Accepting anything of value from a principal, other than the premium; provided, the bondsman shall be permitted to accept collateral security or other indemnity from the principal which shall be returned immediately upon final termination of liability on

the bond and upon satisfaction of all terms, conditions, and obligations contained within the indemnity agreement. Collateral security or other indemnity required by the bondsman shall be reasonable in relation to the amount of the bond;

20. Willful failure to return collateral security to the principal when the principal is entitled thereto;

21. For failing to notify the Commissioner of a change of address, as noted on the license, within five (5) days after a change is made, or failing to respond to a properly mailed notification within a reasonable amount of time;

22. For failing to file a report as required by Section 1314 of this title;

23. For filing a materially untrue monthly report;

24. For filing false affidavits regarding cancellation of the appointment of an insurer;

25. Forcing the Commissioner to withdraw deposited monies to pay forfeitures or any other outstanding judgments;

26. For failing to pay any fees to a district court clerk as are required by this title or failing to pay any fees to a municipal court clerk as are required by this title or by Section 28-127 of Title 11 of the Oklahoma Statutes;

27. For uttering an insufficient check to the Insurance Commissioner for any fees, fines or other payments received by the Commissioner from the bail bondsman; ~~and~~

28. For failing to pay travel expenses for the return of the defendant to custody once having guaranteed the expenses pursuant to the provisions of subparagraph d of paragraph 3 of subsection C of Section 1332 of this title; and

29. The Commissioner may also refuse to renew a licensed bondsman for failing to file all outstanding monthly bail reports, pay any outstanding fines, pay any outstanding monthly report reviewal fees owed to the Commissioner, or respond to a current order issued by the Commissioner.

B. In addition to any applicable denial, censure, suspension, or revocation of a license, any person violating any provision of ~~Section~~ Sections 1301 ~~et seq.~~ through 1340 of this title may be subject to a civil penalty of not less than ~~One Hundred Dollars ($100.00)~~ Two Hundred Fifty Dollars ($250.00) nor more than ~~One Thousand Dollars ($1,000.00)~~ Two Thousand Five Hundred Dollars ($2,500.00) for each occurrence. This fine may be enforced in the same manner in which civil judgments may be enforced. Any order for civil penalties entered by the Commissioner or authorized decision maker for the Insurance Department which has become final may be filed with the court clerk of Oklahoma County and shall then be enforced by the judges of ~~said county~~ Oklahoma County.

C. No bail bondsman or bail bond agency shall advertise as or hold itself out to be a surety company.

D. If any bail bondsman is convicted by any court of a violation of any of the provisions of this act, the license of the individual shall therefore be deemed to be immediately revoked, without any further procedure relative thereto by the Commissioner.

E. For one (1) year after notification by the Commissioner of an alleged violation, or for two (2) years after the last day the person was licensed, whichever is the lesser period of time, the Commissioner shall retain jurisdiction as to any person who cancels his bail bondsman's license or allows the license to lapse, or otherwise ceases to be licensed, if the person while licensed as a bondsman allegedly violated any provision of this title. Notice and opportunity for hearing shall be conducted in the same manner as if the person still maintained a bondsman's license. If the Commissioner or a hearing examiner determines that a violation of the provisions of Sections 1301 through 1340 of this title occurred, any order issued pursuant to the determination shall become a permanent record in the file of the person and may be used if the person should request licensure or reinstatement.

F. Any law enforcement agency, district attorney's office, court clerk's office, or insurer that is aware that a licensed bail bondsman has been convicted of or has pleaded guilty or nolo contendere to any crime, shall notify the Insurance Commissioner of that fact.

SECTION 58. AMENDATORY 59 O.S. 2001, Section 1314, as amended by Section 25, Chapter 432, O.S.L. 2009 (59 O.S. Supp. 2009, Section 1314), is amended to read as follows:

Section 1314. A. When a bail bondsman or managing general agent accepts collateral, ~~he or she~~ the bail bondsman or managing general agent shall give a written receipt for same, and this receipt shall give in detail a full description of the collateral received. A description of the collateral shall be listed on the undertaking by affidavit. All property taken as collateral, whether personal, intangible or real, shall be receipted for and deemed, for all purposes, to be in the name of, and for the use and benefit of, the surety company or licensed professional bondsman, as the case may be. Every receipt, encumbrance, mortgage or other evidence of ~~such~~ the custody, possession or claim shall facially indicate that it has been taken or made on behalf of the surety company or professional bondsman through its authorized agent, the individual licensed bondsman or managing general agent who has transacted the undertaking with the bond principal. Any mortgage or other encumbrance against real property taken under the provisions of this section which does not indicate beneficial ownership of the claim to be in favor of the surety company or professional bondsman shall be deemed to constitute a cloud on the title to real estate and shall subject the person filing, or causing same to be filed, in the real estate records of the county, to a penalty of treble damages or One

Thousand Dollars ($1,000.00), whichever is greater, in an action brought by the person, organization or corporation injured thereby. For collateral taken, or liens or encumbrances taken or made pursuant to the provisions of this section, the individual bondsman or managing general agent taking possession of the property or making the lien, claim or encumbrance shall do so on behalf of ~~his or her~~ the surety company or professional bondsman, as the case may be, and ~~such~~ the individual licensed bondsman shall be deemed to act in the capacity of fiduciary in relation to both:

1. The principal or other person from whom ~~such~~ the property is taken or claimed against~~,~~; and

2. The surety company or professional bondsman whose agent is the licensed bondsman ~~is~~.

As fiduciary and bailee for hire, the individual bondsman shall be liable in criminal or civil actions at law for failure to properly receipt or account for, maintain or safeguard, release or deliver possession upon lawful demand, in addition to any other penalties set forth in this subsection. No person who takes possession of property as collateral pursuant to this section shall use or otherwise dissipate ~~such~~ the asset, or do otherwise with ~~such~~ the property than to safeguard and maintain its condition pending its return to its lawful owner, or deliver to the surety company or professional bondsman, upon lawful demand pursuant to the terms of the bailment.

B. Every licensed bondsman shall file monthly by mail with return receipt requested with the Insurance Commissioner and on forms prescribed by the Commissioner as follows:

1. A ~~notarized~~ monthly report showing every bond written, amount of bond, whether released or revoked during each month, showing the court and county, and the style and number of the case, premiums charged and collateral received; and

2. Professional bondsmen shall submit by mail with return receipt requested notarized monthly reports showing total current liabilities, all bonds written during the month by the professional bondsman and by any licensed bondsman who may countersign for ~~him or her~~ the professional bondsman, all bonds terminated during the month, and the total liability and a list of all bondsmen currently employed by ~~such~~ the professional bondsmen.

Monthly reports shall be postmarked or stamped "received" by the Insurance Commissioner by the fifteenth day of each month. ~~Said~~ The records shall be maintained by the Commissioner as public records.

C. Every licensee shall keep at ~~his or her~~ the place of business of the licensee the usual and customary records pertaining to transactions authorized by ~~his or her~~ the license. All ~~such~~ of the records shall be 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 the transaction. The

Commissioner may require a financial examination or market conduct survey during any investigation of a licensee.

D. Each bail bondsman shall submit each month with ~~his or her~~ the monthly report of the bondsman, a reviewal fee equal to two-tenths of one percent (2/10 of 1%) of the new liability written for that month. ~~Such~~ The fee shall be payable to the Insurance Commissioner who shall deposit same with the State Treasurer.

SECTION 59. AMENDATORY 59 O.S. 2001, Section 1315, is amended to read as follows:

Section 1315. A. The following persons or classes shall not be bail bondsmen and shall not directly or indirectly receive any benefits from the execution of any bail bond:

1. Persons convicted of, or who have pled guilty or nolo contendere to, a felony or a misdemeanor involving dishonesty or moral turpitude;

2. Jailers;

3. Police officers;

4. Committing judges;

5. Municipal or district court judges;

6. Prisoners;

7. Sheriffs, deputy sheriffs and any person having the power to arrest or having anything to do with the control of federal, state, county or municipal prisoners;

8. Any person who possesses a permit pursuant to the provisions of Section 163.11 of Title 37 of the Oklahoma Statutes or is an officer, director or stockholder of any corporation holding such a permit;

9. Any person who is an agent~~, employee,~~ or owner of any establishment at which low-point beer as defined by Section 163.2 of Title 37 of the Oklahoma Statutes is sold for on-premises consumption;

10. Any person who holds any license provided for in Section 518 of Title 37 of the Oklahoma Statutes or is an agent~~,~~ or officer~~, or employee~~ of any such licensee, except for an individual holding an employee license pursuant to paragraph 20 of subsection A of Section 518 of Title 37 of the Oklahoma Statutes;

11. Any person who holds any license or permit from any city, town, county, or other governmental subdivision for the operation of any private club at which alcoholic beverages are consumed or provided; and

12. Any person~~,~~ or agent~~, or employee~~ of a retail liquor package store.

B. This section shall not apply to a sheriff, deputy sheriff, police officer, or officer of the law who is not on duty and who assists in the apprehension of a defendant.

C. The provisions of this section shall not apply to persons possessing permits or licenses pertaining to low-point beer or

alcoholic beverages, as defined in Sections 163.2 and 506 of Title 37 of the Oklahoma Statutes, which were issued prior to May 23, 1984. No one shall be permitted to maintain an office for conducting bail bonds business where low-point beer or alcoholic beverages are sold for on-premises consumption.

SECTION 60. AMENDATORY 59 O.S. 2001, Section 1316, as last amended by Section 58, Chapter 176, O.S.L. 2009 (59 O.S. Supp. 2009, Section 1316), is amended to read as follows:

Section 1316. A. 1. A bail bondsman shall neither sign nor countersign in blank any bond, nor shall the bondsman give a power of attorney to, or otherwise authorize, anyone to countersign ~~his or her~~ the name of the bail bondsman to bonds unless the person so authorized is a licensed surety bondsman or managing general agent directly employed by a licensed professional bondsman giving ~~such~~ the power of attorney. The professional bondsman shall submit to the Insurance Commissioner the agreement between the professional bondsman and the employed bondsman. The agreement shall be submitted to the Commissioner prior to the employed bondsman writing bonds on behalf of the professional. The professional bondsman shall notify the Commissioner whenever any agreement is canceled. If the bondsman surrenders the professional qualification, or the professional qualification is suspended or revoked, or if an insurer authorized to write bail bond business surrenders their bail surety line of authority, or this line of authority is suspended or

revoked, then the Commissioner shall suspend the appointment of all of the ~~professional bondsman's~~ bail agents of the professional bondsman or insurer. The Commissioner shall immediately notify any bail agent whose license is affected and the court clerk of the agent's resident county upon ~~such~~ the suspension or revocation of the ~~professional bondsman's~~ qualification of the professional bondsman. If the professional qualification or the bail surety line of authority is reinstated within twenty-four (24) hours, the Commissioner shall not be required to suspend the bail agent appointments. If the Commissioner reinstates the professional qualification within twenty-four (24) hours, the Commissioner shall also reinstate the appointment of the ~~professional bondsman's~~ bail agents of the professional bondsman or bail insurer. If more than twenty-four (24) hours elapse following the suspension or revocation, then the professional bondsman or insurer shall submit new agent appointments to the Commissioner.

2. Bail bondsmen shall not allow other licensed bondsmen to present bonds that have previously been signed and completed. The individual that presents the bond shall sign the form in the presence of the official that receives the bond.

B. Premium charged ~~must~~ shall be indicated on the appearance bond prior to the filing of the bond.

C. A bail bondsman shall provide the indemnitors with a proper receipt which shall include fees, premium or other payments and copies of any agreements executed relating to the appearance bond.

D. All surety bondsmen or managing general agents shall attach a completed power of attorney to the appearance bond that is filed with the court clerk on each bond written.

E. Any bond written in this state shall contain the name and last-known mailing address of the bondsman and, if applicable, of the insurer.

SECTION 61. AMENDATORY 59 O.S. 2001, Section 1317, as last amended by Section 30, Chapter 184, O.S.L. 2008 (59 O.S. Supp. 2009, Section 1317), is amended to read as follows:

Section 1317. A. Every surety or professional bondsman who appoints a surety bondsman or managing general agent in the state, shall give notice thereof to the Insurance Commissioner. The filing fee for appointment of each surety bondsman or managing general agent shall be Ten Dollars ($10.00), payable to the Commissioner and shall be submitted with the appointment. The appointment shall remain in effect until the surety or professional bondsman submits a notice of cancellation to the Commissioner, the ~~bail bondsman's~~ license of the bail bondsman expires, or the Commissioner cancels the appointment. The Commissioner may cancel a bail surety appointment if the license of the bondsman is suspended, revoked or nonrenewed. If the surety changes the liability limitations of the

surety bondsman or the managing general agent, or any other provisions of the appointment, the surety shall submit an amended appointment form and a filing fee of Ten Dollars ($10.00) payable to the Commissioner.

B. A surety terminating the appointment of a surety bondsman or managing general agent immediately shall file written notice thereof with the Commissioner, together with a statement that it has given or mailed notice to the surety bondsman or managing general agent. The notice filed with the Commissioner shall state the reasons, if any, for the termination.

C. Prior to issuance of a new surety appointment for a surety bondsman or managing general agent, the bondsman or agent shall file an affidavit with the Commissioner stating that no forfeitures are owed to any court, no fines are owed to the insurance department, and no premiums or indemnification for forfeitures or fines are owed to any insurer. This provision shall not require that all outstanding liabilities have been exonerated, but may provide that the liabilities are still being monitored by the bondsman or agent.

D. Every bail bondsman who negotiates and posts a bond shall, in any controversy between the defendant, indemnitor, or guarantor and the bail bondsman or surety, be regarded as representing the surety. This provision shall not affect the apparent authority of a bail bondsman as an agent for the insurer.

SECTION 62. AMENDATORY 59 O.S. 2001, Section 1322, is amended to read as follows:

Section 1322. A. Every ~~"~~bondsman~~"~~ shall file with the undertaking an affidavit stating whether or not ~~he~~ the bondsman or anyone for ~~his~~ the use of the bondsman has been promised or has received any security or consideration for ~~his~~ the undertaking, and if so, the nature and description of security and amount thereof, and the name of the person by whom ~~such~~ the promise was made or from whom ~~such~~ the security or consideration was received. Any willful misstatement in ~~such~~ the affidavit relating to the security or consideration promised or given shall render the person making it subject to the same prosecution and penalty as one who commits the felony of perjury.

B. An action to enforce any indemnity agreement shall not lie in favor of the surety against ~~such~~ the indemnitor, except with respect to agreements set forth in ~~such~~ the affidavit. In an action by the indemnitor against the surety to recover any collateral or security given by the indemnitor, ~~such~~ the surety shall have the right to retain only ~~such~~ the security or collateral as it mentioned in the affidavit required ~~above~~ by this section.

C. If security or consideration other than that reported on the original affidavit is received after the affidavit is filed with the court clerk, an amended affidavit shall be filed with the court clerk indicating ~~such~~ the receipt of security or consideration.

D. If a bondsman accepts a mortgage on real property as collateral on a bond, the bondsman shall file a copy of the mortgage with the bond within thirty (30) days of receipt of the mortgage. The Commissioner shall have the authority to extend or waive this requirement.

SECTION 63. REPEALER 11 O.S. 2001, Section 29-205, is hereby repealed.

SECTION 64. REPEALER 36 O.S. 2001, Sections 6520, 6521, as amended by Section 30, Chapter 125, O.S.L. 2007, 6523 and 6525 (36 O.S. Supp. 2009, Section 6521), are hereby repealed.

SECTION 65. REPEALER 36 O.S. 2001, Section 6608, as amended by Section 4, Chapter 189, O.S.L. 2009 (36 O.S. Supp. 2009, Section 6608), is hereby repealed.

SECTION 66. This act shall become effective November 1, 2010.

52-2-10485 EK 04/05/10