ENGROSSED HOUSE
BILL NO. 1613

By: McDaniel (Randy) and Sullivan of the House

and

Aldridge of the Senate

An Act relating to insurance; amending 36 O.S. 2001, Section 309.4, which relates to Insurance Commissioner examination report review procedures; expanding confidential treatment of certain business work papers; amending Section 15, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2009, Section 311A.13), which relates to work papers; specifying that Commissioner may conduct certain reviews; expanding scope of confidentiality; amending Section 29, Chapter 264, O.S.L. 2006 (36 O.S. Supp. 2009, Section 1126), which relates to public access to certain documents; expanding confidential treatment of certain work papers; amending 36 O.S. 2001, Section 1219.4, as last amended by Section 23, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2009, Section 1219.4), which relates to discount medical plan requirements; providing for confidentiality; providing that certain documents and information are not subject to subpoena or public inspection; allowing access by certain national organization; requiring written agreement for certain access; providing exception; amending 36 O.S. 2001, Section 1443, which relates to certain insurance administrator agreements; providing for confidentiality; providing that certain documents and information are not subject to subpoena or public inspection; allowing access by certain national organization; requiring written agreement for certain access; providing exception; providing for confidentiality for certain documents and information; providing exception; requiring written agreement for certain access; amending Section 45, Chapter 197, O.S.L. 2003 (36 O.S. Supp. 2009, Section 6945), which relates to confidentiality of certain

risk-based capital reports; specifying that confidential treatment shall be extended to certain work papers; authorizing access to certain documentation by certain national organization; requiring written agreement for certain access; providing exception; providing for codification; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2001, Section 309.4, is amended to read as follows:

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

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

rebuttal with respect to any matters contained in the examination report.

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

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

2. Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and refiling pursuant to subsection A of this section; or

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

D. 1. All orders entered pursuant to paragraph 1 of subsection C of this section shall be accompanied by findings and conclusions resulting from the Commissioner's consideration and review of the

examination report, relevant examiner ~~workpapers~~ work papers and any written submissions or rebuttals. Any such order shall be considered a final administrative decision and may be appealed pursuant to the Administrative Procedures Act, and shall be served upon the company by certified mail, together with a copy of the adopted examination report. Within thirty (30) days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders. Upon proper order of the Commissioner, the company shall deliver by mail or otherwise, within thirty (30) days of the date of the order, a copy of the adopted report and related orders to all states and jurisdictions in which the company is licensed to transact the business of insurance.

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

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

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

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

E. 1. Upon the adoption of the examination report under paragraph 1 of subsection C of this section, the Commissioner shall continue to hold the content of the examination report as private and confidential information for a period of two (2) days except to the extent provided in subsection B of this section and subsection F

of Section 309.3 of this title. Thereafter, the Commissioner may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

2. Nothing contained in Sections 309.1 through 309.7 of this title shall prevent or be construed as prohibiting the Commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with Sections 309.1 through 309.7 of this title.

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

F. All working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the Commissioner or any other person in the course of an examination made under Sections 309.1 through 309.7 of this title, or in the course of analysis by the Commissioner or any other person of the financial condition or market conduct of a company, shall be given confidential treatment and are not subject to subpoena and may not

be made public by the Commissioner or any other person, except to the extent provided in subsection E of this section and subsection F of Section 309.3 of this title. Access may also be granted to the National Association of Insurance Commissioners. Such parties shall agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

SECTION 2. AMENDATORY Section 15, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2009, Section 311A.13), is amended to read as follows:

Section 311A.13 A. Work papers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the audit by the accountant of the financial statements of an insurer. Work papers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents, and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of the audit of the financial statements of an insurer and which support the opinion of the accountant.

B. Every insurer required to file an audited financial report pursuant to the Oklahoma Annual Financial Report Act, shall require

the accountant to make available for review by Insurance Department examiners, all work papers prepared in the conduct of the audit by the accountant and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the offices of the Insurance Department, or at any other reasonable place designated by the Insurance Commissioner. The insurer shall require that the accountant retain the audit work papers and communications until the Insurance Department has filed a report on examination covering the period of the audit but no longer than seven (7) years from the date of the audit report.

C. In the conduct of the aforementioned periodic review by the Commissioner or Insurance Department examiners, it shall be agreed that photocopies of pertinent audit work papers may be made and retained by the Insurance Department. Such reviews by the Commissioner or Insurance Department examiners shall be considered investigations and all working papers, recorded information, documents, copies thereof and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination work papers generated by the Insurance Department pursuant to subsection F of Section 309.4 of ~~Title 36 of the Oklahoma Statutes~~ this title.

SECTION 3. AMENDATORY Section 29, Chapter 264, O.S.L. 2006 (36 O.S. Supp. 2009, Section 1126), is amended to read as follows:

Section 1126. A. The Statement of Actuarial Opinion shall be provided with the annual statement in accordance with the appropriate ~~NAIC~~ National Associations of Insurance Commissioners Property and Casualty Annual Statement Instructions and shall be treated as a public document.

B. 1. Documents, materials or other information in the possession or control of the Insurance Department that are considered an actuarial report, ~~workpapers~~ work papers or actuarial opinion summary provided in support of the opinion, and any other material provided by the company to the Insurance Commissioner in connection with the actuarial report, ~~workpapers~~ work papers or actuarial opinion summary, and any work papers used by the Commissioner or any other person in the analysis of the actuarial report, work papers, other material or actuarial opinion summary provided in support of the opinion, shall be confidential by law and privileged, shall not be subject to the Oklahoma Open Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

2. This provision shall not be construed to limit the Commissioner's authority to release the documents to the Actuarial Board for Counseling and Discipline (ABCD) so long as the material is required for the purpose of professional disciplinary proceedings and the ABCD establishes procedures satisfactory to the Commissioner for preserving the confidentiality of the documents, nor shall this

section be construed to limit the Commissioner's authority to use the documents, materials or other information in furtherance of any regulatory or legal action brought as part of the Commissioner's official duties.

C. Neither the Commissioner nor any person who received documents, materials or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection B of this section.

D. In order to assist in the performance of the Commissioner's duties, the Commissioner:

1. May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection B of this section with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities; provided, that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information and has the legal authority to maintain confidentiality;

2. May receive documents, materials or information, including otherwise confidential and privileged documents, materials or

information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

3. May enter into agreements governing sharing and use of information consistent with subsections B through D of this section.

E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection D of this section.

SECTION 4. AMENDATORY 36 O.S. 2001, Section 1219.4, as last amended by Section 23, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2009, Section 1219.4), is amended to read as follows:

Section 1219.4 A. As used in this section:

1. "Direct contract" means a contractual arrangement tying the ultimate seller purporting to offer discounts through the discount card to the health care provider, which expressly states the intent of this agreement to be used for the purpose of offering discounts on health-related purchases to uninsured or noncovered persons;

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

3. "Discount medical plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. The term discount medical plan does not include any product regulated as an insurance product, group health service product or health maintenance organization (HMO) product in the State of Oklahoma or discounts provided by an insurer, group health service, or health maintenance organizations (HMOs) where those discounts are provided at no cost to the insured or member and are offered due to coverage with a licensed insurer, group health service, or HMO;

4. "Discount medical plan organization" means a person or an entity which operates a discount medical plan;

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

6. “Health care provider network” means an entity which directly contracts with physicians and hospitals and has contractual

rights to negotiate on behalf of those health care providers with a discount medical plan organization to provide medical services to members of the discount medical plan organization;

7. "Marketer" means a person or entity who markets, promotes, sells or distributes a discount medical plan, including a private label entity that places its name on and markets or distributes a discount medical plan but does not operate a discount medical plan;

8. "Medical services" means any care, service or treatment of illness or dysfunction of, or injury to, the human body including, but not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, laboratory services, and medical equipment and supplies. The term does not include pharmaceutical supplies or prescriptions;

9. "Member" means any person who pays fees, dues, charges, or other consideration for the right to receive the purported benefits of a discount medical plan; and

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

B. 1. Before doing business in this state as a discount medical plan organization, an entity shall be a corporation, limited liability corporation, partnership, limited liability partnership or

other legal entity, organized under the laws of this state or, if a foreign entity, authorized to transact business in this state, and shall be registered as a discount medical plan organization with the Insurance Department of the State of Oklahoma or be licensed by the Insurance Department of the State of Oklahoma as a licensed insurance company, licensed HMO, licensed group health service organization or motor service club.

2. To register as a discount medical plan organization, an applicant shall:

a. file with the Insurance Department of the State of Oklahoma an application on the form that the Insurance Commissioner requires, and

b. pay to the Department an application fee of Two Hundred Fifty Dollars ($250.00).

3. A registration is valid for a one-year term.

4. A registration expires one year following the registration unless it is renewed as provided in this subsection.

5. Before it expires, a registrant may renew the registration for an additional one-year term if the registrant:

a. otherwise is entitled to be registered,

b. files with the Department a renewal application on the form that the Insurance Commissioner requires, and

c. pays to the Department a renewal fee of Two Hundred Fifty Dollars ($250.00).

6. The Insurance Commissioner may deny a registration to an applicant or refuse to renew, suspend, or revoke the registration of a registrant if the applicant or registrant, or an officer, director, or employee of the applicant or registrant:

a. makes a material misstatement or misrepresentation in an application for registration,

b. fraudulently or deceptively obtains or attempts to obtain a registration for the applicant or registrant or for another,

c. in connection with the administration of a health care discount program, commits fraud or engages in illegal or dishonest activities, or

d. has violated any provisions of this section.

7. Prior to registration by the Insurance Department of the State of Oklahoma, each discount medical plan organization shall establish an Internet web site.

8. All amounts collected as registration or renewal fees shall be deposited into the General Revenue Fund.

9. Nothing in this subsection shall require a provider who provides discounts to his or her own patients to obtain and maintain a registration as a discount medical plan organization.

10. a. Nothing in this subsection shall apply to an affiliate of a licensed insurance company, HMO, group health service organization or motor service club, provided

that the affiliate registers with and maintains registration in good standing with the Insurance Department of the State of Oklahoma in accordance with subparagraphs b and c of this paragraph.

b. An affiliate shall register as a discount medical plan organization on a form prescribed by the Insurance Commissioner prior to the sale, marketing or solicitation of a discount medical plan and pay an application fee of One Hundred Dollars ($100.00).

c. A registration shall expire one (1) year after the date of registration, and each year on that date thereafter. A registrant may renew the registration if the registrant pays an annual registration fee of One Hundred Dollars ($100.00) and remains in good standing with the Insurance Department of the State of Oklahoma.

d. For purposes of this section, "affiliate" means a person that, directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with an insurance company, HMO, group health service organization or motor service club licensed in this state.

C. 1. The Department may examine or investigate the business and affairs of any discount medical plan organization. The

Department may require any discount medical plan organization or applicant to produce any records, books, files, advertising and solicitation materials, or other information and may take statements under oath to determine whether the discount medical plan organization or applicant is in violation of the law or is acting contrary to the public interest. The expenses incurred in conducting any examination or investigation shall be paid by the discount medical plan organization or applicant. Examinations and investigations shall be conducted as provided in Sections 309.1 and 309.3 through 309.7 of this title. Discount medical plan organizations shall be governed by the provisions of this section and shall not be subject to the provisions of the Insurance Code unless specifically referenced.

2. All work papers, recorded information, documents, books, files, advertising and solicitation materials, copies or other information produced by, obtained by or disclosed to the Commissioner or any other person in the course of an examination or investigation made pursuant to this section or in the course of analysis by the Commissioner or other person, shall be given confidential treatment and shall not be subject to subpoena and may not be made public by the Commissioner or any other person, except to the extent provided in this section. Access may be granted to the National Associations of Insurance Commissioners. The parties shall agree in writing prior to receiving the information to provide

to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

3. Failure by the discount medical plan organization to pay the expenses incurred under paragraph 1 of this subsection shall be grounds for denial or revocation of the discount medical plan organization's registration.

D. 1. A discount medical plan organization may charge a reasonable one-time processing fee and a periodic charge.

2. If the member cancels the membership within the first thirty (30) days after receipt of the discount card and other membership materials, the member shall receive a reimbursement of all periodic charges paid. The return of all periodic charges shall be made within thirty (30) days of the date of the cancellation. If all of the periodic charges have not been paid within thirty (30) days, interest shall be assessed and paid on the proceeds at a rate of the Treasury Bill rate of the preceding calendar year, plus two (2) percentage points.

3. The right of cancellation shall be set out in the contract on the first page, in ten-point type or larger.

4. If a discount medical plan charges for a time period in excess of one (1) month, the plan shall, in the event of cancellation of the membership by either party, make a pro rata reimbursement of all periodic charges to the member.

E. 1. A discount medical plan organization may not:

a. use in its advertisements, marketing material, brochures, and discount cards the terms “insurance”, "health plan", "coverage", "copay", "copayments", "preexisting conditions", "guaranteed issue", "premium", "PPO", "preferred provider organization”, or other terms in a manner that could reasonably mislead a person to believe that the discount medical plan is health insurance,

b. except for hospital services, have restrictions on free access to plan providers including waiting periods and notification periods, or

c. pay providers any fees for medical services.

2. A discount medical plan organization may not collect or accept money from a member for payment to a provider for specific medical services furnished or to be furnished to the member unless the organization has an active license from the Insurance Department of the State of Oklahoma to act as an administrator.

F. 1. The following disclosures, to be printed in not less than twelve-point type, shall be made in writing to any prospective member and shall appear on the first page of any advertisements, marketing materials or brochures relating to a discount medical plan:

a. that the plan is not insurance,

b. that the plan provides discounts with certain health care providers for medical services,

c. that the plan does not make payments directly to the providers of medical services,

d. that the plan member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount plan organization, and

e. the name and the location of the registered discount medical plan organization, including the current telephone number of the registered discount medical plan organization or other entity responsible for customer service for the plan, if different from the registered discount medical plan organization.

2. If the discount medical plan is sold, marketed, or solicited by telephone, the disclosures required by this section shall be made orally and provided in the initial written materials that describe the benefits under the discount medical plan provided to the prospective or new member.

3. The discount card provided to members shall prominently display the words "This is not insurance".

G. 1. All providers offering medical services to members under a discount medical plan shall provide such services pursuant to a written agreement. The agreement may be entered into directly by

the health care provider or by a health care provider network to which the provider belongs if the provider network has contracts with the health care provider that allow the provider network to contract on behalf of the health care provider.

2. A health care provider agreement shall provide the following:

a. a description of the services and products to be provided at a discount,

b. the amount or amounts of the discounts or, alternatively, a fee schedule which reflects the health care provider's discounted rates, and

c. a provision that the health care provider will not charge members more than the discounted rates.

3. A health care provider agreement with a health care provider network shall require that the health care provider network have written agreements with its health care providers that:

a. contain the terms described in paragraph 2 of this subsection,

b. authorize the health care provider network to contract with the discount medical plan organization on behalf of the provider, and

c. require the network to maintain an up-to-date list of its contracted health care providers and to provide

that list on a quarterly basis to the discount medical plan organization.

4. The discount medical plan organization shall maintain a copy of each active health care provider agreement into which it has entered.

H. 1. There shall be a written agreement between the discount medical plan organization and the member specifying the benefits under the discount medical plan and complying with the disclosure requirements of this section.

2. All forms used, including the written agreement pursuant to the provisions of subsection G of this section, shall first be filed with the Department. Every form filed shall be identified by a unique form number placed in the lower left corner of each form. A filing fee of Twenty-five Dollars ($25.00) per form shall be payable to the Insurance Department of the State of Oklahoma for deposit into the General Revenue Fund.

I. 1. Each discount medical plan organization required to be registered pursuant to this section except an affiliate shall, at all times, maintain a net worth of at least One Hundred Fifty Thousand Dollars ($150,000.00).

2. The Insurance Department of the State of Oklahoma may not allow a registration unless the discount medical plan organization has a net worth of at least One Hundred Fifty Thousand Dollars ($150,000.00).

J. 1. The Insurance Department of the State of Oklahoma may suspend the authority of a discount medical plan organization to enroll new members, revoke any registration issued to a discount medical plan organization, or order compliance if the Department finds that any of the following conditions exist:

a. the organization is not operating in compliance with the provisions of this section,

b. the organization does not have the minimum net worth as required by this section,

c. the organization has advertised, merchandised or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading or unfair practices with respect to advertising or merchandising,

d. the organization is not fulfilling its obligations as a discount medical plan organization, or

e. the continued operation of the organization would be hazardous to its members.

2. If the Insurance Department of the State of Oklahoma has cause to believe that grounds for the suspension or revocation of a registration exist, the Department shall notify the discount medical plan organization in writing, specifically stating the grounds for suspension or revocation, and shall provide opportunity for a

hearing on the matter in accordance with the Administrative Procedures Act and the Oklahoma Insurance Code.

3. When the certificate of registration of a discount medical plan organization is nonrenewed, surrendered or revoked, such organization shall proceed, immediately following the effective date of the order of revocation, or in the case of nonrenewal, the date of expiration of the certificate of registration, to wind up its affairs transacted under the certificate of registration. The organization may not engage in any further advertising, solicitation, collecting of fees, or renewal of contracts.

4. The Insurance Department of the State of Oklahoma shall, in its order suspending the authority of a discount medical plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, which shall be met by the discount medical plan organization prior to reinstatement of its registration to enroll new members. The order of suspension is subject to rescission or modification by further order of the Department prior to the expiration of the suspension period. Reinstatement may not be made unless requested by the discount medical plan organization; however, the Department may not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to reoccur.

K. Each discount medical plan organization required to be registered pursuant to this section shall provide the Insurance

Department of the State of Oklahoma at least thirty (30) days' advance notice of any change in the discount medical plan organization's name, address, principal business address, or mailing address.

L. Each discount medical plan organization shall maintain an up-to-date list of the names and addresses of the providers with which it has contracted on an Internet web site page, the address of which shall be prominently displayed on all its advertisements, marketing materials, brochures, and discount cards. This section applies to those providers with whom the discount medical plan organization has contracted directly, as well as those who are members of a provider network with which the discount medical plan organization has contracted.

M. 1. All advertisements, marketing materials, brochures and discount cards used by marketers shall be approved in writing for such use by the discount medical plan organization.

2. The discount medical plan organization shall have an executed written agreement with a marketer prior to the marketer's marketing, promoting, selling, or distributing the discount medical plan.

N. The Insurance Commissioner may promulgate rules to administer the provisions of this section.

O. Regulation of discount medical plan organizations shall be done pursuant to the Administrative Procedures Act.

P. 1. A discount medical plan organization required to be registered pursuant to this section except an affiliate shall maintain a surety bond with the Insurance Department of the State of Oklahoma, having at all times a value of not less than Thirty-five Thousand Dollars ($35,000.00), for use by the Department in protecting plan members.

2. No judgment creditor or other claimant of a discount medical plan organization, other than the Insurance Department of the State of Oklahoma, shall have the right to levy upon the surety bond held pursuant to the provisions of paragraph 1 of this subsection.

Q. 1. A person who knowingly and willfully operates as or aids and abets another operating as a discount medical plan organization in violation of subsection B of this section commits a felony, punishable as provided for in Oklahoma law, as if the discount medical plan organization were an unauthorized insurer, and the fees, dues, charges, or other consideration collected from the members by the discount medical plan organization or marketer were insurance premium.

2. A person who collects fees for purported membership in a discount medical plan but fails to provide the promised benefits commits a theft, punishable as provided in Oklahoma law.

R. 1. In addition to the penalties and other enforcement provisions of this section, the Department may seek both temporary and permanent injunctive relief if:

a. a discount medical plan organization is being operated by any person or entity that is not registered pursuant to this section, or

b. any person, entity, or discount medical plan organization has engaged in any activity prohibited by this section or any rule adopted pursuant to this section.

2. The venue for any proceeding brought pursuant to the provisions of this section shall be in the district court of Oklahoma County.

S. 1. The provisions of this section apply to the activities of a discount medical plan organization that is not registered pursuant to this section as if the discount medical plan organization were an unauthorized insurer.

2. A discount medical plan organization being operated by any person or entity that is not registered pursuant to this section, or any person, entity or discount medical plan organization that has engaged or is engaging in any activity prohibited by this section or any rules adopted pursuant to this section shall be subject to the Unauthorized Insurer Act as if the discount medical plan organization were an unauthorized insurer, and shall be subject to all the remedies available to the Insurance Commissioner under the Unauthorized Insurer Act.

T. If the Insurance Commissioner finds that a discount medical plan organization has violated any provision of this section or that grounds exist for the discretionary revocation or suspension of a registration, the Commissioner, in lieu of such revocation or suspension, may impose a fine upon the discount medical plan organization in an amount not to exceed One Thousand Dollars ($1,000.00) per violation.

SECTION 5. AMENDATORY 36 O.S. 2001, Section 1443, is amended to read as follows:

Section 1443. A. No person shall act as an administrator without a written agreement between that person and an insurer. The written agreement shall be retained as part of the official records of both the insurer and the administrator for the duration of the agreement and for five (5) years thereafter.

B. The written agreement required by the provisions of subsection A of this section shall contain provisions stating any of the requirements of Sections ~~4~~ 1444 through ~~8~~ 1448 of ~~the Third-party Administrator Act~~ this title which apply to the functions performed by the administrator.

C. If a policy is issued to a trustee, a copy of the trust agreement and any amendments to the agreement shall be furnished to the insurer by the administrator and shall be retained as part of the official records of both the insurer and the administrator for the duration of the policy and for five (5) years thereafter.

D. Every administrator shall maintain at the principal administrative office of the administrator for the duration of the agreement and for five (5) years thereafter the written agreement required by the provisions of this section and records of all transactions among the administrator, insurers or trusts, and insured persons.

E. 1. For the purposes of examination, audit, and inspection, the Commissioner or any other person in the course of examination, audit and inspection shall have access to books and records maintained by the administrator. Any trade secrets contained in these books and records, including the identity and addresses of policyholders and certificate holders, shall be confidential.

2. All work papers, recorded information, documents and copies thereof produced or obtained by or disclosed to the Commissioner or other person in the course of examination, audit and inspection made pursuant to this section, or in the course of analysis by the Commissioner or other person in the course of examination, audit and inspection, shall be given confidential treatment and are not subject to subpoena and may not be made public by the Commissioner or any other person, except to the extent provided in this section. Access may be granted to the National Association of Insurance Commissioners. The parties shall agree in writing prior to receiving the information to provide to it the same confidential

treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

3. The Commissioner may use this information in any proceedings instituted against the administrator.

F. The insurer or trust shall have the right of continuing access to books and records maintained by the administrator sufficient to permit the insurer or trust to fulfill all of its contractual obligations to insured persons, subject to any restriction in the written agreement between the insurer or trust and the administrator concerning the proprietary rights of the parties to said books and records.

G. The agreement required by the provisions of this section shall include provisions stating the underwriting standards or other standards pertaining to the business underwritten by the insurer or trust.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1509.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

All work papers, recorded information, documents and copies of materials associated with, produced, obtained by or disclosed to the Commissioner or any other person in the course of review or analysis pursuant to Sections 1801 through 1938 of Title 36 of the Oklahoma Statutes shall be given confidential treatment and may not be made public by the Commissioner or any other person, except to the extent

provided in Sections 1801 through 1938 of Title 36 of the Oklahoma Statutes, unless prior written consent of the company to which it pertains has been obtained.

SECTION 7. AMENDATORY Section 45, Chapter 197, O.S.L. 2003 (36 O.S. Supp. 2009, Section 6945), is amended to read as follows:

Section 6945. A. All Risk-Based Capital (RBC) reports, to the extent the information is not required to be provided in a publicly available annual statement schedule, and RBC plans, including the work papers produced, obtained by or disclosed to the Commissioner or any other person in the course of any examination or analysis and the results or report of any examination or analysis of a health maintenance organization performed pursuant to this statute and any corrective order issued by the Commissioner pursuant to examination or analysis, with respect to a domestic health maintenance organization or foreign health maintenance organization that are in the possession or control of the Insurance Commissioner shall, by law, be confidential and privileged, shall not be subject to the provisions of the Oklahoma Open Records Act or the Administrative Procedures Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action; provided, however, the Commissioner is authorized to use the documents, materials or other information in the furtherance of any

regulatory or legal action brought as a part of the Commissioner's official duties.

B. Access to the documentation provided for in subsection A of this section may be granted to the National Association of Insurance Commissioners. The parties shall agree in writing prior to receiving information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

C. Neither the Commissioner nor any person who received documents, materials or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to the provisions of subsection A of this section.

~~C.~~ D. In order to assist in the performance of the Commissioner's duties, the Commissioner:

1. May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to the provisions of subsection A of this section, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities; provided, that the recipient agrees to maintain the confidentiality

and privileged status of the document, material or other information;

2. May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

3. May enter into agreements governing the sharing and use of information consistent with this subsection.

~~D.~~ E. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in paragraph 3 of subsection ~~C~~ D of this section.

~~E.~~ F. Except as otherwise required under the provisions of this act, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over a radio or

television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any health maintenance organization, or of any component derived in the calculation, by any health maintenance organization, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited. Provided, however, that if any materially false statement with respect to the comparison regarding a health maintenance organization's total adjusted capital to its RBC levels, or any of them, or an inappropriate comparison of any other amount to the health maintenance organization's RBC levels is published in any written publication and the health maintenance organization is able to demonstrate to the Commissioner with substantial proof the falsity or inappropriateness of the statement, the health maintenance organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

~~F.~~ G. RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans shall be used by the Commissioner solely in monitoring the solvency of health maintenance organizations and the need for possible corrective action with respect to health maintenance organizations. Such instructions, reports and plans shall not be used by the Commissioner for ratemaking, considered or introduced as evidence in any rate proceeding, or used by the

Commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a health maintenance organization or any affiliate is authorized to write.

SECTION 8. This act shall become effective November 1, 2010.

Passed the House of Representatives the 3rd day of March, 2010.

_____
Presiding Officer of the House of Representatives

Passed the Senate the ____ day of _____, 2010.

_____
Presiding Officer of the Senate