

1 ENGROSSED SENATE
2 BILL NO. 2054

By: Brown of the Senate

3 and

4 Sullivan of the House

5
6
7 [insurance - modifying and repealing various
8 Sections of Titles 11, 36, 40 and 59, which relate
9 to the Insurance Department or the Insurance
10 Commissioner - codification -
11 effective date]

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

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

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

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

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

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

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

20 B. Any document or other information generated by the Insurance
21 Department or received by the Insurance Department from a
22 governmental agency or any other public body of any kind, including
23 an insurance guaranty fund or risk pool board, that has a protection
24 from disclosure under any statute or evidentiary privilege from

1 disclosure, while in the possession of the body that generated or
2 received the information, shall retain its confidential character
3 while in the possession of the Insurance Department. The Insurance
4 Department may require that any agency or public body providing a
5 document or other information, if it expects the information to be
6 treated confidentially by the Insurance Department, to also provide
7 simultaneously an express reference to the claimed protection from
8 disclosure.

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

13 SECTION 3. AMENDATORY Section 1, Chapter 432, O.S.L.
14 2009 (36 O.S. Supp. 2009, Section 307.3), is amended to read as
15 follows:

16 Section 307.3. A. Effective July 1, 2009, there is hereby
17 created in the State Treasury a revolving fund for the Insurance
18 Commissioner called the State Insurance Commissioner Revolving Fund.
19 The revolving fund shall be used to fund the operations of the
20 Office of the Insurance Commissioner.

21 1. Notwithstanding any other law to the contrary, the revolving
22 fund shall consist of and consolidate all funds that are or have
23 been paid or collected by the Insurance Commissioner pursuant to the
24

1 laws of this state and the rules of the Insurance Department except
2 that the revolving fund shall not include:

- 3 a. premium taxes,
- 4 b. monies transferred to the Attorney General's Insurance
5 Fraud Unit Revolving Fund pursuant to Section 362 of
6 this title, and
- 7 c. funds paid to and collected pursuant to the Oklahoma
8 Certified Real Estate Appraisers Act, Section Sections
9 858-700 et seq. through 858-732 of Title ~~36~~ 59 of the
10 Oklahoma Statutes.

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

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

20 C. ~~The~~ After the effective date of this act, the State Treasury
21 is authorized and directed to deduct from the funds paid ~~into~~ or
22 collected by the Insurance Commissioner Revolving Fund after the
23 ~~effective date of this section~~ a sum equal to seventy-six and one
24 half percent (76.5%) of ~~such~~ the payment and place the same to the

1 credit of the General Revenue Fund of the state. The State
2 Treasurer shall place to the credit of the State Insurance
3 Commissioner Revolving Fund the remainder of ~~said~~ the funds so paid
4 and collected ~~shall by the State Treasurer be placed to the credit~~
5 ~~of the State Insurance Commissioner Revolving Fund~~ by the Insurance
6 Commissioner.

7 SECTION 4. AMENDATORY Section 19, Chapter 176, O.S.L.
8 2009 (36 O.S. Supp. 2009, Section 311A.17), is amended to read as
9 follows:

10 Section 311A.17. A. Upon written application of any insurer,
11 the Insurance Commissioner may grant an exemption from compliance
12 with any and all provisions of the Oklahoma Annual Financial Report
13 Act if the Commissioner finds, upon review of the application, that
14 compliance with the Oklahoma Annual Financial Report Act would
15 constitute a financial or organizational hardship upon the insurer.
16 An exemption may be granted at any time and from time to time for a
17 specified period or periods. Within ten (10) days from a denial of
18 the written request of an insurer for an exemption from the Oklahoma
19 Annual Financial Report Act, the insurer may request in writing a
20 hearing on its application for an exemption. The hearing shall be
21 held in accordance with the Administrative Procedures Act and the
22 laws and rules of the Insurance Department.

23 B. Domestic insurers retaining a certified public accountant
24 who qualify as independent on the effective date of the Oklahoma

1 Annual Financial Report Act shall comply with the Oklahoma Annual
2 Financial Report Act for the year ending December 31, 2010, and each
3 year thereafter unless the Commissioner permits otherwise.

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

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

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

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

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

20 F. The requirements of Section ~~16~~ 311A.14 of this ~~act~~ title are
21 to be in effect January 1, 2010. An insurer or group of insurers
22 that is not required to have independent audit committee members or
23 only a majority of independent audit committee members, as opposed
24 to a supermajority, because the total written and assumed premium is

1 below the threshold and subsequently becomes subject to one of the
2 independence requirements due to changes in premium shall have one
3 (1) year following the year the threshold is exceeded, but not
4 earlier than January 1, 2010, to comply with the independence
5 requirements. An insurer acquired as a result of a business
6 combination shall have one (1) calendar year following the date of
7 acquisition or combination to comply with the independence
8 requirements.

9 G. The requirements of Section ~~18~~ 311A.16 of this ~~act~~ title are
10 effective beginning with the reporting period ending December 31,
11 2010, and each year thereafter. An insurer or group of insurers
12 that are not required to file a report because the total written
13 premium is below the threshold and subsequently becomes subject to
14 the reporting requirements shall have two (2) years following the
15 year the threshold is exceeded, but not earlier than December 31,
16 2010, to file a report. Likewise, an insurer acquired in a business
17 combination shall have two (2) calendar years following the date of
18 acquisition or combination to comply with the reporting
19 requirements.

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

22 Section 619. A. The Insurance Commissioner may after
23 opportunity for a hearing refuse to renew, or may revoke or suspend
24

1 an insurer's certificate of authority, in addition to other grounds
2 in this Code, if the insurer:

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

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

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

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

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

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

19 7. Is affiliated with and under the same general management or
20 interlocking directorate or ownership as another insurer which
21 transacts direct insurance in this state without having a
22 certificate of authority therefor, except as permitted to a surplus
23 line insurer ~~under Article 11~~ pursuant to Sections 1101 through 1120
24 of this title ~~(Unauthorized Insurers)~~.

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

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

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

14 Section 628. When by or pursuant to the laws of any other state
15 or foreign country any premium or income or other taxes, or any
16 fees, fines, penalties, licenses, deposit requirements or other
17 material obligations, prohibitions or restrictions are imposed upon
18 Oklahoma insurers doing business, or that might seek to do business
19 in such other state or country, or upon the agents of such insurers,
20 which in the aggregate are in excess of such taxes, fees, fines,
21 penalties, licenses, deposit requirements or other obligations,
22 prohibitions or restrictions directly imposed upon similar insurers
23 or agents of such other state or foreign country under the statutes
24 of this state, so long as such laws continue in force or are so

1 applied, the same obligations, prohibitions and restrictions of
2 whatever kind shall be imposed upon similar insurers or agents of
3 such other state or foreign country doing business in Oklahoma. All
4 insurance companies of other nations shall be held to the same
5 obligations and prohibitions that are imposed by the state where
6 they have elected to make their deposit and establish their
7 principal agency in the United States. Any tax, license or other
8 obligation imposed by any city, county or other political
9 subdivision of a state or foreign country on Oklahoma insurers or
10 their agents shall be deemed to be imposed by such state or foreign
11 country within the meaning of this section. The provisions of this
12 section shall not apply to ad valorem taxes on real or personal
13 property or to personal income taxes. ~~Monies collected pursuant to
14 this section shall be paid by the Insurance Commissioner to the
15 State Treasury to the credit of the General Revenue Fund of the
16 state.~~

17 SECTION 7. AMENDATORY Section 75, Chapter 264, O.S.L.
18 2006, as amended by Section 1, Chapter 177, O.S.L. 2009 (36 O.S.
19 Supp. 2009, Section 924.4), is amended to read as follows:

20 Section 924.4. A. Any person who is not required to be covered
21 under a workers' compensation insurance policy or other plan for the
22 payment of workers' compensation may execute an Affidavit of Exempt
23 Status ~~Under~~ under the Workers' Compensation Act. The affidavit
24 shall be a form prescribed by the Insurance Commissioner. The

1 affidavit shall be available on the ~~Insurance Department's~~ web site,
2 ~~or shall be mailed to any person upon request and payment by the~~
3 ~~requestor of a nonrefundable processing fee in an amount to be set~~
4 ~~by the Commissioner by rule not to exceed Two Dollars and fifty~~
5 ~~cents (\$2.50) of the Insurance Department.~~

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

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

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

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

22 3. The Insurance Commissioner shall immediately notify the
23 Workers' Compensation Fraud Unit in the Office of the Attorney
24 General of any violations or suspected violations of this section.

1 The Commissioner shall cooperate with the Fraud Unit in any
2 investigation involving affidavits executed pursuant to this
3 section.

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

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

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

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

15 2. Deny, cancel or fail to renew a policy of personal insurance
16 solely on the basis of credit information, without consideration of
17 any other applicable underwriting factor independent of credit
18 information and not expressly prohibited by paragraph 1 of this
19 section;

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

23 4. Take ~~an~~ adverse action against a consumer solely because ~~he~~
24 ~~or she~~ the consumer does not have a credit card account, without

1 consideration of any other applicable factor independent of credit
2 information;

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

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

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

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

15 6. Take an adverse action against a consumer based on credit
16 information, unless an insurer obtains and uses a credit report
17 issued or an insurance score calculated within ninety (90) days from
18 the date the policy is first written or renewal is issued;

19 7. Use credit information unless not later than every thirty-
20 six (36) months following the last time that the insurer obtained
21 current credit information for the insured, the insurer recalculates
22 the insurance score or obtains an updated credit report. Regardless
23 of the requirements of this subsection:
24

- 1 a. at annual renewal, upon the request of a consumer or
2 the ~~consumer's~~ agent of the consumer, the insurer
3 shall reunderwrite and rerate the policy based upon a
4 current credit report or insurance score. An insurer
5 need not recalculate the insurance score or obtain the
6 updated credit report of a consumer more frequently
7 than once in a twelve-month period,
- 8 b. the insurer shall have the discretion to obtain
9 current credit information upon any renewal before the
10 thirty-six (36) months, if consistent with its
11 underwriting guidelines, and
- 12 c. no insurer need obtain current credit information for
13 an insured, despite the requirements of paragraph 7 of
14 this section, if one of the following applies:
- 15 (1) the insurer is treating the consumer as otherwise
16 approved by the Commissioner,
- 17 (2) the insured is in the most favorably priced tier
18 of the insurer, within a group of affiliated
19 insurers. However, the insurer shall have the
20 discretion to order ~~such~~ a report, if consistent
21 with its underwriting guidelines,
- 22 (3) credit was not used for underwriting or rating
23 ~~such~~ the insured when the policy was initially
24 written. However, the insurer shall have the

1 discretion to use credit for underwriting or
2 rating ~~such~~ the insured upon renewal, if
3 consistent with its underwriting guidelines, or
4 (4) the insurer reevaluates the insured beginning no
5 later than thirty-six (36) months after inception
6 and thereafter based upon other underwriting or
7 rating factors, excluding credit information; and

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

- 11 a. credit inquiries not initiated by the consumer or
12 inquiries requested by the consumer for ~~his or her own~~
13 the credit information of the consumer,
- 14 b. inquiries relating to insurance coverage, if so
15 identified on a ~~consumer's~~ credit report of the
16 consumer,
- 17 c. collection accounts with a medical industry code, if
18 so identified on the ~~consumer's~~ credit report of the
19 consumer,
- 20 d. multiple lender inquiries, if coded by the consumer
21 reporting agency on the ~~consumer's~~ credit report of
22 the consumer as being from the home mortgage industry
23 and made within thirty (30) days of one another,
24 unless only one inquiry is considered, and

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

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

9 Section 997. Commercial Special Risks.

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

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

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

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

21 ~~4.~~ 3. Specifically designated special risks, including:

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

24 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.

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

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

12 ~~D.~~ E. The investigation and adjustment of any claim in this
13 state arising under an insurance contract issued by an unauthorized
14 insurer shall not be deemed to constitute the transacting of
15 insurance in this state.

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

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

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

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

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

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

21 C. Service of process in any ~~such~~ action or proceeding, in
22 addition to the manner provided herein, shall also be valid if
23 served upon any person within this state who, in this state on
24 behalf of ~~such~~ the insurer, is soliciting insurance, or making,

1 | issuing, or delivering any insurance policy, or collecting or
2 | receiving any premium, membership fee, assessment, or other
3 | consideration for insurance.

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

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

10 | F. An insurer which has been so served with process shall have
11 | the right to appear in and defend ~~such~~ the action and employ
12 | attorneys and other persons in this state to assist in its defense
13 | or settlement.

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

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

- 20 | 1. Ocean marine and foreign trade insurance,
21 | 2. Insurance on subjects located, resident, or to be performed
22 | wholly outside this state, or on vehicles or aircraft owned and
23 | principally garaged outside this state,
24 |

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

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

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

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

1 defend any ~~such~~ action shall be deemed prima facie evidence that its
2 failure to make payment was vexatious and without reasonable cause.

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

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

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

- 14 a. the insurer is financially stable, and
- 15 b. the insurer is controlled by persons possessing
16 competence, experience and integrity, and
- 17 c. the insurer, if a foreign insurer, posts a special
18 deposit in an amount to be determined by the
19 Commissioner, or
- 20 d. the insurer, if an alien insurer, is listed on the
21 National Association of Insurance Commissioners Non-
22 Admitted Insurers Quarterly Listing.

23
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1 The Commissioner may withdraw a certificate of approval or
2 refuse to renew a certificate upon finding that the insurer no
3 longer meets the criteria for approval set out herein;

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

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

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

11 Section 1107. A. After procuring any surplus line insurance,
12 the broker shall execute and file with the Insurance Commissioner
13 ~~his a report thereof in duplicate and~~ under oath, setting forth
14 facts from which it may be determined whether the requirements of
15 Section 1106 of this title have been met, and in addition thereto
16 the following:

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

20 2. Number of the policy issued;

21 3. Name and address of the insured;

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

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

1 6. Other information reasonably required by the Insurance
2 Commissioner.

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

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

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

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

16 Section 1108. A. If after a hearing thereon the Insurance
17 Commissioner finds that a particular insurance coverage or type,
18 class, or kind of coverage is not readily procurable from authorized
19 insurers, he may by order declare ~~such~~ the coverage or coverages to
20 be recognized surplus lines until the Insurance Commissioner's
21 further order. The broker's affidavit provided for in Section 1107
22 of this article shall not be required as to coverages while so
23 recognized. Before holding any ~~such~~ hearing the Commissioner shall
24 give notice to admitted insurers authorized to write such lines of

1 insurance, to rating organizations licensed to make rates for such
2 lines of insurance and to other interested persons in the manner
3 provided by Article 3 of this Code.

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

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

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

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

24

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

4 Section 1115. A. On or before the end of each month following
5 each calendar quarter, each surplus line broker shall remit to the
6 State Treasurer through the Insurance Commissioner a tax on the
7 premiums, exclusive of sums collected to cover federal and state
8 taxes and examination fees, on surplus line insurance subject to tax
9 transacted by the broker for the period covered by the report. ~~Such~~
10 The tax shall be at the rate of six percent (6%) of the gross
11 premiums less premiums returned on account of cancellation or
12 reduction of premium, and shall exclude gross premiums and returned
13 premiums upon business exempted from surplus line provisions
14 pursuant to Section 1119 of this title.

15 B. Except as provided in subsection C of this section, for the
16 purpose of determining the surplus line tax, the total premium
17 charged for surplus line insurance placed in a single transaction
18 with one underwriter or group of underwriters, whether in one or
19 more policies, shall be allocated to this state in such proportion
20 as the total premium on the insured properties or operations in this
21 state, computed on the exposure in this state on the basis of any
22 single standard rating method in use in all states or countries
23 where ~~such~~ the insurance applies, bears to the total premium so
24 computed in all ~~such~~ the states or countries. Policies sold to

1 federally recognized Indian tribes shall be reported as provided in
2 Section 1107 of this title; however, ~~such~~ these policies shall be
3 exempt from the surplus line tax to the extent that the Insurance
4 Commissioner can identify that coverage is for risks which are
5 wholly owned by a tribe and located within Indian Country, as
6 defined in Section 1151 of Title 18 of the United States Code.

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

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

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

17 D. Every person, association, or legal entity procuring or
18 accepting any insurance coverage from ~~an unauthorized~~ a surplus
19 lines insurer, upon, covering, or relating to a subject of insurance
20 resident or having a situs in the this state, or any ~~such~~ insurance
21 coverage which is to be performed in whole or part in this state,
22 except ~~such~~ coverages as are lawfully obtained through a licensed
23 surplus line broker in this state, shall report, within thirty (30)
24 days next succeeding the issuance of evidence of coverage, the

1 purchase of ~~such~~ the coverages of insurance to the Insurance
2 Commissioner, on forms prescribed by the Commissioner, and at the
3 same time shall remit to the Insurance Commissioner a tax in the
4 amount of six percent (6%) of the annual premium agreed to be paid,
5 or paid, for ~~such~~ the insurance. ~~Such~~ The insurance coverages,
6 providing for the payment of retrospective premiums, or coverages on
7 which the premiums are not determinable at the time of issuance,
8 shall be reported to the Insurance Commissioner, by the insured,
9 within thirty (30) days next succeeding the date ~~such~~ the coverages
10 are issued and the tax payable on ~~such~~ the coverages shall be
11 remitted, by the insured, to the Insurance Commissioner within
12 thirty (30) days next succeeding the date ~~such~~ the premiums can be
13 determined. The tax on renewal premiums shall be paid by the
14 insured in accordance with this section, in like manner as provided
15 for payment of the original premium tax, within thirty (30) days
16 next succeeding the date ~~such~~ the premiums can be determined.

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

20 Section 1116. A. Any surplus line broker who fails to remit
21 the surplus line tax provided for by Section 1115 of this title for
22 more than sixty (60) days after it is due shall be liable to a civil
23 penalty of not to exceed Twenty-five Dollars (\$25.00) for each
24 additional day of delinquency. The Insurance Commissioner shall

1 collect the tax by distraint and shall recover the penalty by an
2 action in the name of the State of Oklahoma. The Commissioner may
3 request the Attorney General to appear in the name of the state by
4 relation of the Commissioner.

5 B. If any person, association or legal entity procuring or
6 accepting any insurance coverage from ~~an unauthorized~~ a surplus
7 lines insurer, otherwise than through a licensed surplus line broker
8 in this state, fails to remit the surplus line tax provided for by
9 subsection D of Section 1115 of this title, ~~such~~ the person,
10 association or legal entity shall, in addition to ~~said~~ the tax, be
11 liable to a civil penalty in an amount equal to one percent (1%) of
12 the premiums paid or agreed to be paid for ~~such~~ the policy or
13 policies of insurance for each calendar month of delinquency or a
14 civil penalty in the amount of Twenty-five Dollars (\$25.00)
15 whichever shall be the greater. The Insurance Commissioner shall
16 collect the tax by distraint and shall recover the civil penalty in
17 an action in the name of the State of Oklahoma. The Commissioner
18 may request the Attorney General to appear in the name of the state
19 by relation of the Commissioner.

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

22 Section 1118. A. Every ~~unauthorized~~ surplus lines insurer
23 issuing or delivering a surplus line policy through a surplus line
24 broker in this state shall conclusively be deemed thereby to have

1 irrevocably appointed the Insurance Commissioner as its attorney for
2 acceptance of service of all legal process, other than a subpoena,
3 issued in this state in any action or proceeding under or arising
4 out of ~~such~~ the policy, and service of ~~such~~ process upon the
5 Insurance Commissioner shall be lawful personal service upon ~~such~~
6 the insurer.

7 B. Each surplus line policy shall contain a provision stating
8 the substance of subsection A of this section, and designating the
9 person to whom the Insurance Commissioner shall mail process as
10 provided in subsection C of this section.

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

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

22 Section 1120. Upon request of the Insurance Commissioner any
23 person in Oklahoma who is the insured under any policy issued by an
24 ~~unauthorized~~ a surplus lines insurer upon a subject of insurance

1 resident, located, or to be performed in Oklahoma at the time the
2 policy was issued, shall produce for examination all policies and
3 other documents evidencing and relating to the insurance, and shall
4 disclose the amount of the gross premiums paid or agreed to be paid
5 for the insurance, through whom the insurance was procured, and such
6 other information relative to the placing of ~~such~~ the insurance as
7 may reasonably be required.

8 SECTION 23. AMENDATORY Section 8, Chapter 125, O.S.L.
9 2007 (36 O.S. Supp. 2009, Section 1204.1), is amended to read as
10 follows:

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

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

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

1 particular complaint under investigation or to an inquiry or
2 examination by the Insurance Department.

3 B. Every agent, adjuster, administrator, insurance company
4 representative, or insurer, other than the State Insurance Fund and
5 its representatives, upon receipt of any inquiry from the
6 Commissioner ~~concerning a claim or a problem involving premium~~
7 ~~monies~~ shall, within ~~twenty (20)~~ thirty (30) days ~~after receipt of~~
8 ~~such~~ from the date of the inquiry, furnish the Commissioner with an
9 adequate response to the inquiry.

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

17 D. Any violation by an insurer of this section shall subject
18 the insurer to discipline including a civil penalty of not less than
19 One Hundred Dollars (\$100.00) nor more than Five Thousand Dollars
20 (\$5,000.00).

21 SECTION 25. AMENDATORY 36 O.S. 2001, Section 1452, as
22 last amended by Section 16, Chapter 125, O.S.L. 2007 (36 O.S. Supp.
23 2009, Section 1452), is amended to read as follows:

24

1 Section 1452. On or before June 1 of each year, all licensed
2 administrators shall file an annual report for the previous calendar
3 year ~~prepared by~~. The report shall have been reviewed by a
4 certified public accountant, who shall be independent of the
5 administrator, and which. The report shall be subscribed and sworn
6 to by the president and attested to by the secretary or other proper
7 officers substantiating that the information contained in the report
8 is true and factual concerning each of the plans they administer
9 which are governed pursuant to the provisions of the Third-party
10 Administrator Act. The report shall include the name and address of
11 each fund and a statement of fund equity, paid claims by the covered
12 unit, the accumulated year-to-date paid claims, and the year-to-date
13 reserve status. Failure of any third-party administrator to execute
14 and file ~~such~~ the annual reports as required by this section shall
15 constitute cause, after notice and opportunity for hearing, for
16 censure, suspension, or revocation of administrator licensure to
17 transact business in this state, or a civil penalty of not less than
18 One Hundred Dollars (\$100.00) or more than One Thousand Dollars
19 (\$1,000.00) for each occurrence, or both censure, suspension, or
20 revocation and civil penalty.

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

23 Section 1464. A. 1. To be licensed as a resident life or
24 accident and health insurance broker, an individual or legal entity

1 shall have been a licensed resident ~~or nonresident~~ insurance agent
2 or agency in this state continuously for at least two (2) years
3 immediately prior to application and such agent's license shall
4 remain in effect in order to maintain the broker's license. A
5 nonresident life or accident and health insurance broker applicant
6 may receive a license in this state if they are licensed and in good
7 standing in their home state, and if the home state of the applicant
8 awards nonresident licenses to residents of this state on the same
9 basis.

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

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

21 B. 1. Every applicant for a life or accident and health
22 insurance broker's license shall file with the Commissioner and,
23 upon approval of the application, maintain in force while licensed
24 and for at least two (2) years following termination of the license,

1 evidence satisfactory to the Commissioner of an errors and omissions
2 policy covering the individual applicant in an amount of not less
3 than One Hundred Thousand Dollars (\$100,000.00) annual aggregate for
4 all claims made during the policy period, or covering the applicant
5 under a blanket liability policy insuring other life or accident and
6 health insurance agents or brokers in an amount of not less than
7 Five Hundred Thousand Dollars (\$500,000.00) annual aggregate for all
8 claims made during the policy period.

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

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

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

22 2. The bond shall be continuous in form and in the amount of
23 Five Thousand Dollars (\$5,000.00) total aggregate liability, or more
24 if the Commissioner deems it necessary. The bond shall be

1 conditioned upon full accounting and due payments to the person or
2 company entitled thereto as an incident of life or accident and
3 health insurance transactions and funds brought into the life or
4 accident and health insurance broker's possession under his or her
5 license.

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

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

18 D. Life or accident and health insurance brokers shall be
19 subject to the same violations, fines, and penalties as stated in
20 Section 1428 of this title. Violations of the provisions of the
21 Oklahoma Life, Accident and Health Insurance Broker Act may result,
22 after notice and hearing, in censure, suspension, or revocation of
23 license or a civil penalty of not less than One Hundred Dollars
24

1 (\$100.00), nor more than One Thousand Dollars (\$1,000.00), or a
2 combination thereof for each occurrence.

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

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

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

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

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

17 3. "Genetic information" means, with respect to any
18 individual, information derived from the results of a genetic test.
19 ~~Genetic information shall not include family history, the results of~~
20 ~~a routine physical examination or test, the results of a chemical,~~
21 ~~blood or urine analysis, the results of a test to determine drug~~
22 ~~use, the results of a test for the presence of the human~~
23 ~~immunodeficiency virus, or the results of any other test commonly~~
24 ~~accepted in clinical practice at the time it is ordered by the~~

1 ~~insurer~~ about the genetic tests of an individual, the genetic tests
2 of family members of an individual, and the manifestation of a
3 disease or disorder in family members of the individual. Genetic
4 information includes, but is not limited to, with respect to any
5 individual, any request for, or receipt of, genetic services, or
6 participation in clinical research which includes genetic services,
7 by an individual or any family member of the individual. Any
8 reference to genetic information concerning an individual or family
9 member of an individual who is a pregnant woman, includes genetic
10 information of any fetus carried by a pregnant woman, or with
11 respect to an individual or family member utilizing reproductive
12 technology, includes genetic information of any embryo legally held
13 by an individual or family member. Genetic information shall not
14 include information about the sex or age of any individual;

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

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

- 1 ~~a. a routine physical examination or a routine test~~
2 ~~performed as a part of a physical examination,~~
3 ~~b. a chemical, blood, or urine analysis,~~
4 ~~c. a test to determine drug use,~~
5 ~~d. a test for the presence of the human immunodeficiency~~
6 ~~virus, or~~
7 ~~e. any other test commonly accepted in clinical practice~~
8 ~~at the time it is ordered by the insurer~~ mean an
9 analysis of proteins or metabolites that does not
10 detect genotypes, mutations, or chromosomal changes or
11 an analysis of proteins or metabolites that is
12 directly related to a manifested disease, disorder, or
13 pathological condition that could reasonably be
14 detected by a health care professional with
15 appropriate training and expertise in the field of
16 medicine involved;

17 ~~5.~~ 6. "Insurer" means any individual, corporation, association,
18 partnership, insurance support organization, fraternal benefit
19 society, insurance ~~agent~~ producer, third-party ~~administration~~
20 administrator, self-insurer, or any other legal entity engaged in
21 the business of insurance which is licensed to do business in or
22 incorporated or domesticated or domiciled in or under the statutes
23 of this state, or actually engaged in business in this state,
24 regardless of where the contract of insurance is written or plan is

1 administered or where the corporation is incorporated, that issues
2 accident and health policies or plans or that administers any other
3 type of health insurance policy containing medical provisions
4 including, but not limited to, any nonprofit hospital service and
5 indemnity and medical service and indemnity corporation, health
6 maintenance organizations, preferred provider organizations, prepaid
7 health plans and the State and Education Employees Group Health
8 Insurance Plan. Insurer shall not include insurers issuing life,
9 disability income, or long-term care insurance;

10 ~~6.~~ 7. "Policy" or "policy form" means any policy, contract,
11 plan or agreement of accident and health insurance, or subscriber
12 certificates of medical care corporations, health care corporations,
13 hospital service associations, or health care maintenance
14 organizations, delivered or issued for delivery in this state by any
15 insurer; any certificate, contract or policy issued by a fraternal
16 benefit society; any certificate issued pursuant to a group
17 insurance policy delivered or issued for delivery in this state; and
18 any evidence of coverage issued by a health maintenance
19 organization. Policy or policy form shall not include life,
20 disability income, and long-term care insurance policies; and

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

22 8. "Underwriting purposes" means:

23

24

- 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 pre-existing 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

1 exclusion of benefits under the policy based on a pre-existing
2 condition, on the basis of the genetic information with respect to
3 any individual; and

4 2. ~~Condition the provision of the policy upon a requirement~~
5 ~~that an individual take a genetic test~~ Discriminate in the pricing
6 of the policy or certificate, including but not limited to the
7 adjustment of premium rates, of an individual on the basis of the
8 genetic information with respect to any individual.

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

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

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

1 E. 1. ~~Any violation of subsections C and D of this section by~~
2 ~~an insurer shall be deemed an unfair practice pursuant to Section~~
3 ~~1201 et seq. of Title 36 of the Oklahoma Statutes.~~

4 2. ~~In addition, any individual who is damaged by an insurer's~~
5 ~~violation of this section may recover in a court of competent~~
6 ~~jurisdiction equitable relief, which may include a retroactive~~
7 ~~order, directing the insurer to provide insurance coverage to the~~
8 ~~damaged individual under the same terms and conditions as would have~~
9 ~~applied had the violation not occurred~~ An insurer shall not request
10 or require an individual or a family member of an individual to
11 undergo a genetic test.

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

24

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

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

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

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

15 a. compliance with the request is voluntary, and

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

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

23 4. The insurer notifies the Secretary of Health and Human
24 Services in writing that the insurer is conducting activities

1 pursuant to the exception provided for under this subsection,
2 including but not limited to a description of the activities
3 conducted; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 D. 1. The Commissioner may issue a reinsurance intermediary
2 license to any person, firm, association or corporation who has
3 complied with the requirements of the Reinsurance Intermediary Act.
4 Any ~~such~~ the license issued to a firm or association shall authorize
5 all the members of the firm or association and any designated
6 employees to act as reinsurance intermediaries pursuant to the
7 license, and all such persons shall be named in the application and
8 any supplements thereto. Any ~~such~~ the license issued to a
9 corporation shall authorize all of the officers, and any designated
10 employees and directors thereof to act as reinsurance intermediaries
11 on behalf of the corporation, and all such persons shall be named in
12 the application and any supplements thereto.

13 2. If the applicant for a reinsurance intermediary license is a
14 nonresident, the applicant, as a condition precedent to receiving or
15 holding a license, shall designate the Commissioner as agent for
16 service of process in the manner, and with the same legal effect,
17 provided for by the Reinsurance Intermediary Act for designation of
18 service of process upon ~~unauthorized~~ surplus lines insurers; and
19 also shall furnish the Commissioner with the name and address of a
20 resident of this state upon whom notices or orders of the
21 Commissioner or process affecting ~~such~~ the nonresident reinsurance
22 intermediary may be served. ~~Such~~ The licensee shall promptly notify
23 the Commissioner in writing of every change in its designated agent
24

1 for service of process, and such change shall not become effective
2 until acknowledged by the Commissioner.

3 E. The Commissioner may refuse to issue a reinsurance
4 intermediary license if, in the judgment of the Commissioner, the
5 applicant, any one named on the application, or any member,
6 principal, officer or director of the applicant, or that any
7 controlling person of such applicant, is not trustworthy to act as a
8 reinsurance intermediary, or that any of the foregoing has given
9 cause for revocation or suspension of such license, or has failed to
10 comply with any prerequisite for the issuance of such license. Upon
11 written request therefor, the Commissioner shall furnish a summary
12 of the basis for refusal to issue a license, which document shall be
13 privileged and not subject to the Oklahoma Open Records Act.

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

17 G. Licenses issued by the Commissioner pursuant to this section
18 shall be issued for a period of twenty-four (24) months. The
19 license shall not be issued unless the application for the license
20 is accompanied by a license fee of One Hundred Dollars (\$100.00).
21 The license shall not be renewed unless the renewal application for
22 the license is accompanied by a renewal fee of One Hundred Dollars
23 (\$100.00).

24

1 SECTION 29. AMENDATORY 36 O.S. 2001, Section 6060, as
2 last amended by Section 23, Chapter 184, O.S.L. 2008 (36 O.S. Supp.
3 2009, Section 6060), is amended to read as follows:

4 Section 6060. A. All ~~individual and group health insurance~~
5 ~~policies providing coverage on an expense incurred basis, and all~~
6 ~~individual and group service or indemnity type contracts issued by a~~
7 ~~nonprofit corporation, including the Oklahoma State and Education~~
8 ~~Employees Group Insurance Board, which provide coverage for a female~~
9 ~~thirty five (35) years old or older in this state, except for~~
10 ~~policies that provide coverage for specified disease or other~~
11 ~~limited benefit coverage, health benefit plans shall include the~~
12 coverage specified by this section for a mammography screening ~~in a~~
13 ~~reimbursement amount not to exceed One Hundred Fifteen Dollars~~
14 ~~(\$115.00)~~ for the presence of occult breast cancer. Such coverage
15 shall not:

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

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

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

24

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

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

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

9 Section 6060.2. A. 1. ~~For policies, contracts or agreements~~
10 ~~issued or renewed on and after November 1, 1996, any individual or~~
11 ~~group health insurance policy, contract or agreement providing~~
12 ~~coverage on an expense incurred basis; any policy, contract or~~
13 ~~agreement issued for individual or group coverage by a not for~~
14 ~~profit hospital service and indemnity and medical service and~~
15 ~~indemnity corporation; contracts issued by health benefit plans~~
16 ~~including, but not limited to, health maintenance organizations,~~
17 ~~preferred provider organizations, health services corporations,~~
18 ~~physician sponsored networks, or physician hospital organizations,~~
19 ~~medical coverage provided by self insureds that includes coverage~~
20 ~~for physician services in a physician's office, including coverage~~
21 ~~through private third party payors; coverage provided through the~~
22 ~~State and Education Employees Group Insurance Board; and every~~
23 ~~policy, contract, or agreement which provides medical, major medical~~
24 ~~or similar comprehensive type coverage, group or blanket accident~~

1 ~~and health coverage, or medical expense, surgical, medical~~
2 ~~equipment, medical supplies, or drug prescription benefits~~ Every
3 health benefit plan issued or renewed on or after November 1, 1996,
4 shall, subject to the terms of the policy contract or agreement,
5 include coverage for the following equipment, supplies and related
6 services for the treatment of Type I, Type II, and gestational
7 diabetes, when medically necessary and when recommended or
8 prescribed by a physician or other licensed health care provider
9 legally authorized to prescribe under the laws of this state:

- 10 a. blood glucose monitors,
- 11 b. blood glucose monitors to the legally blind,
- 12 c. test strips for glucose monitors,
- 13 d. visual reading and urine testing strips,
- 14 e. insulin,
- 15 f. injection aids,
- 16 g. cartridges for the legally blind,
- 17 h. syringes,
- 18 i. insulin pumps and appurtenances thereto,
- 19 j. insulin infusion devices,
- 20 k. oral agents for controlling blood sugar, and
- 21 l. podiatric appliances for prevention of complications
22 associated with diabetes.

23 2. The State Board of Health shall develop and annually update,
24 by rule, a list of additional diabetes equipment, related supplies

1 and health care provider services that are medically necessary for
2 the treatment of diabetes, for which coverage shall also be
3 included, subject to the terms of the policy, contract, or
4 agreement, if ~~such~~ the equipment and supplies have been approved by
5 the federal Food and Drug Administration (FDA). ~~Such additional~~
6 Additional FDA-approved diabetes equipment and related supplies, and
7 health care provider services shall be determined in consultation
8 with a national diabetes association affiliated with this state, and
9 at least three (3) medical directors of health benefit plans, to be
10 selected by the State Department of Health.

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

- 13 a. podiatric health care provider services as are deemed
14 medically necessary to prevent complications from
15 diabetes, and
- 16 b. diabetes self-management training. As used in this
17 subparagraph, "diabetes self-management training"
18 means instruction in an inpatient or outpatient
19 setting which enables diabetic patients to understand
20 the diabetic management process and daily management
21 of diabetic therapy as a method of avoiding frequent
22 hospitalizations and complications. Diabetes self-
23 management training shall comply with standards
24 developed by the State Board of Health in consultation

1 with a national diabetes association affiliated with
2 this state and at least three (3) medical directors of
3 health benefit plans selected by the State Department
4 of Health. ~~Such coverage~~ Coverage for diabetes self-
5 management training, including medical nutrition
6 therapy relating to diet, caloric intake, and diabetes
7 management, but excluding programs the only purpose of
8 which are weight reduction, shall be limited to the
9 following:

- 10 (1) visits medically necessary upon the diagnosis of
11 diabetes,
- 12 (2) a physician diagnosis which represents a
13 significant change in the ~~patient's~~ symptoms or
14 condition of the patient making medically
15 necessary changes in the ~~patient's~~ self-
16 management of the patient, and
- 17 (3) visits when reeducation or refresher training is
18 medically necessary;

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

1 4. Diabetes self-management training shall be supervised by a
2 licensed physician or other licensed health care provider legally
3 authorized to prescribe under the laws of this state. Diabetes
4 self-management training may be provided by the physician or other
5 appropriately registered, certified, or licensed health care
6 professional as part of an office visit for diabetes diagnosis or
7 treatment. Training provided by appropriately registered,
8 certified, or licensed health care professionals may be provided in
9 group settings where practicable.

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

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

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

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

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

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

6 ~~b. a health benefit plan which covers persons employed in~~
7 ~~more than one state where the benefit structure was~~
8 ~~the subject of collective bargaining affecting persons~~
9 ~~employed in more than one state, and~~

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

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

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

19 Section 6060.3. A. Every health benefit plan ~~contract~~ issued,
20 amended, renewed or delivered in this state on or after July 1,
21 1996, that provides maternity benefits shall provide for coverage
22 of:

23 1. A minimum of forty-eight (48) hours of inpatient care at a
24 hospital, or a birthing center licensed as a hospital, following a

1 vaginal delivery, for the mother and newborn infant after
2 childbirth, except as otherwise provided in this section;

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

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

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

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

18 (a) the recommended childhood immunization
19 schedule,

20 (b) the importance of childhood immunizations,
21 and

22 (c) resources for obtaining childhood
23 immunizations,
24

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

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

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

7 B. Inpatient care shall include, at a minimum:

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

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

10 a. the recommended childhood immunization schedule,

11 b. the importance of childhood immunizations, and

12 c. resources for obtaining childhood immunizations;

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

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

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

19 1. In the sole medical discretion or judgment of the attending
20 physician licensed by the Oklahoma State Board of Medical Licensure
21 and Supervision or the State Board of Osteopathic Examiners or the
22 certified nurse midwife licensed by the Oklahoma Board of Nursing
23 providing care to the mother and to the newborn infant, it is
24 determined prior to discharge that an earlier discharge of the

1 mother and newborn infant is appropriate and meets medical criteria
2 contained in the most current treatment standards of the American
3 Academy of Pediatrics and the American College of Obstetricians and
4 Gynecologists that determine the appropriate length of stay based
5 upon:

- 6 a. evaluation of the antepartum, intrapartum and
7 postpartum course of the mother and newborn infant,
- 8 b. the gestational age, birth weight and clinical
9 condition of the newborn infant,
- 10 c. the demonstrated ability of the mother to care for the
11 newborn infant postdischarge, and
- 12 d. the availability of postdischarge follow-up to verify
13 the condition of the newborn infant in the first
14 forty-eight (48) hours after delivery.

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

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

- 20 a. physical assessment of the mother and the newborn
21 infant,
- 22 b. parent education, to include, but not be limited to:
 - 23 (1) the recommended childhood immunization schedule,
 - 24 (2) the importance of childhood immunizations, and

- 1 (3) resources for obtaining childhood immunizations,
2 c. training or assistance with breast or bottle feeding,
3 and
4 d. the performance of any medically necessary and
5 clinical tests.

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

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

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

19 F. No health benefit plan subject to the provisions of this
20 section shall terminate the services of, reduce capitation payments
21 for, refuse payment for services, or otherwise discipline a licensed
22 health care provider who orders care consistent with the provisions
23 of this section.
24

1 G. As used in this section, "health benefit plan" means
2 ~~individual or group hospital or medical insurance coverage, a not-~~
3 ~~for-profit hospital or medical service or indemnity plan, a prepaid~~
4 ~~health plan, a health maintenance organization plan, a preferred~~
5 ~~provider organization plan, the State and Education Employees Group~~
6 ~~Health Insurance Plan, and coverage provided by a Multiple Employer~~
7 ~~Welfare Arrangement (MEWA) or employee self-insured plan except as~~
8 ~~exempt under federal ERISA provisions~~ any plan or arrangement as
9 defined in subsection C of Section 6060.4 of this title.

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

12 SECTION 32. AMENDATORY Section 1, Chapter 397, O.S.L.
13 2004 (36 O.S. Supp. 2009, Section 6060.3a), is amended to read as
14 follows:

15 Section 6060.3a. A. Any health benefit plan, including the
16 State and Education Employees Group Health Insurance plan, that is
17 offered, issued or renewed in this state on or after January 1,
18 2005, that provides medical and surgical benefits shall provide
19 coverage for routine annual obstetrical/gynecological examinations.

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

23
24

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

4 D. As used in this section, "health benefit plan" means ~~group~~
5 ~~hospital or medical insurance coverage, a not-for-profit hospital or~~
6 ~~medical service or indemnity plan, a prepaid health plan, a health~~
7 ~~maintenance organization plan, a preferred provider organization~~
8 ~~plan, the State and Education Employees Group Health Insurance plan,~~
9 ~~and coverage provided by a Multiple Employer Welfare Arrangement~~
10 ~~(MEWA) or employee self-insured plan except as exempt under federal~~
11 ~~ERISA provisions. The term shall not include short-term, accident,~~
12 ~~fixed indemnity or specified disease policies, disability income~~
13 ~~contracts, limited benefit or credit disability insurance, workers'~~
14 ~~compensation insurance coverage, automobile medical payment~~
15 ~~insurance, or insurance under which benefits are payable with or~~
16 ~~without regard to fault and which is required by law to be contained~~
17 ~~in any liability insurance policy or equivalent self-insurance any~~
18 ~~plan or arrangement as defined in subsection C of Section 6060.4 of~~
19 ~~this title, except that the term "health benefit plan" does not~~
20 ~~include policies or certificates issued to individuals or groups~~
21 ~~with fewer than fifty (50) employees.~~

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

1 SECTION 33. AMENDATORY 36 O.S. 2001, Section 6060.4, as
2 last amended by Section 65, Chapter 264, O.S.L. 2006 (36 O.S. Supp.
3 2009, Section 6060.4), is amended to read as follows:

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

9 1. Immunization against:

- 10 a. diphtheria,
- 11 b. hepatitis B,
- 12 c. measles,
- 13 d. mumps,
- 14 e. pertussis,
- 15 f. polio,
- 16 g. rubella,
- 17 h. tetanus,
- 18 i. varicella,
- 19 j. haemophilus influenzae type B, and
- 20 k. hepatitis A; and

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

23

24

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

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

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

9 b. is offered by any insurance company, group hospital
10 service corporation, the State and Education Employees
11 Group Insurance Board, or health maintenance
12 organization that delivers or issues for delivery an
13 individual, group, blanket, or franchise insurance
14 policy or insurance agreement, a group hospital
15 service contract, or an evidence of coverage, or, to
16 the extent permitted by the Employee Retirement Income
17 Security Act of 1974, 29 U.S.C., Section 1001 et seq.,
18 by a multiple employer welfare arrangement as defined
19 in Section 3 of the Employee Retirement Income
20 Security Act of 1974, or any other analogous benefit
21 arrangement, whether the payment is fixed or by
22 indemnity.

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

24 a. a plan that provides coverage:

- 1 (1) only for a specified disease or diseases or under
2 an individual limited benefit policy,
3 (2) only for accidental death or dismemberment,
4 (3) for ~~wages or payments in lieu of wages for a~~
5 ~~period during which an employee is absent from~~
6 ~~work because of sickness or injury~~ dental or
7 vision care, or
8 (4) a hospital confinement indemnity policy,
9 (5) disability income insurance or a combination of
10 accident-only and disability income insurance, or
11 (6) as a supplement to liability insurance,

12 b. a Medicare supplemental policy as defined by Section
13 1882(g)(1) of the Social Security Act (42 U.S.C.,
14 Section 1395ss),

15 c. worker's compensation insurance coverage,

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

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

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

1 SECTION 34. AMENDATORY Section 1, Chapter 351, O.S.L.
2 2008 (36 O.S. Supp. 2009, Section 6060.4a), is amended to read as
3 follows:

4 Section 6060.4a. A. No health benefit plan, including, but not
5 limited to, the State and Education Employees Group Health Insurance
6 Plan, that is offered, issued or renewed in the state on or after
7 January 1, 2009, shall exclude otherwise allowable claims which
8 occur in conjunction with the arrest or pretrial detention of the
9 policyholder prior to adjudication of guilt and sentencing to
10 incarceration of ~~such~~ the policyholder. The reimbursement rate for
11 out-of-network claims for these services shall be set at the current
12 Medicare rate.

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

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

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

21 B. Any health benefit plan that is offered, issued or renewed
22 in this state on or after January 1, 1998, that provides medical and
23 surgical benefits with respect to the treatment of breast cancer and
24 other breast conditions shall ensure that coverage is provided for

1 not less than forty-eight (48) hours of inpatient care following a
2 mastectomy and not less than twenty-four (24) hours of inpatient
3 care following a lymph node dissection for the treatment of breast
4 cancer.

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

9 D. Any plan subject to subsection B of this section shall also
10 provide coverage for reconstructive breast surgery performed as a
11 result of a partial or total mastectomy. Because breasts are a
12 paired organ, any such reconstructive breast surgery shall include
13 coverage for all stages of reconstructive breast surgery performed
14 on a nondiseased breast to establish symmetry with a diseased breast
15 when reconstructive surgery on the diseased breast is performed,
16 provided that the reconstructive surgery and any adjustments made to
17 the nondiseased breast must occur within twenty-four (24) months of
18 reconstruction of the diseased breast.

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

24

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

- 6 1. In the next mailing made by the plan to the employee;
- 7 2. As part of any yearly informational packet sent to the
8 enrollee; or
- 9 3. Not later than December 1, 1997;

10 whichever is earlier.

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

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

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

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

1 1. Severely disabled; or

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

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

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

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

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

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

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

11 2. Such coverage:

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

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

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

23 C. ~~This requirement shall not apply to agreements, contracts or~~
24 ~~policies that provide coverage for a specified disease or other~~

1 ~~limited benefit coverage, or groups with fifty or fewer employees~~ As
2 used in this section, "health benefit plan" means any plan or
3 arrangement as defined in subsection C of Section 6060.4 of this
4 title.

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

8 Section 6060.8. A. Any health benefit plan that is offered,
9 issued or renewed in this state on or after January 1, 2000, that
10 provides coverage to men forty (40) years of age or older in this
11 state shall offer coverage for annual screening for the early
12 detection of prostate cancer in men over the age of fifty (50) years
13 and in men over the age of forty (40) years who are in high-risk
14 categories. The coverage shall not be subject to policy
15 deductibles. The coverage shall not exceed the actual cost of the
16 prostate cancer screening up to a maximum of Sixty-five Dollars
17 (\$65.00) per screening.

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

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

23 1. The screening shall be performed by a qualified medical
24 professional including, but not limited to, a an urologist,

1 internist, general practitioner, doctor of osteopathy, nurse
2 practitioner, or physician assistant;

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

5 a. a prostate-specific antigen blood test, and

6 b. a digital rectal examination;

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

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

12 D. As used in this section, "health benefit plan" means ~~group~~
13 ~~hospital or medical insurance coverage, a not-for-profit hospital or~~
14 ~~medical service or indemnity plan, a prepaid health plan, a health~~
15 ~~maintenance organization plan, a preferred provider organization~~
16 ~~plan, the State and Education Employees Group Health Insurance Plan,~~
17 ~~and coverage provided by a Multiple Employer Welfare Arrangement~~
18 ~~(MEWA) or employee self insured plan except as exempt under federal~~
19 ~~ERISA provisions. The term shall not include short term, accident,~~
20 ~~fixed indemnity, or specified disease policies, disability income~~
21 ~~contracts, limited benefit or credit disability insurance, workers'~~
22 ~~compensation insurance coverage, automobile medical payment~~
23 ~~insurance, or insurance under which benefits are payable with or~~
24 ~~without regard to fault and which is required by law to be contained~~

1 ~~in any liability insurance policy or equivalent self-insurance~~ any
2 plan or arrangement as defined in subsection C of Section 6060.4 of
3 this title.

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

6 Section 6060.8a. A. Any health benefit plan, including the
7 State and Education Employees Group Health Insurance Plan, that is
8 offered, issued or renewed in this state on or after January 1,
9 2002, which provides medical and surgical benefits, shall offer
10 coverage for colorectal cancer examinations and laboratory tests for
11 cancer for any nonsymptomatic covered individual, in accordance with
12 standard, accepted published medical practice guidelines for
13 colorectal cancer screening, who is:

- 14 1. At least fifty (50) years of age; or
- 15 2. Less than fifty (50) years of age and at high risk for
16 colorectal cancer according to the standard, accepted published
17 medical practice guidelines.

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

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

24

1 D. As used in this section, "health benefit plan" means any
2 plan or arrangement as defined in subsection ~~D C~~ of Section ~~6060.8~~
3 6060.4 of ~~Title 36 of the Oklahoma Statutes~~ this title; provided,
4 however, the provisions of this section shall not apply to policies
5 or certificates issued to individuals or to groups with fifty (50)
6 or fewer employees, or to plans offered under the state Medicaid
7 program.

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

10 Section 6060.9. A. Any health benefit plan, including the
11 State and Education Employees Group Health Insurance Plan, that is
12 offered, issued, or renewed in this state on or after January 1,
13 2001, that provides medical and surgical benefits with respect to
14 the treatment of cancer and other conditions treated by chemotherapy
15 or radiation therapy shall provide coverage for wigs or other scalp
16 prostheses necessary for the comfort and dignity of the covered
17 person.

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

22 C. A health benefit plan shall provide notice to each insured
23 or enrollee under ~~such~~ the plan regarding the coverage required by
24 this section in the ~~plan's~~ evidence of coverage of the plan and

1 shall provide additional written notice of the coverage to the
2 insured or enrollee as follows:

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

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

7 3. Not later than December 1, 2000;
8 whichever is earlier.

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

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

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

19 Section 6060.10. As used in this act:

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

24 2. a. "Health benefit plan" means+

1 ~~(1) group hospital or medical insurance coverages,~~
2 ~~(2) not for profit hospital or medical service or~~
3 ~~indemnity plans,~~
4 ~~(3) prepaid health plans,~~
5 ~~(4) health maintenance organizations,~~
6 ~~(5) preferred provider plans,~~
7 ~~(6) the State and Education Employees Group Insurance~~
8 ~~Plan,~~
9 ~~(7) Multiple Employer Welfare Arrangements (MEWA), or~~
10 ~~(8) employer self insured plans that are not exempt~~
11 ~~pursuant to the federal Employee Retirement~~
12 ~~Income Security Act (ERISA) provisions any plan~~
13 ~~or arrangement as defined in subsection C of~~
14 ~~Section 6060.4 of this title, except as provided~~
15 ~~in subparagraph b of this paragraph.~~

16 b. The term "health benefit plan" shall not include
17 individual plans; ~~plans that only provide coverage for~~
18 ~~a specified disease, accidental death, or~~
19 ~~dismemberment for wages or payments in lieu of wages~~
20 ~~for a period during which an employee is absent from~~
21 ~~work because of sickness or injury or as a supplement~~
22 ~~to liability insurance; Medicare supplemental policies~~
23 ~~as defined in Section 1882(g)(1) of the federal Social~~
24 ~~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.

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

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

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

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

23 1.—Coverage
24

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

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

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

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

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

21 3. "Base premium rate" means, for each class of business as to
22 a rating period, the lowest premium rate charged or which could have
23 been charged under a rating system for that class of business, by
24 the small employer carrier to small employers with similar case

1 characteristics for health benefit plans with the same or similar
2 coverage;

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

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

7 6. "Carrier" means any entity which provides health insurance
8 in this state. For the purposes of the Small Employer Health
9 Insurance Reform Act, carrier includes a licensed insurance company,
10 not-for-profit hospital service or medical indemnity corporation, a
11 fraternal benefit society, a health maintenance organization, a
12 multiple employer welfare arrangement or any other entity providing
13 a plan of health insurance or health benefits subject to state
14 insurance regulation;

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

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

4 9. "Commissioner" means the Insurance Commissioner;

5 10. "Control" ~~(including the terms, "controlling", "controlled~~
6 ~~by" and or "under common control with")~~ means the possession, direct
7 or indirect, of the power to direct or cause the direction of the
8 management and policies of a person, whether through the ownership
9 of voting securities, by contract or otherwise, unless the power is
10 the result of an official position with or corporate office held by
11 the person. Control shall be presumed to exist if any person,
12 directly or indirectly, owns, controls, holds with the power to
13 vote, or holds proxies representing ten percent (10%) or more of the
14 voting securities of any other person. This presumption may be
15 rebutted by a showing that control does not exist in fact in the
16 manner provided in Section 1654 of this title. The Commissioner may
17 determine, after furnishing all persons in interest notice and
18 opportunity to be heard and making specific findings of fact to
19 support ~~such~~ the determination, that control exists in fact,
20 notwithstanding the absence of a presumption to that effect;

21 11. "Department" means the Insurance Department;

22 12. "Dependent" means a spouse, an unmarried child under the
23 age of eighteen (18), an unmarried child who is a full-time student
24 under the age of twenty-three (23) and who is financially dependent

1 upon the parent, and an unmarried child of any age who is medically
2 certified as disabled and dependent upon the parent;

3 13. "Eligible employee" means an employee who works on a full-
4 time basis or, at the option of the employer, an employee who works
5 on a part-time basis with a normal work week of twenty-four (24) or
6 more hours. The term includes a sole proprietor, a partner of a
7 partnership, and associates of a limited liability company, if the
8 sole proprietor, partner or associate is included as an employee
9 under a health benefit plan of a small employer, but does not
10 include an employee who works on a temporary or substitute basis;

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

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

21 b. Health benefit plan does not include accident-only,
22 credit, dental, vision, Medicare supplement, long-term
23 care, or disability income insurance, coverage issued
24 as a supplement to liability insurance, worker's

1 compensation or similar insurance, ~~any plan certified~~
2 ~~by the Oklahoma Basic Health Benefits Board,~~ or
3 automobile medical payment insurance.

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

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

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

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

22 (b) a summary description of each policy or
23 certificate described in this subparagraph,
24 including the average annual premium rates

1 ~~for~~ range of premium rates in cases where
2 premiums vary by age, gender or other
3 factors~~;~~ charged for such policies and
4 certificates in this state, and

5 (3) in the case of a policy or certificate that is
6 described in this subparagraph and that is
7 offered for the first time in this state on or
8 after the effective date of this act, the carrier
9 files with the Commissioner the information and
10 statement required in division (2) of this
11 subparagraph at least thirty (30) days prior to
12 the date ~~such~~ a policy or certificate is issued
13 or delivered in this state;

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

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

1 a. the individual meets each of the following:

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

5 (2) the individual lost coverage under qualifying
6 previous coverage as a result of termination of
7 employment or eligibility, the involuntary
8 termination of the qualifying previous coverage,
9 death of a spouse or divorce, and

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

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

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

22 18. "New business premium rate" means, for each class of
23 business as to a rating period, the lowest premium rate charged or
24 offered, or which could have been charged or offered, by the small

1 employer carrier to small employers with similar case
2 characteristics for newly issued health benefit plans with the same
3 or similar coverage;

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

6 ~~20. "Premium" means all monies paid by a small employer and~~
7 ~~eligible employees as a condition of receiving coverage from a small~~
8 ~~employer carrier, including any fees or other contributions~~
9 ~~associated with the health benefit plan;~~

10 ~~21. 20.~~ "Program" means the Oklahoma Small Employer Health
11 Reinsurance Program created pursuant to Section 6522 of this title;

12 ~~22. 21.~~ "Qualifying previous coverage" and "qualifying existing
13 coverage" mean benefits or coverage provided under:

14 a. Medicare or Medicaid,

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

19 c. an individual health insurance policy, including
20 coverage issued by a health maintenance organization,
21 fraternal benefit society and those entities set forth
22 in ~~Section 2501 et seq. of Title 63 of the Oklahoma~~
23 ~~Statutes~~ Sections 6901 through 6936 of this title,
24 that provides benefits similar to or exceeding the

1 benefits provided under the basic health benefit plan,
2 provided that ~~such~~ the policy has been in effect for a
3 period of at least one (1) year;

4 ~~23.~~ 22. "Rating period" means the calendar period for which
5 premium rates established by a small employer carrier are assumed to
6 be in effect;

7 ~~24.~~ 23. "Reinsuring carrier" means a small employer carrier
8 participating in the reinsurance program pursuant to Section 6522 of
9 this title;

10 ~~25.~~ 24. "Restricted network provision" means any provision of a
11 health benefit plan that conditions the payment of benefits, in
12 whole or in part, on the use of health care providers that have
13 entered into a contractual arrangement with the carrier pursuant to
14 ~~Section 2501 et seq. of Title 63 of the Oklahoma Statutes~~ Sections
15 6901 through 6963 of this title to provide health care services to
16 covered individuals;

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

20 ~~27.~~ 25. "Small employer" means any person, firm, corporation,
21 partnership, limited liability company or association that is
22 actively engaged in business that, on at least fifty percent (50%)
23 of its working days during the preceding calendar quarter, employed
24 no more than fifty (50) eligible employees, the majority of whom

1 were employed within this state. In determining the number of
2 eligible employees, companies that are affiliated companies, or that
3 are eligible to file a combined tax return for purposes of state
4 income taxation, shall be considered one employer; and

5 ~~28.~~ 26. "Small employer carrier" means a carrier that offers
6 health benefit plans covering eligible employees of one or more
7 small employers in this state, ~~and~~

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

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

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

15 1. The rate manual developed for use by a small employer
16 carrier shall be filed and approved by the Insurance Commissioner
17 prior to use. Any changes to the rate manual shall be filed and
18 approved by the Insurance Commissioner prior to use. Every filing
19 shall be made not less than thirty (30) days prior to the date the
20 small employer carrier intends to implement the rates. The rate
21 manual so filed shall be deemed approved upon expiration of the
22 thirty-day waiting period unless, prior to the end of the period, it
23 has been affirmatively approved or disapproved by order of the
24 Commissioner. Approval of a rate manual by the Commissioner shall

1 constitute a waiver of any unexpired portion of the thirty-day
2 waiting period. The Commissioner may extend the period to approve
3 or disapprove a rate manual by not more than an additional thirty
4 (30) days by giving notice of such extension before expiration of
5 the initial thirty-day period. At the expiration of an extended
6 period, the rate filing shall be deemed approved unless otherwise
7 approved or disapproved by the Commissioner. The Commissioner may
8 at any time, after notice and for cause shown, withdraw approval of
9 a filed rate;

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

23

24

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

4 4. For a class of business, the premium rates charged during a
5 rating period to small employers with similar case characteristics
6 for the same or similar coverage, or the rates that could be charged
7 to such employers under the rating system for that class of
8 business, shall not vary from the index rate by more than twenty-
9 five percent (25%) of the index rate;

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

- 13 a. the percentage change in the new business premium rate
14 measured from the first day of the prior rating period
15 to the first day of the new rating period. In the
16 case of a health benefit plan into which the small
17 employer carrier is no longer enrolling new small
18 employers, the small employer carrier shall use the
19 percentage change in the base premium rate, provided
20 that ~~such~~ the change does not exceed, on a percentage
21 basis, the change in the new business premium rate for
22 the most similar health benefit plan into which the
23 small employer carrier is actively enrolling new small
24 employers,

1 b. any adjustment, not to exceed fifteen percent (15%)
2 annually and adjusted pro rata for rating periods of
3 less than one year, due to the claim experience,
4 health status or duration of coverage of the employees
5 or dependents of the small employer as determined from
6 the ~~small employer carrier's~~ rate manual for the class
7 of business of the small employer carrier, and

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

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

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

22 8. A small employer carrier may utilize industry as a case
23 characteristic in establishing premium rates; provided, the highest
24 rate factor associated with any industry classification shall not

1 exceed the lowest rate factor associated with any industry
2 classification by more than fifteen percent (15%);

3 ~~9.~~ 8. In the case of health benefit plans issued prior to the
4 effective date of the Small Employer Health Insurance Reform Act, a
5 premium rate for a rating period may exceed the ranges set forth in
6 paragraphs 3 and 4 of this subsection for a period of three (3)
7 years following the effective date of the Small Employer Health
8 Insurance Reform Act. In such case, the percentage increase in the
9 premium rate charged to a small employer for a new rating period
10 shall not exceed the sum of the following:

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

23 b. any adjustment due to change in coverage or change in
24 the case characteristics of the small employer, as

1 determined from the ~~carrier's~~ rate manual of the
2 carrier for the class of business;

3 ~~10.~~ 9. Small employer carriers shall:

4 a. apply rating factors, including case characteristics,
5 consistently with respect to all small employers in a
6 class of business. Rating factors shall produce
7 premiums for identical groups within the same class of
8 business which differ only by amounts attributable to
9 plan design and do not reflect differences due to
10 claims experience, health status and duration of
11 coverage, and

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

15 ~~11.~~ 10. For the purposes of this subsection, a health benefit
16 plan that utilizes a restricted provider network shall not be
17 considered similar coverage to a health benefit plan that does not
18 utilize such a network, provided that utilization of the restricted
19 provider network results in substantial differences in claims costs;

20 ~~12.~~ 11. The Insurance Commissioner may establish rules to
21 implement the provisions of this section and to assure that rating
22 practices used by small employer carriers are consistent with the
23 purposes of the Small Employer Health Insurance Reform Act,
24 including:

- 1 a. assuring that differences in rates charged for health
2 benefit plans by small employer carriers are
3 reasonable and reflect objective differences in plan
4 design, not including differences due to claims
5 experience, health status or duration of coverage, and
6 b. prescribing the manner in which case characteristics
7 may be used by small employer carriers.

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

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

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

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

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

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

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

22 b. In the event that the program becomes eligible for
23 additional financing pursuant to paragraph 3 of
24 subsection L of this section, the board shall be

1 expanded to include two additional members who shall
2 be appointed by the Commissioner. In selecting the
3 additional members of the board, the Commissioner
4 shall choose individuals who represent organizations
5 offering categories of health insurance not already
6 represented on the board, including but not limited to
7 excess or stoploss health insurance. The expansion of
8 the board under this subsection shall continue for the
9 period that the program continues to be eligible for
10 additional financing pursuant to paragraph 3 of
11 subsection L of this section.

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

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

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

1 ~~E. Within one hundred eighty (180) days after the appointment~~
2 ~~of the initial board, the board shall submit to the Commissioner a~~
3 ~~plan of operation and, thereafter, any amendments thereto necessary~~
4 ~~or suitable to ensure the fair, reasonable and equitable~~
5 ~~administration of the program. The Commissioner may, after notice~~
6 ~~and hearing, approve the plan of operation if the Commissioner~~
7 ~~determines it to be suitable to ensure the fair, reasonable and~~
8 ~~equitable administration of the program, and to provide for the~~
9 ~~sharing of program gains or losses on an equitable and proportionate~~
10 ~~basis in accordance with the provisions of this section. The plan~~
11 ~~of operation shall become effective upon written approval by the~~
12 ~~Commissioner.~~

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

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

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

24

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

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

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

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

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

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

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

24

1 ~~functions or with persons or other organizations for the performance~~
2 ~~of administrative functions;~~

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

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

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

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

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

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

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

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

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

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

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

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

21 ~~4. a. The program shall not reimburse a reinsuring carrier~~
22 ~~with respect to the claims of a reinsured employee or~~
23 ~~dependent until the carrier has incurred an initial~~
24 ~~level of claims for such employee or dependent of Five~~

1 ~~Thousand Dollars (\$5,000.00) in a calendar year for~~
2 ~~benefits covered by the program. In addition, the~~
3 ~~reinsuring carrier shall be responsible for ten~~
4 ~~percent (10%) of the next Fifty Thousand Dollars~~
5 ~~(\$50,000.00) of benefit payments during a calendar~~
6 ~~year, and the program shall reinsure the remainder. A~~
7 ~~reinsuring carrier's liability under this subparagraph~~
8 ~~shall not exceed a maximum limit of Ten Thousand~~
9 ~~Dollars (\$10,000.00) in any one (1) calendar year with~~
10 ~~respect to any reinsured individual.~~

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

21 ~~5. A small employer carrier may terminate reinsurance with the~~
22 ~~program for one or more of the reinsured employees or dependents of~~
23 ~~a small employer on any anniversary of the health benefit plan;~~
24

1 ~~6. Premium rates charged for reinsurance by the program to a~~
2 ~~health maintenance organization that is federally qualified under 42~~
3 ~~U.S.C. Sec. 300c(e) (2) (A), and as such is subject to requirements~~
4 ~~that limit the amount of risk that may be ceded to the program that~~
5 ~~is more restrictive than those specified in paragraph 4 of this~~
6 ~~subsection, shall be reduced to reflect that portion of the risk~~
7 ~~above the amount set forth in paragraph 4 of this subsection that~~
8 ~~may not be ceded to the program, if any; and~~

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

14 ~~J. 1. The board, as part of the plan of operation, shall~~
15 ~~establish a methodology for determining premium rates to be charged~~
16 ~~by the program for reinsuring small employers and individuals~~
17 ~~pursuant to this section. The methodology shall include a system~~
18 ~~for classification of small employers that reflects the types of~~
19 ~~case characteristics commonly used by small employer carriers in the~~
20 ~~state. The methodology shall provide for the development of base~~
21 ~~reinsurance premium rates which shall be multiplied by the factors~~
22 ~~set forth in paragraph 2 of this subsection to determine the premium~~
23 ~~rates for the program. The base reinsurance premium rates shall be~~
24 ~~established by the board, subject to the approval of the~~

1 ~~Commissioner, and shall be set at levels which reasonably~~
2 ~~approximate gross premiums charged to small employers by small~~
3 ~~employer carriers for health benefit plans with benefits similar to~~
4 ~~the standard health benefit plan, adjusted to reflect retention~~
5 ~~levels required under this act.~~

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

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

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

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

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

21 ~~3. The board periodically shall review the methodology~~
22 ~~established under paragraph 1 of this subsection, including the~~
23 ~~system of classification and any rating factors, to ensure that it~~
24 ~~reasonably reflects the claims experience of the program. The board~~

1 ~~may propose changes to the methodology which shall be subject to the~~
2 ~~approval of the Commissioner.~~

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

6 ~~K. If a health benefit plan for a small employer is entirely or~~
7 ~~partially reinsured with the program, the premium charged to the~~
8 ~~small employer for any rating period for the coverage issued shall~~
9 ~~meet the requirements relating to premium rates set forth in Section~~
10 ~~6515 of this title.~~

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

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

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

22 ~~(1) each reinsuring carrier's share of the total~~
23 ~~premiums earned in the preceding calendar year~~
24 ~~from health benefit plans delivered or issued for~~

1 ~~delivery to small employers in this state by~~
2 ~~reinsuring carriers, and~~

3 ~~(2) each reinsuring carrier's share of the premiums~~
4 ~~earned in the preceding calendar year from newly~~
5 ~~issued health benefit plans delivered or issued~~
6 ~~for delivery during the calendar year to small~~
7 ~~employers in this state by reinsuring carriers.~~

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

21 ~~c. The board may, with approval of the Commissioner,~~
22 ~~change the assessment formula established pursuant to~~
23 ~~subparagraph a of this paragraph from time to time as~~
24 ~~appropriate. The board may provide for the shares of~~

1 ~~the assessment base attributable to total premium and~~
2 ~~to the previous year's premium to vary during a~~
3 ~~transition period.~~

4 ~~d. Subject to the approval of the Commissioner, the board~~
5 ~~shall make an adjustment to the assessment formula for~~
6 ~~reinsuring carriers that are approved health~~
7 ~~maintenance organizations which are federally~~
8 ~~qualified under 42 U.S.C. Sec. 300 et seq., to the~~
9 ~~extent, if any, that restrictions are placed on them~~
10 ~~that are not imposed on other small employer carriers.~~

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

15 ~~b. If the board determines that the assessments needed to~~
16 ~~fund the losses incurred by the program in the~~
17 ~~previous calendar year will exceed five percent (5%)~~
18 ~~of total premiums earned in the previous calendar year~~
19 ~~from health benefit plans delivered or issued for~~
20 ~~delivery to small employers in this state by~~
21 ~~reinsuring carriers, the board shall evaluate the~~
22 ~~operation of the program and report its findings,~~
23 ~~including any recommendations for changes to the plan~~
24 ~~of operation, to the Commissioner within ninety (90)~~

1 ~~days following the end of the calendar year in which~~
2 ~~the losses were incurred. The evaluation shall~~
3 ~~include an estimate of future assessments and~~
4 ~~consideration of the administrative costs of the~~
5 ~~program, the appropriateness of the premiums charged,~~
6 ~~the level of insurer retention under the program and~~
7 ~~the costs of coverage for small employers. If the~~
8 ~~board fails to file a report with the Commissioner~~
9 ~~within ninety (90) days following the end of the~~
10 ~~applicable calendar year, the Commissioner may~~
11 ~~evaluate the operations of the program and implement~~
12 ~~such amendments to the plan of operation the~~
13 ~~Commissioner deems necessary to reduce future losses~~
14 ~~and assessments.~~

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

22 ~~4. If assessments exceed net losses of the program, the excess~~
23 ~~shall be held at interest and used by the board to offset future~~
24 ~~losses or to reduce program premiums. As used in this paragraph,~~

1 ~~"future losses" includes reserves for incurred but not reported~~
2 ~~claims.~~

3 ~~5. Each reinsuring carrier's proportion of the assessment shall~~
4 ~~be determined annually by the board based on annual statements and~~
5 ~~other reports deemed necessary by the board and filed by the~~
6 ~~reinsuring carriers with the board.~~

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

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

22 ~~M. Neither the participation in the program as reinsuring~~
23 ~~carriers, the establishment of rates, forms or procedures, nor any~~
24 ~~other joint or collective action required by this section and~~

1 ~~Section 6523 of this title shall be the basis of any legal action,~~
2 ~~criminal or civil liability, or penalty against the program or any~~
3 ~~of its reinsuring carriers either jointly or separately.~~

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

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

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

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

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

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

1 Section 6608. A. An application for license as a service
2 warranty association shall be made to, and filed with, the Insurance
3 Commissioner on printed forms as prescribed and furnished by the
4 Insurance Commissioner.

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

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

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

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

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

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

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

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

24

1 D. Upon completion of the application for license, the
2 Commissioner shall examine the application and make such further
3 investigation of the applicant as the Commissioner deems advisable.
4 If the Commissioner finds that the applicant is qualified, the
5 Commissioner shall issue to the applicant a license as a service
6 warranty association. If the Commissioner does not find the
7 applicant to be qualified the Commissioner shall refuse to issue the
8 license and shall give the applicant written notice of ~~such~~ the
9 refusal, setting forth the grounds ~~therefor~~ of the refusal.

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

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

22 3. Any entity approved for an exclusion provided by paragraph
23 14 of Section 6602 of this title may be required by the Commissioner
24 to provide subsequent audited financial statements and other

1 information ascertained by the Commissioner to be necessary to
2 determine continued qualification for an exclusion provided by
3 paragraph 14 of Section 6602 of this title.

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

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

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

19 SECTION 49. AMENDATORY 36 O.S. 2001, Section 6615, as
20 last amended by Section 24, Chapter 432, O.S.L. 2009 (36 O.S. Supp.
21 2009, Section 6615), is amended to read as follows:

22 Section 6615. A. In addition to the license fees provided in
23 the Service Warranty Insurance Act for service warranty associations
24 each ~~such~~ service warranty association and insurer shall, annually

1 on or before the ~~last~~ first day of ~~February~~ May, file with the
2 Insurance Commissioner its annual statement in the form prescribed
3 by the Commissioner showing all gross written premiums or
4 assessments received by it in connection with the issuance of
5 service warranties in this state during the preceding calendar year
6 and other relevant financial information as deemed necessary by the
7 Commissioner, using accounting principles which will enable the
8 Commissioner to ascertain whether the financial requirements set
9 forth in Section 6607 of this title have been satisfied.

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

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

19 D. Premiums and assessments received by associations and
20 insurers for service warranties shall not be subject to the premium
21 tax provided for in Section 624 of this title, but shall be subject
22 to an administrative fee of equal to two percent (2%) of the gross
23 premium received on the sale of all service contracts issued in this
24 state during the preceding calendar quarter. Said fees shall be

1 paid quarterly to the Insurance Commissioner. However, licensed
2 associations, licensed insurers and entities with applications for
3 licensure as a service warranty association pending with the
4 Department that have contractual liability insurance in place as of
5 March 31, 2009, from an insurer which satisfies the requirements of
6 ~~subsection~~ subsections B and C of Section 6607 of this title and
7 which covers one hundred percent (100%) of the claims exposure of
8 the association or insurer on all contracts written may elect to pay
9 an annual administrative fee of Three Thousand Dollars (\$3,000.00)
10 in lieu of the two-percent administrative fee.

11 SECTION 50. AMENDATORY 36 O.S. 2001, Section 6620, as
12 last amended by Section 9, Chapter 189, O.S.L. 2009 (36 O.S. Supp.
13 2009, Section 6620), is amended to read as follows:

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

18 SECTION 51. AMENDATORY Section 11, Chapter 390, O.S.L.
19 2003, as amended by Section 54, Chapter 176, O.S.L. 2009 (36 O.S.
20 Supp. 2009, Section 6810), is amended to read as follows:

21 Section 6810. A. Sections 6810 through 6820 of this title
22 shall be known and may be cited as the "Medical Professional
23 Liability Insurance Closed Claim Reports Act".
24

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

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

7 1. "Claim" means:

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

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

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

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

19 4. "Commissioner" means the Insurance Commissioner;

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

23 6. "Economic damages" means objectively verifiable monetary
24 losses, including medical expenses, loss of earnings, burial costs,

1 loss of use of property, cost of replacement or repair, cost of
2 obtaining substitute domestic services, and loss of business or
3 employment opportunities;

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

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

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

21 b. an employee or agent of a person described in
22 subparagraph a of this paragraph, acting in the course
23 and scope of the employment of the employee. If the
24

1 employee or agent is deceased, this includes the
2 estate or personal representative of the employee;

3 9. "Insuring entity" means:

- 4 a. an authorized insurer,
- 5 b. a captive insurer,
- 6 c. a joint underwriting association,
- 7 d. a patient compensation fund,
- 8 e. a risk retention group, or
- 9 f. an unauthorized insurer that provides surplus lines
10 coverage;

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

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

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

1 SECTION 52. AMENDATORY Section 12, Chapter 390, O.S.L.
2 2003, as amended by Section 55, Chapter 176, O.S.L. 2009 (36 O.S.
3 Supp. 2009, Section 6811), is amended to read as follows:

4 Section 6811. A. ~~Not later than the tenth day after the last~~
5 ~~day of the calendar quarter in which~~ When a claim for recovery under
6 a medical professional liability insurance policy is closed, the
7 insurer shall file with the Insurance Department a closed claim
8 report not later than April 1 of the same calendar year if the claim
9 is closed prior to April 1, and if the claim is closed after April
10 1, then the closed claim report shall be filed by April 1 of the
11 subsequent calendar year. These reports ~~must~~ shall include data for
12 all claims closed in the preceding calendar year and any adjustments
13 to data reported in prior years.

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

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

22 D. A closed claim that is covered under a primary policy and
23 one or more excess policies shall be reported only by the insuring
24 entity that issued the primary policy. The insuring entity that

1 issued the primary policy shall report the total amount, if any,
2 paid with respect to the closed claim, including any amount paid
3 under an excess policy, any amount paid by the facility or provider,
4 and any amount paid by any other person on behalf of the facility or
5 provider.

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

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

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

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

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

1 1. If a facility or provider is insured by a risk retention
2 group and the risk retention group refuses to report closed claims
3 and asserts that the federal Liability Risk Retention Act (95 Stat.
4 949; 15 U.S.C. Sec. 3901 et seq.) preempts state law, the facility
5 or provider ~~must~~ shall report all data required by the Medical
6 Professional Liability Insurance Closed Claim Reports Act on behalf
7 of the risk retention group.

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

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

20 SECTION 53. AMENDATORY Section 4, Chapter 64, O.S.L.
21 2002 (40 O.S. Supp. 2009, Section 600.4), is amended to read as
22 follows:

23 Section 600.4. A. Registration required. Except as otherwise
24 provided in the Oklahoma Professional Employer Organization

1 Recognition and Registration Act, no person shall, unless ~~such~~ the
2 person is registered as a PEO or PEO Group under the Oklahoma
3 Professional Employer Organization Recognition and Registration Act,
4 provide, advertise, or otherwise hold itself out as providing
5 professional employer services in this state.

6 B. Registration information.

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

22 ~~1.~~ The

23 a. the name or names under which the PEO or PEO Group
24 conducts business,

1 ~~2.~~ The

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

5 ~~3.~~ The

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

8 ~~4.~~ A

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

14 ~~5.~~ A

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

21 ~~6.~~ A

22 f. a statement of management, which shall include the
23 name and evidence of the business experience of any
24 person who serves as president, chief executive

1 officer, or otherwise has the authority to act as
2 senior executive officer of the PEO, or PEO Group, and

3 ~~7.~~ A

4 g. a financial statement setting forth the financial
5 condition of the PEO or PEO Group, as of a date not
6 earlier than one hundred eighty (180) days prior to
7 the date submitted to the Commissioner, prepared in
8 accordance with generally accepted accounting
9 principles, and audited or reviewed by an independent
10 certified public accountant licensed to practice in
11 the jurisdiction in which such accountant is located.
12 A PEO Group may submit combined or consolidated
13 audited or reviewed financial statements to meet the
14 requirements of this section.

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

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

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

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

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

22 a. evidence that the assurance organization is
23 independent and has an established national program
24 for the accreditation and financial assurance of PEOs

1 and PEO Groups based on requirements similar to the
2 requirements of the Oklahoma Professional Employer
3 Organization Recognition and Registration Act, and any
4 rules promulgated for the implementation of the
5 Oklahoma Professional Employer Organization
6 Recognition and Registration Act,

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

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

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

22 (1) authorize the assurance organization to share
23 with the Commissioner any application and
24 compliance reporting information required under

1 the Oklahoma Professional Employer Organization
2 Recognition and Registration Act that has been
3 provided to the assurance organization by the PEO
4 or PEO Group,

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

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

18 (4) provide the certification of the assurance
19 organization that the PEO or PEO Group is in
20 compliance with the standards and procedures of
21 the assurance organization which are similar to
22 the requirements of the Oklahoma Professional
23 Employer Organization Recognition and
24 Registration Act and is qualified for

1 registration or renewal of registration under the
2 Oklahoma Professional Employer Organization
3 Recognition and Registration Act,

- 4 e. an agreement to provide written notice to the
5 Commissioner within two (2) business days of
6 determination by the assurance organization of the
7 failure of a PEO or PEO Group to meet the
8 qualifications for registration under the Oklahoma
9 Professional Employer Organization Recognition and
10 Registration Act or determination by the assurance
11 organization of the failure of the PEO or PEO Group to
12 meet the qualifications for accreditation or
13 certification by the assurance organization, and
14 f. an agreement to share with the Commissioner in a
15 timely manner the information and supporting
16 documentation provided to the assurance organization
17 by the PEO or PEO Group similar to the information and
18 documentation required for registration or renewal of
19 registration under the Oklahoma Professional Employer
20 Organization Recognition and Registration Act.

21 C. Initial registration.

- 22 1. Each PEO or PEO Group operating within this state as of
23 November 1, 2002, shall complete its initial registration not later
24

1 than one hundred eighty (180) days after the end of the PEO's or PEO
2 Group's first fiscal year ending after November 1, 2002.

3 2. Each PEO or PEO Group not operating within this state as of
4 November 1, 2002, shall complete its initial registration prior to
5 commencement of operations within this state. A registration is
6 valid for a term of one (1) year.

7 D. Renewal. ~~Within one hundred eighty (180) days after the end~~
8 ~~of a registrant's fiscal year, such registrant shall renew its~~
9 ~~registration by notifying the Commissioner of any changes in the~~
10 ~~information provided in such registrant's most recent registration~~
11 ~~or renewal.~~ A registration expires one (1) year following the
12 registration unless it is renewed pursuant to this subsection.

13 Before expiration of the registration, a registrant may renew the
14 registration for an additional one-year term if the registrant:

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

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

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

22 E. Group registration. Any two or more PEOs held under common
23 control of any other person or persons acting in concert may be
24 registered as a PEO Group. A PEO Group may satisfy any reporting

1 and financial requirements of this registration law on a
2 consolidated basis.

3 F. Electronic filing and compliance. A PEO, PEO Group or an
4 approved independent and qualified assurance organization as
5 provided for in subsection B of this section may electronically
6 submit filings in conformance with Sections 15-101 through 15-121 of
7 Title 12A of the Oklahoma Statutes. Electronically submitted
8 filings include, but are not limited to, applications, documents,
9 reports, and other filings required under the Oklahoma Uniform
10 Electronic Transactions Act.

11 G. De minimis exemption.

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

- 15 a. submits a properly executed request for exemption on a
16 form provided by the Department,
- 17 b. is domiciled outside this state and is licensed or
18 registered as a professional employer organization in
19 another state that has the same or greater
20 requirements as the Oklahoma Professional Employer
21 Organization Recognition and Registration Act,
- 22 c. does not maintain an office in this state or solicit
23 in any manner clients located or domiciled within this
24 state, and

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

3 2. An exemption of a professional employer organization from
4 the registration requirements under the Oklahoma Professional
5 Employer Organization Recognition and Registration Act shall be
6 valid for one (1) year, subject to renewal.

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

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

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

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

21 SECTION 54. AMENDATORY Section 5, Chapter 64, O.S.L.
22 2002 (40 O.S. Supp. 2009, Section 600.5), is amended to read as
23 follows:
24

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

5 B. Initial Group Registration. Upon filing an initial Group
6 registration statement pursuant to the Oklahoma Professional
7 Employer Organization Recognition and Registration Act, the PEO
8 Group shall pay an initial registration fee of Five Hundred Dollars
9 (\$500.00) per member of the PEO Group.

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

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

19 E. Exemption. Each PEO exempt from registration under the
20 terms of this subsection shall pay an exemption fee in the amount of
21 Two Hundred Fifty Dollars (\$250.00) upon initial application for
22 exemption and upon each annual renewal of ~~such~~ the exemption.
23
24

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

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

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

8 2. Is of good character and reputation;

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

12 4. Is a citizen of the United States;

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

15 6. Will actively engage in the bail bond business;

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

18 8. Has a high school diploma or its equivalent; provided,
19 however, the provisions of this paragraph shall apply only to
20 initial applications for license submitted on or after November 1,
21 1997, and shall not apply to renewal applications for license.

22 B. The applicant shall apply in writing on forms prepared and
23 supplied by the Insurance Commissioner, and the Commissioner may
24 propound any reasonable interrogatories to an applicant for a

1 license pursuant to ~~Section~~ Sections 1301 ~~et seq.~~ through 1340 of
2 this title, or on any renewal thereof, relating to qualifications,
3 residence, prospective place of business and any other matters
4 which, in the opinion of the Commissioner, are deemed necessary or
5 expedient in order to protect the public and ascertain the
6 qualifications of the applicant. The Commissioner may also conduct
7 any reasonable inquiry or investigation relative to the
8 determination of the ~~applicant's~~ fitness of the applicant to be
9 licensed or to continue to be licensed including, but not limited
10 to, requiring a national criminal history record check as defined by
11 Section 150.9 of Title 74 of the Oklahoma Statutes.

12 C. An applicant shall furnish to the Commissioner a license fee
13 of Two Hundred Fifty Dollars (\$250.00) with the application, a
14 complete set of the ~~applicant's~~ fingerprints of the applicant and
15 two recent credential-size full face photographs of the applicant.
16 The ~~applicant's~~ fingerprints of the applicant shall be certified by
17 an authorized law enforcement officer. The applicant shall provide
18 with the application an investigative fee of One Hundred Dollars
19 (\$100.00) with which the Commissioner will conduct an investigation
20 of the applicant. All fees shall be nonrefundable.

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

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

3 SECTION 56. AMENDATORY 59 O.S. 2001, Section 1306, as
4 last amended by Section 1, Chapter 196, O.S.L. 2009 (59 O.S. Supp.
5 2009, Section 1306), is amended to read as follows:

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

9 2. In addition to the requirements prescribed in Section 1305
10 of this title, an applicant for a professional bondsman license
11 shall submit to the Insurance Commissioner financial statements
12 prepared by an accounting firm or individual holding a permit to
13 practice public accounting in this state in accordance with
14 generally accepted principles of accounting procedures setting forth
15 the total assets of the bondsman less liabilities and debts as
16 follows: For all applications made prior to ~~the effective date of~~
17 ~~this act~~ November 1, 2006, and the subsequent renewals of a license
18 issued upon ~~such~~ the application when continuously maintained in
19 effect as required by law, the statement shall show a net worth of
20 at least Fifty Thousand Dollars (\$50,000.00). For all applications
21 made on and after ~~the effective date of this act~~ November 1, 2006,
22 and the subsequent renewals of a license issued upon ~~such~~ the
23 application when continuously maintained in effect as required by
24 law, or for the renewal or reinstatement of any license that is

1 expired pursuant to subsection D of Section 1309 of this title,
2 suspended or revoked, the statement shall show a net worth of at
3 least One Hundred Fifty Thousand Dollars (\$150,000.00), ~~said the~~ the
4 statements to be current as of a date not earlier than ninety (90)
5 days prior to submission of the application and the statement shall
6 be attested to by an unqualified opinion of the accountant.

7 3. Professional bondsman applicants shall make a deposit with
8 the Insurance Commissioner in the same manner as required of
9 domestic insurance companies of an amount to be determined by the
10 Commissioner. For all applications made prior to ~~the effective date~~
11 ~~of this act~~ November 1, 1996, and the subsequent renewals of a
12 license issued upon ~~such~~ the application when continuously
13 maintained in effect as required by law, the deposit shall not be
14 less than Twenty Thousand Dollars (\$20,000.00). For all
15 applications made on and after ~~the effective date of this act~~
16 November 1, 1996, and the subsequent renewals of a license issued
17 upon ~~such~~ the application when continuously maintained in effect as
18 required by law, or for the renewal or reinstatement of any license
19 that is expired pursuant to subsection D of Section 1309 of this
20 title, suspended or revoked, the deposit shall not be less than
21 Fifty Thousand Dollars (\$50,000.00). ~~Such~~ The deposits shall be
22 subject to all laws, rules and regulations as deposits by domestic
23 insurance companies but in no instance shall a professional bondsman
24 write bonds which equal more than ten times the amount of the

1 deposit which ~~such~~ the bondsman has submitted to the Commissioner.
2 In addition, a professional bondsman may make the deposit by
3 purchasing an annuity through a licensed domestic insurance company
4 in the State of Oklahoma. The annuity shall be in the name of the
5 bondsman as owner with legal assignment to the Insurance
6 Commissioner. The assignment form shall be approved by the
7 Commissioner. If a bondsman exceeds the above limitation, the
8 bondsman shall be notified by the Commissioner by mail with return
9 receipt requested that the excess shall be reduced or the deposit
10 increased within ten (10) days of notification, or the license of
11 the bondsman shall be suspended immediately after the ten-day
12 period, pending a hearing on the matter.

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

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

24

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

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

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

18 D. Notwithstanding any other provision of ~~Section~~ Sections 1301
19 ~~et seq.~~ through 1340 of this title, the license of a professional
20 bondsman is transferable upon the death or legal or physical
21 incapacitation of the bondsman to the ~~bondsman's~~ spouse of the
22 bondsman, or to such other transferee as the professional bondsman
23 may designate in writing, and the transferee may elect to act as a
24 professional bondsman until the expiration of the license or for a

1 period of one hundred eighty (180) days, whichever is greater, if
2 the following conditions are met:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 13. Cheating on an examination for licensure;

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

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

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

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

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

24

1 19. Accepting anything of value from a principal, other than
2 the premium; provided, the bondsman shall be permitted to accept
3 collateral security or other indemnity from the principal which
4 shall be returned immediately upon final termination of liability on
5 the bond and upon satisfaction of all terms, conditions, and
6 obligations contained within the indemnity agreement. Collateral
7 security or other indemnity required by the bondsman shall be
8 reasonable in relation to the amount of the bond;

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

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

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

17 23. For filing a materially untrue monthly report;

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

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

22 26. For failing to pay any fees to a district court clerk as
23 are required by this title or failing to pay any fees to a municipal
24

1 court clerk as are required by this title or by Section 28-127 of
2 Title 11 of the Oklahoma Statutes;

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

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

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

15 B. In addition to any applicable denial, censure, suspension,
16 or revocation of a license, any person violating any provision of
17 ~~Section~~ Sections 1301 ~~et seq.~~ through 1340 of this title may be
18 subject to a civil penalty of not less than ~~One Hundred Dollars~~
19 ~~(\$100.00)~~ Two Hundred Fifty Dollars (\$250.00) nor more than ~~One~~
20 ~~Thousand Dollars (\$1,000.00)~~ Two Thousand Five Hundred Dollars
21 (\$2,500.00) for each occurrence. This fine may be enforced in the
22 same manner in which civil judgments may be enforced. Any order for
23 civil penalties entered by the Commissioner or authorized decision
24 maker for the Insurance Department which has become final may be

1 filed with the court clerk of Oklahoma County and shall then be
2 enforced by the judges of ~~said county~~ Oklahoma County.

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

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

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

23 F. Any law enforcement agency, district attorney's office,
24 court clerk's office, or insurer that is aware that a licensed bail

1 bondsman has been convicted of or has pleaded guilty or nolo
2 contendere to any crime, shall notify the Insurance Commissioner of
3 that fact.

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

7 Section 1314. A. When a bail bondsman or managing general
8 agent accepts collateral, ~~he or she~~ the bail bondsman or managing
9 general agent shall give a written receipt for same, and this
10 receipt shall give in detail a full description of the collateral
11 received. A description of the collateral shall be listed on the
12 undertaking by affidavit. All property taken as collateral, whether
13 personal, intangible or real, shall be receipted for and deemed, for
14 all purposes, to be in the name of, and for the use and benefit of,
15 the surety company or licensed professional bondsman, as the case
16 may be. Every receipt, encumbrance, mortgage or other evidence of
17 ~~such~~ the custody, possession or claim shall facially indicate that
18 it has been taken or made on behalf of the surety company or
19 professional bondsman through its authorized agent, the individual
20 licensed bondsman or managing general agent who has transacted the
21 undertaking with the bond principal. Any mortgage or other
22 encumbrance against real property taken under the provisions of this
23 section which does not indicate beneficial ownership of the claim to
24 be in favor of the surety company or professional bondsman shall be

1 deemed to constitute a cloud on the title to real estate and shall
2 subject the person filing, or causing same to be filed, in the real
3 estate records of the county, to a penalty of treble damages or One
4 Thousand Dollars (\$1,000.00), whichever is greater, in an action
5 brought by the person, organization or corporation injured thereby.
6 For collateral taken, or liens or encumbrances taken or made
7 pursuant to the provisions of this section, the individual bondsman
8 or managing general agent taking possession of the property or
9 making the lien, claim or encumbrance shall do so on behalf of ~~his~~
10 ~~or her~~ the surety company or professional bondsman, as the case may
11 be, and ~~such~~ the individual licensed bondsman shall be deemed to act
12 in the capacity of fiduciary in relation to both:

13 1. The principal or other person from whom ~~such~~ the property is
14 taken or claimed against_{7i} and

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

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

1 its return to its lawful owner, or deliver to the surety company or
2 professional bondsman, upon lawful demand pursuant to the terms of
3 the bailment.

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

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

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

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

21 C. Every licensee shall keep at ~~his or her~~ the place of
22 business of the licensee the usual and customary records pertaining
23 to transactions authorized by ~~his or her~~ the license. All ~~such~~ of
24 the records shall be available and open to the inspection of the

1 Commissioner at any time during business hours during the three (3)
2 years immediately following the date of the transaction. The
3 Commissioner may require a financial examination or market conduct
4 survey during any investigation of a licensee.

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

10 SECTION 59. AMENDATORY 36 O.S. 2001, Section 1315, is
11 amended to read as follows:

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

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

18 2. Jailers;

19 3. Police officers;

20 4. Committing judges;

21 5. Municipal or district court judges;

22 6. Prisoners;

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

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

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

12 10. Any person who holds any license provided for in Section
13 518 of Title 37 of the Oklahoma Statutes or is an agent, or officer,
14 ~~or employee~~ of any such licensee, except for an individual holding
15 an employee license pursuant to paragraph 20 of subsection A of
16 Section 518 of Title 37 of the Oklahoma Statutes;

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

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

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

4 C. The provisions of this section shall not apply to persons
5 possessing permits or licenses pertaining to low-point beer or
6 alcoholic beverages, as defined in Sections 163.2 and 506 of Title
7 37 of the Oklahoma Statutes, which were issued prior to May 23,
8 1984. No one shall be permitted to maintain an office for
9 conducting bail bonds business where low-point beer or alcoholic
10 beverages are sold for on-premises consumption.

11 SECTION 60. AMENDATORY 59 O.S. 2001, Section 1316, as
12 last amended by Section 58, Chapter 176, O.S.L. 2009 (59 O.S. Supp.
13 2009, Section 1316), is amended to read as follows:

14 Section 1316. A. 1. A bail bondsman shall neither sign nor
15 countersign in blank any bond, nor shall the bondsman give a power
16 of attorney to, or otherwise authorize, anyone to countersign ~~his or~~
17 ~~her~~ the name of the bail bondsman to bonds unless the person so
18 authorized is a licensed surety bondsman or managing general agent
19 directly employed by a licensed professional bondsman giving ~~such~~
20 the power of attorney. The professional bondsman shall submit to
21 the Insurance Commissioner the agreement between the professional
22 bondsman and the employed bondsman. The agreement shall be
23 submitted to the Commissioner prior to the employed bondsman writing
24 bonds on behalf of the professional. The professional bondsman

1 shall notify the Commissioner whenever any agreement is canceled.
2 If the bondsman surrenders the professional qualification, or the
3 professional qualification is suspended or revoked, or if an insurer
4 authorized to write bail bond business surrenders their bail surety
5 line of authority, or this line of authority is suspended or
6 revoked, then the Commissioner shall suspend the appointment of all
7 of the ~~professional bondsman's~~ bail agents of the professional
8 bondsman or insurer. The Commissioner shall immediately notify any
9 bail agent whose license is affected and the court clerk of the
10 agent's resident county upon ~~such~~ the suspension or revocation of
11 the ~~professional bondsman's~~ qualification of the professional
12 bondsman. If the professional qualification or the bail surety line
13 of authority is reinstated within twenty-four (24) hours, the
14 Commissioner shall not be required to suspend the bail agent
15 appointments. If the Commissioner reinstates the professional
16 qualification within twenty-four (24) hours, the Commissioner shall
17 also reinstate the appointment of the ~~professional bondsman's~~ bail
18 agents of the professional bondsman or bail insurer. If more than
19 twenty-four (24) hours elapse following the suspension or
20 revocation, then the professional bondsman or insurer shall submit
21 new agent appointments to the Commissioner.

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

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

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

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

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

14 SECTION 61. AMENDATORY 59 O.S. 2001, Section 1317, as
15 last amended by Section 30, Chapter 184, O.S.L. 2008 (59 O.S. Supp.
16 2009, Section 1317), is amended to read as follows:

17 Section 1317. A. Every surety or professional bondsman who
18 appoints a surety bondsman or managing general agent in the state,
19 shall give notice thereof to the Insurance Commissioner. The filing
20 fee for appointment of each surety bondsman or managing general
21 agent shall be Ten Dollars (\$10.00), payable to the Commissioner and
22 shall be submitted with the appointment. The appointment shall
23 remain in effect until the surety or professional bondsman submits a
24 notice of cancellation to the Commissioner, the ~~bail bondsman's~~

1 license of the bail bondsman expires, or the Commissioner cancels
2 the appointment. The Commissioner may cancel a bail surety
3 appointment if the license of the bondsman is suspended, revoked or
4 nonrenewed. If the surety changes the liability limitations of the
5 surety bondsman or the managing general agent, or any other
6 provisions of the appointment, the surety shall submit an amended
7 appointment form and a filing fee of Ten Dollars (\$10.00) payable to
8 the Commissioner.

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

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

23 D. Every bail bondsman who negotiates and posts a bond shall,
24 in any controversy between the defendant, indemnitor, or guarantor

1 and the bail bondsman or surety, be regarded as representing the
2 surety. This provision shall not affect the apparent authority of a
3 bail bondsman as an agent for the insurer.

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

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

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

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

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

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

12 SECTION 64. REPEALER 36 O.S. 2001, Sections 6520, 6521,
13 as amended by Section 30, Chapter 125, O.S.L. 2007, 6523 and 6525
14 (36 O.S. Supp. 2009, Section 6521), are hereby repealed.

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

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