

1 STATE OF OKLAHOMA

2 2nd Session of the 52nd Legislature (2010)

3 SENATE BILL 2054

By: Brown

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5
6 AS INTRODUCED

7 An Act relating to insurance; authorizing the
8 Insurance Commissioner to require certain documents
9 to be filed electronically; authorizing the
10 Commissioner to promulgate certain rules; amending 36
11 O.S. 2001, Section 306, which relates to records;
12 clarifying confidentiality of certain information;
13 amending Section 1, Chapter 432, O.S.L. 2009 (36 O.S.
14 Supp. 2009, Section 307.3), which relates to the
15 State Insurance Commissioner Revolving Fund;
16 correcting statutory cite; amending Section 19,
17 Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2009, Section
18 311A.17), which relates to the Oklahoma Annual
19 Financial Report Act; modifying date; updating
20 statutory cites; amending 36 O.S. 2001, Section 628,
21 which relates to retaliatory actions; eliminating
22 deposit of certain fund to the General Revenue Fund;
23 amending Section 75, Chapter 264, O.S.L. 2006, as
24 amended by Section 1, Chapter 177, O.S.L. 2009 (36
O.S. Supp. 2009, Section 924.4), which relates to an
affidavit of exempt status; eliminating requirement
that certain affidavit be mailed; amending Section 4,
Chapter 127, O.S.L. 2003 (36 O.S. Supp. 2009, Section
953), which relates to the Use of Credit Information
in Personal Insurance Act; clarifying language;
allowing an insurer to make certain exceptions for
persons whose credit information has been influenced
by certain specified events; allowing an insurer to
take certain actions in response to the request;
specifies that an insurer is not out of compliance
for granting certain exceptions; requiring insurer to
provide notice regarding such exceptions; specifying
time period for an insurer to respond to the request
for a reasonable exception; amending 36 O.S. 2001,
Section 997, as amended by Section 26, Chapter 264,
O.S.L. 2006 (36 O.S. Supp. 2009, Section 997), which

1 relates to commercial special risks; eliminating
2 category of special risks; amending 36 O.S. 2001,
3 Section 1107, which relates to surplus line brokers;
4 modifying report filing requirement; amending Section
5 8, Chapter 125, O.S.L. 2007 (36 O.S. Supp. 2009,
6 Section 1204.1), which relates to information made
7 available to policyholders; requiring advisory board
8 or advisory organization to make certain information
9 available to policyholders; amending 36 O.S. 2001,
10 Section 1250.4, which relates to Unfair Claims
11 Settlement Practices Act; modifying time period for
12 certain persons to respond to the Commissioner;
13 amending 36 O.S. 2001, Section 1452, as last amended
14 by Section 16, Chapter 125, O.S.L. 2007 (36 O.S.
15 Supp. 2009, Section 1452), which relates to third-
16 party administrators; requiring annual report to be
17 reviewed by a certified public accountant; amending
18 36 O.S. 2001, Section 1464, which relates to the
19 Oklahoma Life, Accident and Health Insurance Broker
20 Act; allowing a nonresident broker applicant to
21 receive a license in this state if certain conditions
22 are met; amending 36 O.S. 2001, Section 3614.1, which
23 relates to the Genetic Nondiscrimination in Insurance
24 Act; modifying definitions; adding definitions;
prohibiting certain actions by insurers on the basis
of genetic information; allowing an insurer to take
certain actions in certain conditions; eliminating
certain penalties; allowing an insurer to use the
results of a genetic test in making certain
determinations; allowing an insurer to request
certain test if certain specified conditions are met;
prohibiting an insurer from using genetic information
for underwriting purposes or prior to enrollment;
providing that the obtaining of certain information
is not considered a violation of certain requirement;
amending 36 O.S. 2001, Sections 6060, as last amended
by Section 23, Chapter 184, O.S.L. 2008, 6060.2,
6060.3, as amended by Section 5, Chapter 464, O.S.L.
2003, Section 1, Chapter 397, O.S.L. 2004, 6060.4, as
last amended by Section 65, Chapter 264, O.S.L. 2006,
Section 1, Chapter 351, O.S.L. 2008, Section 6060.5,
as amended by Section 7, Chapter 464, O.S.L. 2003,
6060.6, 6060.7, as amended by Section 1, Chapter 30,
O.S.L. 2002, 6060.8, as amended by Section 8, Chapter
464, O.S.L. 2003, 6060.8a, 6060.9, 6060.10 and
6060.11 (36 O.S. Supp. 2009, Sections 6060, 6060.3,
6060.3a, 6060.4, 6060.4a, 6060.5, 6060.7 and 6060.8),

1 which relate to health benefits; modifying definition
2 of health benefit plans; modifying statutory cite;
3 allowing any health benefit plan to provide benefits
4 for other forms of mental health or substance use
5 disorder benefits subject to certain limitations;
6 specifying that treatment limitations applicable to
7 certain benefits shall be no more restrictive than
8 other limitations applied to all medical and surgical
9 benefits; amending 36 O.S. 2001, Sections 6512, as
10 amended by Section 50, Chapter 176, O.S.L. 2009,
11 6515, 6522 and 6526 (36 O.S. Supp. 2009, Section
12 6512), which relates to the Small Employer Health
13 Insurance Reform Act; modifying definitions; deleting
14 requirement relating to certain premium rates;
15 eliminating the Oklahoma Small Employer Health
16 Reinsurance Program; requiring the board to develop
17 certain plan and to submit the plan to the
18 Commissioner within specified time period; specifying
19 details of the plan; clarifying statutory cites;
20 amending 36 O.S. 2001, Section 6608, as amended by
21 Section 53, Chapter 176, O.S.L. 2009, 6609, as
22 amended by Section 27, Chapter 184, O.S.L. 2008,
23 6615, as last amended by Section 24, Chapter 432,
24 O.S.L. 2009 and 6620, as last amended by Section 9,
Chapter 189, O.S.L. 2009 (36 O.S. Supp. 2009,
Sections 6608, 6609, 6615 and 6620), which relate the
Service Warranty Insurance Act; eliminating reference
to specified fee; requiring certain entity to file an
audited financial statement; increasing amount of
license fee; modifying date when certain annual
statement is filed; requiring statement to show
certain gross written premiums or assessments;
correcting statutory cite; amending Section 11,
Chapter 390, O.S.L. 2003, as amended by Section 54,
Chapter 176, O.S.L. 2009 and Section 12, Chapter 390,
O.S.L. 2003, as amended by Section 55, Chapter 176,
O.S.L. 2009 (36 O.S. Supp. 2009, Sections 6810 and
6811), which relate to the Medical Professional
Liability Insurance Closed Claim Reports Act; making
the Medical Professional Liability Insurance Closed
Claim Reports Act applicable to all medical
professional liability claims in this state;
specifying time period for filing of certain reports;
amending Section 4, Chapter 64, O.S.L. 2002 and
Section 5, Chapter 64, O.S.L. 2002 (40 O.S. Supp.
2009, Sections 600.4 and 600.5), which relate to the
Oklahoma Professional Employer Organization

1 Recognition and Registration Act; allowing a PEO to
2 use a qualified assurance organization to provide
3 certain services; defining term; providing procedures
4 for approval as an assurance organization; specifying
5 term of registration of a PEO; modifying renewal
6 requirements; allowing for certain electronic
7 filings; requiring the Commissioner to maintain list
8 of approved assurance organizations; authorizing the
9 Commissioner to promulgate rules; clarifying
10 authority of Commissioner as it relates to the
11 Oklahoma Professional Employer Organization
12 Recognition and Registration Act; providing for
13 initial and annual renewal fees for a PEO Group;
14 amending 59 O.S. 2001, Sections 1305, as amended by
15 Section 5, Chapter 204, O.S.L. 2003, 1306, as last
16 amended by Section 1, Chapter 196, O.S.L. 2009, 1310,
17 1314, as amended by Section 25, Chapter 432, O.S.L.
18 2009, 1316, as last amended by Section 58, Chapter
19 176, O.S.L. 2009, 1317, as last amended by Section
20 30, Chapter 184, O.S.L. 2008 and 1322 (59 O.S. Supp.
21 2009, Sections 1305, 1306, 1314, 1316 and 1317),
22 which relate to bail bondsman; providing fee for
23 duplicate license; clarifying language; adding cause
for denial of bail bondsman license; modifying amount
of certain civil penalty; requiring the Commissioner
to suspend the appointment of bail agents if certain
line of authority is surrendered, suspended or
revoked; allowing the Commissioner to cancel a bail
surety appointment under certain circumstances;
requiring a bondsman to file copy of certain document
with the Insurance Commissioner within specified time
period; allowing the Commissioner to waive the filing
requirement; repealing 11 O.S. 2001, Section 29-205,
which relates to filing of certain ordinances with
the Insurance Commissioner; repealing 36 O.S. 2001,
Sections 6520, 6521, as amended by Section 30,
Chapter 125, O.S.L. 2007, 6523 and 6525 (36 O.S.
Supp. 2009, Section 6521), which relate to the Small
Employer Health Insurance Reform Act; repealing 36
O.S. 2001, Section 6608, as amended by Section 4,
Chapter 189, O.S.L. 2009 (36 O.S. Supp. 2009, Section
6608), which is a duplicate section relating to the
Service Warranty Insurance Act; providing for
codification; and providing an effective date.

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

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

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

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

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

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

14 Section 306. A. The records, books, and papers pertaining to
15 the official transactions, filings, examinations, investigations,
16 and proceedings of the Insurance Department shall be maintained by
17 the Department until disposition thereof has been approved by the
18 Archives and Records Commission. These records, books, and papers
19 shall be public records of the state. However, reports of
20 examinations of insurers shall be filed and made public only as
21 provided in Section 309.4 of this title. Open and ongoing
22 investigative and disciplinary files shall not be made public until
23 their completion or unless they are ordered to be made public by the
24 proper judicial official. Files of the claims division of the

1 ~~Commissioner's~~ office of the Commissioner, including but not limited
2 to complaints and requests for assistance from insureds, and
3 insurance agency and company records, shall not be public records
4 and shall not be disclosed except in connection with disciplinary
5 proceedings by the Commissioner. Final market conduct orders shall
6 be open public records.

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

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

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1 SECTION 3. AMENDATORY Section 1, Chapter 432, O.S.L.
2 2009 (36 O.S. Supp. 2009, Section 307.3), is amended to read as
3 follows:

4 Section 307.3. A. Effective July 1, 2009, there is hereby
5 created in the State Treasury a revolving fund for the Insurance
6 Commissioner called the State Insurance Commissioner Revolving Fund.
7 The revolving fund shall be used to fund the operations of the
8 Office of the Insurance Commissioner.

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

- 14 a. premium taxes,
- 15 b. monies transferred to the Attorney General's Insurance
16 Fraud Unit Revolving Fund pursuant to Section 362 of
17 this title, and
- 18 c. funds paid to and collected pursuant to the Oklahoma
19 Certified Real Estate Appraisers Act, ~~Section~~ Sections
20 858-700 ~~et seq.~~ through 858-732 of Title ~~36~~ 59 of the
21 Oklahoma Statutes.

22 2. The revolving fund shall be a continuing fund, not subject
23 to fiscal year limitations. Expenditures from the revolving fund
24 shall be made pursuant to the laws of this state and the statutes

1 relating to the Insurance Department. Warrants for expenditures
2 from the revolving fund shall be drawn by the State Treasurer, based
3 on claims signed by an authorized employee or employees of the
4 Insurance Department and filed with the Director of State Finance.

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

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

15 SECTION 4. AMENDATORY Section 19, Chapter 176, O.S.L.
16 2009 (36 O.S. Supp. 2009, Section 311A.17), is amended to read as
17 follows:

18 Section 311A.17. A. Upon written application of any insurer,
19 the Insurance Commissioner may grant an exemption from compliance
20 with any and all provisions of the Oklahoma Annual Financial Report
21 Act if the Commissioner finds, upon review of the application, that
22 compliance with the Oklahoma Annual Financial Report Act would
23 constitute a financial or organizational hardship upon the insurer.
24 An exemption may be granted at any time and from time to time for a

1 specified period or periods. Within ten (10) days from a denial of
2 the written request of an insurer for an exemption from the Oklahoma
3 Annual Financial Report Act, the insurer may request in writing a
4 hearing on its application for an exemption. The hearing shall be
5 held in accordance with the Administrative Procedures Act and the
6 laws and rules of the Insurance Department.

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

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

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

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

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

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

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

17 G. The requirements of Section ~~18~~ 311A.16 of this ~~act~~ title are
18 effective beginning with the reporting period ending December 31,
19 2010, and each year thereafter. An insurer or group of insurers
20 that are not required to file a report because the total written
21 premium is below the threshold and subsequently becomes subject to
22 the reporting requirements shall have two (2) years following the
23 year the threshold is exceeded, but not earlier than December 31,
24 2010, to file a report. Likewise, an insurer acquired in a business

1 combination shall have two (2) calendar years following the date of
2 acquisition or combination to comply with the reporting
3 requirements.

4 SECTION 5. AMENDATORY 36 O.S. 2001, Section 628, is
5 amended to read as follows:

6 Section 628. When by or pursuant to the laws of any other state
7 or foreign country any premium or income or other taxes, or any
8 fees, fines, penalties, licenses, deposit requirements or other
9 material obligations, prohibitions or restrictions are imposed upon
10 Oklahoma insurers doing business, or that might seek to do business
11 in such other state or country, or upon the agents of such insurers,
12 which in the aggregate are in excess of such taxes, fees, fines,
13 penalties, licenses, deposit requirements or other obligations,
14 prohibitions or restrictions directly imposed upon similar insurers
15 or agents of such other state or foreign country under the statutes
16 of this state, so long as such laws continue in force or are so
17 applied, the same obligations, prohibitions and restrictions of
18 whatever kind shall be imposed upon similar insurers or agents of
19 such other state or foreign country doing business in Oklahoma. All
20 insurance companies of other nations shall be held to the same
21 obligations and prohibitions that are imposed by the state where
22 they have elected to make their deposit and establish their
23 principal agency in the United States. Any tax, license or other
24 obligation imposed by any city, county or other political

1 subdivision of a state or foreign country on Oklahoma insurers or
2 their agents shall be deemed to be imposed by such state or foreign
3 country within the meaning of this section. The provisions of this
4 section shall not apply to ad valorem taxes on real or personal
5 property or to personal income taxes. ~~Monies collected pursuant to~~
6 ~~this section shall be paid by the Insurance Commissioner to the~~
7 ~~State Treasury to the credit of the General Revenue Fund of the~~
8 ~~state.~~

9 SECTION 6. AMENDATORY Section 75, Chapter 264, O.S.L.
10 2006, as amended by Section 1, Chapter 177, O.S.L. 2009 (36 O.S.
11 Supp. 2009, Section 924.4), is amended to read as follows:

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

22 B. Execution of the affidavit shall establish a rebuttable
23 presumption that the executor is not an employee for purposes of the
24 Workers' Compensation Act and that an individual or company

1 possessing the affidavit is in compliance and therefore shall not be
2 responsible for workers' compensation claims made by the executor.

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

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

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

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

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

23

24

1 SECTION 7. AMENDATORY Section 4, Chapter 127, O.S.L.
2 2003 (36 O.S. Supp. 2009, Section 953), is amended to read as
3 follows:

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

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

9 2. Deny, cancel or fail to renew a policy of personal insurance
10 solely on the basis of credit information, without consideration of
11 any other applicable underwriting factor independent of credit
12 information and not expressly prohibited by paragraph 1 of this
13 section;

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

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

21 5. Consider an absence of credit information or an inability to
22 calculate an insurance score in underwriting or rating personal
23 insurance, unless the insurer does one of the following:
24

- 1 a. treats the consumer as otherwise approved by the
2 Insurance Commissioner, if the insurer presents
3 information that ~~such~~ an absence or inability relates
4 to the risk for the insurer,
- 5 b. treats the consumer as if the applicant or insured had
6 neutral credit information, as defined by the insurer,
7 or
- 8 c. excludes the use of credit information as a factor and
9 use only other underwriting criteria;

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

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

- 19 a. at annual renewal, upon the request of a consumer or
20 the ~~consumer's~~ agent of the consumer, the insurer
21 shall reunderwrite and rerate the policy based upon a
22 current credit report or insurance score. An insurer
23 need not recalculate the insurance score or obtain the
24

1 updated credit report of a consumer more frequently
2 than once in a twelve-month period,

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

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

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

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

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

23 (4) the insurer reevaluates the insured beginning no
24 later than thirty-six (36) months after inception

1 and thereafter based upon other underwriting or
2 rating factors, excluding credit information; and

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

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

1 SECTION 8. NEW LAW A new section of law to be codified
2 in the Oklahoma Statutes as Section 953.1 of Title 36, unless there
3 is created a duplication in numbering, reads as follows:

4 A. An insurer that uses credit information shall, on written
5 request from an applicant for insurance coverage or an insured,
6 provide reasonable exceptions to the rates, rating classifications,
7 company or tier placement, or underwriting rules or guidelines of
8 the insurer for a consumer who has experienced and whose credit
9 information has been directly influenced by any of the following
10 events:

11 1. A catastrophic event, as declared by the federal or state
12 government;

13 2. A serious illness or injury, or serious illness of, or
14 injury to, an immediate family member;

15 3. The death of a spouse, child or parent;

16 4. A divorce or involuntary interruption of legally owed
17 alimony or support payments;

18 5. Identity theft;

19 6. A temporary loss of employment for a period of three (3)
20 months or more, if it results from involuntary termination;

21 7. Military deployment overseas; or

22 8. Other events, as determined by the insurer.

23

24

1 B. If an applicant or insured submits a request for an
2 exception as set forth in subsection A of this section, an insurer
3 may, in its sole discretion:

4 1. Require the consumer to provide reasonable written and
5 independently verifiable documentation of the event;

6 2. Require the consumer to demonstrate that the event had
7 direct and meaningful impact on the credit information of the
8 consumer;

9 3. Require the request be made no more than sixty (60) days
10 from the date of the application for insurance or policy renewal;

11 4. Grant an exception despite the consumer not providing the
12 initial request for an exception in writing; or

13 5. Grant an exception where the consumer asks for consideration
14 of repeated events or the insurer has considered the event
15 previously.

16 C. An insurer is not out of compliance with any law or rule
17 relating to underwriting, rating, or rate filing as a result of
18 granting an exception under this section. Nothing in this section
19 shall be construed to provide a consumer or other insured with a
20 cause of action that does not exist in the absence of this section.

21 D. The insurer shall provide notice to consumers that
22 reasonable exceptions are available and information about how the
23 consumer may inquire further.

1 E. Within thirty (30) days of the receipt of sufficient
2 documentation by the insurer of an event described in subsection A
3 of this section, the insurer shall inform the consumer of the
4 outcome of their request for a reasonable exception. The
5 communication shall be in writing or provided to an applicant in the
6 same medium as the request.

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

10 Section 997. Commercial Special Risks.

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

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

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

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

22 4. 3. Specifically designated special risks, including:

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

- b. all commercial insurance aviation risks,
- c. all credit insurance risks,
- d. all boiler ~~and~~, machinery or equipment breakdown risks,
- e. all inland marine risks,
- f. all fidelity and surety risks, and
- g. any other risk that the Commissioner determines to fall within the special risk category.

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

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

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

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

- 1 3. Name and address of the insured;
- 2 4. Nature and amount of liability assumed by the insurer;
- 3 5. Premium, and any membership, application, policy or
- 4 registration fees; and
- 5 6. Other information reasonably required by the Insurance
- 6 Commissioner.

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

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

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

18 SECTION 11. AMENDATORY Section 8, Chapter 125, O.S.L.
19 2007 (36 O.S. Supp. 2009, Section 1204.1), is amended to read as
20 follows:

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

1 SECTION 12. AMENDATORY 36 O.S. 2001, Section 1250.4, is
2 amended to read as follows:

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

13 B. Every agent, adjuster, administrator, insurance company
14 representative, or insurer, other than the State Insurance Fund and
15 its representatives, upon receipt of any inquiry from the
16 Commissioner ~~concerning a claim or a problem involving premium~~
17 ~~monies~~ shall, within ~~twenty (20)~~ thirty (30) days ~~after receipt of~~
18 ~~such~~ from the date of the inquiry, furnish the Commissioner with an
19 adequate response to the inquiry.

20 C. Every insurer, upon receipt of any pertinent ~~written~~
21 communication from a claimant which reasonably suggests that a
22 response is expected, shall, within thirty (30) days ~~after receipt~~
23 ~~thereof~~ from the date of the communication, furnish the claimant
24 with an adequate response to the communication.

1 D. Any violation by an insurer of this section shall subject
2 the insurer to discipline including a civil penalty of not less than
3 One Hundred Dollars (\$100.00) nor more than Five Thousand Dollars
4 (\$5,000.00).

5 SECTION 13. AMENDATORY 36 O.S. 2001, Section 1452, as
6 last amended by Section 16, Chapter 125, O.S.L. 2007 (36 O.S. Supp.
7 2009, Section 1452), is amended to read as follows:

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

1 One Hundred Dollars (\$100.00) or more than One Thousand Dollars
2 (\$1,000.00) for each occurrence, or both censure, suspension, or
3 revocation and civil penalty.

4 SECTION 14. AMENDATORY 36 O.S. 2001, Section 1464, is
5 amended to read as follows:

6 Section 1464. A. 1. To be licensed as a resident life or
7 accident and health insurance broker, an individual or legal entity
8 shall have been a licensed resident ~~or nonresident~~ insurance agent
9 or agency in this state continuously for at least two (2) years
10 immediately prior to application and such agent's license shall
11 remain in effect in order to maintain the broker's license. A
12 nonresident life or accident and health insurance broker applicant
13 may receive a license in this state if they are licensed and in good
14 standing in their home state, and if the home state of the applicant
15 awards nonresident licenses to residents of this state on the same
16 basis.

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

22 3. The fee for a life or accident and health insurance broker's
23 license shall be Fifty Dollars (\$50.00). The license may be renewed
24 each year for the same fee. Late application for renewal of a

1 license shall require a fee of double the amount of the original
2 current license fee. The fees shall be placed in the State
3 Insurance Commissioner Revolving Fund.

4 B. 1. Every applicant for a life or accident and health
5 insurance broker's license shall file with the Commissioner and,
6 upon approval of the application, maintain in force while licensed
7 and for at least two (2) years following termination of the license,
8 evidence satisfactory to the Commissioner of an errors and omissions
9 policy covering the individual applicant in an amount of not less
10 than One Hundred Thousand Dollars (\$100,000.00) annual aggregate for
11 all claims made during the policy period, or covering the applicant
12 under a blanket liability policy insuring other life or accident and
13 health insurance agents or brokers in an amount of not less than
14 Five Hundred Thousand Dollars (\$500,000.00) annual aggregate for all
15 claims made during the policy period.

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

22 3. Failure to maintain a policy in force shall result in
23 automatic termination of licensure, and the license shall be
24

1 returned by its lawful custodian to the Commissioner for further
2 cancellation.

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

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

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

23

24

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

4 D. Life or accident and health insurance brokers shall be
5 subject to the same violations, fines, and penalties as stated in
6 Section 1428 of this title. Violations of the provisions of the
7 Oklahoma Life, Accident and Health Insurance Broker Act may result,
8 after notice and hearing, in censure, suspension, or revocation of
9 license or a civil penalty of not less than One Hundred Dollars
10 (\$100.00), nor more than One Thousand Dollars (\$1,000.00), or a
11 combination thereof for each occurrence.

12 SECTION 15. AMENDATORY 36 O.S. 2001, Section 3614.1, is
13 amended to read as follows:

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

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

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

22 2. ~~"DNA" means deoxyribonucleic acid~~ "Family member" means,
23 with respect to an individual, any other individual who is a first-
24

1 degree, second-degree, third-degree, or fourth-degree relative of
2 the individual;

3 3. "Genetic information" means, with respect to any
4 individual, information derived from the results of a genetic test.
5 ~~Genetic information shall not include family history, the results of~~
6 ~~a routine physical examination or test, the results of a chemical,~~
7 ~~blood or urine analysis, the results of a test to determine drug~~
8 ~~use, the results of a test for the presence of the human~~
9 ~~immunodeficiency virus, or the results of any other test commonly~~
10 ~~accepted in clinical practice at the time it is ordered by the~~
11 ~~insurer~~ about the genetic tests of an individual, the genetic tests
12 of family members of an individual, and the manifestation of a
13 disease or disorder in family members of the individual. Genetic
14 information includes, but is not limited to, with respect to any
15 individual, any request for, or receipt of, genetic services, or
16 participation in clinical research which includes genetic services,
17 by an individual or any family member of the individual. Any
18 reference to genetic information concerning an individual or family
19 member of an individual who is a pregnant woman, includes genetic
20 information of any fetus carried by a pregnant woman, or with
21 respect to an individual or family member utilizing reproductive
22 technology, includes genetic information of any embryo legally held
23 by an individual or family member. Genetic information shall not
24 include information about the sex or age of any individual;

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

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

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

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

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

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

17 e. ~~any other test commonly accepted in clinical practice~~
18 ~~at the time it is ordered by the insurer~~ mean an
19 analysis of proteins or metabolites that does not
20 detect genotypes, mutations, or chromosomal changes or
21 an analysis of proteins or metabolites that is
22 directly related to a manifested disease, disorder, or
23 pathological condition that could reasonably be
24 detected by a health care professional with

1 appropriate training and expertise in the field of
2 medicine involved;

3 ~~5.~~ 6. "Insurer" means any individual, corporation, association,
4 partnership, insurance support organization, fraternal benefit
5 society, insurance ~~agent~~ producer, third-party ~~administration~~
6 administrator, self-insurer, or any other legal entity engaged in
7 the business of insurance which is licensed to do business in or
8 incorporated or domesticated or domiciled in or under the statutes
9 of this state, or actually engaged in business in this state,
10 regardless of where the contract of insurance is written or plan is
11 administered or where the corporation is incorporated, that issues
12 accident and health policies or plans or that administers any other
13 type of health insurance policy containing medical provisions
14 including, but not limited to, any nonprofit hospital service and
15 indemnity and medical service and indemnity corporation, health
16 maintenance organizations, preferred provider organizations, prepaid
17 health plans and the State and Education Employees Group Health
18 Insurance Plan. ~~Insurer shall not include insurers issuing life,~~
19 ~~disability income, or long term care insurance;~~

20 ~~6.~~ 7. "Policy" or "policy form" means any policy, contract,
21 plan or agreement of accident and health insurance, or subscriber
22 certificates of medical care corporations, health care corporations,
23 hospital service associations, or health care maintenance
24 organizations, delivered or issued for delivery in this state by any

1 insurer; any certificate, contract or policy issued by a fraternal
2 benefit society; any certificate issued pursuant to a group
3 insurance policy delivered or issued for delivery in this state; and
4 any evidence of coverage issued by a health maintenance
5 organization. ~~Policy or policy form shall not include life,~~
6 ~~disability income, and long term care insurance policies; and~~

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

8 8. "Underwriting purposes" means:

- 9 a. rules for, or determination of, eligibility, including
10 but not limited to enrollment and continued
11 eligibility, for benefits under the policy,
12 b. the computation of premium or contribution amounts
13 under the policy,
14 c. the application of any pre-existing condition
15 exclusion under the policy, and
16 d. other activities related to the creation, renewal, or
17 replacement of a contract of health insurance or
18 health benefits.

19 C. No insurer offering an individual or group accident and
20 health insurance policy shall, for the purpose of determining
21 eligibility of any individual for any insurance coverage,
22 establishing premiums, limiting coverage, renewing coverage,
23 terminating coverage or any other underwriting decision in
24 connection with the offer, sale or renewal or continuation of a

1 ~~policy, except to the extent and in the same fashion as an insurer~~
2 ~~limits coverage, or increases premiums for loss caused or~~
3 ~~contributed to by other medical conditions presenting an increased~~
4 ~~degree of risk:~~

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

12 2. ~~Condition the provision of the policy upon a requirement~~
13 ~~that an individual take a genetic test Discriminate in the pricing~~
14 ~~of the policy or certificate, including but not limited to the~~
15 ~~adjustment of premium rates, of an individual on the basis of the~~
16 ~~genetic information with respect to any individual.~~

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

23 1. Denying or conditioning the issuance or effectiveness of the
24 policy or certificate or increasing the premium for a group on the

1 basis of manifestations of any condition, disease or disorder of an
2 insured or applicant; or

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

9 E. ~~1. Any violation of subsections C and D of this section by~~
10 ~~an insurer shall be deemed an unfair practice pursuant to Section~~
11 ~~1201 et seq. of Title 36 of the Oklahoma Statutes.~~

12 ~~2. In addition, any individual who is damaged by an insurer's~~
13 ~~violation of this section may recover in a court of competent~~
14 ~~jurisdiction equitable relief, which may include a retroactive~~
15 ~~order, directing the insurer to provide insurance coverage to the~~
16 ~~damaged individual under the same terms and conditions as would have~~
17 ~~applied had the violation not occurred~~ An insurer shall not request
18 or require an individual or a family member of an individual to
19 undergo a genetic test.

20 F. ~~Notwithstanding any language in this section to the~~
21 ~~contrary, this section shall not apply to an insurer or to an~~
22 ~~individual or third party dealing with an insurer in the ordinary~~
23 ~~course of underwriting, conducting, or administering the business of~~
24 ~~life, disability income, or long term care insurance~~ Subsection E of

1 this section shall not be construed to preclude an insurer from
2 obtaining and using the results of a genetic test in making a
3 determination regarding payment, as defined for the purposes of
4 applying the regulations promulgated under part C of Title XI and
5 Section 264 of the Health Insurance Portability and Accountability
6 Act of 1996, as may be revised from time to time, and consistent
7 with subsection C of this section.

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

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

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

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

22 a. compliance with the request is voluntary, and
23 b. noncompliance shall have no effect on enrollment
24 status or premium or contribution amounts;

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

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

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

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

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

20 K. If an insurer obtains genetic information incidental to the
21 requesting, requiring, or purchasing of other information concerning
22 any individual, the request, requirement, or purchase shall not be
23 considered a violation of subsection J of this section if the
24

1 request, requirement, or purchase is not in violation of subsection
2 I of this section.

3 SECTION 16. AMENDATORY 36 O.S. 2001, Section 6060, as
4 last amended by Section 23, Chapter 184, O.S.L. 2008 (36 O.S. Supp.
5 2009, Section 6060), is amended to read as follows:

6 Section 6060. A. ~~All individual and group health insurance~~
7 ~~policies providing coverage on an expense incurred basis, and all~~
8 ~~individual and group service or indemnity type contracts issued by a~~
9 ~~nonprofit corporation, including the Oklahoma State and Education~~
10 ~~Employees Group Insurance Board, which provide coverage for a female~~
11 ~~thirty five (35) years old or older in this state, except for~~
12 ~~policies that provide coverage for specified disease or other~~
13 ~~limited benefit coverage, health benefit plans shall include the~~
14 ~~coverage specified by this section for a mammography screening in a~~
15 ~~reimbursement amount not to exceed One Hundred Fifteen Dollars~~
16 ~~(\$115.00) for the presence of occult breast cancer. Such coverage~~
17 shall not:

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

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

22 B. 1. Any female thirty-five (35) through thirty-nine (39)
23 years of age shall be entitled pursuant to the provisions of this
24

1 section to coverage for a mammography screening once every five (5)
2 years.

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

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

9 SECTION 17. AMENDATORY 36 O.S. 2001, Section 6060.2, is
10 amended to read as follows:

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

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

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

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

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

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

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

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

21 provided, however, payment for the coverage required for diabetes
22 self-management training pursuant to the provisions of this section
23 shall be required only upon certification by the health care
24

1 provider providing the training that the patient has successfully
2 completed diabetes self-management training.

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

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

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

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

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

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

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

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

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

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

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

21 Section 6060.3. A. Every health benefit plan ~~contract~~ issued,
22 amended, renewed or delivered in this state on or after July 1,
23 1996, that provides maternity benefits shall provide for coverage
24 of:

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

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

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

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

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

20 (a) the recommended childhood immunization
21 schedule,

22 (b) the importance of childhood immunizations,
23 and
24

1 (c) resources for obtaining childhood
2 immunizations,

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

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

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

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

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

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

12 a. the recommended childhood immunization schedule,

13 b. the importance of childhood immunizations, and

14 c. resources for obtaining childhood immunizations;

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

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

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

21 1. In the sole medical discretion or judgment of the attending
22 physician licensed by the Oklahoma State Board of Medical Licensure
23 and Supervision or the State Board of Osteopathic Examiners or the
24 certified nurse midwife licensed by the Oklahoma Board of Nursing

1 providing care to the mother and to the newborn infant, it is
2 determined prior to discharge that an earlier discharge of the
3 mother and newborn infant is appropriate and meets medical criteria
4 contained in the most current treatment standards of the American
5 Academy of Pediatrics and the American College of Obstetricians and
6 Gynecologists that determine the appropriate length of stay based
7 upon:

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

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

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

- 22 a. physical assessment of the mother and the newborn
23 infant,
- 24 b. parent education, to include, but not be limited to:

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

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

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

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

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

1 health care provider who orders care consistent with the provisions
2 of this section.

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

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

14 SECTION 19. AMENDATORY Section 1, Chapter 397, O.S.L.
15 2004 (36 O.S. Supp. 2009, Section 6060.3a), is amended to read as
16 follows:

17 Section 6060.3a. A. Any health benefit plan, including the
18 State and Education Employees Group Health Insurance plan, that is
19 offered, issued or renewed in this state on or after January 1,
20 2005, that provides medical and surgical benefits shall provide
21 coverage for routine annual obstetrical/gynecological examinations.

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

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 20. 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 21. 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 22. 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 23. 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 24. 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 25. 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 26. 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 27. 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 28. 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~~ 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 29. 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 30. 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. 6. "Case characteristics" means demographic or other
16 objective characteristics of a small employer that are considered by
17 the small employer carrier in the determination of premium rates for
18 the small employer, provided that claim experience, health status
19 and duration of coverage shall not be case characteristics for the
20 purposes of the Small Employer Health Insurance Reform Act. A
21 small employer carrier shall not use case characteristics, other
22 than age, gender, industry, geographic area and family composition,
23 without prior approval of the Insurance Commissioner. Group size
24 shall not be used as a case characteristic;

1 ~~8.~~ 7. "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.~~ 8. "Commissioner" means the Insurance Commissioner;

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

22 ~~11.~~ 10. "Department" means the Insurance Department;

23 ~~12.~~ 11. "Dependent" means a spouse, an unmarried child under
24 the age of eighteen (18), an unmarried child who is a full-time

1 student under the age of twenty-three (23) and who is financially
2 dependent upon the parent, and an unmarried child of any age who is
3 medically certified as disabled and dependent upon the parent;

4 ~~13.~~ 12. "Eligible employee" means an employee who works on a
5 full-time basis or, at the option of the employer, an employee who
6 works on a part-time basis with a normal work week of twenty-four
7 (24) or more hours. The term includes a sole proprietor, a partner
8 of a partnership, and associates of a limited liability company, if
9 the sole proprietor, partner or associate is included as an employee
10 under a health benefit plan of a small employer, but does not
11 include an employee who works on a temporary or substitute basis;

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

17 ~~15.~~

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

23 b. Health benefit plan does not include accident-only,
24 credit, dental, vision, Medicare supplement, long-term

1 care, or disability income insurance, coverage issued
2 as a supplement to liability insurance, worker's
3 compensation or similar insurance, ~~any plan certified~~
4 ~~by the Oklahoma Basic Health Benefits Board,~~ or
5 automobile medical payment insurance.

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

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

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

17 (a) a statement from the carrier certifying that
18 policies or certificates described in this
19 subparagraph are being offered and marketed
20 as supplemental health insurance and not as
21 a substitute for hospital or medical expense
22 insurance or major medical expense
23 insurance, and
24

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

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

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

21 ~~17.~~ 16. "Late enrollee" means an eligible employee or dependent
22 who requests enrollment in a health benefit plan of a small employer
23 following the initial enrollment period during which the individual
24 is entitled to enroll under the terms of the health benefit plan,

1 provided that the initial enrollment period is a period of at least
2 thirty-one (31) days. However, an eligible employee or dependent
3 shall not be considered a late enrollee if:

4 a. the individual meets each of the following:

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

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

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

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

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

1 ~~18.~~ 17. "New business premium rate" means, for each class of
2 business as to a rating period, the lowest premium rate charged or
3 offered, or which could have been charged or offered, by the small
4 employer carrier to small employers with similar case
5 characteristics for newly issued health benefit plans with the same
6 or similar coverage;

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

9 ~~20.~~ 18. "Premium" means all monies paid by a small employer and
10 eligible employees as a condition of receiving coverage from a small
11 employer carrier, including any fees or other contributions
12 associated with the health benefit plan;

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

15 ~~22.~~ 19. "Qualifying previous coverage" and "qualifying existing
16 coverage" mean benefits or coverage provided under:

- 17 a. Medicare or Medicaid,
- 18 b. an employer-based health insurance or health benefit
19 arrangement that provides benefits similar to or
20 exceeding benefits provided under the basic health
21 benefit plan, or
- 22 c. an individual health insurance policy, including
23 coverage issued by a health maintenance organization,
24 fraternal benefit society and those entities set forth

1 in ~~Section 2501 et seq. of Title 63 of the Oklahoma~~
2 ~~Statutes~~ Sections 6901 through 6936 of this title,
3 that provides benefits similar to or exceeding the
4 benefits provided under the basic health benefit plan,
5 provided that ~~such~~ the policy has been in effect for a
6 period of at least one (1) year;

7 ~~23.~~ 20. "Rating period" means the calendar period for which
8 premium rates established by a small employer carrier are assumed to
9 be in effect;

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

13 ~~25.~~ 21. "Restricted network provision" means any provision of a
14 health benefit plan that conditions the payment of benefits, in
15 whole or in part, on the use of health care providers that have
16 entered into a contractual arrangement with the carrier pursuant to
17 ~~Section 2501 et seq. of Title 63 of the Oklahoma Statutes~~ Sections
18 6901 through 6963 of this title to provide health care services to
19 covered individuals;

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

23 ~~27.~~ 22. "Small employer" means any person, firm, corporation,
24 partnership, limited liability company or association that is

1 actively engaged in business that, on at least fifty percent (50%)
2 of its working days during the preceding calendar quarter, employed
3 no more than fifty (50) eligible employees, the majority of whom
4 were employed within this state. In determining the number of
5 eligible employees, companies that are affiliated companies, or that
6 are eligible to file a combined tax return for purposes of state
7 income taxation, shall be considered one employer; and

8 ~~28.~~ 23. "Small employer carrier" means a carrier that offers
9 health benefit plans covering eligible employees of one or more
10 small employers in this state; ~~and~~

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

13 SECTION 31. AMENDATORY 36 O.S. 2001, Section 6515, is
14 amended to read as follows:

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

18 1. The rate manual developed for use by a small employer
19 carrier shall be filed and approved by the Insurance Commissioner
20 prior to use. Any changes to the rate manual shall be filed and
21 approved by the Insurance Commissioner prior to use. Every filing
22 shall be made not less than thirty (30) days prior to the date the
23 small employer carrier intends to implement the rates. The rate
24 manual so filed shall be deemed approved upon expiration of the

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

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

24

1 period in accordance with accepted actuarial principles and
2 practices;

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

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

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

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

1 small employer carrier is actively enrolling new small
2 employers,

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

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

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

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

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

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

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

1 small employer carrier is actively enrolling new small
2 employers, and

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

7 ~~10.~~ 9. Small employer carriers shall:

- 8 a. apply rating factors, including case characteristics,
9 consistently with respect to all small employers in a
10 class of business. Rating factors shall produce
11 premiums for identical groups within the same class of
12 business which differ only by amounts attributable to
13 plan design and do not reflect differences due to
14 claims experience, health status and duration of
15 coverage, and
- 16 b. treat all health benefit plans issued or renewed in
17 the same calendar month as having the same rating
18 period;

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

1 ~~12.~~ 11. The Insurance Commissioner may establish rules to
2 implement the provisions of this section and to assure that rating
3 practices used by small employer carriers are consistent with the
4 purposes of the Small Employer Health Insurance Reform Act,
5 including:

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

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

20 C. The Commissioner may suspend for a specified period the
21 application of paragraph 3 of subsection A of this section as to the
22 premium rates applicable to one or more small employers included
23 within a class of business of a small employer carrier for one or
24 more rating periods upon a filing by the small employer carrier and

1 a finding by the Commissioner either that the suspension is
2 reasonably necessary in light of the financial condition of the
3 small employer carrier or that the suspension would enhance the
4 efficiency and fairness of the marketplace for small employer health
5 insurance.

6 SECTION 32. AMENDATORY 36 O.S. 2001, Section 6522, is
7 amended to read as follows:

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

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

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

18 ~~2. a. In selecting the members of the board, the~~
19 ~~Commissioner shall include representatives of small~~
20 ~~employers and small employer carriers and such other~~
21 ~~individuals determined to be qualified by the~~
22 ~~Commissioner. At least five members of the board~~
23 ~~shall be representatives of carriers and shall be~~
24 ~~selected from individuals nominated in this state~~

1 ~~pursuant to procedures and guidelines developed by the~~
2 ~~Commissioner.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1 ~~1. Enter into contracts as are necessary or proper to carry out~~
2 ~~the provisions and purposes of this act, including the authority,~~
3 ~~with the approval of the Commissioner, to enter into contracts with~~
4 ~~similar programs of other states for the joint performance of common~~
5 ~~functions or with persons or other organizations for the performance~~
6 ~~of administrative functions;~~
- 7 ~~2. Sue or be sued, including taking any legal actions necessary~~
8 ~~or proper to recover any assessments and penalties for, on behalf~~
9 ~~of, or against the program or any reinsuring carriers;~~
- 10 ~~3. Take any legal action necessary to avoid the payment of~~
11 ~~improper claims against the program;~~
- 12 ~~4. Define the health benefit plans for which reinsurance will~~
13 ~~be provided, and to issue reinsurance policies, in accordance with~~
14 ~~the requirements of this act;~~
- 15 ~~5. Establish rules, conditions and procedures for reinsuring~~
16 ~~risks under the program;~~
- 17 ~~6. Establish actuarial functions as appropriate for the~~
18 ~~operation of the program;~~
- 19 ~~7. Assess reinsuring carriers in accordance with the provisions~~
20 ~~of subsection L of this section, and to make advance interim~~
21 ~~assessments as may be reasonable and necessary for organizational~~
22 ~~and interim operating expenses. Any interim assessments shall be~~
23 ~~credited as offsets against any regular assessments due following~~
24 ~~the close of the fiscal year;~~

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

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

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

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

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

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

1 ~~4. a. The program shall not reimburse a reinsuring carrier~~
2 ~~with respect to the claims of a reinsured employee or~~
3 ~~dependent until the carrier has incurred an initial~~
4 ~~level of claims for such employee or dependent of Five~~
5 ~~Thousand Dollars (\$5,000.00) in a calendar year for~~
6 ~~benefits covered by the program. In addition, the~~
7 ~~reinsuring carrier shall be responsible for ten~~
8 ~~percent (10%) of the next Fifty Thousand Dollars~~
9 ~~(\$50,000.00) of benefit payments during a calendar~~
10 ~~year, and the program shall reinsure the remainder. A~~
11 ~~reinsuring carrier's liability under this subparagraph~~
12 ~~shall not exceed a maximum limit of Ten Thousand~~
13 ~~Dollars (\$10,000.00) in any one (1) calendar year with~~
14 ~~respect to any reinsured individual.~~

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

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

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

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

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

1 ~~set forth in paragraph 2 of this subsection to determine the premium~~
2 ~~rates for the program. The base reinsurance premium rates shall be~~
3 ~~established by the board, subject to the approval of the~~
4 ~~Commissioner, and shall be set at levels which reasonably~~
5 ~~approximate gross premiums charged to small employers by small~~
6 ~~employer carriers for health benefit plans with benefits similar to~~
7 ~~the standard health benefit plan, adjusted to reflect retention~~
8 ~~levels required under this act.~~

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

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

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

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

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

24

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

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

10 ~~K. If a health benefit plan for a small employer is entirely or~~
11 ~~partially reinsured with the program, the premium charged to the~~
12 ~~small employer for any rating period for the coverage issued shall~~
13 ~~meet the requirements relating to premium rates set forth in Section~~
14 ~~6515 of this title.~~

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

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

22 ~~a. The board shall establish, as part of the plan of~~
23 ~~operation, a formula by which to make assessments~~

1 ~~against reinsuring carriers. The assessment formula~~
2 ~~shall be based on:~~

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

8 ~~(2) each reinsuring carrier's share of the premiums~~
9 ~~earned in the preceding calendar year from newly~~
10 ~~issued health benefit plans delivered or issued~~
11 ~~for delivery during the calendar year to small~~
12 ~~employers in this state by reinsuring carriers.~~

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

1 ~~delivery to small employers in this state by all~~
2 ~~reinsuring carriers.~~

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

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

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

21 ~~b. If the board determines that the assessments needed to~~
22 ~~fund the losses incurred by the program in the~~
23 ~~previous calendar year will exceed five percent (5%)~~
24 ~~of total premiums earned in the previous calendar year~~

1 ~~from health benefit plans delivered or issued for~~
2 ~~delivery to small employers in this state by~~
3 ~~reinsuring carriers, the board shall evaluate the~~
4 ~~operation of the program and report its findings,~~
5 ~~including any recommendations for changes to the plan~~
6 ~~of operation, to the Commissioner within ninety (90)~~
7 ~~days following the end of the calendar year in which~~
8 ~~the losses were incurred. The evaluation shall~~
9 ~~include an estimate of future assessments and~~
10 ~~consideration of the administrative costs of the~~
11 ~~program, the appropriateness of the premiums charged,~~
12 ~~the level of insurer retention under the program and~~
13 ~~the costs of coverage for small employers. If the~~
14 ~~board fails to file a report with the Commissioner~~
15 ~~within ninety (90) days following the end of the~~
16 ~~applicable calendar year, the Commissioner may~~
17 ~~evaluate the operations of the program and implement~~
18 ~~such amendments to the plan of operation the~~
19 ~~Commissioner deems necessary to reduce future losses~~
20 ~~and assessments.~~

21 ~~c. If assessments in each two (2) consecutive calendar~~
22 ~~years exceed five percent (5%) of total premiums~~
23 ~~earned in the previous calendar year from health~~
24 ~~benefit plans delivered or issued for delivery to~~

1 ~~small employers in this state by reinsuring carriers,~~
2 ~~the program shall be eligible to receive additional~~
3 ~~financing as provided in Section 6523 of this title.~~

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

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

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

15 ~~7. A reinsuring carrier may seek from the Commissioner a~~
16 ~~deferment from all or part of an assessment imposed by the board.~~
17 ~~The Commissioner may defer all or part of the assessment of a~~
18 ~~reinsuring carrier if the Commissioner determines that the payment~~
19 ~~of the assessment would place the reinsuring carrier in a~~
20 ~~financially impaired condition. If all or part of an assessment~~
21 ~~against a reinsuring carrier is deferred, the amount deferred shall~~
22 ~~be assessed against the other participating carriers in a manner~~
23 ~~consistent with the basis for assessment set forth in this~~
24 ~~subsection. The reinsuring carrier receiving the deferment shall~~

1 ~~remain liable to the program for the amount deferred and shall be~~
2 ~~prohibited from reinsuring any individuals or groups with the~~
3 ~~program until such time as it pays the assessments.~~

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

10 ~~N. The program shall be exempt from any and all taxes~~ Upon the
11 repeal of the Oklahoma Small Employer Health Reinsurance Program by
12 the legislature, the board shall develop a plan to wind up business
13 of the Oklahoma Employer Health Reinsurance Program.

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

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

22 SECTION 33. AMENDATORY 36 O.S. 2001, Section 6526, is
23 amended to read as follows:
24

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

6 SECTION 34. AMENDATORY 36 O.S. 2001, Section 6608, as
7 amended by Section 53, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2009,
8 Section 6608), is amended to read as follows:

9 Section 6608. A. An application for license as a service
10 warranty association shall be made to, and filed with, the Insurance
11 Commissioner on printed forms as prescribed and furnished by the
12 Insurance Commissioner.

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

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

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

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

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

23 1. A copy of the articles of incorporation of the applicant,
24 certified by the public official having custody of the original, and

1 a copy of the bylaws of the applicant, certified by the chief
2 executive officer of the applicant;

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

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

8 D. Upon completion of the application for license, the
9 Commissioner shall examine the application and make such further
10 investigation of the applicant as the Commissioner deems advisable.
11 If the Commissioner finds that the applicant is qualified, the
12 Commissioner shall issue to the applicant a license as a service
13 warranty association. If the Commissioner does not find the
14 applicant to be qualified the Commissioner shall refuse to issue the
15 license and shall give the applicant written notice of ~~such~~ the
16 refusal, setting forth the grounds ~~therefor~~ of the refusal.

17 E. 1. Any entity that claims one or more of the exclusions
18 from the definition of service warranty provided in paragraph 14 of
19 Section 6602 of this title shall file audited financial statements
20 and other information as requested by the Commissioner by May 1,
21 2010, to document and verify that the ~~entity's~~ contracts of the
22 entity are not included within the definition of service warranty.

23 2. Any entity that fails to meet the May 1, 2010, deadline or
24 that begins claiming an exclusion exemption provided by paragraph 14

1 of Section 6602 of this title after May 1, 2010, shall file audited
2 financial statements and other information as requested by the
3 Commissioner prior to conducting or continuing business in this
4 state.

5 3. Any entity approved for an exclusion provided by paragraph
6 14 of Section 6602 of this title may be required by the Commissioner
7 to provide subsequent audited financial statements and other
8 information ascertained by the Commissioner to be necessary to
9 determine continued qualification for an exclusion provided by
10 paragraph 14 of Section 6602 of this title.

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

15 SECTION 35. AMENDATORY 36 O.S. 2001, Section 6609, as
16 amended by Section 27, Chapter 184, O.S.L. 2008 (36 O.S. Supp. 2009,
17 Section 6609), is amended to read as follows:

18 Section 6609. Each license issued to a service warranty
19 association shall expire on November 1 following the date of
20 issuance. If the association is then qualified ~~therefor~~ under the
21 provisions of the Service Warranty Insurance Act, its license may be
22 renewed annually, upon its request, and upon payment to the
23 Insurance Commissioner of the license fee in the amount of ~~Two~~

24

1 ~~Hundred Dollars (\$200.00)~~ Four Hundred Dollars (\$400.00) in advance
2 for each such license year.

3 SECTION 36. AMENDATORY 36 O.S. 2001, Section 6615, as
4 last amended by Section 24, Chapter 432, O.S.L. 2009 (36 O.S. Supp.
5 2009, Section 6615), is amended to read as follows:

6 Section 6615. A. In addition to the license fees provided in
7 the Service Warranty Insurance Act for service warranty associations
8 each ~~such~~ service warranty association and insurer shall, annually
9 on or before the ~~last~~ first day of ~~February~~ May, file with the
10 Insurance Commissioner its annual statement in the form prescribed
11 by the Commissioner showing all gross written premiums or
12 assessments received by it in connection with the issuance of
13 service warranties in this state during the preceding calendar year
14 and other relevant financial information as deemed necessary by the
15 Commissioner, using accounting principles which will enable the
16 Commissioner to ascertain whether the financial requirements set
17 forth in Section 6607 of this title have been satisfied.

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

22 C. In addition to an annual statement, the Commissioner may
23 require of licensees, under oath and in the form prescribed by it,
24 quarterly statements or special reports which the Commissioner deems

1 necessary for the proper supervision of licensees under the Service
2 Warranty Insurance Act.

3 D. Premiums and assessments received by associations and
4 insurers for service warranties shall not be subject to the premium
5 tax provided for in Section 624 of this title, but shall be subject
6 to an administrative fee of equal to two percent (2%) of the gross
7 premium received on the sale of all service contracts issued in this
8 state during the preceding calendar quarter. Said fees shall be
9 paid quarterly to the Insurance Commissioner. However, licensed
10 associations, licensed insurers and entities with applications for
11 licensure as a service warranty association pending with the
12 Department that have contractual liability insurance in place as of
13 March 31, 2009, from an insurer which satisfies the requirements of
14 ~~subsection~~ subsections B and C of Section 6607 of this title and
15 which covers one hundred percent (100%) of the claims exposure of
16 the association or insurer on all contracts written may elect to pay
17 an annual administrative fee of Three Thousand Dollars (\$3,000.00)
18 in lieu of the two-percent administrative fee.

19 SECTION 37. AMENDATORY 36 O.S. 2001, Section 6620, as
20 last amended by Section 9, Chapter 189, O.S.L. 2009 (36 O.S. Supp.
21 2009, Section 6620), is amended to read as follows:

22 Section 6620. Along with the annual statement filed pursuant to
23 Section ~~6618~~ 6615 of this title, each service warranty association
24

1 or insurer shall provide the name and business address of each sales
2 representative utilized by it in this state.

3 SECTION 38. AMENDATORY Section 11, Chapter 390, O.S.L.
4 2003, as amended by Section 54, Chapter 176, O.S.L. 2009 (36 O.S.
5 Supp. 2009, Section 6810), is amended to read as follows:

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

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

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

15 1. "Claim" means:

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

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

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

23 3. "Closed claim" means a claim that has been settled or
24 otherwise disposed of by the insuring entity, self-insurer,

1 facility, or provider. A claim may be closed with or without an
2 indemnity payment to a claimant;

3 4. "Commissioner" means the Insurance Commissioner;

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

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

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

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

18 a. a person licensed to provide health care or related
19 services, including an acupuncturist, doctor of
20 medicine or osteopathy, a dentist, a nurse, an
21 optometrist, a podiatric physician and surgeon, a
22 chiropractor, a physical therapist, a psychologist, a
23 pharmacist, an optician, a physician's assistant, a
24 midwife, an osteopathic physician's assistant, a nurse

1 practitioner, or a physician's trained mobile
2 intensive care paramedic. If the person is deceased,
3 this includes the estate or personal representative of
4 the person, or

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

10 9. "Insuring entity" means:

- 11 a. an authorized insurer,
- 12 b. a captive insurer,
- 13 c. a joint underwriting association,
- 14 d. a patient compensation fund,
- 15 e. a risk retention group, or
- 16 f. an unauthorized insurer that provides surplus lines
17 coverage;

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

21 11. "Noneconomic damages" means subjective, nonmonetary losses,
22 including pain, suffering, inconvenience, mental anguish, disability
23 or disfigurement incurred by the injured party, emotional distress,
24 loss of society and companionship, loss of consortium, humiliation

1 and injury to reputation, and destruction of the parent-child
2 relationship; and

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

6 SECTION 39. AMENDATORY Section 12, Chapter 390, O.S.L.
7 2003, as amended by Section 55, Chapter 176, O.S.L. 2009 (36 O.S.
8 Supp. 2009, Section 6811), is amended to read as follows:

9 Section 6811. A. ~~Not later than the tenth day after the last~~
10 ~~day of the calendar quarter in which~~ When a claim for recovery under
11 a medical professional liability insurance policy is closed, the
12 insurer shall file with the Insurance Department a closed claim
13 report not later than April 1 of the same calendar year if the claim
14 is closed prior to April 1, and if the claim is closed after April
15 1, then the closed claim report shall be filed by April 1 of the
16 subsequent calendar year. These reports ~~must~~ shall include data for
17 all claims closed in the preceding calendar year and any adjustments
18 to data reported in prior years.

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

23 C. Every insuring entity or self-insurer that provides medical
24 professional liability insurance to any facility or provider in this

1 state ~~must~~ shall report each medical professional liability closed
2 claim to the Insurance Commissioner.

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

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

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

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

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

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

6 1. If a facility or provider is insured by a risk retention
7 group and the risk retention group refuses to report closed claims
8 and asserts that the federal Liability Risk Retention Act (95 Stat.
9 949; 15 U.S.C. Sec. 3901 et seq.) preempts state law, the facility
10 or provider ~~must~~ shall report all data required by the Medical
11 Professional Liability Insurance Closed Claim Reports Act on behalf
12 of the risk retention group.

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

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

1 SECTION 40. AMENDATORY Section 4, Chapter 64, O.S.L.
2 2002 (40 O.S. Supp. 2009, Section 600.4), is amended to read as
3 follows:

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

11 B. Registration information.

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

1 ~~1.~~ The

2 a. the name or names under which the PEO conducts
3 business~~+~~,

4 ~~2.~~ The

5 b. the address of the principal place of business of the
6 PEO and the address of each office it maintains in
7 this state~~+~~,

8 ~~3.~~ The

9 c. the PEO's taxpayer or employer identification number~~+~~,

10 ~~4.~~ A

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

15 ~~5.~~ A

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

22 ~~6.~~ A

23 f. a statement of management, which shall include the
24 name and evidence of the business experience of any

1 person who serves as president, chief executive
2 officer, or otherwise has the authority to act as
3 senior executive officer of the PEO~~7~~, and

4 ~~7.~~ ~~A~~

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

16 2. For purposes of the Oklahoma Professional Employer
17 Organization Recognition and Registration Act, "assurance
18 organization" means an independent entity approved by the
19 Commissioner to certify the qualifications of a PEO for registration
20 under this section and Section 600.6 of this title and any related
21 requirements and procedures. To be considered for approval as an
22 independent and qualified assurance organization, the assurance
23 organization shall submit a written request for approval to the
24

1 Commissioner. The written request shall include, but not be limited
2 to, the following:

3 a. evidence that the assurance organization has an
4 established national program for the accreditation and
5 financial assurance of PEOs based on requirements
6 consistent with the requirements of the Oklahoma
7 Professional Employer Organization Recognition and
8 Registration Act,

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

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

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

23 (1) authorize the assurance organization to share
24 with the Commissioner any application and

1 compliance reporting information required under
2 the Oklahoma Professional Employer Organization
3 Recognition and Registration Act that has been
4 provided to the assurance organization by the
5 PEO,

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

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

18 (4) provide the certification of the assurance
19 organization that the PEO is in compliance with
20 all requirements of the Oklahoma Professional
21 Employer Organization Recognition and
22 Registration Act and is qualified for
23 registration or renewal of registration under the
24

1 Oklahoma Professional Employer Organization
2 Recognition and Registration Act,

3 e. an agreement to provide written notice to the
4 Commissioner within two (2) business days of any
5 failure of a PEO to meet the qualifications for
6 registration under the Oklahoma Professional Employer
7 Organization Recognition and Registration Act or any
8 failure of the PEO to meet the qualifications for
9 accreditation or certification by the assurance
10 organization, and

11 f. an agreement to share with the Commissioner in a
12 timely manner the information and supporting
13 documentation provided to the assurance organization
14 by the PEO consistent with the information and
15 documentation required for registration or renewal of
16 registration under the Oklahoma Professional Employer
17 Organization Recognition and Registration Act.

18 C. Initial registration.

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

23 2. Each PEO not operating within this state as of November 1,
24 2002, shall complete its initial registration prior to commencement

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

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

9 Before expiration of the registration, a registrant may renew the
10 registration for an additional one (1) year term if the registrant:

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

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

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

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

23 F. Electronic filing and compliance. A PEO or an approved
24 independent and qualified assurance organization as provided for in

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

7 G. De minimis exemption.

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

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

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

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

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

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

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

12 K. Nothing in this section shall limit or change the authority
13 of the Commissioner to register or terminate registration of a PEO
14 or to investigate or enforce any provision of this act.

15 SECTION 41. AMENDATORY Section 5, Chapter 64, O.S.L.
16 2002 (40 O.S. Supp. 2009, Section 600.5), is amended to read as
17 follows:

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

22 B. Initial Group Registration. Upon filing an initial Group
23 registration statement pursuant to the Oklahoma Professional
24 Employer Organization Recognition and Registration Act, the PEO

1 Group shall pay an initial registration fee of Five Hundred Dollars
2 (\$500.00) per member of the PEO Group.

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

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

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

16 SECTION 42. AMENDATORY 59 O.S. 2001, Section 1305, as
17 amended by Section 5, Chapter 204, O.S.L. 2003 (59 O.S. Supp. 2009,
18 Section 1305), is amended to read as follows:

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

- 21 1. Is a person who has reached the age of twenty-one (21)
22 years;
- 23 2. Is of good character and reputation;

24

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

4 4. Is a citizen of the United States;

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

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

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

10 8. Has a high school diploma or its equivalent; provided,
11 however, the provisions of this paragraph shall apply only to
12 initial applications for license submitted on or after November 1,
13 1997, and shall not apply to renewal applications for license.

14 B. The applicant shall apply in writing on forms prepared and
15 supplied by the Insurance Commissioner, and the Commissioner may
16 propound any reasonable interrogatories to an applicant for a
17 license pursuant to ~~Section~~ Sections 1301 ~~et seq.~~ through 1340 of
18 this title, or on any renewal thereof, relating to qualifications,
19 residence, prospective place of business and any other matters
20 which, in the opinion of the Commissioner, are deemed necessary or
21 expedient in order to protect the public and ascertain the
22 qualifications of the applicant. The Commissioner may also conduct
23 any reasonable inquiry or investigation relative to the
24 determination of the ~~applicant's~~ fitness of the applicant to be

1 licensed or to continue to be licensed including, but not limited
2 to, requiring a national criminal history record check as defined by
3 Section 150.9 of Title 74 of the Oklahoma Statutes.

4 C. An applicant shall furnish to the Commissioner a license fee
5 of Two Hundred Fifty Dollars (\$250.00) with the application, a
6 complete set of the ~~applicant's~~ fingerprints of the applicant and
7 two recent credential-size full face photographs of the applicant.
8 The ~~applicant's~~ fingerprints of the applicant shall be certified by
9 an authorized law enforcement officer. The applicant shall provide
10 with the application an investigative fee of One Hundred Dollars
11 (\$100.00) with which the Commissioner will conduct an investigation
12 of the applicant. All fees shall be nonrefundable.

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

17 E. The fee for a duplicate license shall be Twenty-five Dollars
18 (\$25.00).

19 SECTION 43. AMENDATORY 59 O.S. 2001, Section 1306, as
20 last amended by Section 1, Chapter 196, O.S.L. 2009 (59 O.S. Supp.
21 2009, Section 1306), is amended to read as follows:

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

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

23 3. Professional bondsman applicants shall make a deposit with
24 the Insurance Commissioner in the same manner as required of

1 domestic insurance companies of an amount to be determined by the
2 Commissioner. For all applications made prior to ~~the effective date~~
3 ~~of this act~~ November 1, 1996 and the subsequent renewals of a
4 license issued upon ~~such~~ the application when continuously
5 maintained in effect as required by law, the deposit shall not be
6 less than Twenty Thousand Dollars (\$20,000.00). For all
7 applications made on and after ~~the effective date of this act~~
8 November 1, 1996 and the subsequent renewals of a license issued
9 upon ~~such~~ the application when continuously maintained in effect as
10 required by law, or for the renewal or reinstatement of any license
11 that is expired pursuant to subsection D of Section 1309 of this
12 title, suspended or revoked, the deposit shall not be less than
13 Fifty Thousand Dollars (\$50,000.00). ~~Such~~ The deposits shall be
14 subject to all laws, rules and regulations as deposits by domestic
15 insurance companies but in no instance shall a professional bondsman
16 write bonds which equal more than ten times the amount of the
17 deposit which ~~such~~ the bondsman has submitted to the Commissioner.
18 In addition, a professional bondsman may make the deposit by
19 purchasing an annuity through a licensed domestic insurance company
20 in the State of Oklahoma. The annuity shall be in the name of the
21 bondsman as owner with legal assignment to the Insurance
22 Commissioner. The assignment form shall be approved by the
23 Commissioner. If a bondsman exceeds the above limitation, the
24 bondsman shall be notified by the Commissioner by mail with return

1 receipt requested that the excess shall be reduced or the deposit
2 increased within ten (10) days of notification, or the license of
3 the bondsman shall be suspended immediately after the ten-day
4 period, pending a hearing on the matter.

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

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

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

21 B. The deposit provided in this section shall be held in
22 safekeeping by the Insurance Commissioner and shall only be used if
23 a bondsman fails to pay an order and judgment of forfeiture after
24 being properly notified or shall be used if the license of a

1 professional bondsman has been revoked. The deposit shall be held
2 in the name of the Insurance Commissioner and the bondsman. The
3 bondsman shall execute an assignment of the deposit to the Insurance
4 Commissioner for the payment of unpaid bond forfeitures.

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

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

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

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

22 SECTION 44. AMENDATORY 59 O.S. 2001, Section 1310, is
23 amended to read as follows:

24

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

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

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

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

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

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

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

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

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

24

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

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

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

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

20 13. Cheating on an examination for licensure;

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

23 15. For paying a fee or rebate, or giving or promising anything
24 of value to a jailer, trustee, police officer, law enforcement

1 officer, or other officer of the law, or any other person who has
2 power to arrest or hold in custody, or to any public official or
3 public employee in order to secure a settlement, compromise,
4 remission, or reduction of the amount of any bail bond or
5 estreatment thereof, or to secure delay or other advantage. This
6 shall not apply to a jailer, police officer, or officer of the law
7 who is not on duty and who assists in the apprehension of a
8 defendant;

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

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

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

17 19. Accepting anything of value from a principal, other than
18 the premium; provided, the bondsman shall be permitted to accept
19 collateral security or other indemnity from the principal which
20 shall be returned immediately upon final termination of liability on
21 the bond and upon satisfaction of all terms, conditions, and
22 obligations contained within the indemnity agreement. Collateral
23 security or other indemnity required by the bondsman shall be
24 reasonable in relation to the amount of the bond;

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

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

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

9 23. For filing a materially untrue monthly report;

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

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

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

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

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

1 29. In the instance where the bondsman is seeking a renewal of
2 a license, for failing to file all outstanding monthly bail reports,
3 pay any outstanding fines or monthly report reviewal fees owed to
4 the Commissioner, resolve any pending disciplinary matters with the
5 Commissioner or respond to a current order issued by the
6 Commissioner. These matters shall be concluded before the
7 Commissioner will process the renewal application of the bondsman.

8 B. In addition to any applicable denial, censure, suspension,
9 or revocation of a license, any person violating any provision of
10 ~~Section~~ Sections 1301 et seq. through 1340 of this title may be
11 subject to a civil penalty of not less than ~~One Hundred Dollars~~
12 ~~(\$100.00)~~ Two Hundred Fifty Dollars (\$250.00) nor more than ~~One~~
13 ~~Thousand Dollars (\$1,000.00)~~ Two Thousand Five Hundred Dollars
14 (\$2,500.00) for each occurrence. This fine may be enforced in the
15 same manner in which civil judgments may be enforced. Any order for
16 civil penalties entered by the Commissioner or authorized decision
17 maker for the Insurance Department which has become final may be
18 filed with the court clerk of Oklahoma County and shall then be
19 enforced by the judges of ~~said county~~ Oklahoma County.

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

22 D. If any bail bondsman is convicted by any court of a
23 violation of any of the provisions of this act, the license of the
24

1 individual shall therefore be deemed to be immediately revoked,
2 without any further procedure relative thereto by the Commissioner.

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

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

22 SECTION 45. AMENDATORY 59 O.S. 2001, Section 1314, as
23 amended by Section 25, Chapter 432, O.S.L. 2009 (59 O.S. Supp. 2009,
24 Section 1314), is amended to read as follows:

1 Section 1314. A. When a bail bondsman or managing general
2 agent accepts collateral, ~~he or she~~ the bail bondsman or managing
3 general agent shall give a written receipt for same, and this
4 receipt shall give in detail a full description of the collateral
5 received. A description of the collateral shall be listed on the
6 undertaking by affidavit. All property taken as collateral, whether
7 personal, intangible or real, shall be receipted for and deemed, for
8 all purposes, to be in the name of, and for the use and benefit of,
9 the surety company or licensed professional bondsman, as the case
10 may be. Every receipt, encumbrance, mortgage or other evidence of
11 ~~such~~ the custody, possession or claim shall facially indicate that
12 it has been taken or made on behalf of the surety company or
13 professional bondsman through its authorized agent, the individual
14 licensed bondsman or managing general agent who has transacted the
15 undertaking with the bond principal. Any mortgage or other
16 encumbrance against real property taken under the provisions of this
17 section which does not indicate beneficial ownership of the claim to
18 be in favor of the surety company or professional bondsman shall be
19 deemed to constitute a cloud on the title to real estate and shall
20 subject the person filing, or causing same to be filed, in the real
21 estate records of the county, to a penalty of treble damages or One
22 Thousand Dollars (\$1,000.00), whichever is greater, in an action
23 brought by the person, organization or corporation injured thereby.
24 For collateral taken, or liens or encumbrances taken or made

1 pursuant to the provisions of this section, the individual bondsman
2 or managing general agent taking possession of the property or
3 making the lien, claim or encumbrance shall do so on behalf of ~~his~~
4 ~~or her~~ the surety company or professional bondsman, as the case may
5 be, and ~~such~~ the individual licensed bondsman shall be deemed to act
6 in the capacity of fiduciary in relation to both:

7 1. The principal or other person from whom ~~such~~ the property is
8 taken or claimed against₇; and

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

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

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

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

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

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

15 C. Every licensee shall keep at ~~his or her~~ the place of
16 business of the licensee the usual and customary records pertaining
17 to transactions authorized by ~~his or her~~ the license. All ~~such~~ of
18 the records shall be available and open to the inspection of the
19 Commissioner at any time during business hours during the three (3)
20 years immediately following the date of the transaction. The
21 Commissioner may require a financial examination or market conduct
22 survey during any investigation of a licensee.

23 D. Each bail bondsman shall submit each month with ~~his or her~~
24 the monthly report of the bondsman, a renewal fee equal to two-

1 tenths of one percent (2/10 of 1%) of the new liability written for
2 that month. ~~Such~~ The fee shall be payable to the Insurance
3 Commissioner who shall deposit same with the State Treasurer.

4 SECTION 46. AMENDATORY 59 O.S. 2001, Section 1316, as
5 last amended by Section 58, Chapter 176, O.S.L. 2009 (59 O.S. Supp.
6 2009, Section 1316), is amended to read as follows:

7 Section 1316. A. 1. A bail bondsman shall neither sign nor
8 countersign in blank any bond, nor shall the bondsman give a power
9 of attorney to, or otherwise authorize, anyone to countersign ~~his or~~
10 ~~her~~ the name of the bail bondsman to bonds unless the person so
11 authorized is a licensed surety bondsman or managing general agent
12 directly employed by a licensed professional bondsman giving ~~such~~
13 the power of attorney. The professional bondsman shall submit to
14 the Insurance Commissioner the agreement between the professional
15 bondsman and the employed bondsman. The agreement shall be
16 submitted to the Commissioner prior to the employed bondsman writing
17 bonds on behalf of the professional. The professional bondsman
18 shall notify the Commissioner whenever any agreement is canceled.
19 If the bondsman surrenders the professional qualification, or the
20 professional qualification is suspended or revoked, or if an insurer
21 authorized to write bail bond business surrenders their bail surety
22 line of authority, or this line of authority is suspended or
23 revoked, then the Commissioner shall suspend the appointment of all
24 of the ~~professional bondsman's~~ bail agents of the professional

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

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

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

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

24

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

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

7 SECTION 47. AMENDATORY 59 O.S. 2001, Section 1317, as
8 last amended by Section 30, Chapter 184, O.S.L. 2008 (59 O.S. Supp.
9 2009, Section 1317), is amended to read as follows:

10 Section 1317. A. Every surety or professional bondsman who
11 appoints a surety bondsman or managing general agent in the state,
12 shall give notice thereof to the Insurance Commissioner. The filing
13 fee for appointment of each surety bondsman or managing general
14 agent shall be Ten Dollars (\$10.00), payable to the Commissioner and
15 shall be submitted with the appointment. The appointment shall
16 remain in effect until the surety or professional bondsman submits a
17 notice of cancellation to the Commissioner, the ~~bail bondsman's~~
18 license of the bail bondsman expires, or the Commissioner cancels
19 the appointment. The Commissioner may cancel a bail surety
20 appointment if the license of the bondsman is suspended, revoked or
21 nonrenewed. If the surety changes the liability limitations of the
22 surety bondsman or the managing general agent, or any other
23 provisions of the appointment, the surety shall submit an amended
24

1 appointment form and a filing fee of Ten Dollars (\$10.00) payable to
2 the Commissioner.

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

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

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

22 SECTION 48. AMENDATORY 59 O.S. 2001, Section 1322, is
23 amended to read as follows:

24

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

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

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

23 D. If a bondsman accepts a mortgage or deed on real property as
24 collateral on a bond, the bondsman shall file a copy of the mortgage

1 or deed with the bond within thirty (30) days of receipt of the
2 mortgage or deed. The Commissioner shall have the authority to
3 waive this requirement.

4 SECTION 49. REPEALER 11 O.S. 2001, Section 29-205, is
5 hereby repealed.

6 SECTION 50. REPEALER 36 O.S. 2001, Sections 6520, 6521,
7 as amended by Section 30, Chapter 125, O.S.L. 2007, 6523 and 6525
8 (36 O.S. Supp. 2009, Section 6521), are hereby repealed.

9 SECTION 51. REPEALER 36 O.S. 2001, Section 6608, as
10 amended by Section 4, Chapter 189, O.S.L. 2009 (36 O.S. Supp. 2009,
11 Section 6608), is hereby repealed.

12 SECTION 52. This act shall become effective November 1, 2010.

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