ENGROSSED SENATE AMENDMENT
TO
ENGROSSED HOUSE
BILL NO. 2072 By: Key of the House

and

Brown of the Senate

(insurance - amending various sections in Title 36 - repealing various sections in Title 36 - codification - noncodification - effective date - emergency)

AMENDMENT NO. 1. Page 1, strike the stricken title, enacting clause and entire bill and insert

"An Act relating to insurance; stating legislative intent; amending Section 8, Chapter 307, O.S.L. 2002 (36 O.S. Supp. 2010, Section 615,1), which relates to application to transact insurance; requiring the Insurance Commissioner to review certain applications with a focus on certain specified items; amending 36 O.S. 2001, Section 628, as amended by Section 6, Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Section 628), which relates to the imposition of certain taxes or other obligations on foreign insurers; making the imposition of certain taxes or other obligations on state insurers optional; creating the Unauthorized Insurers and Surplus Lines Insurance Act; providing short title; defining terms; authorizing the Insurance Commissioner to enter into certain agreements; amending 36 O.S. 2001, Sections 1101, as amended by Section 10, Chapter 222, O.S.L. 2010, Section 22, Chapter 176, O.S.L. 2009, 1103, as amended by Section 12, Chapter 222, O.S.L. 2010, 1105, as amended by Section 14, Chapter 222, O.S.L. 2010, 1106, as last amended by Section 15, Chapter 222, O.S.L. 2010, 1107, as amended by Section 16,

Chapter 222, O.S.L. 2010, 1108, as amended by Section 17, Chapter 222, O.S.L. 2010, 1109, as last amended by Section 18, Chapter 222, O.S.L. 2010, 1111, 1112, as amended by Section 10, Chapter 307, O.S.L. 2002, 1113, 1114, 1115, as last amended by Section 19, Chapter 222, O.S.L. 2010, 1116, as last amended by Section 20, Chapter 222, O.S.L. 2010 and 1118, as amended by Section 21, Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Sections 1101, 1101.1, 1103, 1105, 1106, 1107, 1108, 1109, 1112, 1115, 1116 and 1118), which relate to the Unauthorized Insurers and Surplus Lines Insurance Act; requiring certain transactions to be performed only by a surplus lines licensee or broker; specifying that certain surplus lines premiums shall be subject to surplus premium tax pursuant to certain agreements entered into by the Insurance Commissioner; modifying service of process; modifying circumstances for award of certain attorney fees; modifying conditions in which insurance may be procured from surplus lines insurers; providing procedures for the procurement of certain insurance for an exempt commercial purchaser; defining term; specifying information to be submitted to the surplus lines clearinghouse; providing schedule for filing and payment of certain taxes; providing penalty for failure to file certain information; allowing certain coverage to be placed with certain insurers; clarifying type of licensee; requiring surplus lines insurer to meet certain financial requirements; requiring certain information submitted to the surplus lines clearinghouse to be retained by certain licensees or brokers; modifying procedures relating to the levying, collection, payment and distribution of the surplus lines premium tax; amending Section 3, Chapter 323, O.S.L. 2009 (36 O.S. Supp. 2010, Section 1250.17), which relates to certain patient affidavit requirement; modifying affidavit to form; providing that false statements shall be considered willful misrepresentation; amending 36 O.S. 2001, Section 1435.23, as last amended by Section 12, Chapter 432, O.S.L. 2009 (36 O.S. Supp. 2010, Section 1435.23), which relates to fees for licensure and examinations; modifying amounts of fees; amending 36 O.S. 2001, Section 1435.29, as last amended by Section 13, Chapter 432, O.S.L. 2009 (36 O.S. Supp. 2010, Section 1435.29), which relates to continuing education; modifying requirements; authorizing Insurance

Commissioner to assess civil penalty against continuing education providers for failure to comply with certain requirements; amending 36 O.S. 2001, Section 1524, which relates to the Risk-based Capital for Insurers Act; modifying definition of a company action level event; amending 36 O.S. 2001, Section 3639.1, which relates to homeowner's insurance policy; requiring the insurer to give to the insured certain written renewal notice on a private passenger auto or homeowners policy; specifying information to be contained on the renewal notice; specifying duration of the coverage if notice is not given; specifying when notice is given; specifying effective date of changes if insured accepts the renewal; defining terms; requiring the filing and approval of certain forms by the Insurance Commissioner; authorizing Commissioner to disapprove certain forms; specifying required contents of form; deeming certain forms approved without filing; prohibiting issuance of certain form; allowing certain addendums; specifying scope of applicability; providing exceptions; distinguishing certificates from policy provisions; limiting reference to contracts or certificates; specifying notice requirements; authorizing certain service fees; providing certificates in violation of requirements shall be void; specifying penalty for certain violations; specifying authority of Commissioner to enforce provisions; authorizing the adoption of certain rules and regulations; requiring every health benefit plan to file certain rates and adjustments with the Insurance Commissioner; authorizing the Commissioner to determine if such rate or rate adjustment is unreasonable, excessive, unjustified or unfairly discriminatory; requiring the Commissioner to make and deliver certain written decision; defining term; amending 36 O.S. 2001, Sections 6202, as amended by Section 23, Chapter 125, O.S.L. 2007, 6203, as amended by Section 40, Chapter 176, O.S.L. 2009, 6205, as last amended by Section 42, Chapter 176, O.S.L. 2009, 6212, as amended by Section 47, Chapter 176, O.S.L. 2009 and 6217, as last amended by Section 2, Chapter 355, O.S.L. 2010 (36 O.S. Supp. 2010, Sections 6202, 6203, 6205, 6212 and 6217), which relate to the Insurance Adjusters Licensing Act; adding definition; modifying exceptions to licensing requirements; prohibiting licensing of certain

applicants unless certain conditions are met; requiring licensees to inform the Insurance Commission of a change in legal name or addresses within certain time period; providing administrative fees for failure to provide notice of change in legal name or addresses; authorizing Insurance Commissioner to assess civil penalty against continuing education providers for failure to comply with certain requirements; creating the Uniform Health Carrier External Review Act; stating purpose of act; defining terms; specifying act shall apply to all health carriers; providing exceptions; requiring health carriers to notify insured parties of certain external review rights; specifying requirements of notice; authorizing Insurance Commissioner to promulgate certain rules; specifying requests for external review requirements; authorizing Commissioner to prescribe certain forms; authorizing certain requests for reviews of adverse determinations; requiring insured persons to exhaust internal grievance process before external review is allowed; specifying exhaustion requirements; allowing certain retrospective review determinations after exhaustion; specifying procedure for expedited grievance reviews; requiring independent reviewing organizations to complete certain process before conducting external review; requiring independent review organization to give certain notice; authorizing certain requests by waiver; authorizing requests for certain review if requirements are waived; authorizing requests for certain reviews after adverse determination; directing Commissioner to send copy of request to insurer; requiring insurer to complete certain review; specifying issues to be reviewed; requiring certain notice; specifying contents of notice; authorizing Commissioner to order certain external reviews; providing procedure for certain external reviews; specifying certain independent reviewers shall not be bound by previous decision; requiring production of certain information; providing procedure if health carrier fails to provide certain information; specifying independent review requirements; allowing health carrier to reconsider certain determinations; providing procedure for reversed determinations; specifying requirements of independent reviews; requiring decisions within certain time frame;

specifying required contents of certain notices; requiring approval of coverage after certain determinations; directing Commissioner to assign independent review organizations randomly; allowing requests for certain external reviews; requiring certain determinations in order to request external reviews; directing health carriers to determine whether certain requests are reviewable; specifying procedure for certain external reviews; directing Commissioner to assign organization to conduct reviews in certain circumstances; providing that independent review organization shall not be bound by prior determinations; directing health carrier to provide certain information to independent review organizations; providing requirements for certain determinations by independent review organizations; providing that certain determinations by independent review organizations shall be done within certain time frame; specifying notice requirements; requiring health carrier to approve coverage in certain circumstances; specifying that expedited reviews may not be provided in certain circumstances; directing Commissioner to assign certain reviews randomly; providing procedure to request certain external review; directing Commissioner to notify health carrier of certain reviews; requiring health carrier to conduct certain preliminary review; specifying requirements of review; directing health carrier to provide certain notice to insured; specifying requirements of notice; authorizing Commissioner to specify certain forms and supporting information in notice; establishing notice procedure; providing requirements for the selection of a clinical reviewer; providing procedure for clinical reviews; requiring certain report by clinical reviewer; specifying clinical reviewer report requirements; specifying information clinical reviewers shall consider; establishing procedure for decisions reached by a group of clinical reviewers; specifying notice requirements for certain reports; providing that external reviews shall be binding on health carrier; providing that external reviews shall be binding on covered persons; providing exception; prohibiting the filing of requests for reviews of certain adverse determinations; directing Commissioner to approve certain independent review organizations; establishing eligibility requirements

for independent review organizations; directing Commissioner to develop certain application forms; providing application procedure for independent review organizations; providing eligibility requirements; authorizing Commissioner to charge an application fee; specifying approval shall be effective for two years; authorizing Commissioner to terminate approval of independent review organizations in certain circumstances; directing Commissioner to maintain list of approved organizations; providing requirements for organizations conducting external reviews; prohibiting independent review organizations from controlling a health benefit plan; prohibiting certain conflicts of interest; establishing presumption that certain accreditation shall meet requirements; requiring Commissioner to review certain accreditation standards; authorizing acceptance by the Commissioner of certain reviews; prohibiting the imposition of liability for certain damages on an independent review organization; providing exception; requiring independent review organizations to maintain certain records; directing independent review organizations to provide certain report to Commissioner upon request; specifying contents of report; requiring the retention of certain records for three years; requiring health carrier to pay cost of certain external review; requiring health carriers to include external review procedures in certain publications; specifying Commissioner shall provide format for certain disclosures; specifying required disclosures; amending Section 12, Chapter 390, O.S.L. 2003, as last amended by Section 52, Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Section 6811) which relates to closed claim filing reporting requirements; modifying reporting requirements; amending Section 40, Chapter 197, O.S.. 2003 (36 O.S. Supp. 2010, Section 6940), which relates to the Risk-based Capital for Health Maintenance Organizations Act of 2003; modifying definition of a company action level event; prohibiting insurer from charging for costs of certain documentation needed to underwrite a policy; making prohibition applicable to only personal insurance; repealing 63 O.S. 2001, Sections 2528.1, 2528.2, 2528.3, 2528.4, 2528.5, 2528.6, 2528.7, 2528.8, 2528.9 and 2528.10, which relate to the

Oklahoma Managed Care External Review Act; providing for codification; providing for noncodification; providing effective dates; and declaring an emergency.

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

SECTION 1. NEW LAW A new section of law not to be codified in the Oklahoma Statutes reads as follows:

The Oklahoma Legislature recognizes that the Insurance Department of the State of Oklahoma is charged with regulating a variety of entities. Each of these entities is a part of the financial services industry in some way. It is the intent of this bill to modify the law as it relates to entities regulated by the Insurance Department.

SECTION 2. AMENDATORY Section 8, Chapter 307, O.S.L. 2002 (36 O.S. Supp. 2010, Section 615.1), is amended to read as follows:

Section 615.1. A. Unless otherwise instructed by the Insurance Commissioner, an applicant requesting to be admitted to transact insurance in this state shall follow the instructions outlined in the National Association of Insurance Commissioners (NAIC) Uniform Certificate of Authority Application (UCAA) instructions.

B. The Commissioner shall review and analyze each application with focus on the following:

1. Identification and evaluation of the business and strategic plans of the applicant, including but not limited to pro forma financial projections;

2. Assessment of the quality and expertise of the ultimate controlling person, proposed officers and directors, appointed actuary and appointed accountant, including the use of the NAIC Form A and SAD databases;

3. Adequacy of any proposed reinsurance program;

4. Adequacy of investment policy;

5. Adequacy of short-term and long-term financing arrangements, including, but not limited to:

a. initial financing of proposed operations or transaction, and

b. maintenance of adequate capital and surplus levels;

6. Biographical affidavits;

7. Related party agreements' compliance with SSAP No. 25; and

8. Any other information the Commissioner deems necessary to review.

SECTION 3. AMENDATORY 36 O.S. 2001, Section 628, as amended by Section 6, Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Section 628), is amended to read as follows:

Section 628. When by or pursuant to the laws of any other state or foreign country any premium or income or other taxes, or any fees, fines, penalties, licenses, deposit requirements or other

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

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1100 of Title 36, unless there is created a duplication in numbering, reads as follows:

Sections 4, 5, 6 and 12 of this act and Sections 1101 through 1121 of Title 36 of the Oklahoma Statutes shall be known and may be cited as the "Unauthorized Insurers and Surplus Lines Insurance Act".

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1100.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Unauthorized Insurers and Surplus Lines Insurance Act:

1. "Admitted insurer" means, with respect to a state, an insurer that is licensed to transact the business of insurance in such state;

2. "Home state" means:

a. except as provided in subparagraphs b through e of this paragraph, with respect to an insured:

(1) the state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence, or

(2) if one hundred percent (100%) of the insured risk is located out of the state referred to in division (1) of this subparagraph, the state to which the greatest percentage of the insured's

taxable premium for the insurance contract is allocated,

b. with respect to determining the home state of the insured, "principal place of business" means:

(1) the state where the insured maintains its headquarters and where the insured's high-level officers direct, control and coordinate the business activities, or

(2) if the insured's high-level officers direct, control and coordinate business activities in more than one state, the state in which the greatest percentage of the insured's taxable premium for the insurance contract is allocated, or

(3) if the insured maintains its headquarters or the insured's high-level officers direct, control and coordinate the business activities outside any state, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated,

c. with respect to determining the home state of the insured "principal residence" means:

(1) the state where the insured resides for the greatest number of days during the calendar year, or

(2) if the insured's principal residence is located outside any state, the state to which the greatest percentage of the insured's taxable premium for that insurance is allocated,

d. if more than one insured from an affiliated group are named insureds on a single nonadmitted insurance contract, the term “home state” means the home state, as determined pursuant to division (1) of subparagraph a of this paragraph, of the member affiliated group that has the largest percentage of premium attributed to it under such insurance contract, or

e. when the group policyholder pays one hundred percent (100%) of the premium from its own funds, the term "home state" means the home state, as determined pursuant to division (1) of subparagraph a of this paragraph, of the group policyholder. When the group policyholder does not pay one hundred percent (100%) of the premium from its own funds, the term home state means the home state, as determined pursuant to division (1) of subparagraph a of this paragraph, or of the group member;

3. "Independently procured insurance" means insurance procured by an insured directly from a nonadmitted insurer;

4. "Licensed" means, with respect to an insurer, authorization to transact the business of insurance by a license, certificate of authority, charter or otherwise;

5. "Multistate risk" means a risk covered by a nonadmitted insurer with insured exposures in more than one state;

6. "Nonadmitted insurance" means any property and casualty insurance permitted in a state to be placed directly through a surplus lines licensee or broker with a nonadmitted insurer eligible to accept such insurance. For purposes of the Unauthorized Insurers and Surplus Lines Insurance Act, nonadmitted insurance includes independently procured insurance and surplus lines insurance;

7. "Nonadmitted insurer" means, with respect to a state, an insurer not licensed to engage in the business of insurance in such state, but shall not include a risk retention group as that term is defined under applicable federal law;

8. "Single-state risk" means a risk insured with insured exposures in only one state;

9. "Surplus lines insurer" means insurance procured by a surplus lines licensee or broker from a surplus lines insurer as permitted under the law of the home state; and

10. "Surplus lines licensee or broker" means an individual, firm or corporation that is licensed in a state to sell, solicit, or

negotiate insurance, including the agent of record on a nonadmitted insurance policy, on properties, risks or exposures located or to be performed in a state with nonadmitted insurers.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1100.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

For the purposes of carrying out the Nonadmitted and Reinsurance Reform Act of 2010, the Insurance Commissioner is authorized to enter into the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose, in order to:

1. Facilitate the collection, allocation and disbursement of premium taxes attributable to the placement of nonadmitted insurance through a central clearinghouse;

2. Provide for uniform methods of allocation and reporting among nonadmitted insurance risk classifications through a central clearinghouse; and

3. Share information among states relating to nonadmitted insurance premium taxes.

SECTION 7. AMENDATORY 36 O.S. 2001, Section 1101, as amended by Section 10, Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Section 1101), is amended to read as follows:

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

~~B.~~ No person in Oklahoma shall in any manner:

1. Represent or assist any nonadmitted insurer ~~not then duly authorized to transact insurance in Oklahoma~~ as defined in the Unauthorized Insurers and Surplus Lines Insurance Act, in the soliciting, procuring, placing, or maintenance of any nonadmitted insurance coverage upon or with relation to any subject of insurance resident, located, or to be performed in Oklahoma~~.~~ without being a surplus lines licensee or broker; or

2. Inspect or examine any risk or collect or receive any premium on behalf of ~~the~~ any nonadmitted insurer without being a surplus lines broker or licensee.

~~C.~~ B. Any person transacting insurance or acting as a surplus lines broker or licensee in violation of this section shall be liable to the insured for the performance of any contract between the insured and the insurer resulting from the transaction.

~~D.~~ C. This section shall not apply as to reinsurance, to surplus line insurance lawfully procured pursuant to ~~this article~~ the Unauthorized Insurers and Surplus Lines Insurance Act, to transactions exempt under Section 606 of this title (Authorization of Insurers and General Qualifications), or to professional services of an adjuster or attorney-at-law from time to time with respect to

claims under policies lawfully solicited, issued, and delivered outside of Oklahoma.

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

~~F. Insurance companies not licensed in the State of Oklahoma~~ E. Nonadmitted insurers shall ~~not~~ contract with the trustees of any fund which will insure residents in this state ~~without the previous written approval of the Insurance Commissioner~~ in a manner consistent with the requirements, nature and scope of the Unauthorized Insurers and Surplus Lines Insurance Act.

SECTION 8. AMENDATORY Section 22, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2010, Section 1101.1), is amended to read as follows:

Section 1101.1 A. An Oklahoma domestic insurer possessing policyholder surplus of at least Fifteen Million Dollars ($15,000,000.00) may, pursuant to a resolution by its board of directors, and with the written approval of the Insurance Commissioner, be designated as a domestic surplus line insurer. Such insurers shall write surplus line insurance in any jurisdiction within which it does business, including this state.

B. A domestic surplus line insurer may only insure in this state any risk procured pursuant to Article 11 of the Oklahoma

Insurance Code governing surplus line insurers and brokers and its premium shall be subject to surplus line premium tax pursuant to Section 1115 of this title and pursuant to the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose the Insurance Commissioner may enter into or join.

C. A domestic surplus line insurer may not issue a policy designed to satisfy the motor vehicle financial responsibility requirement of this state, the Oklahoma Workers' Compensation Act, or any other law mandating insurance coverage by a licensed insurance company.

D. A domestic surplus line insurer is not subject to the provisions of the Oklahoma Property & Casualty Insurance Guaranty Act nor the Oklahoma Life and Health Insurance Guaranty Association Act.

SECTION 9. AMENDATORY 36 O.S. 2001, Section 1103, as amended by Section 12, Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Section 1103), is amended to read as follows:

Section 1103. A. Delivery, effectuation, or solicitation of any insurance contract, by mail or otherwise, within this state by a surplus lines insurer, or the performance within this state of any other service or transaction connected with the insurance by or on behalf of the insurer, shall be deemed to constitute an appointment by the insurer of the Insurance Commissioner and the Commissioner's

successors in office as its attorney, upon whom may be served all lawful process issued within this state in any action or proceeding against the insurer arising out of any such contract or transaction.

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

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

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

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

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

SECTION 10. AMENDATORY 36 O.S. 2001, Section 1105, as amended by Section 14, Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Section 1105), is amended to read as follows:

Section 1105. In any action against a surplus lines insurer pursuant to Section 1103 of this ~~article~~ title, if the insurer has failed for thirty (30) days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract of insurance or in accordance with Section 1115 of this title, and it appears to the court that the refusal was vexatious and without reasonable cause, the court may allow to the plaintiff a reasonable attorney fee and include the fee in any judgment that may be rendered in the action. The fee shall not exceed one-third (1/3) of the amount which the court or jury finds the plaintiff is entitled to recover against the insurer, but in no event shall a fee be less than One Hundred Dollars ($100.00). Failure of an insurer to defend any action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

SECTION 11. AMENDATORY 36 O.S. 2001, Section 1106, as last amended by Section 15, Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Section 1106), is amended to read as follows:

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

1. The surplus lines insurer shall ~~have a certificate of approval from the Commissioner, and meet all relevant statutory requirements, including the following~~ meet the requirements of the Unauthorized Insurers and Surplus Lines Insurance Act and the following conditions:

a. the insurer ~~is financially stable, and~~

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

~~c. the insurer, if a foreign insurer, posts a special deposit in an amount to be determined by the Commissioner, or~~ has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which equals the greater of:

(1) the minimum capital and surplus requirements under the laws of this state, or

(2) Fifteen Million Dollars ($15,000,000.00),

b. the requirements of subparagraph a of this paragraph may be satisfied by an insurer's possessing less than the minimum capital and surplus upon an affirmative

finding of acceptability by the Insurance Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and reputation within the industry. In no event shall the Insurance Commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than Four Million Five Hundred Thousand Dollars ($4,500,000.00), and

~~d.~~

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

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

2. The insurance shall be procured through a licensed surplus ~~line~~ lines licensee or broker~~, hereinafter in this article referred to as the "broker"; and~~ licensed in a state. An Oklahoma surplus lines license is required only where Oklahoma is the home state of the insured.

~~3. The broker shall file the appropriate affidavit as required by Section 1107 of this title~~ For the purposes of carrying out the provisions of the Nonadmitted and Reinsurance Reform Act of 2010, the Insurance Commissioner is authorized to utilize the national insurance producer database of the National Association of Insurance Commissioners, or any other equivalent uniform national database, for the licensure of an individual or entity as a surplus lines licensee or broker and for renewal of such license.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1106.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A surplus lines broker is not required to make a due diligence search to determine whether the full amount or type of insurance can be obtained from admitted insurers when the broker is seeking to procure or place nonadmitted insurance for an exempt commercial purchaser, provided:

1. The broker procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight; and

2. The exempt commercial purchaser has subsequently requested in writing for the broker to procure or place such insurance from a nonadmitted insurer.

B. For purposes of this section, the term "exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

1. The person employs or retains a qualified risk manager to negotiate insurance coverage;

2. The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of One Hundred Thousand Dollars ($100,000.00) in the immediately preceding twelve (12) months;

3. The person meets at least one of the following criteria:

a. the person possesses a net worth in excess of Twenty Million Dollars ($20,000,000.00), as such amount is adjusted pursuant to paragraph 4 of this subsection,

b. the person generates annual revenues in excess of Fifty Million Dollars ($50,000,000.00), as such amount is adjusted pursuant to paragraph 4 of this subsection,

c. the person employs more than five hundred full-time-equivalent employees per individual insured or is a member of an affiliated group employing more than one thousand employees in the aggregate,

d. the person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least Thirty Million Dollars ($30,000,000.00), as such

amount is adjusted pursuant to paragraph 4 of this subsection, or

e. the person is a municipality with a population in excess of fifty thousand (50,000) persons; and

4. Effective on January 1, 2015, and every five (5) years thereafter, the amounts in subparagraphs a, b and d of paragraph 3 of this subsection shall be adjusted to reflect the percentage change for such five-year period in the Consumer Price Index of All Urban Consumers published by the Bureau of Labor Statistics of the U.S. Department of Labor.

SECTION 13. AMENDATORY 36 O.S. 2001, Section 1107, as amended by Section 16, Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Section 1107), is amended to read as follows:

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

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

~~2. Number of the policy issued;~~

~~3. Name and address of the insured;~~

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

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

~~6. Other information reasonably required by the Insurance Commissioner.~~

~~B. The Insurance Commissioner shall prescribe and furnish the required report form. The Insurance Commissioner shall have the authority to grant approval to the surplus line broker for the master bordereau style reporting of surplus line activity on a quarterly basis~~ submit such information required to be submitted to the surplus lines clearinghouse as established by the Insurance Commissioner through joining the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose.

B. Pursuant to Section 1115 of this title, when Oklahoma is the home state, the surplus lines licensee and broker shall make the tax filings and payments required by subsection A of this section to the clearinghouse in a quarterly manner, utilizing the following dates only:

1. February 15 for the quarter ending the preceding December 31;

2. May 15 for the quarter ending the preceding March 31;

3. August 15 for the quarter ending the preceding June 30; and

4. November 15 for the quarter ending the preceding September 30.

C. Failure to file the ~~report~~ required information with the clearinghouse pursuant to this section and Section 1115 of this title where Oklahoma is the home state shall result, after notice and hearing, in censure, suspension, or revocation of license or a fine of up to Five Hundred Dollars ($500.00) for each occurrence or by both such fine and licensure penalty.

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

SECTION 14. AMENDATORY 36 O.S. 2001, Section 1108, as amended by Section 17, Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Section 1108), is amended to read as follows:

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

~~insurance and to other interested persons in the manner provided by Article 3 of this Code.~~

~~B. Any order shall be subject to modification, and the Insurance Commissioner shall so modify as to any coverage found by the Commissioner to be no longer entitled to recognition after a hearing held upon the initiative of the Commissioner or upon request of any insurance agent, surplus line broker, broker, insurer, rating or advisory organization, or other person~~ in Oklahoma, a surplus lines licensee or broker may place the coverage with a nonadmitted insurer or surplus lines insurer as defined in the Unauthorized Insurers and Surplus Lines Insurance Act.

SECTION 15. AMENDATORY 36 O.S. 2001, Section 1109, as last amended by Section 18, Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Section 1109), is amended to read as follows:

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

B. Insurance contracts procured as surplus line coverage shall contain in bold-face type notification stamped by the surplus lines licensee or broker or surplus lines insurer on the declaration page of the policy that the contracts are not subject to the protection

of any guaranty association in the event of liquidation or receivership of the insurer.

SECTION 16. AMENDATORY 36 O.S. 2001, Section 1111, is amended to read as follows:

Section 1111. A ~~licensed~~ surplus ~~line~~ lines licensee or broker may accept and place surplus ~~line business~~ lines insurance from any insurance agent or broker licensed in this state for the kind of insurance involved, and may compensate such agent or broker therefor. The surplus lines licensee or broker shall have the right to receive from the surplus lines insurer the customary commission.

SECTION 17. AMENDATORY 36 O.S. 2001, Section 1112, as amended by Section 10, Chapter 307, O.S.L. 2002 (36 O.S. Supp. 2010, Section 1112), is amended to read as follows:

Section 1112. A. A surplus ~~line~~ lines licensee or broker shall not knowingly place any such coverage in an insurer which is in an unsound financial condition. To be considered financially sound, a surplus ~~line company~~ lines insurer shall ~~have a minimum capital and surplus of not less than Fifteen Million Dollars ($15,000,000.00)~~ meet the requirements of Section 1106 of this title. A surplus ~~line~~ lines licensee or broker shall not place any such coverage in an insurer unless the insurer meets the requirements of Section 1106 of this title or has been approved in writing by the Insurance Commissioner as a surplus ~~line~~ lines insurer and such approval has not been withdrawn. A surplus ~~line~~ lines licensee or broker shall

not place any surplus ~~line~~ lines insurance in an insurer that ~~has been disapproved by the Commissioner as a surplus line insurer~~ does not meet the requirements of Section 1106 of this title.

B. For violation of this section, in addition to any other penalty provided by law, the broker's license shall be revoked, and the broker shall not again be so licensed within a period of two (2) years thereafter. In addition, any surplus ~~line~~ lines licensee and broker licensed in Oklahoma who violates this section shall be guilty of a misdemeanor and upon conviction thereof shall be punished for each offense, by a fine of not more than One Thousand Dollars ($1,000.00) or by confinement in jail for not more than ninety (90) days, or by both such fine and imprisonment.

SECTION 18. AMENDATORY 36 O.S. 2001, Section 1113, is amended to read as follows:

Section 1113. Each surplus ~~line~~ lines licensee or broker licensed in Oklahoma shall keep in the broker's office in this state a full and true record of each surplus ~~line~~ lines contract procured by the broker, and such record may be examined at any time within three (3) years thereafter by the Insurance Commissioner. The record shall include ~~the following items as are applicable:~~

~~1. Name and address of the insurer;~~

~~2. Name and address of the insured;~~

~~3. Amount of insurance;~~

~~4. Gross premium charged;~~

~~5. Return premium paid, if any;~~

~~6. Rate of premium charged on the several items of coverage;~~

~~7. Effective date of the contract and the terms thereof; and~~

~~8. Brief general description of the risks insured against and the property insured~~ such information required to be submitted to the surplus lines clearinghouse as established by the Insurance Commissioner through joining the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose.

SECTION 19. AMENDATORY 36 O.S. 2001, Section 1114, is amended to read as follows:

Section 1114. Each surplus ~~line~~ lines licensee or broker licensed in Oklahoma shall on or before ~~the first day of~~ April 1 of each year file with the Insurance Commissioner a verified statement of all surplus ~~line~~ lines insurance transacted by ~~him~~ the broker during the preceding calendar year where Oklahoma is the state of the insured. The statement shall be on a form prescribed and furnished by the Insurance Commissioner and shall show~~:~~

~~1. Gross amount of each kind of insurance transacted,~~

~~2. Aggregate gross premiums charged,~~

~~3. Aggregate of return premiums paid to insureds,~~

~~4. Aggregate of net premiums, and~~

~~5. Such additional information as may reasonably be required by the Insurance Commissioner~~ such information required to be submitted

to the surplus lines clearinghouse as established by the Insurance Commissioner through joining the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose.

SECTION 20. AMENDATORY 36 O.S. 2001, Section 1115, as last amended by Section 19, Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Section 1115), is amended to read as follows:

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

~~B. Except as provided in subsection C of this section, for the purpose of determining the surplus line tax, the total premium charged for surplus line insurance placed in a single transaction with one underwriter or group of underwriters, whether in one or more policies, shall be allocated to this state in such proportion as the total premium on the insured properties or operations in this~~

~~state, computed on the exposure in this state on the basis of any single standard rating method in use in all states or countries where the insurance applies, bears to the total premium so computed in all the states or countries~~ In addition to the full amount of gross premiums charged by the insurer for the insurance, where Oklahoma is the home state of the insured, every person licensed pursuant to Section 1106 of this title shall collect and pay to the surplus lines clearinghouse, as provided in Section 3 of this act, a sum based on the total gross premiums charged in connection with any broker-procured insurance, less any return premiums, for surplus lines insurance provided by the licensee pursuant to the license. Where the insurance covers properties, risks or exposures located or to be performed both in and out of Oklahoma, the sum payable shall be computed based on an amount equal to six percent (6%) on that portion of the gross premiums allocated to Oklahoma, plus an amount equal to the portion of the premiums allocated to other states or territories on the basis of tax rates and fees applicable to properties, risks or exposures located or to be performed outside Oklahoma pursuant to subsection E of this section less the amount of gross premium unearned at termination of the surplus lines insurance. Any such unearned gross premium credited by the state to the surplus broker or licensee shall be returned to the policyholder by the broker or licensee. The surplus lines licensee is prohibited from rebating, for any reason, any part of the tax.

B. Gross premiums charged for independently procured insurance, less any return premiums, are subject to a tax at the rate of six percent (6%). At the time of filing the report required in this section, the insured procuring independently procured insurance, where Oklahoma is the home state, shall pay the tax to the surplus lines clearinghouse, as provided in Section 3 of this act, who shall transmit the same for distribution as provided by the Unauthorized Insurers and Surplus Lines Insurance Act. Where the insurance covers properties, risks or exposures located or to be performed both in and out of Oklahoma, the sum payable shall be computed based on an amount equal to six percent (6%) on that portion of the gross premiums allocated to Oklahoma pursuant to subsection A of this section, plus an amount equal to the portion of the premiums allocated to other states or territories on the basis of the tax rates and fees applicable to properties, risks or exposures located or to be performed outside of this state pursuant to this subsection.

C. The Insurance Commissioner is authorized to participate in the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose for the purpose of collecting and disbursing to reciprocal states any funds collected pursuant to the Unauthorized Insurers and Surplus Lines Insurance Act applicable to other properties, risks or exposures located or to be performed outside of Oklahoma. To the

extent that other states where portions of the properties, risks or exposures reside have failed to enter into a compact or reciprocal allocation procedure with Oklahoma, the net premium tax collected shall be retained by Oklahoma. When the surplus lines coverage of an Oklahoma home state insured covers properties, risks or exposures located only in Oklahoma, the surplus lines licensee or broker shall nevertheless make the required surplus premium tax filings and remittances as described in subsection A of this section pursuant to the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose the Insurance Commissioner may agree to or enter.

D. In order to participate in the Nonadmitted Insurance Multi-State Agreement, the Insurance Commissioner is authorized to establish a uniform, statewide rate of taxation applicable to lines of nonadmitted insurance subject to the Agreement. This rate shall encompass all existing rates of taxation, fees and assessments imposed by this state and any political subdivision hereof, pursuant to subsection A of this section and the Insurance Commissioner shall document the method by which the statewide rate is calculated. The Insurance Commissioner is authorized to receive any monies obtained through the clearinghouse established through the Agreement for the collection and then the disbursement of such funds as provided by the Insurance Code.

E. The Insurance Commissioner is authorized to utilize or adopt the allocation schedule included in the Nonadmitted Insurance Multi-State Agreement or any other multistate agreement or compact with the same function and purpose of allocating risk and computing the tax due on the portion of premium attributable to each risk classification and to each state where properties, risks or exposures are located.

F. Subsections A through E of this section shall apply equally to single-state risks and multistate risks.

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

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

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

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

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

~~as provided for payment of the original premium tax, within thirty (30) days next succeeding the date the premiums can be determined.~~

SECTION 21. AMENDATORY 36 O.S. 2001, Section 1116, as last amended by Section 20, Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Section 1116), is amended to read as follows:

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

B. If any person, association or legal entity procuring or accepting any insurance coverage from a surplus lines insurer where Oklahoma is the home state of the insured, otherwise than through a ~~licensed~~ surplus ~~line~~ lines licensee or broker ~~in this state~~, fails to remit the surplus line tax provided for by ~~subsection D of~~ Section 1115 of this title, the person, association or legal entity shall, in addition to the tax, be liable to a civil penalty in an amount equal to one percent (1%) of the premiums paid or agreed to be paid for the policy or policies of insurance for each calendar month of delinquency or a civil penalty in the amount of Twenty-five

Dollars ($25.00) whichever shall be the greater. The Insurance Commissioner shall collect the tax by distraint and shall recover the civil penalty in an action in the name of the State of Oklahoma. The Commissioner may request the Attorney General to appear in the name of the state by relation of the Commissioner.

SECTION 22. AMENDATORY 36 O.S. 2001, Section 1118, as amended by Section 21, Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Section 1118), is amended to read as follows:

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

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

C. Triplicate copies of legal process against such an insurer shall be served upon the Insurance Commissioner, and at time of service the plaintiff shall pay to the Insurance Commissioner Twenty

Dollars ($20.00), taxable as costs in the action. The Insurance Commissioner shall immediately mail one copy of the process so served to the person designated by the insurer in the policy for the purpose, by mail with return receipt requested. The insurer shall have forty (40) days after the date of mailing within which to plead, answer, or otherwise defend the action.

SECTION 23. AMENDATORY Section 3, Chapter 323, O.S.L. 2009 (36 O.S. Supp. 2010, Section 1250.17), is amended to read as follows:

Section 1250.17. The Insurance Commissioner shall develop, by rule, ~~an affidavit~~ a form to be presented to patients by health care providers prior to rendering nonemergency services. The ~~affidavit~~ form shall be designed to seek information from the patient to further determine the eligibility of the patient for benefits under the patient's insurance policy. Making false statements on the ~~affidavit~~ form shall ~~carry the same penalties under law as perjury~~ be regarded as willful misrepresentation.

SECTION 24. AMENDATORY 36 O.S. 2001, Section 1435.23, as last amended by Section 12, Chapter 432, O.S.L. 2009 (36 O.S. Supp. 2010, Section 1435.23), is amended to read as follows:

Section 1435.23. A. All applications shall be accompanied by the applicable fees. An appointment may be deemed by the Commissioner to have terminated upon failure by the insurer to pay the prescribed renewal fee. The Commissioner may also by order

impose a civil penalty equal to double the amount of the unpaid renewal fee.

The Insurance Commissioner shall collect in advance the following fees and licenses:

1. For filing appointment of Insurance Commissioner as agent for service of process..... $ 20.00

2. Miscellaneous:

a. Certificate and Clearance of Commissioner..... $ 3.00

b. Insurance producer's study manual:

Life, Accident & Health..... not to exceed $ 40.00

Property and Casualty..... not to exceed $ 40.00

c. For filing organizational documents of an entity applying for a license as an insurance producer..... $ 20.00

3. Examination for license:

For each examination covering laws and one or more lines of insurance.... not to exceed $100.00

4. Licenses:

a. Insurance producer’s biennial license, ~~regardless of number of companies represented~~..... $ 60.00

b. Non-resident insurance producer’s biennial license..... $100.00

c. Insurance producer’s biennial license for sale or solicitation of ~~separate accounts or agreements, as provided for in Section 6061 of this title~~ variable insurance products..... $ 60.00

~~c.~~

d. Limited lines producer biennial license..... $ 40.00

~~d.~~

e. Temporary license as agent..... $ 20.00

~~e.~~

f. Managing general agent's biennial license..... $ 60.00

~~f.~~

g. Surplus lines broker's biennial license..... $100.00

~~g.~~

h. Insurance vending machine, each machine, biennial fee..... $100.00

~~h.~~

i. Insurance consultant's biennial license, resident or nonresident..... $100.00

~~i.~~

j. Customer service representative biennial license..... $ 40.00

~~j. Insurance producer's provisional license $ 20.00~~

5. ~~Biennial~~ Annual fee for each appointed insurance producer, managing general agent, or limited lines producer by insurer, each license of each insurance producer or representative ~~$55.00~~ $30.00

6. Renewal fee for all licenses shall be the same as the current initial license fee.

7. The fee for a duplicate license shall be one-half (1/2) the fee of an original license.

8. The renewal of a license shall require a fee of double the current original license fee if the application for renewal is late, or incomplete on the renewal deadline.

9. The administrative fee for submission of a change of legal name or address more than thirty (30) days after the change occurred shall be Fifty Dollars ($50.00).

B. If for any reason an insurance producer license or appointment is not issued or renewed by the Commissioner, all fees

accompanying the appointment or application for the license shall be deemed earned and shall not be refundable except as provided in Section 352 of this title.

C. The Insurance Commissioner, by order, may waive licensing fees in extraordinary circumstances for a class of producers where the Commissioner deems that the public interest will be best served.

SECTION 25. AMENDATORY 36 O.S. 2001, Section 1435.29, as last amended by Section 13, Chapter 432, O.S.L. 2009 (36 O.S. Supp. 2010, Section 1435.29), is amended to read as follows:

Section 1435.29 A. 1. Each insurance producer, with the exception of title producers and aircraft title producers or any other producer exempt by rule, shall, biennially, complete not less than twenty-one (21) clock hours of continuing insurance education which shall cover subjects in the lines for which the insurance producer is licensed. Such education may include a written or oral examination.

2. Each customer service representative shall, biennially, complete not less than ten (10) clock hours of continuing insurance education which shall cover subjects in the lines for which the licensee is authorized to conduct insurance-related business on behalf of the appointing agent, broker, or agency.

3. Licensees, with the exception of title producers and aircraft title producers or any other producer exempt by rule, shall

complete, in addition to the foregoing, three (3) clock hours of ethics course work in this same period.

4. Each title producer and aircraft title producer shall, biennially, complete not less than sixteen (16) clock hours of continuing insurance education, two (2) hours of which shall be ethics course work, which shall cover the line for which the producer is licensed. Such education may include a written or oral examination.

B. 1. The Insurance Commissioner shall approve courses and providers of resident provisional producer prelicensing education and continuing education. The Insurance Department may use one or more of the following to review and provide a nonbinding recommendation to the Insurance Commissioner on approval or disapproval of courses and providers of resident provisional producer prelicensing education and continuing education:

a. employees of the Insurance Commissioner,

b. a continuing education advisory committee, or

c. an independent service whose normal business activities include the review and approval of continuing education courses and providers. The Commissioner may negotiate agreements with such independent service to review documents and other materials submitted for approval of courses and providers and provide the Commissioner with its

nonbinding recommendation. The Commissioner may require such independent service to collect the fee charged by the independent service for reviewing materials provided for review directly from the course providers.

The Insurance Commissioner has sole authority to approve courses and providers of resident provisional producer prelicensing education and continuing education. If the Insurance Commissioner uses one of the entities listed above to provide a nonbinding recommendation, the Commissioner shall adopt or decline to adopt the recommendation within thirty (30) days of receipt of the recommendation. In the event the Insurance Commissioner takes no action within said thirty-day period, the recommendation made to the Commissioner will be deemed to have been adopted by the Commissioner.

The Insurance Commissioner may certify providers and courses offered for license examination study. The Insurance Department shall use employees of the Insurance Commissioner to review and certify license examination study program providers and courses.

2. Each insurance company shall be allowed to provide continuing education to insurance producers and customer service representatives as required by this section; provided that such continuing education meets the general standards for education otherwise established by the Insurance Commissioner.

3. An insurance producer who, during the time period prior to renewal, participates in ~~an approved~~ a professional designation program, approved by the Insurance Commissioner, shall be deemed to have met the biennial requirement for continuing education.

~~Each course in the~~ The curriculum for the program shall total a minimum of twenty-four (24) hours within a twenty-four-month period. Each approved professional designation program included in this section shall be reviewed for quality and compliance every three (3) years in accordance with standardized criteria promulgated by rule. Continuation of approved status is contingent upon the findings of the review. The list of professional designation programs approved under this paragraph shall be made available to producers and providers annually.

4. The Insurance Department may promulgate rules providing that courses or programs offered by professional associations shall qualify for presumptive continuing education credit approval. The rules shall include standardized criteria for reviewing the professional associations' mission, membership, and other relevant information, and shall provide a procedure for the Department to disallow all or part of a presumptively approved course. Professional association courses approved in accordance with this paragraph shall be reviewed every three (3) years to determine whether they continue to qualify for continuing education credit.

5. Subject to approval by the Commissioner, the active membership of the licensed producer or broker in local, regional, state, or national professional insurance organizations or associations may be approved for up to one (1) annual hour of instruction. The hour shall be credited upon timely filing with the Commissioner, or designee of the Commissioner, and appropriate written evidence acceptable to the Commissioner of such active membership in the organization or association.

6. The active service of a licensed producer as a member of a continuing education advisory committee, as described in paragraph 1 of this subsection, shall be deemed to qualify for continuing education credit on an hour-for-hour basis.

C. 1. Annual fees and course submission fees shall be set forth as a rule by the Commissioner. The fees are payable to the Insurance Commissioner. Provided, public-funded educational institutions, federal agencies, nonprofit organizations, not-for-profit organizations, and Oklahoma state agencies shall be exempt from this subsection.

2. The Commissioner may assess a civil penalty, after notice and opportunity for hearing, against a continuing education provider who fails to comply with the requirements of the Oklahoma Producer Licensing Act, of not less than One Hundred Dollars ($100.00) nor more than Five Hundred Dollars ($500.00), for each occurrence. The

civil penalty may be enforced in the same manner in which civil judgments may be enforced.

D. Failure of an insurance producer or customer service representative to comply with the requirements of the Oklahoma Producer Licensing Act may, after notice and opportunity for hearing, result in censure, suspension, nonrenewal of license or a civil penalty of up to Five Hundred Dollars ($500.00) or by both such penalty and civil penalty. Said civil penalty may be enforced in the same manner in which civil judgments may be enforced.

E. Limited lines producers and nonresident agents who have successfully completed an equivalent or greater requirement shall be exempt from the provisions of this section.

F. Members of the Legislature shall be exempt from this section.

G. The Commissioner shall adopt and promulgate such rules as are necessary for effective administration of this section.

SECTION 26. AMENDATORY 36 O.S. 2001, Section 1524, is amended to read as follows:

Section 1524. A. "Company Action Level Event" means any of the following events:

1. The filing of an RBC Report by an insurer which indicates that:

a. the insurer's Total Adjusted Capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC, ~~or~~

b. if a life or health insurer, the insurer has Total Adjusted Capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 2.5 and has a negative trend, or

c. if a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the Property and Casualty RBC instructions;

2. The notification by the Insurance Commissioner to the insurer of an Adjusted RBC Report that indicates an event described in paragraph 1 of this subsection, provided the insurer does not challenge the Adjusted RBC Report under Section ~~9~~ 1528 of this ~~act~~ title; or

3. If, pursuant to Section ~~9~~ 1528 of this ~~act~~ title, an insurer challenges an Adjusted RBC Report that indicates the event described in paragraph 1 of this subsection, the notification by the

Commissioner to the insurer that the Commissioner has, after opportunity for a hearing, rejected the insurer's challenge.

B. In the event of a Company Action Level Event, the insurer shall, unless otherwise directed by the Commissioner, prepare and submit to the Commissioner an RBC Plan which shall include the following five elements:

1. Conditions which contribute to the Company Action Level Event;

2. Proposals of corrective actions which the insurer intends to take and which would be expected to result in the elimination of the Company Action Level Event;

3. Projections of the insurer's financial results in the current year and at least the four (4) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, or capital and surplus. Unless the Commissioner otherwise directs, the projections for both new and renewal business shall include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

4. The key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

5. The quality of, and problems associated with, the insurer's business, including, but not limited to, its assets, anticipated

business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

C. The RBC Plan shall be submitted:

1. Within forty-five (45) days of the Company Action Level Event; or

2. If the insurer challenges an Adjusted RBC Report pursuant to Section 9 of this act, within forty-five (45) days after notification to the insurer that the Commissioner has, after opportunity for a hearing, rejected the insurer's challenge.

D. Within sixty (60) days after the submission by an insurer of an RBC Plan to the Commissioner, the Commissioner shall notify the insurer whether the RBC Plan shall be implemented or is, in the judgment of the Commissioner, unsatisfactory. If the Commissioner determines the RBC Plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC Plan satisfactory, in the judgment of the Commissioner. Upon notification from the Commissioner, the insurer shall prepare a Revised RBC Plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the Revised RBC Plan to the Commissioner:

1. Within forty-five (45) days after the notification from the Commissioner; or

2. If the insurer challenges the notification from the Commissioner under Section ~~9~~ 1528 of this ~~act~~ title, within forty-five (45) days after a notification to the insurer that the Commissioner has, after opportunity for a hearing, rejected the insurer's challenge.

E. In the event of a notification by the Commissioner to an insurer that the insurer's RBC Plan or Revised RBC Plan is unsatisfactory, the Commissioner may at the Commissioner's discretion, subject to the insurer's right to a hearing under Section ~~9~~ 1528 of this ~~act~~ title, specify in the notification that the notification constitutes a Regulatory Action Level Event.

F. Every domestic insurer that files an RBC Plan or Revised RBC Plan with the Commissioner shall file a copy of the RBC Plan or Revised RBC Plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

1. The state has an RBC provision substantially similar to subsection A of Section ~~12~~ 1531 of this ~~act~~ title; and

2. The insurance commissioner of that state has notified the insurer of its request for the filing in writing. If such a request is made, the insurer shall file a copy of the RBC Plan or Revised RBC Plan in that state no later than the later of:

a. fifteen (15) days after the receipt of the request to file a copy of its RBC Plan or Revised RBC Plan with the state, or

b. the date on which the RBC Plan or Revised RBC Plan is filed under subsections C and D of this section.

SECTION 27. AMENDATORY 36 O.S. 2001, Section 3639.1, is amended to read as follows:

Section 3639.1. A. No insurer shall cancel, refuse to renew or increase the premium of a homeowner's insurance policy, which has been in effect more than forty-five (45) days, solely because the insured filed a first claim against the policy. The provisions of this section shall not be construed to prevent the cancellation, nonrenewal or increase in premium of a homeowner's insurance policy for the following reasons:

1. Nonpayment of premium;

2. Discovery of fraud or material misrepresentation in the procurement of the insurance or with respect to any claims submitted thereunder;

3. Discovery of willful or reckless acts or omissions on the part of the named insured which increase any hazard insured against;

4. A change in the risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed;

5. Violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof which substantially increases any hazard insured against;

6. A determination by the Insurance Commissioner that the continuation of the policy would place the insurer in violation of the insurance laws of this state; or

7. Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured against.

B. An insurer shall give to the named insured at the mailing address shown on a private passenger auto or homeowners policy, a written renewal notice that shall include new premium, new deductible, new limits or coverage at least thirty (30) days prior to the expiration date of the policy. If the insurer fails to provide such notice, the premium, deductible, limits and coverage provided to the named insurer prior to the change shall remain in effect until notice is given or until the effective date of replacement coverage obtained by the named insured, whichever occurs first. If notice is given by mail, the notice shall be deemed to have been given on the day the notice is mailed. If the insured elects not to renew, any earned premium for the period of extension of the terminated policy shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, the premium increase, if any, and other changes shall be effective the day following the prior policy's expiration or anniversary date.

SECTION 28. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 3640 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in this section:

1. "Certificate" or "certificate of insurance" means any document or instrument, no matter how titled or described, which is prepared or issued by an insurer or insurance producer as evidence of property or casualty insurance coverage. "Certificate" or "certificate of insurance" shall not include a policy of insurance or insurance binder;

2. "Certificate holder" means any person, other than a policyholder, that requests, obtains, or possesses a certificate of insurance;

3. "Insurance producer" shall be defined as provided in Section 1435.2 of Title 36 of the Oklahoma Statutes;

4. "Insurer" shall be defined as provided in Section 103 of Title 36 of the Oklahoma Statutes; and

5. "Policyholder" means a person who has contracted with a property or casualty insurer for insurance coverage.

B. No person may prepare, issue, or request the issuance of a certificate of insurance unless the form has been filed with and approved by the Insurance Commissioner, except as provided in subsection E of this section. No person may alter or modify an approved certificate of insurance form.

C. The Commissioner shall disapprove a form filed pursuant to this section, or withdraw approval of a form, if the form:

1. Is unjust, unfair, misleading, or deceptive, or violates public policy;

2. Fails to comply with the requirements of subsection D of this section; or

3. Violates any law, including any regulation adopted by the Insurance Commissioner.

D. Each certificate of insurance shall contain the following or similar statement: "This certificate of insurance is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend, or alter the coverage, terms, exclusions, and conditions afforded by the policies referenced herein."

E. Standard certificate of insurance forms promulgated by the Association of Cooperative Operations Research and Development or the Insurance Services Office are deemed approved by the Insurance Commissioner and shall not be required to be filed if the forms otherwise comply with the requirements of this section.

F. No person, wherever located, shall demand or require the issuance of a certificate of insurance from an insurer, insurance producer, or policyholder which contains any false or misleading information concerning the policy of insurance to which the certificate makes reference.

G. No person, wherever located, may knowingly prepare or issue a certificate of insurance that contains any false or misleading information or that purports to affirmatively or negatively alter, amend, or extend the coverage provided by the policy of insurance to which the certificate makes reference.

H. No person may prepare, issue, demand, or require, either in addition to or in lieu of a certificate of insurance, an opinion letter or other document or correspondence that is inconsistent with this section; provided, however, an insurer or insurance producer may prepare or issue an addendum to a certificate that clarifies and explains the coverages provided by a policy of insurance and otherwise complies with the requirements of this section.

I. The provisions of this section apply to all certificate holders, policyholders, insurers or insurance producers with regard to a certificate of insurance issued on property or casualty operations or a risk located in this state, regardless of where the certificate holder, policyholder, insurer or insurance producer is located. These provisions shall not be construed to apply to:

1. Evidence of insurance required by a lender in a lending transaction involving:

a. a mortgage,

b. a lien,

c. a deed or trust, or

d. any other security interest in real or personal property as security for a loan;

2. A certificate issued under:

a. a group or individual policy for:

(1) life insurance,

(2) credit insurance,

(3) accident and health insurance,

(4) long-term care benefit insurance, or

(5) Medicare supplement insurance, or

b. an annuity contract; or

3. Standard proof of motor vehicle liability insurance pursuant to the requirements of Section 3636 of Title 36 of the Oklahoma Statutes.

J. A certificate of insurance is not a policy of insurance and does not affirmatively or negatively amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate holder new or additional rights beyond what the referenced policy of insurance expressly provides.

K. No certificate of insurance shall contain references to contracts, including construction or service contracts, other than the referenced contract of insurance. Notwithstanding any requirements, term, or condition of any contract or other document with respect to which a certificate of insurance may be issued or

may pertain, the insurance afforded by the referenced policy of insurance shall be subject to all the terms, exclusions and conditions of the policy itself.

L. A certificate holder shall only have a legal right to notice of cancellation, nonrenewal, or any material change, or any similar notice concerning a policy of insurance if the person is named within the policy or any endorsement as an additional insured and the policy or endorsement requires notice to be provided. The terms and conditions of the notice, including the required timing of the notice, are governed by the policy of insurance and cannot be altered by a certificate of insurance.

M. An insurance producer who is not associated with an insurer's captive distribution system may charge a reasonable service fee for issuing a certificate to a policy holder or certificate holder.

N. Any certificate of insurance or any other document or correspondence prepared, issued, demanded, or required in violation of this section shall be null and void and of no force and effect.

O. Any person who violates this section may be fined up to One Thousand Dollars ($1,000.00) per violation.

P. The Commissioner shall have the authority to examine and investigate the activities of any person that the Commissioner reasonably believes has been or is engaged in an act or practice prohibited by this section. The Commissioner shall have the

authority to enforce the provisions of this section and impose any authorized penalty or remedy against any person who violates this section.

Q. The Commissioner may adopt reasonable rules and regulations as are necessary or proper to carry out the provisions of this section.

SECTION 29. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4250 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. On or after November 1, 2011, pursuant to the provisions of this section and any other applicable section of Title 36 of the Oklahoma Statutes, every health benefit plan shall file all group and individual initial rates and group and individual rate adjustments with the Insurance Commissioner. If the Commissioner determines that the initial rate or rate adjustment is unreasonable, excessive, unjustified or unfairly discriminatory, the Commissioner shall make a written decision stating the reason or reasons for the determination, and shall deliver a copy of the determination to the company within thirty (30) calendar days unless the Commissioner extends the determination period for an additional thirty (30) calendar days.

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

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

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

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

a. a plan that provides coverage:

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

(2) only for accidental death or dismemberment,

(3) for dental or vision care,

(4) a hospital confinement indemnity policy or other fixed indemnity insurance,

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

(6) as a supplement to liability insurance,

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

c. worker's compensation insurance coverage,

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

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

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

g. policy issued under Title XVIII, or

h. a plan issued to any person, firm, corporation, partnership, limited liability company or association that is actively engaged in business and that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed more than fifty (50) eligible employees.

SECTION 30. AMENDATORY 36 O.S. 2001, Section 6202, as amended by Section 23, Chapter 125, O.S.L. 2007 (36 O.S. Supp. 2010, Section 6202), is amended to read as follows:

Section 6202. ~~Terms~~ As used in the Insurance Adjusters Licensing Act ~~are defined as follows~~:

1. "Commissioner" means the Insurance Commissioner of the state or his or her lawfully authorized representative;

2. "Adjuster" means either an insurance adjuster or a public adjuster;

3. "Insurance adjuster" means any person, firm, association, company, or legal entity that acts in this state for an insurer, and that investigates claims, adjusts losses, negotiates claim settlements, or performs incidental duties arising pursuant to the provisions of insurance contracts on behalf of an insurer and includes:

a. "independent adjusters", meaning any insurance adjuster that suggests or presents to the insurance industry and public that said adjuster acts as an adjuster for a fee or other compensation, and

b. "company or staff adjusters", meaning adjusters who engage in the investigation, adjustment, and negotiation of claims as salaried employees of an insurer;

4. "Public adjuster" means any person, firm, association, company, or corporation that suggests or presents to members of the public that said public adjuster represents the interests of an insured or third party for a fee or compensation. Public adjusters may investigate claims and negotiate losses to property only;

5. "Insurer" means any authorized insurance company, corporation, reciprocal group, mutual group, underwriting association or bureau, or any combination thereof, writing or underwriting any insurance contracts; ~~and~~

6. "Home state" means the District of Columbia and any state or territory of the United States in which the adjuster's principal place of residence or principal place of business is located. If neither the state in which the adjuster maintains the principal place of residence nor the state in which the adjuster maintains the principal place of business has a licensing or examination requirement, the adjuster may declare another state which has an examination requirement and in which the adjuster is licensed to be the "home state"; and

7. "Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation and final resolution of consumer electronic products insurance claims which:

a. may only be utilized by a licensed independent adjuster, licensed agent, or individuals supervised by a licensed independent adjuster or licensed agent,

b. shall comply with all claims payment requirements of the Oklahoma Insurance Code, and

c. shall be certified as compliant by a licensed independent adjuster.

SECTION 31. AMENDATORY 36 O.S. 2001, Section 6203, as amended by Section 40, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2010, Section 6203), is amended to read as follows:

Section 6203. ~~For the purpose of the Insurance Adjusters Licensing Act, no one shall be deemed to be an adjuster or be required to obtain a license as an adjuster who is~~ The definition of an insurance adjuster shall not be deemed to include, and a license as an insurance adjuster shall not be required of the following:

1. A licensed agent or general agent of an insurer who processes undisputed or uncontested losses for said insurers solely pursuant to the provisions of policies issued by the agent, or his agency, if the agent or general agent receives no extra compensation for such services; ~~or~~

2. Engaged in investigating, adjusting, negotiating, or processing claims arising pursuant to the provisions of life insurance, annuity, or accident and health insurance contracts; ~~or~~

3. A nonresident who occasionally is in this state to adjust a single loss or losses arising pursuant to the provisions of a policy of marine insurance; ~~or~~

4. A salaried employee of a licensed insurer whose primary duties are not adjusting, investigating, or supervising insurance claims; ~~or~~

5. A licensed attorney in the State of Oklahoma who adjusts insurance losses from time to time, incidental to the practice of law, and who does not advertise or represent that he is an adjuster; ~~or~~

6. A person employed solely for the purpose of furnishing technical assistance to a licensed adjuster, including but not limited to photographers, appraisers, estimators, private detectives, engineers, handwriting experts, and attorneys-at-law; ~~or~~

7. A person who performs clerical duties for a licensed insurer or organization that handles claims and who does not negotiate disputed or contested claims for the insurer or organization that handles claims; ~~or~~

8. A nonresident insurance adjuster who is actively licensed in another state and who is in this state no more than once a year for the purpose of adjusting a single loss or losses arising out of an occurrence common to all such losses, or who is acting as a temporary substitute for a licensed adjuster; or

9. An individual who collects claim information from, or furnishes claim information to, insured customers or claimants, and who conducts data entry including entering data into an automated claims adjudication system, provided that the individual is an employee of a licensed independent adjuster or an affiliate where no more than twenty-five persons are under the supervision of one licensed independent adjuster or licensed agent. A licensed agent acting as a supervisor pursuant to this paragraph is not required to be licensed as an adjuster.

SECTION 32. AMENDATORY 36 O.S. 2001, Section 6205, as last amended by Section 42, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2010, Section 6205), is amended to read as follows:

Section 6205. A. Application for a license as an adjuster shall be made to the Insurance Commissioner upon forms prescribed and furnished by the Commissioner. As a part of and in connection with the application, the applicant shall furnish such information concerning the applicant's identity, personal history, business experience, business record and such other pertinent information which the Commissioner shall reasonably require.

B. Unless denied licensure pursuant to Section 6220 of this title, a nonresident applicant shall receive a nonresident adjuster license if:

1. The applicant has passed an examination in the applicant’s home state;

2. The applicant is currently licensed and in good standing in the home state of the applicant;

3. The applicant has submitted the proper request for licensure and has paid the fees required by Section 6212 of this title; and

4. The applicant’s home state awards nonresident adjuster licenses to residents of this state on the same basis.

C. If a nonresident applicant’s home state does not license or require an examination for an adjuster license, the adjuster may declare another state which has an examination requirement and in which the adjuster is licensed to be the home state. Should the applicant not hold an active adjuster license in his or her home state or declared home state, the applicant shall pass the adjuster examination of this state prior to receiving a nonresident adjuster license.

D. An individual who is a resident of Canada shall not be licensed pursuant to the Insurance Adjusters Licensing Act nor designate this state as the individual's home state, unless the individual has successfully passed the adjuster examination and has complied with all applicable requirements of the Insurance Adjusters Licensing Act; except that, any such applicant shall not be required to comply with paragraph 2 of subsection A of Section 6206 of this title or Section 6215 of this title.

SECTION 33. AMENDATORY 36 O.S. 2001, Section 6212, as amended by Section 47, Chapter 176, O.S.L. 2009 (36 O.S. Supp. 2010, Section 6212), is amended to read as follows:

Section 6212. A. The Insurance Commissioner or an administrator approved by the Insurance Commissioner shall collect a fee of Twenty Dollars ($20.00) for an examination for an adjuster's license in any of the following single classes of business. The fee for any examination which includes two or more classes of business shall not exceed Forty Dollars ($40.00). The classes of business are:

1. Motor vehicle physical damage;

2. Fire and allied lines (property);

3. Casualty;

4. Workers' compensation;

5. Crime and fidelity bonds; and

6. Crop/hail.

B. The Commissioner shall collect the following fees for an adjuster's license:

1. For a license in any single class of business, every two (2) years, Thirty Dollars ($30.00);

2. For a license in any combination of two or more classes of business, every two years, Fifty Dollars ($50.00);

3. Public adjuster, every two years, Thirty Dollars ($30.00);

4. Emergency adjuster, as provided for in Section 6218 of this title, each year, Fifteen Dollars ($15.00); and

5. Apprentice adjuster, as provided for in Section 6204.1 of this title, Twenty Dollars ($20.00).

C. The fees prescribed in this section shall accompany the application for an original license or a renewal of a license.

D. The fee for the original license or renewal license shall be collected in advance of issuance. Late application for renewal shall require a fee of double the amount of the original license fee.

E. The Commissioner may issue a duplicate license for any lost, stolen, or destroyed license issued pursuant to the provisions of the Insurance Adjusters Licensing Act if an affidavit is submitted by the licensee to the Commissioner concerning the facts of such loss, theft, or destruction. ~~Said~~ The affidavit shall be in a form prescribed by the Commissioner. The fee for a duplicate license shall be one-half (1/2) the fee of the license.

F. ~~The administrative fee for submission of a change of legal name or address more than thirty (30) days after the change occurred shall be Fifty Dollars ($50.00)~~ Licensees shall inform by any means acceptable to the Commissioner of a change of legal name, address or email address within thirty (30) days of the change to permit the Commissioner to give proper notice to licensees. A change in legal name or address submitted more than thirty (30) days after the

change shall include an administrative fee of Fifty Dollars ($50.00). Failure to provide acceptable notification of a change of legal name or address to the Commissioner within forty-five (45) days of the date the administrative fee is assessed shall result in penalties pursuant to subsection B of Section 6220 of this title.

SECTION 34. AMENDATORY 36 O.S. 2001, Section 6217, as last amended by Section 2, Chapter 355, O.S.L. 2010 (36 O.S. Supp. 2010, Section 6217), is amended to read as follows:

Section 6217. A. All licenses issued pursuant to the provisions of the Insurance Adjusters Licensing Act shall continue in force not longer than twenty-four (24) months. The renewal dates for the licenses may be staggered throughout the year by notifying licensees in writing of the expiration and renewal date being assigned to the licensees by the Insurance Commissioner and by making appropriate adjustments in the biennial licensing fee.

B. Any licensee applying for renewal of a license as an adjuster shall have completed not less than twenty-four (24) clock hours of continuing insurance education, of which three (3) hours must be in ethics, within the previous twenty-four (24) months prior to renewal of the license. Such continuing education shall cover subjects in the classes of insurance for which the adjuster is licensed. The Insurance Commissioner shall approve courses and providers of continuing education for insurance adjusters as required by this section.

The Insurance Department may use one or more of the following to review and provide a nonbinding recommendation to the Insurance Commissioner on approval or disapproval of courses and providers of continuing education:

1. Employees of the Insurance Commissioner;

2. A continuing education advisory committee. The continuing education advisory committee is separate and distinct from the Advisory Board established by Section 6221 of this title;

3. An independent service whose normal business activities include the review and approval of continuing education courses and providers. The Commissioner may negotiate agreements with such independent service to review documents and other materials submitted for approval of courses and providers and present the Commissioner with its nonbinding recommendation. The Commissioner may require such independent service to collect the fee charged by the independent service for reviewing materials provided for review directly from the course providers.

C. An adjuster who, during the time period prior to renewal, participates in an approved professional designation program shall be deemed to have met the biennial requirement for continuing education. Each course in the curriculum for the program shall total a minimum of twenty (20) hours. Each approved professional designation program included in this section shall be reviewed for quality and compliance every three (3) years in accordance with

standardized criteria promulgated by rule. Continuation of approved status is contingent upon the findings of the review. The list of professional designation programs approved under this subsection shall be made available to producers and providers annually.

D. A claims adjuster for any insurer duly authorized to transact workers' compensation insurance shall complete six (6) hours of continuing education relating to the Workers' Compensation Act as part of the twenty-four (24) clock hours of continuing insurance education.

E. The Insurance Department may promulgate rules providing that courses or programs offered by professional associations shall qualify for presumptive continuing education credit approval. The rules shall include standardized criteria for reviewing the professional associations' mission, membership, and other relevant information, and shall provide a procedure for the Department to disallow a presumptively approved course. Professional association courses approved in accordance with this subsection shall be reviewed every three (3) years to determine whether they continue to qualify for continuing education credit.

F. The active service of a licensed adjuster as a member of a continuing education advisory committee, as described in paragraph 2 of subsection B of this section, shall be deemed to qualify for continuing education credit on an hour-for-hour basis.

G. 1. Each provider of continuing education shall, after approval by the Commissioner, submit an annual fee. A fee may be assessed for each course submission at the time it is first submitted for review and upon submission for renewal at expiration. Annual fees and course submission fees shall be set forth as a rule by the Commissioner. The fees are payable to the Insurance Commissioner and shall be deposited in the State Insurance Commissioner Revolving Fund, created in subsection C of Section 1435.23 of this title, for the purposes of fulfilling and accomplishing the conditions and purposes of the Oklahoma Producer Licensing Act and the Insurance Adjusters Licensing Act. Public-funded educational institutions, federal agencies, nonprofit organizations, not-for-profit organizations and Oklahoma state agencies shall be exempt from this subsection.

2. The Commissioner may assess a civil penalty, after notice and opportunity for hearing, against a continuing education provider who fails to comply with the requirements of the Insurance Adjusters Licensing Act, of not less than One Hundred Dollars ($100.00) nor more than Five Hundred Dollars ($500.00), for each occurrence. The civil penalty may be enforced in the same manner in which civil judgments may be enforced.

H. Subject to the right of the Commissioner to suspend, revoke, or refuse to renew a license of an adjuster, any such license may be renewed by filing on the form prescribed by the Commissioner on or

before the expiration date a written request by or on behalf of the licensee for such renewal and proof of completion of the continuing education requirement set forth in subsection B of this section, accompanied by payment of the renewal fee.

I. If the request, proof of compliance with the continuing education requirement and fee for renewal of a license as an adjuster are filed with the Commissioner prior to the expiration of the existing license, the licensee may continue to act pursuant to said license, unless revoked or suspended prior to the expiration date, until the issuance of a renewal license or until the expiration of ten (10) days after the Commissioner has refused to renew the license and has mailed notice of said refusal to the licensee. Any request for renewal filed after the date of expiration may be considered by the Commissioner as an application for a new license.

SECTION 35. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

Sections 35 through 51 of this act shall be known and may be cited as the "Uniform Health Carrier External Review Act".

SECTION 36. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

The purpose of the Uniform Health Carrier External Review Act is to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in this act.

SECTION 37. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

For purposes of the Uniform Health Carrier External Review Act

1. "Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated;

2. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting;

3. "Authorized representative" means:

a. a person to whom a covered person has given express written consent to represent the covered person in an external review,

b. a person authorized by law to provide substituted consent for a covered person, or

c. a family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent;

4. "Best evidence" means evidence based on:

a. randomized clinical trials,

b. if randomized clinical trials are not available, cohort studies or case-control studies,

c. if subparagraphs a and b of this paragraph are not available, case-series, or

d. if subparagraphs a, b and c of this paragraph are not available, expert opinion;

5. "Case-control study" means a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received;

6. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions;

7. "Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group;

8. “Certification” means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness;

9. “Clinical review criteria” means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services;

10. “Cohort study” means a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention or specific interventions;

11. “Commissioner” means the Insurance Commissioner;

12. “Concurrent review” means utilization review conducted during a hospital stay or course of treatment of a patient;

13. “Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan;

14. “Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan;

15. “Discharge planning” means the formal process for determining, prior to discharge from a facility, the coordination

and management of the care that a patient receives following discharge from a facility;

16. "Disclose" means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information;

17. "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy;

18. "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition;

19. "Evidence-based standard" means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients;

20. "Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention or therapy;

21. "Facility" means an institution providing health care services or a health care setting, including but not limited to

hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

22. "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures;

23. "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services;

24. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law;

25. "Health care provider" or "provider" means a health care professional or a facility;

26. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease;

27. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to

provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including but not limited to a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services;

28. "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relate to:

a. the past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family,

b. the provision of health care services to an individual, or

c. payment for the provision of health care services to an individual;

29. "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations;

30. "Medical or scientific evidence" means evidence found in the following sources:

a. peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific

manuscripts and that submit most of the published articles for review by experts who are not part of the editorial staff,

b. peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE),

c. medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act,

d. the following standard reference compendia:

(1) the American Hospital Formulary Service-Drug Information,

(2) Drug Facts and Comparisons,

(3) the American Dental Association Accepted Dental Therapeutics, and

(4) the United States Pharmacopoeia-Drug Information,

e. findings, studies or research conducted by or under the auspices of federal government agencies and

nationally recognized federal research institutes, including but not limited to:

(1) the federal Agency for Healthcare Research and Quality,

(2) the National Institutes of Health,

(3) the National Cancer Institute,

(4) the National Academy of Sciences,

(5) the Centers for Medicare and Medicaid Services,

(6) the federal Food and Drug Administration, and

(7) any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services, or

f. any other medical or scientific evidence that is comparable to the sources listed in subparagraphs a through e of this paragraph;

31. "NAIC" means the National Association of Insurance Commissioners;

32. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing;

33. "Prospective review" means utilization review conducted prior to an admission or a course of treatment;

34. "Protected health information" means health information:

a. that identifies an individual who is the subject of the information, or

b. with respect to which there is a reasonable basis to believe that the information could be used to identify an individual;

35. "Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time;

36. "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment;

37. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service;

38. "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity,

appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include but are not limited to ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review; and

39. "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing a review for its own health benefit plans.

SECTION 38. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as provided in subsection B of this section, the Uniform Health Carrier External Review Act shall apply to all health carriers.

B. The provisions of the Uniform Health Carrier External Review Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined in Section 4424 of Title 36 of the Oklahoma Statutes, vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined in Section 3611.1 of Title 36 of the Oklahoma Statutes, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under

Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

SECTION 39. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. A health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to Section 42, 43 or 44 of this act and include the appropriate statements and information set forth in subsection B of this section at the same time the health carrier sends written notice of:

a. an adverse determination upon completion of the health carrier's utilization review process set forth in Sections 6551 through 6565 of Title 36 of the Oklahoma Statutes, and

b. a final adverse determination.

2. As part of the written notice required under paragraph 1 of this subsection, a health carrier shall include the following, or substantially equivalent, language: "We have denied your request for the provision of or payment for a health care service or course

of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Oklahoma Insurance Department".

3. The Insurance Commissioner may promulgate any necessary rule providing for the form and content of the notice required under this section.

B. 1. The health carrier shall include in the notice required under subsection A of this section:

a. for a notice related to an adverse determination, a statement informing the covered person that:

(1) if the covered person has a medical condition where the time frame for completion of an expedited review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to Section 44 of this act, or Section 45 of this act if the adverse

determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination, but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review, and

(2) the covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process, but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within

thirty (30) days following the date the covered person or the covered person's authorized representative files the grievance with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to Section 40 of this act and shall be considered to have exhausted the health carrier's internal grievance process for purposes of Section 41 of this act, and

b. for a notice related to a final adverse determination, a statement informing the covered person that:

(1) if the covered person has a medical condition where the time frame for completion of a standard external review pursuant to Section 42 of this act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to Section 43 of this act, or

(2) if the final adverse determination concerns:

(a) an admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person or the covered person's authorized representative may request an expedited external review pursuant to Section 43 of this act, or

(b) a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or the covered person's authorized representative may file a request for a standard external review to be conducted pursuant to Section 44 of this act or if the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, the covered person or the covered person's

authorized representative may request an expedited external review to be conducted under Section 44 of this act.

2. In addition to the information to be provided pursuant to paragraph 1 of this subsection, the health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to Section 51 of this act, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

3. As part of any forms provided under paragraph 2 of this subsection, the health carrier shall include an authorization form, or other document approved by the Commissioner that complies with the requirements of 45 CFR, Section 164.508, by which the covered person, for purposes of conducting an external review under this act, authorizes the health carrier and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review.

SECTION 40. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. Except for a request for an expedited external review as set forth in Section 43 of this act, all requests for external review shall be made in writing to the Insurance Commissioner.

2. The Commissioner may prescribe by rule the form and content of external review requests required to be submitted under this section.

B. A covered person or the covered person's authorized representative may make a request for an external review of an adverse determination or final adverse determination.

SECTION 41. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. Except as provided in subsection B of this section, a request for an external review pursuant to Section 42, 43 or 44 of this act shall not be made until the covered person has exhausted the health carrier's internal grievance process.

2. A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the covered person or the covered person's authorized representative:

a. has filed a grievance involving an adverse determination, and

b. except to the extent the covered person or the covered person's authorized representative requested or agreed

to a delay, has not received a written decision on the grievance from the health carrier within thirty (30) days following the date the covered person or the covered person's authorized representative filed the grievance with the health carrier.

3. Notwithstanding paragraph 2 of this subsection, a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination made pursuant to Sections 6551 through 6565 of Title 36 of the Oklahoma Statutes until the covered person has exhausted the health carrier's internal grievance process.

B. 1. a. At the same time a covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination, the covered person or the covered person's authorized representative may file a request for an expedited external review of the adverse determination:

(1) under Section 43 of this act if the covered person has a medical condition where the time frame for completion of an expedited review of the grievance involving an adverse determination would seriously jeopardize the life or health of

the covered person or would jeopardize the covered person's ability to regain maximum function, or

(2) under Section 44 of this act if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated,

b. upon receipt of a request for an expedited external review under subparagraph a of this paragraph, the independent review organization conducting the external review in accordance with the provisions of Section 43 or 44 of this act shall determine whether the covered person shall be required to complete the expedited review process before it conducts the expedited external review,

c. upon a determination made pursuant to subparagraph b of this paragraph that the covered person must first complete the expedited grievance review process, the

independent review organization immediately shall notify the covered person and, if applicable, the covered person's authorized representative of this determination and that it will not proceed with the expedited external review set forth in Section 43 of this act until completion of the expedited grievance review process and the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

2. A request for an external review of an adverse determination may be made before the covered person has exhausted the health carrier's internal grievance procedures whenever the health carrier agrees to waive the exhaustion requirement.

C. If the requirement to exhaust the health carrier's internal grievance procedures is waived under paragraph 2 of subsection B of this section, the covered person or the covered person's authorized representative may file a request in writing for a standard external review as set forth in Section 42 or 44 of this act.

SECTION 42. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.8 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. Within four (4) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 39 of this act, a covered person or the covered

person's authorized representative may file a request for an external review with the Insurance Commissioner.

2. Within one (1) business day after the date of receipt of a request for external review pursuant to paragraph 1 of this subsection, the Commissioner shall send a copy of the request to the health carrier.

B. Within five (5) business days following the date of receipt of the copy of the external review request from the Commissioner under paragraph 2 of subsection A of this section, the health carrier shall complete a preliminary review of the request to determine whether:

1. The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

2. The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

3. The covered person has exhausted the health carrier's internal grievance process unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 41 of this act; and

4. The covered person has provided all the information and forms required to process an external review, including the release form provided under subsection B of Section 39 of this act.

C. 1. Within one (1) business day after completion of the preliminary review, the health carrier shall notify the Commissioner and covered person and, if applicable, the covered person's authorized representative in writing whether:

a. the request is complete, and

b. the request is eligible for external review.

2. If the request:

a. is not complete, the health carrier shall inform the covered person and, if applicable, the covered person's authorized representative and the Commissioner in writing and include in the notice what information or materials are needed to make the request complete, or

b. is not eligible for external review, the health carrier shall inform the covered person, if applicable, the covered person's authorized representative and the Commissioner in writing and

include in the notice the reasons for its ineligibility.

3. a. The Commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

b. The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Commissioner.

4. a. The Commissioner may determine that a request is eligible for external review under subsection B of Section 42 of this act notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

b. In making a determination under subparagraph a of this paragraph, the Commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all

applicable provisions of the Uniform Health Carrier External Review Act.

D. 1. Whenever the Commissioner receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection C of this section, within one (1) business day after the date of receipt of the notice, the Commissioner shall:

a. assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Section 46 of this act to conduct the external review and notify the health carrier of the name of the assigned independent review organization, and

b. notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review.

2. In reaching a decision, the assigned independent review organization shall not be bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in Sections 6551 through 6555 of Title 36 of the Oklahoma Statutes or the health carrier's internal grievance process.

3. The Commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized

representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five (5) business days following the date of receipt of the notice provided pursuant to paragraph 1 of this subsection additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five (5) business days.

E. 1. Within five (5) business days after the date of receipt of the notice provided pursuant to paragraph 1 of subsection D of this section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.

2. Except as provided in paragraph 3 of this subsection, failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in paragraph 1 of this subsection shall not delay the conduct of the external review.

3. a. If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in paragraph 1 of this subsection, the assigned independent review

organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

b. Within one (1) business day after making the decision under subparagraph a of this paragraph, the independent review organization shall notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the Commissioner.

F. 1. The assigned independent review organization shall review all of the information and documents received pursuant to subsection E of this section and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to paragraph 3 of subsection D of this section.

2. Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to paragraph 3 of subsection D of this section, the assigned independent review organization shall within one (1) business day forward the information to the health carrier.

G. 1. Upon receipt of the information, if any, required to be forwarded pursuant to paragraph 2 of subsection F of this section, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

2. Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to paragraph 1 of this subsection shall not delay or terminate the external review.

3. The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

4. a. Within one (1) business day after making the decision to reverse its adverse determination or final adverse determination, as provided in paragraph 3 of this subsection, the health carrier shall notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization, and the Commissioner in writing of its decision.

b. The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subparagraph a of this paragraph.

H. In addition to the documents and information provided pursuant to subsection E of this section, the assigned independent review organization, to the extent the information or documents are

available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

1. The covered person's medical records;

2. The attending health care professional's recommendation;

3. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

4. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

5. The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

6. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization; and

7. The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs 1 through 6 of this subsection to the extent the information or

documents are available and the clinical reviewer or reviewers consider appropriate.

I. 1. Within forty-five (45) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:

a. the covered person,

b. if applicable, the covered person's authorized representative,

c. the health carrier, and

d. the Commissioner.

2. The independent review organization shall include in the notice sent pursuant to paragraph 1 of this subsection:

a. a general description of the reason for the request for external review,

b. the date the independent review organization received the assignment from the Commissioner to conduct the external review,

c. the date the external review was conducted,

d. the date of its decision,

e. the principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision,

f. the rationale for its decision, and

g. references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

3. Upon receipt of a notice of a decision pursuant to paragraph 1 of this subsection reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

J. The assignment by the Commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to subsection D of Section 47 of this act.

SECTION 43. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.9 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as provided in subsection F of this section, a covered person or the covered person's authorized representative may

make a request for an expedited external review with the Insurance Commissioner at the time the covered person receives:

1. An adverse determination if:

a. the adverse determination involves a medical condition of the covered person for which the time frame for completion of an expedited internal review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, and

b. the covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination; or

2. A final adverse determination:

a. if the covered person has a medical condition where the time frame for completion of a standard external review pursuant to Section 42 of this act would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, or

b. if the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person

received emergency services, but has not been discharged from a facility.

B. 1. Upon receipt of a request for an expedited external review, the Commissioner immediately shall send a copy of the request to the health carrier.

2. Immediately upon receipt of the request pursuant to paragraph 1 of this subsection, the health carrier shall determine whether the request meets the reviewability requirements set forth in subsection B of Section 42 of this act. The health carrier shall immediately notify the Commissioner and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.

3. a. The Commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

b. The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that an external review request is ineligible for review may be appealed to the Commissioner.

4. a. The Commissioner may determine that a request is eligible for external review under subsection B of Section 42 of this act notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

b. In making a determination under subparagraph a of this paragraph, the Commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of the Uniform Health Carrier External Review Act.

5. Upon receipt of the notice that the request meets the reviewability requirements, the Commissioner immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Section 46 of this act. The Commissioner shall immediately notify the health carrier of the name of the assigned independent review organization.

6. In reaching a decision in accordance with subsection E of this section, the assigned independent review organization shall not be bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in Sections 6551

through 6565 of Title 36 of the Oklahoma Statutes or the health carrier's internal grievance process.

C. Upon receipt of the notice from the Commissioner of the name of the independent review organization assigned to conduct the expedited external review pursuant to paragraph 5 of subsection B of this section, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

D. In addition to the documents and information provided or transmitted pursuant to subsection C of this section, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

1. The covered person's pertinent medical records;

2. The attending health care professional's recommendation;

3. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative or the covered person's treating provider;

4. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

5. The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

6. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations; and

7. The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs 1 through 6 of this subsection to the extent the information and documents are available and the clinical reviewer or reviewers consider appropriate.

E. 1. As expeditiously as the covered person's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in subsection B of Section 42 of this act, the assigned independent review organization shall:

a. make a decision to uphold or reverse the adverse determination or final adverse determination, and

b. notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the Commissioner of the decision.

2. If the notice provided pursuant to paragraph 1 of this subsection was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall:

a. provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, the health carrier, and the Commissioner, and

b. include the information set forth in paragraph 2 of subsection I of Section 42 of this act.

3. Upon receipt of the notice of a decision pursuant to paragraph 1 of this subsection reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

F. An expedited external review may not be provided for retrospective adverse or final adverse determinations.

G. The assignment by the Commissioner of an approved independent review organization to conduct an external review in

accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to subsection D of Section 47 of this act.

SECTION 44. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.10 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. Within four (4) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 39 of this act that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the Insurance Commissioner.

2. a. A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to paragraph 1 of this subsection if the covered person's treating physician certifies, in writing, that the recommended

or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

b. Upon receipt of a request for an expedited external review, the Commissioner immediately shall notify the health carrier.

c. (1) Upon notice of the request for expedited external review, the health carrier immediately shall determine whether the request meets the reviewability requirements of subsection B of this section. The health carrier shall immediately notify the Commissioner and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.

(2) The Commissioner may specify the form for the health carrier's notice of initial determination under division (1) of this subparagraph and any supporting information to be included in the notice.

(3) The notice of initial determination under division (1) of this subparagraph shall include a statement informing the covered person and, if applicable, the covered person's authorized

representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Commissioner.

d. (1) The Commissioner may determine that a request is eligible for external review under paragraph 2 of subsection B of this section notwithstanding a health carrier's initial determination the request is ineligible and require that it be referred for external review.

(2) In making a determination under division (1) of this subparagraph, the Commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of the Uniform Health Carrier External Review Act.

e. Upon receipt of the notice that the expedited external review request meets the reviewability requirements of paragraph 2 of subsection B of this section, the Commissioner immediately shall assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Section 46 of this act and

notify the health carrier of the name of the assigned independent review organization.

f. At the time the health carrier receives the notice of the assigned independent review organization pursuant to subparagraph e of this paragraph, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

B. 1. Except for a request for an expedited external review made pursuant to paragraph 2 of subsection A of this section, within one (1) business day after the date of receipt of the request, the Commissioner receives a request for an external review, the Commissioner shall notify the health carrier.

2. Within five (5) business days following the date of receipt of the notice sent pursuant to paragraph 1 of this subsection, the health carrier shall conduct and complete a preliminary review of the request to determine whether:

a. the individual is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or requested or,

in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service or treatment was provided,

b. the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:

(1) is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition, and

(2) is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier,

c. the covered person's treating physician has certified that one of the following situations is applicable:

(1) standard health care services or treatments have not been effective in improving the condition of the covered person,

(2) standard health care services or treatments are not medically appropriate for the covered person, or

(3) there is no available standard health care service or treatment covered by the health

carrier that is more beneficial than the recommended or requested health care service or treatment described in subparagraph d of this paragraph,

d. the covered person's treating physician:

(1) has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments, or

(2) who is a licensed, board-certified or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments,

e. the covered person has exhausted the health carrier's internal grievance process unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 41 of this act, and

f. the covered person has provided all the information and forms required by the Commissioner that are necessary to process an external review, including the release form provided under subsection B of Section 39 of this act.

C. 1. Within one (1) business day after completion of the preliminary review, the health carrier shall notify the Commissioner and the covered person and, if applicable, the covered person's authorized representative in writing whether:

a. the request is complete, and

b. the request is eligible for external review.

2. If the request:

a. is not complete, the health carrier shall inform in writing the Commissioner and the covered person and, if applicable, the covered person's authorized representative and include in the notice what information or materials are needed to make the request complete, or

b. is not eligible for external review, the health carrier shall inform the covered person, the covered person's authorized representative, if applicable, and the Commissioner in writing and include in the notice the reasons for its ineligibility.

3. a. The Commissioner may specify the form for the health carrier's notice of initial determination under paragraph 2 of this subsection and any supporting information to be included in the notice.

b. The notice of initial determination provided under paragraph 2 of this subsection shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Commissioner.

4. a. The Commissioner may determine that a request is eligible for external review under paragraph 2 of subsection B of this section notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

b. In making a determination under subparagraph a of this paragraph, the Commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of the Uniform Health Carrier External Review Act.

5. Whenever a request for external review is determined eligible for external review, the health carrier shall notify the Commissioner and the covered person and, if applicable, the covered person's authorized representative.

D. 1. Within one (1) business day after the receipt of the notice from the health carrier that the external review request is eligible for external review pursuant to subparagraph d of paragraph 2 of subsection A of this section or paragraph 5 of subsection C of this section, the Commissioner shall:

a. assign an independent review organization to conduct the external review from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Section 46 of this act and notify the health carrier of the name of the assigned independent review organization, and

b. notify in writing the covered person and, if applicable, the covered person's authorized

representative of the request's eligibility and acceptance for external review.

2. The Commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five (5) business days following the date of receipt of the notice provided pursuant to paragraph 1 of this subsection, additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five (5) business days.

3. Within one (1) business day after the receipt of the notice of assignment to conduct the external review pursuant to paragraph 1 of this subsection, the assigned independent review organization shall:

a. select one or more clinical reviewers, as it determines is appropriate, pursuant to paragraph 4 of this subsection to conduct the external review, and

b. based on the opinion of the clinical reviewer, or opinions if more than one clinical reviewer has been selected to conduct the external review, make a

decision to uphold or reverse the adverse determination or final adverse determination.

4. a. In selecting clinical reviewers pursuant to subparagraph a of paragraph 3 of this subsection, the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in Section 47 of this act and, through clinical experience in the past three (3) years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

b. Neither the covered person, the covered person's authorized representative, if applicable, nor the health carrier, shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

5. In accordance with subsection H of this section, each clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

6. In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in Sections 6551 through

6565 of Title 36 of the Oklahoma Statutes or the health carrier's internal grievance process.

E. 1. Within five (5) business days after the date of receipt of the notice provided pursuant to paragraph 1 of subsection D of this section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or the final adverse determination.

2. Except as provided in paragraph 3 of this subsection, failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in paragraph 1 of this subsection shall not delay the conduct of the external review.

3. a. If the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in paragraph 1 of this subsection, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

b. Immediately upon making the decision under subparagraph a of this paragraph, the independent review organization shall notify the covered person,

the covered person's authorized representative, if applicable, the health carrier, and the Commissioner.

F. 1. Each clinical reviewer selected pursuant to subsection D of this section shall review all of the information and documents received pursuant to subsection E of this section and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to paragraph 2 of subsection D of this section.

2. Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to paragraph 2 of subsection D of this section, within one (1) business day after the receipt of the information, the assigned independent review organization shall forward the information to the health carrier.

G. 1. Upon receipt of the information required to be forwarded pursuant to paragraph 2 of subsection F of this section, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

2. Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to paragraph 1 of this subsection shall not delay or terminate the external review.

3. The external review may be terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide

coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

4. a. Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in paragraph 3 of this subsection, the health carrier shall notify the covered person, the covered person's authorized representative if applicable, the assigned independent review organization, and the Commissioner in writing of its decision.

b. The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subparagraph a of this paragraph.

H. 1. Except as provided in paragraph 3 of this subsection, within twenty (20) days after being selected in accordance with subsection D of this section to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization pursuant to subsection I of this section on whether the recommended or requested health care service or treatment should be covered.

2. Except for an opinion provided pursuant to paragraph 3 of this subsection, each clinical reviewer's opinion shall be in writing and include the following information:

a. a description of the covered person's medical condition,

b. a description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments,

c. a description and analysis of any medical or scientific evidence, as that term is defined in Section 37 of this act, considered in reaching the opinion,

d. a description and analysis of any evidence-based standard, as that term is defined in Section 37 of this act, and

e. information on whether the reviewer's rationale for the opinion is based on subparagraph a or b of paragraph 5 of subsection I of this section.

3. a. For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances require, but in no event more than five (5) calendar days after being selected in accordance with subsection D of this section.

b. If the opinion provided pursuant to subparagraph a of this paragraph was not in writing, within forty-eight (48) hours following the date the opinion was provided the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under paragraph 2 of this subsection.

I. In addition to the documents and information provided pursuant to paragraph 2 of subsection A of this section or subsection E of this section, each clinical reviewer selected pursuant to subsection D of this section, to the extent the information or documents are available and the reviewer considers

appropriate, shall consider the following in reaching an opinion pursuant to subsection H of this section:

1. The covered person's pertinent medical records;

2. The attending physician or health care professional's recommendation;

3. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating physician or health care professional;

4. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

5. Whether:

a. the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition, or

b. medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or

treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

J. 1. a. Except as provided in subparagraph b of this paragraph, within twenty (20) days after the date it receives the opinion of each clinical reviewer pursuant to subsection I of this section, the assigned independent review organization, in accordance with paragraph 2 of this subsection, shall make a decision and provide written notice of the decision to:

(1) the covered person,

(2) if applicable, the covered person's authorized representative,

(3) the health carrier, and

(4) the Commissioner.

b. (1) For an expedited external review, within forty-eight (48) hours after the date it receives the opinion of each clinical reviewer pursuant to subsection I of this section, the assigned independent review organization, in accordance

with paragraph 2 of this subsection, shall make a decision and provide notice of the decision orally or in writing to the persons listed in subparagraph a of this paragraph.

(2) If the notice provided under division (1) of this subparagraph was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the persons listed in subparagraph a of this paragraph and include the information set forth in paragraph 3 of this subsection.

2. a. If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.

b. If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold

the health carrier's adverse determination or final adverse determination.

c. (1) If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to subparagraph a or b of this paragraph.

(2) The additional clinical reviewer selected under division (1) of this subparagraph shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to subsection I of this section.

(3) The selection of the additional clinical reviewer under this subparagraph shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers selected pursuant to paragraph 1 of subsection D of this section.

3. The independent review organization shall include in the notice provided pursuant to paragraph 1 of this subsection:

a. a general description of the reason for the request for external review,

b. the written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation,

c. the date the independent review organization was assigned by the Commissioner to conduct the external review,

d. the date the external review was conducted,

e. the date of its decision,

f. the principal reason or reasons for its decision, and

g. the rationale for its decision.

4. Upon receipt of a notice of a decision pursuant to paragraph 1 of this subsection reversing the adverse determination or final adverse determination, the health carrier immediately shall approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

K. The assignment by the Commissioner of an approved independent review organization to conduct an external review in

accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to subsection D of Section 47 of this act.

SECTION 45. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.11 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An external review decision is binding on the health carrier except to the extent the health carrier has other remedies available under applicable state law.

B. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

C. A covered person or the covered person's authorized representative shall not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to the Uniform Health Carrier External Review Act.

SECTION 46. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.12 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under the Uniform Health Carrier External Review Act.

B. In order to be eligible for approval by the Commissioner under this section to conduct external reviews under the Uniform Health Carrier External Review Act an independent review organization:

1. Except as otherwise provided in this section, shall be accredited by a nationally recognized private accrediting entity that the Commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under Section 47 of this act; and

2. Shall submit an application for approval in accordance with subsection D of this section.

C. The Commissioner shall develop an application form by rule for initially approving and for reapproving independent review organizations to conduct external reviews.

D. 1. Any independent review organization wishing to be approved to conduct external reviews under this act shall submit the application form and include with the form all documentation and

information necessary for the Commissioner to determine if the independent review organization satisfies the minimum qualifications established under Section 47 of this act.

2. a. Subject to subparagraph b of this paragraph, an independent review organization is eligible for approval under this section only if it is accredited by a nationally recognized private accrediting entity that the Commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under Section 47 of this act.

b. The Commissioner may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

3. The Commissioner may charge an application fee that independent review organizations shall submit to the Commissioner with an application for approval and reapproval.

E. 1. An approval is effective for two (2) years, unless the Commissioner determines before its expiration that the independent

review organization is not satisfying the minimum qualifications established under Section 48 of this act.

2. Whenever the Commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under Section 48 of this act, the Commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under the Uniform Health Carrier External Review Act that is maintained by the Commissioner pursuant to subsection F of this section.

F. The Commissioner shall maintain and periodically update a list of approved independent review organizations.

G. The Commissioner may promulgate rules to carry out the provisions of this section.

SECTION 47. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.13 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. To be approved under Section 46 of this act to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this act that include, at a minimum:

1. A quality assurance mechanism in place that:

a. ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner,

b. ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective,

c. ensures the confidentiality of medical and treatment records and clinical review criteria, and

d. ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this act;

2. A toll-free telephone service to receive information on a twenty-four-hour-a-day, seven-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

3. Agree to maintain and provide to the Insurance Commissioner the information set out in Section 49 of this act.

B. All clinical reviewers assigned by an independent review organization to conduct external reviews shall be physicians or

other appropriate health care providers who meet the following minimum qualifications:

1. Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

2. Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

3. Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

4. Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental or professional competence or moral character.

C. In addition to the requirements set forth in subsection A of this section, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of health care providers.

D. 1. In addition to the requirements set forth in subsections A, B and C of this section, to be approved pursuant to Section 46 of this act to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

a. the health carrier that is the subject of the external review,

b. the covered person whose treatment is the subject of the external review or the covered person's authorized representative,

c. any officer, director or management employee of the health carrier that is the subject of the external review,

d. the health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review,

e. the facility at which the recommended health care service or treatment would be provided, or

f. the developer or manufacturer of the principal drug, device, procedure or other therapy being recommended

for the covered person whose treatment is the subject of the external review.

2. In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of paragraph 1 of this subsection, the Commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in paragraph 1 of this subsection, but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

E. 1. An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the Commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under Section 46 of this act.

2. The Commissioner shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The Commissioner may accept a review conducted by the NAIC for the purpose of the determination under this paragraph.

3. Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the NAIC in order for the Commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The Commissioner may exclude any private accrediting entity that is not reviewed by the NAIC.

F. An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

SECTION 48. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.14 of Title 36, unless there is created a duplication in numbering, reads as follows:

No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent or contractor of an independent review organization shall be

liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this act, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

SECTION 49. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.15 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. An independent review organization assigned pursuant to Section 42, 43 or 44 of this act to conduct an external review shall maintain written records in the aggregate by state and by health carrier on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the Insurance Commissioner, as required under paragraph 2 of this subsection.

2. Each independent review organization required to maintain written records on all requests for external review pursuant to paragraph 1 of this subsection for which it was assigned to conduct an external review shall submit to the Commissioner, upon request, a report in the format specified by the Commissioner.

3. The report shall include in the aggregate by state, and for each health carrier:

a. the total number of requests for external review,

b. the number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination,

c. the average length of time for resolution,

d. a summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the Commissioner,

e. the number of external reviews pursuant to subsection G of Section 42 of this act that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative, and

f. any other information the Commissioner may request or require.

4. The independent review organization shall retain the written records required pursuant to this subsection for at least three (3) years.

B. 1. Each health carrier shall maintain written records in the aggregate, by state and for each type of health benefit plan offered by the health carrier on all requests for external review

that the health carrier receives notice of from the Commissioner pursuant to this act.

2. Each health carrier required to maintain written records on all requests for external review pursuant to paragraph 1 of this subsection shall submit to the Commissioner, upon request, a report in the format specified by the Commissioner.

3. The report shall include in the aggregate, by state, and by type of health benefit plan:

a. the total number of requests for external review,

b. from the total number of requests for external review reported under subparagraph a of this paragraph, the number of requests determined eligible for a full external review, and

c. any other information the Commissioner may request or require.

4. The health carrier shall retain the written records required pursuant to this subsection for at least three (3) years.

SECTION 50. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.16 of Title 36, unless there is created a duplication in numbering, reads as follows:

The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

SECTION 51. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475.17 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. Each health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons.

2. The disclosure required by paragraph 1 of this subsection shall be in a format prescribed by the Insurance Commissioner.

B. The description required under subsection A of this section shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the Commissioner. The statement shall explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness. The statement shall include the telephone number and address of the Commissioner.

C. In addition to subsection B of this section, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be

required to be reviewed for the purpose of reaching a decision on the external review.

SECTION 52. AMENDATORY Section 12, Chapter 390, O.S.L. 2003, as last amended by Section 52, Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Section 6811), is amended to read as follows:

Section 6811. A. ~~When a claim for recovery under a medical professional liability insurance policy is closed, the insurer shall file with the Insurance Department a closed claim report not later than April 1 of the same calendar year if the claim is closed prior to April 1, and if the claim is closed after April 1, then the closed claim report shall be filed by April 1 of the subsequent calendar year~~ <u>An insuring entity shall file, between January 1 and March 15 of each year, a closed claim report</u>. These reports shall include data for all claims closed in the preceding calendar year and any adjustments to data reported in prior years.

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

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

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

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

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

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

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

F. If a claim is covered by an insuring entity or self-insurer that fails to report the claim to the Commissioner, the facility or

provider named in the claim shall report it to the Commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties.

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

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

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

SECTION 53. AMENDATORY Section 40, Chapter 197, O.S.L. 2003 (36 O.S. Supp. 2010, Section 6940), is amended to read as follows:

Section 6940. A. "Company Action Level Event" means any of the following events:

1. The filing of an RBC report by a health maintenance organization that indicates that the health maintenance organization's total adjusted capital is greater than or equal to its Regulatory Action Level RBC, but less than its Company Action Level RBC;

2. Notification by the Insurance Commissioner to the health maintenance organization of an adjusted RBC report that indicates an event in paragraph 1 of this subsection, provided the health maintenance organization does not challenge the adjusted RBC report under Section 44 6944 of this ~~act~~ title; ~~or~~

3. If, pursuant to the provisions of Section ~~44~~ 6944 of this ~~act~~ title, a health maintenance organization challenges an adjusted RBC report that indicates the event in paragraph 1 of this subsection, the notification by the Commissioner to the health maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge; or

4. If a health maintenance organization has total adjusted capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC

and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the Health RBC instructions.

B. In the event of a Company Action Level Event, the health maintenance organization shall prepare and submit to the Commissioner an RBC plan that shall:

1. Identify the conditions that contribute to the Company Action Level Event;

2. Contain proposals of corrective actions that the health maintenance organization intends to take and that would be expected to result in the elimination of the Company Action Level Event;

3. Provide projections of the health maintenance organization's financial results in the current year and at least the two (2) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

4. Identify the key assumptions affecting the health maintenance organization's projections and the sensitivity of the projections to the assumptions; and

5. Identify the quality of, and problems associated with, the health maintenance organization's business including, but not

limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

C. The RBC plan shall be submitted:

1. Within forty-five (45) days of the Company Action Level Event; or

2. If the health maintenance organization challenges an adjusted RBC report pursuant to the provisions of Section ~~44~~ 6944 of this ~~act~~ title, within forty-five (45) days after notification to the health maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge.

D. Within sixty (60) days after the submission by a health maintenance organization of an RBC plan to the Commissioner, the Commissioner shall notify the health maintenance organization whether the RBC plan will be implemented or whether, in the judgment of the Commissioner, the RBC plan is unsatisfactory. If the Commissioner determines that the RBC plan is unsatisfactory, the notification to the health maintenance organization shall state the reasons for the determination, and may list proposed revisions that will, in the judgment of the Commissioner, render the RBC plan satisfactory. Upon notification from the Commissioner, the health maintenance organization shall prepare a revised RBC plan, that may incorporate by reference any revisions proposed by the Commissioner, and shall submit the revised RBC plan to the Commissioner:

1. Within forty-five (45) days after the notification from the Commissioner; or

2. If the health maintenance organization challenges the notification from the Commissioner pursuant to the provisions of Section ~~44~~ 6944 of this ~~act~~ title, within forty-five (45) days after a notification to the health maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge.

E. In the event of a notification by the Commissioner to a health maintenance organization that the health maintenance organization's RBC plan or revised RBC plan is unsatisfactory, the Commissioner may, at the Commissioner's discretion and subject to the health maintenance organization's right to a hearing pursuant to the provisions of Section ~~44~~ 6944 of this ~~act~~ title, specify in the notification that the notification constitutes a Regulatory Action Level Event.

F. Every domestic health maintenance organization that files an RBC plan or revised RBC plan with the Commissioner shall file a copy of the RBC plan or revised RBC plan with the Insurance Commissioner in any state in which the health maintenance organization is authorized to do business if:

1. The state has an RBC provision substantially similar to subsection A of Section ~~45~~ 6945 of this ~~act~~ title; and

2. The Insurance Commissioner of that state has notified the health maintenance organization of its request for the filing in writing, in which case the health maintenance organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

a. fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state, or

b. the date on which the RBC plan or revised RBC plan is filed under subsections C and D of this section.

SECTION 54. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 3623.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

No insurer, at any time, shall charge the insured or the insurance producer for any costs associated with the necessary documentation or records needed to underwrite a policy. The provisions of this section shall apply only to personal insurance as defined in Section 952 of Title 36 of the Oklahoma Statutes.

SECTION 55. REPEALER 63 O.S. 2001, Sections 2528.1, 2528.2, 2528.3, 2528.4, 2528.5, 2528.6, 2528.7, 2528.8, 2528.9 and 2528.10, are hereby repealed.

SECTION 56. Sections 3 and 24 of this act shall become effective upon order of the Insurance Commissioner.

SECTION 57. Sections 1, 4 through 22, 29, 35 through 51 and 55 of this act shall become effective July 1, 2011.

SECTION 58. Sections 2, 23, 25 through 28, 30 through 34, and 52 through 54 of this act shall become effective November 1, 2011.

SECTION 59. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval."

Passed the Senate the 19th day of April, 2011.

_____
Presiding Officer of the Senate

Passed the House of Representatives the ____ day of _____, 2011.

_____
Presiding Officer of the House of Representatives