

1 STATE OF OKLAHOMA

2 1st Session of the 53rd Legislature (2011)

3 COMMITTEE SUBSTITUTE
4 FOR ENGROSSED

5 SENATE BILL NO. 778

6 By: Aldridge of the Senate

7 and

8 Sullivan of the House

9 COMMITTEE SUBSTITUTE

10 An Act relating to insurance; stating legislative
11 intent; amending Section 8, Chapter 307, O.S.L. 2002
12 (36 O.S. Supp. 2010, Section 615.1), which relates to
13 application to transact insurance; requiring the
14 Insurance Commissioner to review certain applications
15 with a focus on certain specified items; amending 36
16 O.S. 2001, Section 628, as amended by Section 6,
17 Chapter 222, O.S.L. 2010 (36 O.S. Supp. 2010, Section
18 628), which relates to the imposition of certain
19 taxes or other obligations on foreign insurers;
20 making the imposition of certain taxes or other
21 obligations on state insurers optional; creating the
22 Unauthorized Insurers and Surplus Lines Insurance
23 Act; providing short title; defining terms;
24 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

1 amended by Section 21, Chapter 222, O.S.L. 2010 (36
2 O.S. Supp. 2010, Sections 1101, 1101.1, 1103, 1105,
3 1106, 1107, 1108, 1109, 1112, 1115, 1116 and 1118),
4 which relate to the Unauthorized Insurers and Surplus
5 Lines Insurance Act; requiring certain transactions
6 to be performed only by a surplus lines licensee or
7 broker; specifying that certain surplus lines
8 premiums shall be subject to surplus premium tax
9 pursuant to certain agreements entered into by the
10 Insurance Commissioner; modifying service of process;
11 modifying circumstances for award of certain attorney
12 fees; modifying conditions in which insurance may be
13 procured from surplus lines insurers; providing
14 procedures for the procurement of certain insurance
15 for an exempt commercial purchaser; defining term;
16 specifying information to be submitted to the surplus
17 lines clearinghouse; providing schedule for filing
18 and payment of certain taxes; providing penalty for
19 failure to file certain information; allowing certain
20 coverage to be placed with certain insurers;
21 clarifying type of licensee; requiring surplus lines
22 insurer to meet certain financial requirements;
23 requiring certain information submitted to the
24 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

1 policy; requiring the insurer to give to the insured
2 certain written renewal notice on a private passenger
3 auto or homeowner's policy; specifying information to
4 be contained on the renewal notice; specifying
5 duration of the coverage if notice is not given;
6 specifying when notice is given; specifying effective
7 date of changes if insured accepts the renewal;
8 defining terms; requiring the filing and approval of
9 certain forms by the Insurance Commissioner;
10 authorizing Commissioner to disapprove certain forms;
11 specifying required contents of form; deeming certain
12 forms approved without filing; prohibiting issuance
13 of certain form; allowing certain addendums;
14 specifying scope of applicability; providing
15 exceptions; distinguishing certificates from policy
16 provisions; limiting reference to contracts or
17 certificates; specifying notice requirements;
18 authorizing certain service fees; providing
19 certificates in violation of requirements shall be
20 void; specifying penalty for certain violations;
21 specifying authority of Commissioner to enforce
22 provisions; authorizing the adoption of certain rules
23 and regulations; requiring every health benefit plan
24 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

1 providers for failure to comply with certain
2 requirements; creating the Uniform Health Carrier
3 External Review Act; stating purpose of act; defining
4 terms; specifying act shall apply to all health
5 carriers; providing exceptions; requiring health
6 carriers to notify insured parties of certain
7 external review rights; specifying requirements of
8 notice; authorizing Insurance Commissioner to
9 promulgate certain rules; specifying requests for
10 external review requirements; authorizing
11 Commissioner to prescribe certain forms; authorizing
12 certain requests for reviews of adverse
13 determinations; requiring insured persons to exhaust
14 internal grievance process before external review is
15 allowed; specifying exhaustion requirements; allowing
16 certain retrospective review determinations after
17 exhaustion; specifying procedure for expedited
18 grievance reviews; requiring independent reviewing
19 organizations to complete certain process before
20 conducting external review; requiring independent
21 review organization to give certain notice;
22 authorizing certain requests by waiver; authorizing
23 requests for certain review if requirements are
24 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

1 whether certain requests are reviewable; specifying
2 procedure for certain external reviews; directing
3 Commissioner to assign organization to conduct
4 reviews in certain circumstances; providing that
5 independent review organization shall not be bound by
6 prior determinations; directing health carrier to
7 provide certain information to independent review
8 organizations; providing requirements for certain
9 determinations by independent review organizations;
10 providing that certain determinations by independent
11 review organizations shall be done within certain
12 time frame; specifying notice requirements; requiring
13 health carrier to approve coverage in certain
14 circumstances; specifying that expedited reviews may
15 not be provided in certain circumstances; directing
16 Commissioner to assign certain reviews randomly;
17 providing procedure to request certain external
18 review; directing Commissioner to notify health
19 carrier of certain reviews; requiring health carrier
20 to conduct certain preliminary review; specifying
21 requirements of review; directing health carrier to
22 provide certain notice to insured; specifying
23 requirements of notice; authorizing Commissioner to
24 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

1 terminate approval of independent review
2 organizations in certain circumstances; directing
3 Commissioner to maintain list of approved
4 organizations; providing requirements for
5 organizations conducting external reviews;
6 prohibiting independent review organizations from
7 controlling a health benefit plan; prohibiting
8 certain conflicts of interest; establishing
9 presumption that certain accreditation shall meet
10 requirements; requiring Commissioner to review
11 certain accreditation standards; authorizing
12 acceptance by the Commissioner of certain reviews;
13 prohibiting the imposition of liability for certain
14 damages on an independent review organization;
15 providing exception; requiring independent review
16 organizations to maintain certain records; directing
17 independent review organizations to provide certain
18 report to Commissioner upon request; specifying
19 contents of report; requiring the retention of
20 certain records for three years; requiring health
21 carrier to pay cost of certain external review;
22 requiring health carriers to include external review
23 procedures in certain publications; specifying
24 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.L. 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; 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:

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

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

9 SECTION 2. AMENDATORY Section 8, Chapter 307, O.S.L.
10 2002 (36 O.S. Supp. 2010, Section 615.1), is amended to read as
11 follows:

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

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

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

22 2. Assessment of the quality and expertise of the ultimate
23 controlling person, proposed officers and directors, appointed
24

- 1 actuary and appointed accountant, including the use of the NAIC Form
2 A and SAD databases;
3 3. Adequacy of any proposed reinsurance program;
4 4. Adequacy of investment policy;
5 5. Adequacy of short-term and long-term financing arrangements,
6 including, but not limited to:
7 a. initial financing of proposed operations or
8 transaction, and
9 b. maintenance of adequate capital and surplus levels;
10 6. Biographical affidavits;
11 7. Related party agreements' compliance with SSAP No. 25; and
12 8. Any other information the Commissioner deems necessary to
13 review.

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

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

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

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

20 Sections 4, 5, 6 and 12 of this act and Sections 1101 through
21 1121 of Title 36 of the Oklahoma Statutes shall be known and may be
22 cited as the "Unauthorized Insurers and Surplus Lines Insurance
23 Act".
24

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

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

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

9 2. "Home state" means:

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

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

16 (2) if one hundred percent (100%) of the insured risk
17 is located out of the state referred to in
18 division (1) of this subparagraph, the state to
19 which the greatest percentage of the insured's
20 taxable premium for the insurance contract is
21 allocated,

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

24

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

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

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

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

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

22 (2) if the insured's principal residence is located
23 outside any state, the state to which the
24

1 greatest percentage of the insured's taxable
2 premium for that insurance is allocated,

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

10 e. when the group policyholder pays one hundred percent
11 (100%) of the premium from its own funds, the term
12 "home state" means the home state, as determined
13 pursuant to division (1) of subparagraph a of this
14 paragraph, of the group policyholder. When the group
15 policyholder does not pay one hundred percent (100%)
16 of the premium from its own funds, the term home state
17 means the home state, as determined pursuant to
18 division (1) of subparagraph a of this paragraph, or
19 of the group member;

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

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

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

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

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

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

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

18 10. "Surplus lines licensee" or "broker" means an individual,
19 firm or corporation that is licensed in a state to sell, solicit, or
20 negotiate insurance, including the agent of record on a nonadmitted
21 insurance policy, on properties, risks or exposures located or to be
22 performed in a state with nonadmitted insurers.

23

24

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

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

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

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

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

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

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

23 ~~B.~~ No person in Oklahoma shall in any manner:
24

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

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

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

15 ~~D.~~ C. This section shall not apply as to reinsurance, to
16 surplus line insurance lawfully procured pursuant to ~~this article~~
17 the Unauthorized Insurers and Surplus Lines Insurance Act, to
18 transactions exempt under Section 606 of this title (Authorization
19 of Insurers and General Qualifications), or to professional services
20 of an adjuster or attorney-at-law from time to time with respect to
21 claims under policies lawfully solicited, issued, and delivered
22 outside of Oklahoma.

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

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

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

9 SECTION 8. AMENDATORY Section 22, Chapter 176, O.S.L.
10 2009 (36 O.S. Supp. 2010, Section 1101.1), is amended to read as
11 follows:

12 Section 1101.1 A. An Oklahoma domestic insurer possessing
13 policyholder surplus of at least Fifteen Million Dollars
14 (\$15,000,000.00) may, pursuant to a resolution by its board of
15 directors, and with the written approval of the Insurance
16 Commissioner, be designated as a domestic surplus line insurer.
17 Such insurers shall write surplus line insurance in any jurisdiction
18 within which it does business, including this state.

19 B. A domestic surplus line insurer may only insure in this
20 state any risk procured pursuant to Article 11 of the Oklahoma
21 Insurance Code governing surplus line insurers and brokers and its
22 premium shall be subject to surplus line premium tax pursuant to
23 Section 1115 of this title and pursuant to the Nonadmitted Insurance
24 Multi-State Agreement or any other multistate agreement or compact

1 with the same function and purpose the Insurance Commissioner may
2 enter into or join.

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

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

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

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

24

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

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

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

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

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

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

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

18 SECTION 11. AMENDATORY 36 O.S. 2001, Section 1106, as
19 last amended by Section 15, Chapter 222, O.S.L. 2010 (36 O.S. Supp.
20 2010, Section 1106), is amended to read as follows:

21 Section 1106. If insurance required to protect the interest of
22 the assured cannot be procured from authorized insurers after direct
23 inquiry to authorized insurers, ~~the insurance, hereinafter~~

24

1 ~~designated as "surplus line",~~ may be procured from surplus lines
2 insurers subject to the following conditions:

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

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

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

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

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

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

19 b. the requirements of subparagraph a of this paragraph
20 may be satisfied by an insurer's possessing less than
21 the minimum capital and surplus upon an affirmative
22 finding of acceptability by the Insurance
23 Commissioner. The finding shall be based upon such
24 factors as quality of management, capital and surplus

1 of any parent company, company underwriting profit and
2 investment income trends, market availability and
3 company record and reputation within the industry. In
4 no event shall the Insurance Commissioner make an
5 affirmative finding of acceptability when the
6 nonadmitted insurer's capital and surplus is less than
7 Four Million Five Hundred Thousand Dollars
8 (\$4,500,000.00), and

9 ~~d.~~

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

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

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

21 ~~3. The broker shall file the appropriate affidavit as required~~
22 ~~by Section 1107 of this title~~ For the purposes of carrying out the
23 provisions of the Nonadmitted and Reinsurance Reform Act of 2010,
24 the Insurance Commissioner is authorized to utilize the national

1 insurance producer database of the National Association of Insurance
2 Commissioners, or any other equivalent uniform national database,
3 for the licensure of an individual or entity as a surplus lines
4 licensee or broker and for renewal of such license.

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

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

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

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

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

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

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

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

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

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

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

17 d. the person is a not-for-profit organization or public
18 entity generating annual budgeted expenditures of at
19 least Thirty Million Dollars (\$30,000,000.00), as such
20 amount is adjusted pursuant to paragraph 4 of this
21 subsection, or

22 e. the person is a municipality with a population in
23 excess of fifty thousand (50,000) persons; and
24

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

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

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

- 16 ~~1. Name and address of the insurer, and name and address of the~~
17 ~~person named in the policy pursuant to Section 1118 of this title to~~
18 ~~whom the Insurance Commissioner shall send copies of legal process;~~
19 ~~2. Number of the policy issued;~~
20 ~~3. Name and address of the insured;~~
21 ~~4. Nature and amount of liability assumed by the insurer;~~
22 ~~5. Premium, and any membership, application, policy or~~
23 ~~registration fees; and~~

24

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

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

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

17 1. February 15 for the quarter ending the preceding December
18 31;

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

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

21 4. November 15 for the quarter ending the preceding September
22 30.

23 C. Failure to file the ~~report~~ required information with the
24 clearinghouse pursuant to this section and Section 1115 of this

1 title where Oklahoma is the home state shall result, after notice
2 and hearing, in censure, suspension, or revocation of license or a
3 fine of up to Five Hundred Dollars (\$500.00) for each occurrence or
4 by both such fine and licensure penalty.

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

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

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

22 ~~B. Any order shall be subject to modification, and the~~
23 ~~Insurance Commissioner shall so modify as to any coverage found by~~
24 ~~the Commissioner to be no longer entitled to recognition after a~~

1 ~~hearing held upon the initiative of the Commissioner or upon request~~
2 ~~of any insurance agent, surplus line broker, broker, insurer, rating~~
3 ~~or advisory organization, or other person~~ in Oklahoma, a surplus
4 lines licensee or broker may place the coverage with a nonadmitted
5 insurer or surplus lines insurer as defined in the Unauthorized
6 Insurers and Surplus Lines Insurance Act.

7 SECTION 15. AMENDATORY 36 O.S. 2001, Section 1109, as
8 last amended by Section 18, Chapter 222, O.S.L. 2010 (36 O.S. Supp.
9 2010, Section 1109), is amended to read as follows:

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

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

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

23 Section 1111. A ~~licensed~~ surplus line lines licensee or broker
24 may accept and place surplus ~~line business~~ lines insurance from any

1 insurance agent or broker licensed in this state for the kind of
2 insurance involved, and may compensate such agent or broker
3 therefor. The surplus lines licensee or broker shall have the right
4 to receive from the surplus lines insurer the customary commission.

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

8 Section 1112. A. A surplus ~~line~~ lines licensee or broker shall
9 not knowingly place any such coverage in an insurer which is in an
10 unsound financial condition. To be considered financially sound, a
11 surplus ~~line company~~ lines insurer shall ~~have a minimum capital and~~
12 ~~surplus of not less than Fifteen Million Dollars (\$15,000,000.00)~~
13 meet the requirements of Section 1106 of this title. A surplus ~~line~~
14 lines licensee or broker shall not place any such coverage in an
15 insurer unless the insurer meets the requirements of Section 1106 of
16 this title or has been approved in writing by the Insurance
17 Commissioner as a surplus ~~line~~ lines insurer and such approval has
18 not been withdrawn. A surplus ~~line~~ lines licensee or broker shall
19 not place any surplus ~~line~~ lines insurance in an insurer that ~~has~~
20 ~~been disapproved by the Commissioner as a surplus line insurer~~ does
21 not meet the requirements of Section 1106 of this title.

22 B. For violation of this section, in addition to any other
23 penalty provided by law, the broker's license shall be revoked, and
24 the broker shall not again be so licensed within a period of two (2)

1 years thereafter. In addition, any surplus ~~line~~ lines licensee and
2 broker licensed in Oklahoma who violates this section shall be
3 guilty of a misdemeanor and upon conviction thereof shall be
4 punished for each offense, by a fine of not more than One Thousand
5 Dollars (\$1,000.00) or by confinement in jail for not more than
6 ninety (90) days, or by both such fine and imprisonment.

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

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

- 15 ~~1. Name and address of the insurer;~~
- 16 ~~2. Name and address of the insured;~~
- 17 ~~3. Amount of insurance;~~
- 18 ~~4. Gross premium charged;~~
- 19 ~~5. Return premium paid, if any;~~
- 20 ~~6. Rate of premium charged on the several items of coverage;~~
- 21 ~~7. Effective date of the contract and the terms thereof; and~~
- 22 ~~8. Brief general description of the risks insured against and~~
23 ~~the property insured such information required to be submitted to~~
24 the surplus lines clearinghouse as established by the Insurance

1 Commissioner through joining the Nonadmitted Insurance Multi-State
2 Agreement or any other multistate agreement or compact with the same
3 function and purpose.

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

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

- 13 ~~1. Gross amount of each kind of insurance transacted,~~
- 14 ~~2. Aggregate gross premiums charged,~~
- 15 ~~3. Aggregate of return premiums paid to insureds,~~
- 16 ~~4. Aggregate of net premiums, and~~
- 17 ~~5. Such additional information as may reasonably be required by~~
18 ~~the Insurance Commissioner~~ such information required to be submitted
19 to the surplus lines clearinghouse as established by the Insurance
20 Commissioner through joining the Nonadmitted Insurance Multi-State
21 Agreement or any other multistate agreement or compact with the same
22 function and purpose.

23
24

1 SECTION 20. AMENDATORY 36 O.S. 2001, Section 1115, as
2 last amended by Section 19, Chapter 222, O.S.L. 2010 (36 O.S. Supp.
3 2010, Section 1115), is amended to read as follows:

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

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

1 gross premiums charged by the insurer for the insurance, where
2 Oklahoma is the home state of the insured, every person licensed
3 pursuant to Section 1106 of this title shall collect and pay to the
4 surplus lines clearinghouse, as provided in Section 628 of this
5 title, a sum based on the total gross premiums charged in connection
6 with any broker-procured insurance, less any return premiums, for
7 surplus lines insurance provided by the licensee pursuant to the
8 license. Where the insurance covers properties, risks or exposures
9 located or to be performed both in and out of Oklahoma, the sum
10 payable shall be computed based on an amount equal to six percent
11 (6%) on that portion of the gross premiums allocated to Oklahoma,
12 plus an amount equal to the portion of the premiums allocated to
13 other states or territories on the basis of tax rates and fees
14 applicable to properties, risks or exposures located or to be
15 performed outside Oklahoma pursuant to subsection E of this section
16 less the amount of gross premium unearned at termination of the
17 surplus lines insurance. Any such unearned gross premium credited
18 by the state to the surplus broker or licensee shall be returned to
19 the policyholder by the broker or licensee. The surplus lines
20 licensee is prohibited from rebating, for any reason, any part of
21 the tax.

22 B. Gross premiums charged for independently procured insurance,
23 less any return premiums, are subject to a tax at the rate of six
24 percent (6%). At the time of filing the report required in this

1 section, the insured procuring independently procured insurance,
2 where Oklahoma is the home state, shall pay the tax to the surplus
3 lines clearinghouse, as provided in Section 628 of this title, who
4 shall transmit the same for distribution as provided by the
5 Unauthorized Insurers and Surplus Lines Insurance Act. Where the
6 insurance covers properties, risks or exposures located or to be
7 performed both in and out of Oklahoma, the sum payable shall be
8 computed based on an amount equal to six percent (6%) on that
9 portion of the gross premiums allocated to Oklahoma pursuant to
10 subsection A of this section, plus an amount equal to the portion of
11 the premiums allocated to other states or territories on the basis
12 of the tax rates and fees applicable to properties, risks or
13 exposures located or to be performed outside of this state pursuant
14 to this subsection.

15 C. The Insurance Commissioner is authorized to participate in
16 the Nonadmitted Insurance Multi-State Agreement or any other
17 multistate agreement or compact with the same function and purpose
18 for the purpose of collecting and disbursing to reciprocal states
19 any funds collected pursuant to the Unauthorized Insurers and
20 Surplus Lines Insurance Act applicable to other properties, risks or
21 exposures located or to be performed outside of Oklahoma. To the
22 extent that other states where portions of the properties, risks or
23 exposures reside have failed to enter into a compact or reciprocal
24 allocation procedure with Oklahoma, the net premium tax collected

1 shall be retained by Oklahoma. When the surplus lines coverage of
2 an Oklahoma home state insured covers properties, risks or exposures
3 located only in Oklahoma, the surplus lines licensee or broker shall
4 nevertheless make the required surplus premium tax filings and
5 remittances as described in subsection A of this section pursuant to
6 the Nonadmitted Insurance Multi-State Agreement or any other
7 multistate agreement or compact with the same function and purpose
8 the Insurance Commissioner may agree to or enter.

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

21 E. The Insurance Commissioner is authorized to utilize or adopt
22 the allocation schedule included in the Nonadmitted Insurance Multi-
23 State Agreement or any other multistate agreement or compact with
24 the same function and purpose of allocating risk and computing the

1 tax due on the portion of premium attributable to each risk
2 classification and to each state where properties, risks or
3 exposures are located.

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

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

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

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

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

23 ~~D. Every person, association, or legal entity procuring or~~
24 ~~accepting any insurance coverage from a surplus lines insurer, upon,~~

1 ~~covering, or relating to a subject of insurance resident or having a~~
2 ~~situs in the this state, or any insurance coverage which is to be~~
3 ~~performed in whole or part in this state, except coverages as are~~
4 ~~lawfully obtained through a licensed surplus line broker in this~~
5 ~~state, shall report, within thirty (30) days next succeeding the~~
6 ~~issuance of evidence of coverage, the purchase of the coverages of~~
7 ~~insurance to the Insurance Commissioner, on forms prescribed by the~~
8 ~~Commissioner, and at the same time shall remit to the Insurance~~
9 ~~Commissioner a tax in the amount of six percent (6%) of the annual~~
10 ~~premium agreed to be paid, or paid, for the insurance. The~~
11 ~~insurance coverages, providing for the payment of retrospective~~
12 ~~premiums, or coverages on which the premiums are not determinable at~~
13 ~~the time of issuance, shall be reported to the Insurance~~
14 ~~Commissioner, by the insured, within thirty (30) days next~~
15 ~~succeeding the date the coverages are issued and the tax payable on~~
16 ~~the coverages shall be remitted, by the insured, to the Insurance~~
17 ~~Commissioner within thirty (30) days next succeeding the date the~~
18 ~~premiums can be determined. The tax on renewal premiums shall be~~
19 ~~paid by the insured in accordance with this section, in like manner~~
20 ~~as provided for payment of the original premium tax, within thirty~~
21 ~~(30) days next succeeding the date the premiums can be determined.~~

22 SECTION 21. AMENDATORY 36 O.S. 2001, Section 1116, as
23 last amended by Section 20, Chapter 222, O.S.L. 2010 (36 O.S. Supp.
24 2010, Section 1116), is amended to read as follows:

1 Section 1116. A. Any surplus ~~line~~ lines licensee or broker who
2 fails to remit the surplus line tax provided for by Section 1115 of
3 this title for more than sixty (60) days after it is due shall be
4 liable to a civil penalty of not to exceed Twenty-five Dollars
5 (\$25.00) for each additional day of delinquency. The Insurance
6 Commissioner shall collect the tax by distraint and shall recover
7 the penalty by an action in the name of the State of Oklahoma. The
8 Commissioner may request the Attorney General to appear in the name
9 of the state by relation of the Commissioner.

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

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

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

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

17 C. Triplicate copies of legal process against such an insurer
18 shall be served upon the Insurance Commissioner, and at time of
19 service the plaintiff shall pay to the Insurance Commissioner Twenty
20 Dollars (\$20.00), taxable as costs in the action. The Insurance
21 Commissioner shall immediately mail one copy of the process so
22 served to the person designated by the insurer in the policy for the
23 purpose, by mail with return receipt requested. The insurer shall
24

1 have forty (40) days after the date of mailing within which to
2 plead, answer, or otherwise defend the action.

3 SECTION 23. AMENDATORY Section 3, Chapter 323, O.S.L.
4 2009 (36 O.S. Supp. 2010, Section 1250.17), is amended to read as
5 follows:

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

14 SECTION 24. AMENDATORY 36 O.S. 2001, Section 1435.23, as
15 last amended by Section 12, Chapter 432, O.S.L. 2009 (36 O.S. Supp.
16 2010, Section 1435.23), is amended to read as follows:

17 Section 1435.23 A. All applications shall be accompanied by
18 the applicable fees. An appointment may be deemed by the
19 Commissioner to have terminated upon failure by the insurer to pay
20 the prescribed renewal fee. The Commissioner may also by order
21 impose a civil penalty equal to double the amount of the unpaid
22 renewal fee.

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

1	<u>c.</u>	Insurance producer's biennial license	
2		for sale or solicitation of separate	
3		accounts or agreements, as provided for	
4		in Section 6061 of this title <u>variable</u>	
5		<u>insurance products</u>	\$ 60.00
6	e.		
7	<u>d.</u>	Limited lines producer biennial license.....	\$ 40.00
8	d.		
9	<u>e.</u>	Temporary license as agent.....	\$ 20.00
10	e.		
11	<u>f.</u>	Managing general agent's biennial	
12		license.....	\$ 60.00
13	f.		
14	<u>g.</u>	Surplus lines broker's biennial license.....	\$100.00
15	g.		
16	<u>h.</u>	Insurance vending machine, each machine,	
17		biennial fee.....	\$100.00
18	h.		
19	<u>i.</u>	Insurance consultant's biennial license,	
20		resident or nonresident.....	\$100.00
21	i.		
22	<u>j.</u>	Customer service representative biennial	
23		license.....	\$ 40.00
24	j.	Insurance producer's provisional license	\$ 20.00

1 5. ~~Biennial~~ Annual fee for each appointed
2 insurance producer, managing general agent, or
3 limited lines producer by insurer, each
4 license of each insurance producer or
5 representative ~~\$55.00~~
6 \$30.00

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

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

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

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

17 B. If for any reason an insurance producer license or
18 appointment is not issued or renewed by the Commissioner, all fees
19 accompanying the appointment or application for the license shall be
20 deemed earned and shall not be refundable except as provided in
21 Section 352 of this title.

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

1 SECTION 25. AMENDATORY 36 O.S. 2001, Section 1435.29, as
2 last amended by Section 13, Chapter 432, O.S.L. 2009 (36 O.S. Supp.
3 2010, Section 1435.29), is amended to read as follows:

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

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

16 3. Licensees, with the exception of title producers and
17 aircraft title producers or any other producer exempt by rule, shall
18 complete, in addition to the foregoing, three (3) clock hours of
19 ethics course work in this same period.

20 4. Each title producer and aircraft title producer shall,
21 biennially, complete not less than sixteen (16) clock hours of
22 continuing insurance education, two (2) hours of which shall be
23 ethics course work, which shall cover the line for which the
24

1 producer is licensed. Such education may include a written or oral
2 examination.

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

- 10 a. employees of the Insurance Commissioner,
- 11 b. a continuing education advisory committee, or
- 12 c. an independent service whose normal business
13 activities include the review and approval of
14 continuing education courses and providers. The
15 Commissioner may negotiate agreements with such
16 independent service to review documents and other
17 materials submitted for approval of courses and
18 providers and provide the Commissioner with its
19 nonbinding recommendation. The Commissioner may
20 require such independent service to collect the fee
21 charged by the independent service for reviewing
22 materials provided for review directly from the course
23 providers.

24

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

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

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

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

24

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

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

20 5. Subject to approval by the Commissioner, the active
21 membership of the licensed producer or broker in local, regional,
22 state, or national professional insurance organizations or
23 associations may be approved for up to one (1) annual hour of
24 instruction. The hour shall be credited upon timely filing with the

1 Commissioner, or designee of the Commissioner, and appropriate
2 written evidence acceptable to the Commissioner of such active
3 membership in the organization or association.

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

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

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

21 D. Failure of an insurance producer or customer service
22 representative to comply with the requirements of the Oklahoma
23 Producer Licensing Act may, after notice and opportunity for
24 hearing, result in censure, suspension, nonrenewal of license or a

1 civil penalty of up to Five Hundred Dollars (\$500.00) or by both
2 such penalty and civil penalty. Said civil penalty may be enforced
3 in the same manner in which civil judgments may be enforced.

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

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

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

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

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

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

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

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

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

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

13 3. If, pursuant to Section 9 1528 of this ~~act~~ title, an insurer
14 challenges an Adjusted RBC Report that indicates the event described
15 in paragraph 1 of this subsection, the notification by the
16 Commissioner to the insurer that the Commissioner has, after
17 opportunity for a hearing, rejected the insurer's challenge.

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

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

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

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

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

15 5. The quality of, and problems associated with, the insurer's
16 business, including, but not limited to, its assets, anticipated
17 business growth and associated surplus strain, extraordinary
18 exposure to risk, mix of business, and use of reinsurance, if any,
19 in each case.

20 C. The RBC Plan shall be submitted:

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

23 2. If the insurer challenges an Adjusted RBC Report pursuant to
24 Section 9 1528 of this ~~act~~ title, within forty-five (45) days after

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

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

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

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

22 E. In the event of a notification by the Commissioner to an
23 insurer that the insurer's RBC Plan or Revised RBC Plan is
24 unsatisfactory, the Commissioner may at the Commissioner's

1 discretion, subject to the insurer's right to a hearing under
2 Section ~~9~~ 1528 of this ~~act~~ title, specify in the notification that
3 the notification constitutes a Regulatory Action Level Event.

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

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

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

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

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

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

21 Section 3639.1 A. No insurer shall cancel, refuse to renew or
22 increase the premium of a homeowner's insurance policy, which has
23 been in effect more than forty-five (45) days, solely because the
24 insured filed a first claim against the policy. The provisions of

1 this section shall not be construed to prevent the cancellation,
2 nonrenewal or increase in premium of a homeowner's insurance policy
3 for the following reasons:

4 1. Nonpayment of premium;

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

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

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

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

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

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

22 B. An insurer shall give to the named insured at the mailing
23 address shown on a private passenger auto or homeowners policy, a
24 written renewal notice that shall include new premium, new

1 deductible, new limits or coverage at least thirty (30) days prior
2 to the expiration date of the policy. If the insurer fails to
3 provide such notice, the premium, deductible, limits and coverage
4 provided to the named insurer prior to the change shall remain in
5 effect until notice is given or until the effective date of
6 replacement coverage obtained by the named insured, whichever occurs
7 first. If notice is given by mail, the notice shall be deemed to
8 have been given on the day the notice is mailed. If the insured
9 elects not to renew, any earned premium for the period of extension
10 of the terminated policy shall be calculated pro rata at the lower
11 of the current or previous year's rate. If the insured accepts the
12 renewal, the premium increase, if any, and other changes shall be
13 effective the day following the prior policy's expiration or
14 anniversary date.

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

18 A. As used in this section:

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

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

4 3. "Insurance producer" shall be defined as provided in Section
5 1435.2 of Title 36 of the Oklahoma Statutes;

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

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

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

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

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

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

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

23 D. Each certificate of insurance shall contain the following or
24 similar statement: "This certificate of insurance is issued as a

1 matter of information only and confers no rights upon the
2 certificate holder. This certificate does not amend, extend, or
3 alter the coverage, terms, exclusions, and conditions afforded by
4 the policies referenced herein."

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

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

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

20 H. No person may prepare, issue, demand, or require, either in
21 addition to or in lieu of a certificate of insurance, an opinion
22 letter or other document or correspondence that is inconsistent with
23 this section; provided, however, an insurer or insurance producer
24 may prepare or issue an addendum to a certificate that clarifies and

1 explains the coverages provided by a policy of insurance and
2 otherwise complies with the requirements of this section.

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

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

- 11 a. a mortgage,
- 12 b. a lien,
- 13 c. a deed or trust, or
- 14 d. any other security interest in real or personal
15 property as security for a loan;

16 2. A certificate issued under:

- 17 a. a group or individual policy for:
 - 18 (1) life insurance,
 - 19 (2) credit insurance,
 - 20 (3) accident and health insurance,
 - 21 (4) long-term care benefit insurance, or
 - 22 (5) Medicare supplement insurance, or
- 23 b. an annuity contract; or

24

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

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

10 K. No certificate of insurance shall contain references to
11 contracts, including construction or service contracts, other than
12 the referenced contract of insurance. Notwithstanding any
13 requirements, term, or condition of any contract or other document
14 with respect to which a certificate of insurance may be issued or
15 may pertain, the insurance afforded by the referenced policy of
16 insurance shall be subject to all the terms, exclusions and
17 conditions of the policy itself.

18 L. A certificate holder shall only have a legal right to notice
19 of cancellation, nonrenewal, or any material change, or any similar
20 notice concerning a policy of insurance if the person is named
21 within the policy or any endorsement as an additional insured and
22 the policy or endorsement requires notice to be provided. The terms
23 and conditions of the notice, including the required timing of the
24

1 notice, are governed by the policy of insurance and cannot be
2 altered by a certificate of insurance.

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

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

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

12 P. The Commissioner shall have the authority to examine and
13 investigate the activities of any person that the Commissioner
14 reasonably believes has been or is engaged in an act or practice
15 prohibited by this section. The Commissioner shall have the
16 authority to enforce the provisions of this section and impose any
17 authorized penalty or remedy against any person who violates this
18 section.

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

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

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

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

- 15 a. provides benefits for medical or surgical expenses
16 incurred as a result of a health condition, accident,
17 or sickness, and
- 18 b. is offered by any insurance company, group hospital
19 service corporation, or health maintenance
20 organization that delivers or issues for delivery an
21 individual, group, blanket, or franchise insurance
22 policy or insurance agreement, a group hospital
23 service contract, or an evidence of coverage, or, to
24 the extent permitted by the Employee Retirement Income

1 Security Act of 1974, 29 U.S.C., Section 1001 et seq.,
2 by a multiple employer welfare arrangement as defined
3 in Section 3 of the Employee Retirement Income
4 Security Act of 1974, or any other analogous benefit
5 arrangement, whether the payment is fixed or by
6 indemnity.

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

8 a. a plan that provides coverage:

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

11 (2) only for accidental death or dismemberment,

12 (3) for dental or vision care, or

13 (4) as a supplement to liability insurance,

14 b. a hospital confinement indemnity policy or other fixed
15 indemnity insurance,

16 c. disability income insurance or a combination of
17 accident-only and disability income insurance,

18 d. a Medicare supplemental policy as defined by Section
19 1882(g)(1) of the Social Security Act (42 U.S.C.,
20 Section 1395ss),

21 e. worker's compensation insurance coverage,

22 f. medical payment insurance issued as part of a motor
23 vehicle insurance policy,

24

- 1 g. a long-term care policy, including a nursing home
2 fixed indemnity policy, unless a determination is made
3 that the policy provides benefit coverage so
4 comprehensive that the policy meets the definition of
5 a health benefit plan,
- 6 h. short-term health insurance issued on a nonrenewable
7 basis with a duration of six (6) months or less,
- 8 i. policy issued under Title XVIII, or
- 9 j. a plan issued to any person, firm, corporation,
10 partnership, limited liability company or association
11 that is actively engaged in business and that, on at
12 least fifty percent (50%) of its working days during
13 the preceding calendar quarter, employed more than
14 fifty (50) eligible employees.

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

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

- 20 1. "Commissioner" means the Insurance Commissioner of the state
21 or his or her lawfully authorized representative;
- 22 2. "Adjuster" means either an insurance adjuster or a public
23 adjuster;
- 24

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

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

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

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

20 5. "Insurer" means any authorized insurance company,
21 corporation, reciprocal group, mutual group, underwriting
22 association or bureau, or any combination thereof, writing or
23 underwriting any insurance contracts; and
24

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

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

- 14 a. may only be utilized by a licensed independent
15 adjuster, licensed agent, or individuals supervised by
16 a licensed independent adjuster or licensed agent,
17 b. shall comply with all claims payment requirements of
18 the Oklahoma Insurance Code, and
19 c. shall be certified as compliant by a licensed
20 independent adjuster.

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

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

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

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

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

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

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

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

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

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

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

23
24

1 SECTION 32. AMENDATORY 36 O.S. 2001, Section 6205, as
2 last amended by Section 42, Chapter 176, O.S.L. 2009 (36 O.S. Supp.
3 2010, Section 6205), is amended to read as follows:

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

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

14 1. The applicant has passed an examination in the applicant's
15 home state;

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

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

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

22 C. If a nonresident applicant's home state does not license or
23 require an examination for an adjuster license, the adjuster may
24 declare another state which has an examination requirement and in

1 which the adjuster is licensed to be the home state. Should the
2 applicant not hold an active adjuster license in his or her home
3 state or declared home state, the applicant shall pass the adjuster
4 examination of this state prior to receiving a nonresident adjuster
5 license.

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

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

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

24 1. Motor vehicle physical damage;

1 2. Fire and allied lines (property);

2 3. Casualty;

3 4. Workers' compensation;

4 5. Crime and fidelity bonds; and

5 6. Crop/hail.

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

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

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

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

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

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

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

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

23 E. The Commissioner may issue a duplicate license for any lost,
24 stolen, or destroyed license issued pursuant to the provisions of

1 the Insurance Adjusters Licensing Act if an affidavit is submitted
2 by the licensee to the Commissioner concerning the facts of such
3 loss, theft, or destruction. ~~Said~~ The affidavit shall be in a form
4 prescribed by the Commissioner. The fee for a duplicate license
5 shall be one-half (1/2) the fee of the license.

6 F. ~~The administrative fee for submission of a change of legal~~
7 ~~name or address more than thirty (30) days after the change occurred~~
8 ~~shall be Fifty Dollars (\$50.00)~~ Licensees shall inform by any means
9 acceptable to the Commissioner of a change of legal name, address or
10 e-mail address within thirty (30) days of the change to permit the
11 Commissioner to give proper notice to licensees. A change in legal
12 name or address submitted more than thirty (30) days after the
13 change shall include an administrative fee of Fifty Dollars
14 (\$50.00). Failure to provide acceptable notification of a change of
15 legal name or address to the Commissioner within forty-five (45)
16 days of the date the administrative fee is assessed shall result in
17 penalties pursuant to subsection B of Section 6220 of this title.

18 SECTION 34. AMENDATORY 36 O.S. 2001, Section 6217, as
19 last amended by Section 2, Chapter 355, O.S.L. 2010 (36 O.S. Supp.
20 2010, Section 6217), is amended to read as follows:

21 Section 6217. A. All licenses issued pursuant to the
22 provisions of the Insurance Adjusters Licensing Act shall continue
23 in force not longer than twenty-four (24) months. The renewal dates
24 for the licenses may be staggered throughout the year by notifying

1 licensees in writing of the expiration and renewal date being
2 assigned to the licensees by the Insurance Commissioner and by
3 making appropriate adjustments in the biennial licensing fee.

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

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

- 17 1. Employees of the Insurance Commissioner;
- 18 2. A continuing education advisory committee. The continuing
19 education advisory committee is separate and distinct from the
20 Advisory Board established by Section 6221 of this title;
- 21 3. An independent service whose normal business activities
22 include the review and approval of continuing education courses and
23 providers. The Commissioner may negotiate agreements with such
24 independent service to review documents and other materials

1 submitted for approval of courses and providers and present the
2 Commissioner with its nonbinding recommendation. The Commissioner
3 may require such independent service to collect the fee charged by
4 the independent service for reviewing materials provided for review
5 directly from the course providers.

6 C. An adjuster who, during the time period prior to renewal,
7 participates in an approved professional designation program shall
8 be deemed to have met the biennial requirement for continuing
9 education. Each course in the curriculum for the program shall
10 total a minimum of twenty (20) hours. Each approved professional
11 designation program included in this section shall be reviewed for
12 quality and compliance every three (3) years in accordance with
13 standardized criteria promulgated by rule. Continuation of approved
14 status is contingent upon the findings of the review. The list of
15 professional designation programs approved under this subsection
16 shall be made available to producers and providers annually.

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

22 E. The Insurance Department may promulgate rules providing that
23 courses or programs offered by professional associations shall
24 qualify for presumptive continuing education credit approval. The

1 rules shall include standardized criteria for reviewing the
2 professional associations' mission, membership, and other relevant
3 information, and shall provide a procedure for the Department to
4 disallow a presumptively approved course. Professional association
5 courses approved in accordance with this subsection shall be
6 reviewed every three (3) years to determine whether they continue to
7 qualify for continuing education credit.

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

12 G. 1. Each provider of continuing education shall, after
13 approval by the Commissioner, submit an annual fee. A fee may be
14 assessed for each course submission at the time it is first
15 submitted for review and upon submission for renewal at expiration.
16 Annual fees and course submission fees shall be set forth as a rule
17 by the Commissioner. The fees are payable to the Insurance
18 Commissioner and shall be deposited in the State Insurance
19 Commissioner Revolving Fund, created in subsection C of Section
20 1435.23 of this title, for the purposes of fulfilling and
21 accomplishing the conditions and purposes of the Oklahoma Producer
22 Licensing Act and the Insurance Adjusters Licensing Act. Public-
23 funded educational institutions, federal agencies, nonprofit

24

1 organizations, not-for-profit organizations and Oklahoma state
2 agencies shall be exempt from this subsection.

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

10 H. Subject to the right of the Commissioner to suspend, revoke,
11 or refuse to renew a license of an adjuster, any such license may be
12 renewed by filing on the form prescribed by the Commissioner on or
13 before the expiration date a written request by or on behalf of the
14 licensee for such renewal and proof of completion of the continuing
15 education requirement set forth in subsection B of this section,
16 accompanied by payment of the renewal fee.

17 I. If the request, proof of compliance with the continuing
18 education requirement and fee for renewal of a license as an
19 adjuster are filed with the Commissioner prior to the expiration of
20 the existing license, the licensee may continue to act pursuant to
21 said license, unless revoked or suspended prior to the expiration
22 date, until the issuance of a renewal license or until the
23 expiration of ten (10) days after the Commissioner has refused to
24 renew the license and has mailed notice of said refusal to the

1 licensee. Any request for renewal filed after the date of
2 expiration may be considered by the Commissioner as an application
3 for a new license.

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

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

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

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

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

21 For purposes of the Uniform Health Carrier External Review Act:

22 1. "Adverse determination" means a determination by a health
23 carrier or its designee utilization review organization that an
24 admission, availability of care, continued stay or other health care

1 service that is a covered benefit has been reviewed and, based upon
2 the information provided, does not meet the health carrier's
3 requirements for medical necessity, appropriateness, health care
4 setting, level of care or effectiveness, and the requested service
5 or payment for the service is therefore denied, reduced or
6 terminated;

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

9 3. "Authorized representative" means:

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

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

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

18 4. "Best evidence" means evidence based on:

19 a. randomized clinical trials,

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

22 c. if subparagraphs a and b of this paragraph are not
23 available, case-series, or
24

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

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

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

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

11 8. "Certification" means a determination by a health carrier or
12 its designee utilization review organization that an admission,
13 availability of care, continued stay or other health care service
14 has been reviewed and, based on the information provided, satisfies
15 the health carrier's requirements for medical necessity,
16 appropriateness, health care setting, level of care and
17 effectiveness;

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

22 10. "Cohort study" means a prospective evaluation of two groups
23 of patients with only one group of patients receiving a specific
24 intervention or specific interventions;

- 1 11. "Commissioner" means the Insurance Commissioner;
- 2 12. "Concurrent review" means utilization review conducted
3 during a hospital stay or course of treatment of a patient;
- 4 13. "Covered benefits" or "benefits" means those health care
5 services to which a covered person is entitled under the terms of a
6 health benefit plan;
- 7 14. "Covered person" means a policyholder, subscriber, enrollee
8 or other individual participating in a health benefit plan;
- 9 15. "Discharge planning" means the formal process for
10 determining, prior to discharge from a facility, the coordination
11 and management of the care that a patient receives following
12 discharge from a facility;
- 13 16. "Disclose" means to release, transfer or otherwise divulge
14 protected health information to any person other than the individual
15 who is the subject of the protected health information;
- 16 17. "Emergency medical condition" means the sudden and, at the
17 time, unexpected onset of a health condition or illness that
18 requires immediate medical attention, where failure to provide
19 medical attention would result in a serious impairment to bodily
20 functions, serious dysfunction of a bodily organ or part, or would
21 place the person's health in serious jeopardy;
- 22 18. "Emergency services" means health care items and services
23 furnished or required to evaluate and treat an emergency medical
24 condition;

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

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

9 21. "Facility" means an institution providing health care
10 services or a health care setting, including but not limited to
11 hospitals and other licensed inpatient centers, ambulatory surgical
12 or treatment centers, skilled nursing centers, residential treatment
13 centers, diagnostic, laboratory and imaging centers, and
14 rehabilitation and other therapeutic health settings;

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

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

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

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

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

9 27. "Health carrier" means an entity subject to the insurance
10 laws and regulations of this state, or subject to the jurisdiction
11 of the Commissioner, that contracts or offers to contract to
12 provide, deliver, arrange for, pay for or reimburse any of the costs
13 of health care services, including but not limited to a sickness and
14 accident insurance company, a health maintenance organization, a
15 nonprofit hospital and health service corporation, or any other
16 entity providing a plan of health insurance, health benefits or
17 health care services;

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

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

24

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

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

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

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

10 a. peer-reviewed scientific studies published in or
11 accepted for publication by medical journals that meet
12 nationally recognized requirements for scientific
13 manuscripts and that submit most of the published
14 articles for review by experts who are not part of the
15 editorial staff,

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

- 1 c. medical journals recognized by the Secretary of Health
2 and Human Services under Section 1861(t)(2) of the
3 federal Social Security Act,
- 4 d. the following standard reference compendia:
- 5 (1) the American Hospital Formulary Service-Drug
6 Information,
 - 7 (2) Drug Facts and Comparisons,
 - 8 (3) the American Dental Association Accepted Dental
9 Therapeutics, and
 - 10 (4) the United States Pharmacopoeia-Drug Information,
- 11 e. findings, studies or research conducted by or under
12 the auspices of federal government agencies and
13 nationally recognized federal research institutes,
14 including but not limited to:
- 15 (1) the federal Agency for Healthcare Research and
16 Quality,
 - 17 (2) the National Institutes of Health,
 - 18 (3) the National Cancer Institute,
 - 19 (4) the National Academy of Sciences,
 - 20 (5) the Centers for Medicare and Medicaid Services,
 - 21 (6) the federal Food and Drug Administration, and
 - 22 (7) any national board recognized by the National
23 Institutes of Health for the purpose of
24

1 evaluating the medical value of health care
2 services, or

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

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

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

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

14 34. "Protected health information" means health information:

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

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

20 35. "Randomized clinical trial" means a controlled, prospective
21 study of patients that have been randomized into an experimental
22 group and a control group at the beginning of the study with only
23 the experimental group of patients receiving a specific
24

1 intervention, which includes study of the groups for variables and
2 anticipated outcomes over time;

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

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

13 38. "Utilization review" means a set of formal techniques
14 designed to monitor the use of, or evaluate the clinical necessity,
15 appropriateness, efficacy, or efficiency of, health care services,
16 procedures, or settings. Techniques may include but are not limited
17 to ambulatory review, prospective review, second opinion,
18 certification, concurrent review, case management, discharge
19 planning, or retrospective review; and

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

23

24

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

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

7 B. The provisions of the Uniform Health Carrier External Review
8 Act shall not apply to a policy or certificate that provides
9 coverage only for a specified disease, specified accident or
10 accident-only coverage, credit, dental, disability income, hospital
11 indemnity, long-term care insurance, as defined in Section 4424 of
12 Title 36 of the Oklahoma Statutes, vision care or any other limited
13 supplemental benefit or to a Medicare supplement policy of
14 insurance, as defined in Section 3611.1 of Title 36 of the Oklahoma
15 Statutes, coverage under a plan through Medicare, Medicaid, or the
16 federal employees health benefits program, any coverage issued under
17 Chapter 55 of Title 10, U.S. Code and any coverage issued as
18 supplement to that coverage, any coverage issued as supplemental to
19 liability insurance, workers' compensation or similar insurance,
20 automobile medical-payment insurance or any insurance under which
21 benefits are payable with or without regard to fault, whether
22 written on a group blanket or individual basis.

23

24

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

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

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

14 b. a final adverse determination.

15 2. As part of the written notice required under paragraph 1 of
16 this subsection, a health carrier shall include the following, or
17 substantially equivalent, language: "We have denied your request
18 for the provision of or payment for a health care service or course
19 of treatment. You may have the right to have our decision reviewed
20 by health care professionals who have no association with us if our
21 decision involved making a judgment as to the medical necessity,
22 appropriateness, health care setting, level of care or effectiveness
23 of the health care service or treatment you requested by submitting
24 a request for external review to the Oklahoma Insurance Department".

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

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

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

8 (1) if the covered person has a medical condition
9 where the time frame for completion of an
10 expedited review of a grievance involving an
11 adverse determination would seriously jeopardize
12 the life or health of the covered person or would
13 jeopardize the covered person's ability to regain
14 maximum function, the covered person or the
15 covered person's authorized representative may
16 file a request for an expedited external review
17 to be conducted pursuant to Section 44 of this
18 act, or Section 45 of this act if the adverse
19 determination involves a denial of coverage based
20 on a determination that the recommended or
21 requested health care service or treatment is
22 experimental or investigational and the covered
23 person's treating physician certifies in writing
24 that the recommended or requested health care

1 service or treatment that is the subject of the
2 adverse determination would be significantly less
3 effective if not promptly initiated, at the same
4 time the covered person or the covered person's
5 authorized representative files a request for an
6 expedited review of a grievance involving an
7 adverse determination, but that the independent
8 review organization assigned to conduct the
9 expedited external review will determine whether
10 the covered person shall be required to complete
11 the expedited review of the grievance prior to
12 conducting the expedited external review, and

13 (2) the covered person or the covered person's
14 authorized representative may file a grievance
15 under the health carrier's internal grievance
16 process, but if the health carrier has not issued
17 a written decision to the covered person or the
18 covered person's authorized representative within
19 thirty (30) days following the date the covered
20 person or the covered person's authorized
21 representative files the grievance with the
22 health carrier and the covered person or the
23 covered person's authorized representative has
24 not requested or agreed to a delay, the covered

1 person or the covered person's authorized
2 representative may file a request for external
3 review pursuant to Section 40 of this act and
4 shall be considered to have exhausted the health
5 carrier's internal grievance process for purposes
6 of Section 41 of this act, and

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

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

19 (2) if the final adverse determination concerns:

20 (a) an admission, availability of care,
21 continued stay or health care service for
22 which the covered person received emergency
23 services, but has not been discharged from a
24 facility, the covered person or the covered

1 person's authorized representative may
2 request an expedited external review
3 pursuant to Section 43 of this act, or

4 (b) a denial of coverage based on a
5 determination that the recommended or
6 requested health care service or treatment
7 is experimental or investigational, the
8 covered person or the covered person's
9 authorized representative may file a request
10 for a standard external review to be
11 conducted pursuant to Section 44 of this act
12 or if the covered person's treating
13 physician certifies in writing that the
14 recommended or requested health care service
15 or treatment that is the subject of the
16 request would be significantly less
17 effective if not promptly initiated, the
18 covered person or the covered person's
19 authorized representative may request an
20 expedited external review to be conducted
21 under Section 44 of this act.

22 2. In addition to the information to be provided pursuant to
23 paragraph 1 of this subsection, the health carrier shall include a
24 copy of the description of both the standard and expedited external

1 review procedures the health carrier is required to provide pursuant
2 to Section 51 of this act, highlighting the provisions in the
3 external review procedures that give the covered person or the
4 covered person's authorized representative the opportunity to submit
5 additional information and including any forms used to process an
6 external review.

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

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

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

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

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

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

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

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

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

17 b. except to the extent the covered person or the covered
18 person's authorized representative requested or agreed
19 to a delay, has not received a written decision on the
20 grievance from the health carrier within thirty (30)
21 days following the date the covered person or the
22 covered person's authorized representative filed the
23 grievance with the health carrier.

24

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

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

15 (1) under Section 43 of this act if the covered
16 person has a medical condition where the time
17 frame for completion of an expedited review of
18 the grievance involving an adverse determination
19 would seriously jeopardize the life or health of
20 the covered person or would jeopardize the
21 covered person's ability to regain maximum
22 function, or

23 (2) under Section 44 of this act if the adverse
24 determination involves a denial of coverage based

1 on a determination that the recommended or
2 requested health care service or treatment is
3 experimental or investigational and the covered
4 person's treating physician certifies in writing
5 that the recommended or requested health care
6 service or treatment that is the subject of the
7 adverse determination would be significantly less
8 effective if not promptly initiated,

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

17 c. upon a determination made pursuant to subparagraph b
18 of this paragraph that the covered person must first
19 complete the expedited grievance review process, the
20 independent review organization immediately shall
21 notify the covered person and, if applicable, the
22 covered person's authorized representative of this
23 determination and that it will not proceed with the
24 expedited external review set forth in Section 43 of

1 this act until completion of the expedited grievance
2 review process and the covered person's grievance at
3 the completion of the expedited grievance review
4 process remains unresolved.

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

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

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

17 A. 1. Within four (4) months after the date of receipt of a
18 notice of an adverse determination or final adverse determination
19 pursuant to Section 39 of this act, a covered person or the covered
20 person's authorized representative may file a request for an
21 external review with the Insurance Commissioner.

22 2. Within one (1) business day after the date of receipt of a
23 request for external review pursuant to paragraph 1 of this
24

1 subsection, the Commissioner shall send a copy of the request to the
2 health carrier.

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

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

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

20 3. The covered person has exhausted the health carrier's
21 internal grievance process unless the covered person is not required
22 to exhaust the health carrier's internal grievance process pursuant
23 to Section 41 of this act; and
24

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

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

8 a. the request is complete, and

9 b. the request is eligible for external review.

10 2. If the request:

11 a. is not complete, the health carrier shall inform the

12 covered person and, if applicable, the covered

13 person's authorized representative and the

14 Commissioner in writing and include in the notice what

15 information or materials are needed to make the

16 request complete, or

17 b. is not eligible for external review, the health

18 carrier shall inform the covered person, if

19 applicable, the covered person's authorized

20 representative and the Commissioner in writing and

21 include in the notice the reasons for its

22 ineligibility.

23 3. a. The Commissioner may specify the form for the health

24 carrier's notice of initial determination under this

1 subsection and any supporting information to be
2 included in the notice.

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

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

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

21 D. 1. Whenever the Commissioner receives a notice that a
22 request is eligible for external review following the preliminary
23 review conducted pursuant to subsection C of this section, within
24

1 one (1) business day after the date of receipt of the notice, the
2 Commissioner shall:

- 3 a. assign an independent review organization from the
4 list of approved independent review organizations
5 compiled and maintained by the Commissioner pursuant
6 to Section 46 of this act to conduct the external
7 review and notify the health carrier of the name of
8 the assigned independent review organization, and
- 9 b. notify in writing the covered person and, if
10 applicable, the covered person's authorized
11 representative of the request's eligibility and
12 acceptance for external review.

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

18 3. The Commissioner shall include in the notice provided to the
19 covered person and, if applicable, the covered person's authorized
20 representative a statement that the covered person or the covered
21 person's authorized representative may submit in writing to the
22 assigned independent review organization within five (5) business
23 days following the date of receipt of the notice provided pursuant
24 to paragraph 1 of this subsection additional information that the

1 independent review organization shall consider when conducting the
2 external review. The independent review organization is not required
3 to, but may, accept and consider additional information submitted
4 after five (5) business days.

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

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

16 3. a. If the health carrier or its utilization review
17 organization fails to provide the documents and
18 information within the time specified in paragraph 1
19 of this subsection, the assigned independent review
20 organization may terminate the external review and
21 make a decision to reverse the adverse determination
22 or final adverse determination.

23 b. Within one (1) business day after making the decision
24 under subparagraph a of this paragraph, the

1 independent review organization shall notify the
2 covered person, if applicable, the covered person's
3 authorized representative, the health carrier, and the
4 Commissioner.

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

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

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

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

23 3. The external review may only be terminated if the health
24 carrier decides, upon completion of its reconsideration, to reverse

1 its adverse determination or final adverse determination and provide
2 coverage or payment for the health care service that is the subject
3 of the adverse determination or final adverse determination.

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

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

16 H. In addition to the documents and information provided
17 pursuant to subsection E of this section, the assigned independent
18 review organization, to the extent the information or documents are
19 available and the independent review organization considers them
20 appropriate, shall consider the following in reaching a decision:

- 21 1. The covered person's medical records;
- 22 2. The attending health care professional's recommendation;
- 23 3. Consulting reports from appropriate health care
24 professionals and other documents submitted by the health carrier,

1 covered person, the covered person's authorized representative, or
2 the covered person's treating provider;

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

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

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

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

20 I. 1. Within forty-five (45) days after the date of receipt of
21 the request for an external review, the assigned independent review
22 organization shall provide written notice of its decision to uphold
23 or reverse the adverse determination or the final adverse
24 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

1 the coverage that was the subject of the adverse determination or
2 final adverse determination.

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

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

15 A. Except as provided in subsection F of this section, a
16 covered person or the covered person's authorized representative may
17 make a request for an expedited external review with the Insurance
18 Commissioner at the time the covered person receives:

- 19 1. An adverse determination if:
- 20 a. the adverse determination involves a medical condition
 - 21 of the covered person for which the time frame for
 - 22 completion of an expedited internal review of a
 - 23 grievance involving an adverse determination would
 - 24 seriously jeopardize the life or health of the covered

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

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

7 2. A final adverse determination:

- 8 a. if the covered person has a medical condition where
9 the time frame for completion of a standard external
10 review pursuant to Section 42 of this act would
11 seriously jeopardize the life or health of the covered
12 person or would jeopardize the covered person's
13 ability to regain maximum function, or
14 b. if the final adverse determination concerns an
15 admission, availability of care, continued stay or
16 health care service for which the covered person
17 received emergency services, but has not been
18 discharged from a facility.

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

22 2. Immediately upon receipt of the request pursuant to
23 paragraph 1 of this subsection, the health carrier shall determine
24 whether the request meets the reviewability requirements set forth

1 in subsection B of Section 42 of this act. The health carrier shall
2 immediately notify the Commissioner and the covered person and, if
3 applicable, the covered person's authorized representative of its
4 eligibility determination.

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

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

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

22 b. In making a determination under subparagraph a of this
23 paragraph, the Commissioner's decision shall be made
24 in accordance with the terms of the covered person's

1 health benefit plan and shall be subject to all
2 applicable provisions of the Uniform Health Carrier
3 External Review Act.

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

12 6. In reaching a decision in accordance with subsection E of
13 this section, the assigned independent review organization shall not
14 be bound by any decisions or conclusions reached during the health
15 carrier's utilization review process as set forth in Sections 6551
16 through 6565 of Title 36 of the Oklahoma Statutes or the health
17 carrier's internal grievance process.

18 C. Upon receipt of the notice from the Commissioner of the name
19 of the independent review organization assigned to conduct the
20 expedited external review pursuant to paragraph 5 of subsection B of
21 this section, the health carrier or its designee utilization review
22 organization shall provide or transmit all necessary documents and
23 information considered in making the adverse determination or final
24 adverse determination to the assigned independent review

1 organization electronically or by telephone or facsimile or any
2 other available expeditious method.

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

9 1. The covered person's pertinent medical records;

10 2. The attending health care professional's recommendation;

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

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

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

24

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

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

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

- 15 a. make a decision to uphold or reverse the adverse
16 determination or final adverse determination, and
- 17 b. notify the covered person, if applicable, the covered
18 person's authorized representative, the health
19 carrier, and the Commissioner of the decision.

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

24

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

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

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

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

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

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

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

12 2. a. A covered person or the covered person's authorized
13 representative may make an oral request for an
14 expedited external review of the adverse determination
15 or final adverse determination pursuant to paragraph 1
16 of this subsection if the covered person's treating
17 physician certifies, in writing, that the recommended
18 or requested health care service or treatment that is
19 the subject of the request would be significantly less
20 effective if not promptly initiated.

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

24

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

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

15 (3) The notice of initial determination under
16 division (1) of this subparagraph shall include a
17 statement informing the covered person and, if
18 applicable, the covered person's authorized
19 representative that a health carrier's initial
20 determination that the external review request is
21 ineligible for review may be appealed to the
22 Commissioner.

23 d. (1) The Commissioner may determine that a request is
24 eligible for external review under paragraph 2 of

1 subsection B of this section notwithstanding a
2 health carrier's initial determination the
3 request is ineligible and require that it be
4 referred for external review.

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

11 e. Upon receipt of the notice that the expedited external
12 review request meets the reviewability requirements of
13 paragraph 2 of subsection B of this section, the
14 Commissioner immediately shall assign an independent
15 review organization to review the expedited request
16 from the list of approved independent review
17 organizations compiled and maintained by the
18 Commissioner pursuant to Section 46 of this act and
19 notify the health carrier of the name of the assigned
20 independent review organization.

21 f. At the time the health carrier receives the notice of
22 the assigned independent review organization pursuant
23 to subparagraph e of this paragraph, the health
24 carrier or its designee utilization review

1 organization shall provide or transmit all necessary
2 documents and information considered in making the
3 adverse determination or final adverse determination
4 to the assigned independent review organization
5 electronically or by telephone or facsimile or any
6 other available expeditious method.

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

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

- 16 a. the individual is or was a covered person in the
17 health benefit plan at the time the health care
18 service or treatment was recommended or requested or,
19 in the case of a retrospective review, was a covered
20 person in the health benefit plan at the time the
21 health care service or treatment was provided,
- 22 b. the recommended or requested health care service or
23 treatment that is the subject of the adverse
24 determination or final adverse determination:

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

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

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

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

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

17 (3) there is no available standard health care
18 service or treatment covered by the health
19 carrier that is more beneficial than the
20 recommended or requested health care service or
21 treatment described in subparagraph d of this
22 paragraph,

23 d. the covered person's treating physician:
24

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

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

19 e. the covered person has exhausted the health carrier's
20 internal grievance process unless the covered person
21 is not required to exhaust the health carrier's
22 internal grievance process pursuant to Section 41 of
23 this act, and
24

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

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

- 10 a. the request is complete, and
11 b. the request is eligible for external review.

12 2. If the request:

- 13 a. is not complete, the health carrier shall inform in
14 writing the Commissioner and the covered person and,
15 if applicable, the covered person's authorized
16 representative and include in the notice what
17 information or materials are needed to make the
18 request complete, or
19 b. is not eligible for external review, the health
20 carrier shall inform the covered person, the covered
21 person's authorized representative, if applicable, and
22 the Commissioner in writing and include in the notice
23 the reasons for its ineligibility.

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

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

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

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

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

5 D. 1. Within one (1) business day after the receipt of the
6 notice from the health carrier that the external review request is
7 eligible for external review pursuant to subparagraph d of paragraph
8 2 of subsection A of this section or paragraph 5 of subsection C of
9 this section, the Commissioner shall:

- 10 a. assign an independent review organization to conduct
11 the external review from the list of approved
12 independent review organizations compiled and
13 maintained by the Commissioner pursuant to Section 46
14 of this act and notify the health carrier of the name
15 of the assigned independent review organization, and
16 b. notify in writing the covered person and, if
17 applicable, the covered person's authorized
18 representative of the request's eligibility and
19 acceptance for external review.

20 2. The Commissioner shall include in the notice provided to the
21 covered person and, if applicable, the covered person's authorized
22 representative a statement that the covered person or the covered
23 person's authorized representative may submit in writing to the
24 assigned independent review organization within five (5) business

1 days following the date of receipt of the notice provided pursuant
2 to paragraph 1 of this subsection, additional information that the
3 independent review organization shall consider when conducting the
4 external review. The independent review organization is not
5 required to, but may, accept and consider additional information
6 submitted after five (5) business days.

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

- 11 a. select one or more clinical reviewers, as it
12 determines is appropriate, pursuant to paragraph 4 of
13 this subsection to conduct the external review, and
- 14 b. based on the opinion of the clinical reviewer, or
15 opinions if more than one clinical reviewer has been
16 selected to conduct the external review, make a
17 decision to uphold or reverse the adverse
18 determination or final adverse determination.

19 4. a. In selecting clinical reviewers pursuant to
20 subparagraph a of paragraph 3 of this subsection, the
21 assigned independent review organization shall select
22 physicians or other health care professionals who meet
23 the minimum qualifications described in Section 47 of
24 this act and, through clinical experience in the past

1 three (3) years, are experts in the treatment of the
2 covered person's condition and knowledgeable about the
3 recommended or requested health care service or
4 treatment.

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

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

14 6. In reaching an opinion, clinical reviewers are not bound by
15 any decisions or conclusions reached during the health carrier's
16 utilization review process as set forth in Sections 6551 through
17 6565 of Title 36 of the Oklahoma Statutes or the health carrier's
18 internal grievance process.

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

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

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

13 b. Immediately upon making the decision under
14 subparagraph a of this paragraph, the independent
15 review organization shall notify the covered person,
16 the covered person's authorized representative, if
17 applicable, the health carrier, and the Commissioner.

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

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

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

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

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

20 4. a. Immediately upon making the decision to reverse its
21 adverse determination or final adverse determination,
22 as provided in paragraph 3 of this subsection, the
23 health carrier shall notify the covered person, the
24 covered person's authorized representative if

1 applicable, the assigned independent review
2 organization, and the Commissioner in writing of its
3 decision.

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

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

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

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

20 b. a description of the indicators relevant to
21 determining whether there is sufficient evidence to
22 demonstrate that the recommended or requested health
23 care service or treatment is more likely than not to
24 be beneficial to the covered person than any available

1 standard health care services or treatments and the
2 adverse risks of the recommended or requested health
3 care service or treatment would not be substantially
4 increased over those of available standard health care
5 services or treatments,

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

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

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

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

23 b. If the opinion provided pursuant to subparagraph a of
24 this paragraph was not in writing, within forty-eight

1 (48) hours following the date the opinion was provided
2 the clinical reviewer shall provide written
3 confirmation of the opinion to the assigned
4 independent review organization and include the
5 information required under paragraph 2 of this
6 subsection.

7 I. In addition to the documents and information provided
8 pursuant to paragraph 2 of subsection A of this section or
9 subsection E of this section, each clinical reviewer selected
10 pursuant to subsection D of this section, to the extent the
11 information or documents are available and the reviewer considers
12 appropriate, shall consider the following in reaching an opinion
13 pursuant to subsection H of this section:

14 1. The covered person's pertinent medical records;

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

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

21 4. The terms of coverage under the covered person's health
22 benefit plan with the health carrier to ensure that, but for the
23 health carrier's determination that the recommended or requested
24 health care service or treatment that is the subject of the opinion

1 is experimental or investigational, the reviewer's opinion is not
2 contrary to the terms of coverage under the covered person's health
3 benefit plan with the health carrier; and

4 5. Whether:

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

9 b. medical or scientific evidence or evidence-based
10 standards demonstrate that the expected benefits of
11 the recommended or requested health care service or
12 treatment is more likely than not to be beneficial to
13 the covered person than any available standard health
14 care service or treatment and the adverse risks of the
15 recommended or requested health care service or
16 treatment would not be substantially increased over
17 those of available standard health care services or
18 treatments.

19 J. 1. a. Except as provided in subparagraph b of this
20 paragraph, within twenty (20) days after the date it
21 receives the opinion of each clinical reviewer
22 pursuant to subsection I of this section, the assigned
23 independent review organization, in accordance with
24

1 paragraph 2 of this subsection, shall make a decision
2 and provide written notice of the decision to:

- 3 (1) the covered person,
- 4 (2) if applicable, the covered person's authorized
5 representative,
- 6 (3) the health carrier, and
- 7 (4) the Commissioner.

8 b. (1) For an expedited external review, within forty-
9 eight (48) hours after the date it receives the
10 opinion of each clinical reviewer pursuant to
11 subsection I of this section, the assigned
12 independent review organization, in accordance
13 with paragraph 2 of this subsection, shall make a
14 decision and provide notice of the decision
15 orally or in writing to the persons listed in
16 subparagraph a of this paragraph.

17 (2) If the notice provided under division (1) of this
18 subparagraph was not in writing, within forty-
19 eight (48) hours after the date of providing that
20 notice, the assigned independent review
21 organization shall provide written confirmation
22 of the decision to the persons listed in
23 subparagraph a of this paragraph and include the
24

1 information set forth in paragraph 3 of this
2 subsection.

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

9 b. If a majority of the clinical reviewers recommend that
10 the recommended or requested health care service or
11 treatment should not be covered, the independent
12 review organization shall make a decision to uphold
13 the health carrier's adverse determination or final
14 adverse determination.

15 c. (1) If the clinical reviewers are evenly split as to
16 whether the recommended or requested health care
17 service or treatment should be covered, the
18 independent review organization shall obtain the
19 opinion of an additional clinical reviewer in
20 order for the independent review organization to
21 make a decision based on the opinions of a
22 majority of the clinical reviewers pursuant to
23 subparagraph a or b of this paragraph.
24

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

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

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

- 16 a. a general description of the reason for the request
17 for external review,
18 b. the written opinion of each clinical reviewer,
19 including the recommendation of each clinical reviewer
20 as to whether the recommended or requested health care
21 service or treatment should be covered and the
22 rationale for the reviewer's recommendation,
23
24

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

4 d. the date the external review was conducted,

5 e. the date of its decision,

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

7 g. the rationale for its decision.

8 4. Upon receipt of a notice of a decision pursuant to paragraph
9 1 of this subsection reversing the adverse determination or final
10 adverse determination, the health carrier immediately shall approve
11 coverage of the recommended or requested health care service or
12 treatment that was the subject of the adverse determination or final
13 adverse determination.

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

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

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

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

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

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

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

22 B. In order to be eligible for approval by the Commissioner
23 under this section to conduct external reviews under the Uniform
24

1 Health Carrier External Review Act an independent review
2 organization:

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

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

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

14 D. 1. Any independent review organization wishing to be
15 approved to conduct external reviews under this act shall submit the
16 application form and include with the form all documentation and
17 information necessary for the Commissioner to determine if the
18 independent review organization satisfies the minimum qualifications
19 established under Section 47 of this act.

20 2. a. Subject to subparagraph b of this paragraph, an
21 independent review organization is eligible for
22 approval under this section only if it is accredited
23 by a nationally recognized private accrediting entity
24 that the Commissioner has determined has independent

1 review organization accreditation standards that are
2 equivalent to or exceed the minimum qualifications for
3 independent review organizations under Section 47 of
4 this act.

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

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

14 E. 1. An approval is effective for two (2) years, unless the
15 Commissioner determines before its expiration that the independent
16 review organization is not satisfying the minimum qualifications
17 established under Section 48 of this act.

18 2. Whenever the Commissioner determines that an independent
19 review organization has lost its accreditation or no longer
20 satisfies the minimum requirements established under Section 48 of
21 this act, the Commissioner shall terminate the approval of the
22 independent review organization and remove the independent review
23 organization from the list of independent review organizations
24 approved to conduct external reviews under the Uniform Health

1 Carrier External Review Act that is maintained by the Commissioner
2 pursuant to subsection F of this section.

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

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

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

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

- 15 1. A quality assurance mechanism in place that:
- 16 a. ensures that external reviews are conducted within the
17 specified time frames and required notices are
18 provided in a timely manner,
 - 19 b. ensures the selection of qualified and impartial
20 clinical reviewers to conduct external reviews on
21 behalf of the independent review organization and
22 suitable matching of reviewers to specific cases and
23 that the independent review organization employs or
24

1 contracts with an adequate number of clinical
2 reviewers to meet this objective,

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

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

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

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

15 B. All clinical reviewers assigned by an independent review
16 organization to conduct external reviews shall be physicians or
17 other appropriate health care providers who meet the following
18 minimum qualifications:

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

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

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

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

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

17 D. 1. In addition to the requirements set forth in subsections
18 A, B and C of this section, to be approved pursuant to Section 46 of
19 this act to conduct an external review of a specified case, neither
20 the independent review organization selected to conduct the external
21 review nor any clinical reviewer assigned by the independent
22 organization to conduct the external review may have a material
23 professional, familial or financial conflict of interest with any of
24 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

1 a specified case or a clinical reviewer to be assigned by the
2 independent review organization to conduct an external review of a
3 specified case may have an apparent professional, familial or
4 financial relationship or connection with a person described in
5 paragraph 1 of this subsection, but that the characteristics of that
6 relationship or connection are such that they are not a material
7 professional, familial or financial conflict of interest that
8 results in the disapproval of the independent review organization or
9 the clinical reviewer from conducting the external review.

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

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

23 3. Upon request, a nationally recognized private accrediting
24 entity shall make its current independent review organization

1 accreditation standards available to the commissioner or the NAIC in
2 order for the Commissioner to determine if the entity's standards
3 are equivalent to or exceed the minimum qualifications established
4 under this section. The Commissioner may exclude any private
5 accrediting entity that is not reviewed by the NAIC.

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

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

13 No independent review organization or clinical reviewer working
14 on behalf of an independent review organization or an employee,
15 agent or contractor of an independent review organization shall be
16 liable in damages to any person for any opinions rendered or acts or
17 omissions performed within the scope of the organization's or
18 person's duties under the law during or upon completion of an
19 external review conducted pursuant to this act, unless the opinion
20 was rendered or act or omission performed in bad faith or involved
21 gross negligence.

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

1 A. 1. An independent review organization assigned pursuant to
2 Section 42, 43 or 44 of this act to conduct an external review shall
3 maintain written records in the aggregate by state and by health
4 carrier on all requests for external review for which it conducted
5 an external review during a calendar year and, upon request, submit
6 a report to the Insurance Commissioner, as required under paragraph
7 2 of this subsection.

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

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

- 15 a. the total number of requests for external review,
- 16 b. the number of requests for external review resolved
17 and, of those resolved, the number resolved upholding
18 the adverse determination or final adverse
19 determination and the number resolved reversing the
20 adverse determination or final adverse determination,
- 21 c. the average length of time for resolution,
- 22 d. a summary of the types of coverages or cases for which
23 an external review was sought, as provided in the
24 format required by the Commissioner,

- 1 e. the number of external reviews pursuant to subsection
2 G of Section 42 of this act that were terminated as
3 the result of a reconsideration by the health carrier
4 of its adverse determination or final adverse
5 determination after the receipt of additional
6 information from the covered person or the covered
7 person's authorized representative, and
8 f. any other information the Commissioner may request or
9 require.

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

13 B. 1. Each health carrier shall maintain written records in
14 the aggregate, by state and for each type of health benefit plan
15 offered by the health carrier on all requests for external review
16 that the health carrier receives notice of from the Commissioner
17 pursuant to this act.

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

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

- 24 a. the total number of requests for external review,

- 1 b. from the total number of requests for external review
2 reported under subparagraph a of this paragraph, the
3 number of requests determined eligible for a full
4 external review, and
5 c. any other information the Commissioner may request or
6 require.

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

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

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

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

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

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

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

11 C. In addition to subsection B of this section, the statement
12 shall inform the covered person that, when filing a request for an
13 external review, the covered person will be required to authorize
14 the release of any medical records of the covered person that may be
15 required to be reviewed for the purpose of reaching a decision on
16 the external review.

17 SECTION 52. AMENDATORY Section 12, Chapter 390, O.S.L.
18 2003, as last amended by Section 52, Chapter 222, O.S.L. 2010 (36
19 O.S. Supp. 2010, Section 6811), is amended to read as follows:

20 Section 6811. A. ~~When a claim for recovery under a medical~~
21 ~~professional liability insurance policy is closed, the insurer shall~~
22 ~~file with the Insurance Department a closed claim report not later~~
23 ~~than April 1 of the same calendar year if the claim is closed prior~~
24 ~~to April 1, and if the claim is closed after April 1, then the~~

1 ~~closed claim report shall be filed by April 1 of the subsequent~~
2 ~~calendar year~~ An insuring entity shall file, between January 1 and
3 March 15 of each year, a closed claim report. These reports shall
4 include data for all claims closed in the preceding calendar year
5 and any adjustments to data reported in prior years.

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

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

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

22 E. If a claim is not covered by an insuring entity or self-
23 insurer, the facility or provider named in the claim shall report it
24 to the Commissioner after a final claim disposition has occurred due

1 to a court proceeding or a settlement by the parties. Instances in
2 which a claim may not be covered by an insuring entity or self-
3 insurer include situations in which:

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

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

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

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

17 1. If a facility or provider is insured by a risk retention
18 group and the risk retention group refuses to report closed claims
19 and asserts that the federal Liability Risk Retention Act (95 Stat.
20 949; 15 U.S.C. Sec. 3901 et seq.) preempts state law, the facility
21 or provider shall report all data required by the Medical
22 Professional Liability Insurance Closed Claim Reports Act on behalf
23 of the risk retention group.

24

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

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

13 SECTION 53. AMENDATORY Section 40, Chapter 197, O.S.L.
14 2003 (36 O.S. Supp. 2010, Section 6940), is amended to read as
15 follows:

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

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

23 2. Notification by the Insurance Commissioner to the health
24 maintenance organization of an adjusted RBC report that indicates an

1 event in paragraph 1 of this subsection, provided the health
2 maintenance organization does not challenge the adjusted RBC report
3 under Section ~~44~~ 6944 of this ~~act~~ title; ~~or~~

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

10 4. If a health maintenance organization has total adjusted
11 capital which is greater than or equal to its Company Action Level
12 RBC but less than the product of its Authorized Control Level RBC
13 and 3.0 and triggers the trend test determined in accordance with
14 the trend test calculation included in the Health RBC instructions.

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

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

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

23 3. Provide projections of the health maintenance organization's
24 financial results in the current year and at least the two (2)

1 succeeding years, both in the absence of proposed corrective actions
2 and giving effect to the proposed corrective actions, including
3 projections of statutory balance sheets, operating income, net
4 income, capital and surplus, and RBC levels. The projections for
5 both new and renewal business might include separate projections for
6 each major line of business and separately identify each significant
7 income, expense and benefit component;

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

11 5. Identify the quality of, and problems associated with, the
12 health maintenance organization's business including, but not
13 limited to, its assets, anticipated business growth and associated
14 surplus strain, extraordinary exposure to risk, mix of business and
15 use of reinsurance, if any, in each case.

16 C. The RBC plan shall be submitted:

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

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

24

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

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

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

22 E. In the event of a notification by the Commissioner to a
23 health maintenance organization that the health maintenance
24 organization's RBC plan or revised RBC plan is unsatisfactory, the

1 Commissioner may, at the Commissioner's discretion and subject to
2 the health maintenance organization's right to a hearing pursuant to
3 the provisions of Section ~~44~~ 6944 of this ~~act~~ title, specify in the
4 notification that the notification constitutes a Regulatory Action
5 Level Event.

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

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

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

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

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

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1 SECTION 54. REPEALER 63 O.S. 2001, Sections 2528.1,
2 2528.2, 2528.3, 2528.4, 2528.5, 2528.6, 2528.7, 2528.8, 2528.9 and
3 2528.10, are hereby repealed.

4 SECTION 55. Sections 3 and 24 of this act shall become
5 effective June 20, 2011.

6 SECTION 56. Sections 1, 4 through 22, 29, 35 through 51 and 54
7 of this act shall become effective July 1, 2011.

8 SECTION 57. Sections 2, 23, 25 through 28, 30 through 34, and
9 52 through 53 of this act shall become effective November 1, 2011.

10 SECTION 58. It being immediately necessary for the preservation
11 of the public peace, health and safety, an emergency is hereby
12 declared to exist, by reason whereof this act shall take effect and
13 be in full force from and after its passage and approval.

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