SENATE FLOOR VERSION
April 2, 2012

ENGROSSED HOUSE
BILL NO. 2453 By: Key of the House

and

Brown of the Senate

An Act relating to insurance; amending 36 O.S. 2011, Sections 924.4 and 924.5, which relate to affidavit of exempt status; updating statutory cites; amending 36 O.S. 2011, Section 1435.6, which relates to the Oklahoma Producer Licensing Act; modifying time period to take certain examination; placing time limit for making an application for a producer's license; modifying requirements relating to subsequent examinations; amending 36 O.S. 2011, Sections 1473 and 1477, which relate to the Managing General Agents Act; correcting statutory cite; clarifying language; amending 36 O.S. 2011, Sections 1608, 1609 and 1620, which relate to investments; clarifying types of investments; specifying types of investments that are not acceptable; providing that certificates of deposits or other time deposit instruments shall be classified as negotiable and transferrable; amending 36 O.S. 2011, Sections 1703 and 1707, which relate to administration of deposits; adding time deposits to definition of cash; specifying when a deposit can be released; amending 36 O.S. 2011, Section 3639.1, which relates to homeowner's insurance policies; prohibiting insurer from canceling or renewing policy or increasing premium of other personal residential insurance coverage because of the filing of claims after certain time period; exempting insurer from providing certain notice for certain policies; amending 36 O.S. 2011, Section 4509, which relates to the termination of certain employee insurance coverage; requiring an offer to continue certain coverage; specifying carrier notice requirements; requiring employee to request continuation in

writing; specifying time limitation; authorizing the charging of premiums for coverage continuation; providing for the termination of coverage; specifying criteria for termination; modifying right to continuation of health insurance coverage in certain circumstances; amending 36 O.S. 2011, Sections 6206 and 6217, which relate to the Insurance Adjusters Licensing Act; specifying that the exam for an adjusters license must be passed within certain specified time; eliminating continuing education requirement relating to workers' compensation for certain adjusters; requiring an adjuster to report certain actions or prosecutions to the Insurance Commissioner; amending 36 O.S. 2011, Section 6475.13, which relates to the Uniform Health Carrier External Review Act; requiring an independent review organization to possess any additional qualifications promulgated by the Insurance Commissioner; allowing the Insurance Commissioner to accept certain accreditation standards; amending 36 O.S. 2011, Section 6608, which relates to the Service Warranty Insurance Act; specifying that certain reporting date is an annual requirement; providing for codification; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2011, Section 924.4, is amended to read as follows:

Section 924.4 A. Any person who is not required to be covered under a workers' compensation insurance policy or other plan for the payment of workers' compensation may execute an Affidavit of Exempt Status under the Workers' Compensation Act. The affidavit shall be a form prescribed by the Insurance Commissioner. The affidavit shall be available on the web site of the Insurance Department.

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

C. Except as otherwise provided in Section ~~11~~ 314 of Title 85 of the Oklahoma Statutes, the execution of an affidavit shall not affect the rights or coverage of any employee of the individual executing the affidavit.

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

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

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

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

SECTION 2. AMENDATORY 36 O.S. 2011, Section 924.5, is amended to read as follows:

Section 924.5 In addition to any other penalty prescribed by law, any employer who knowingly and willfully requires an employee or subcontractor to execute an affidavit under Section ~~75~~ 924.4 of this ~~act~~ title when the employer knows that the employee or subcontractor is required to be covered under a workers' compensation insurance policy or other plan for the payment of workers' compensation shall be liable for a civil penalty, to be assessed by the Insurance Department, of not more than Five Hundred Dollars ($500.00) for a first offense, and shall be liable for a civil penalty of not more than One Thousand Dollars ($1,000.00) for a second or subsequent offense. All civil penalties collected pursuant to this section shall be deposited into the State Insurance Commissioner's Revolving Fund.

SECTION 3. AMENDATORY 36 O.S. 2011, Section 1435.6, is amended to read as follows:

Section 1435.6 A. A resident individual applying for an insurance producer license shall pass a written examination unless exempt pursuant to Section 1435.10 of this title. The examination shall test the knowledge of the individual concerning the lines of

authority for which application is made, the duties and responsibilities of an insurance producer and the insurance laws and regulations of this state. Examinations required by this section shall be developed and conducted under rules and regulations prescribed by the Insurance Commissioner.

B. The Commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and collecting the nonrefundable fee set forth in Section 1435.23 of this title.

C. Each individual applying for an examination shall remit a nonrefundable fee as prescribed by the Insurance Commissioner as set forth in Section 1435.23 of this title.

D. ~~After~~ Prior to completion and filing of the application ~~with~~, the Insurance Commissioner~~, except as provided in Section 1435.10 of this title, the Commissioner~~ shall subject each applicant for license as an insurance ~~agent~~ producer, insurance consultant, limited insurance representative, or customer service representative to an examination approved by the Commissioner as to competence to act as a licensee, which each applicant shall personally take and pass to the satisfaction of the Commissioner except as provided in Section 1435.10 of this title. The Commissioner may accept examinations administered by a testing service as satisfying the examination requirements of persons seeking license as agents, solicitors, counselors, or adjusters under the Oklahoma Insurance

Code. The Commissioner may negotiate agreements with such testing services to include performance of examination development, test scheduling, examination site arrangements, test administration, grading, reporting, and analysis. The Commissioner may require such testing services to correspond directly with the applicants with regard to the administration of such examinations and that such testing services collect fees for administering such examinations directly from the applicants. The Commissioner may stipulate that any agreements with such testing services provide for the administration of examinations in specific locales and at specified frequencies. The Commissioner shall retain the authority to establish the scope and type of all examinations.

E. If the applicant is a legal entity, the examination shall be taken by each individual who is to act for the entity as a licensee.

F. Each examination for a license shall be approved for use by the Commissioner and shall reasonably test the knowledge of the applicant as to the lines of insurance, policies, and transactions to be handled pursuant to the license applied for, the duties and responsibilities of the licensee, and the pertinent insurance laws of this state.

G. Examination for licensing shall be at such reasonable times and places as are designated by the Commissioner.

H. The Commissioner or testing service shall give, conduct, and grade all examinations in a fair and impartial manner and without discrimination among individuals examined.

I. The applicant shall pass the examination with a grade determined by the Commissioner to indicate satisfactory knowledge and understanding of the line or lines of insurance for which the applicant seeks qualification. Within ten (10) days after the examination, the Commissioner shall inform the applicant and the appointing insurer, when applicable, as to whether or not the applicant has passed. ~~Formal evidence of licensing shall be issued by the Commissioner to the licensee within a reasonable time~~ An application for licensure shall be made within two (2) years after passing the examination.

J. An applicant who has failed to pass the ~~first~~ examination for the license applied for may take ~~a second~~ the examination ~~within thirty (30) days following the first examination~~ subsequent times. Examination fees for subsequent examinations shall not be waived.

K. ~~An applicant who has failed to pass the first two examinations for the license applied for shall not be permitted to take a subsequent examination until the expiration of thirty (30) days after the last previous examination. Examination fees for subsequent examinations shall not be waived.~~

~~L.~~ An applicant for a license as a resident surplus lines broker shall have passed the property and casualty insurance

examination on the line or lines of insurance to be written to qualify for a surplus lines broker license.

SECTION 4. AMENDATORY 36 O.S. 2011, Section 1473, is amended to read as follows:

Section 1473. A. No person shall act in the capacity of a managing general agent with respect to risks located in this state for an insurer unless such person is licensed as ~~an agent or broker~~ a producer pursuant to ~~Section 1421 et seq. of Title 36 of the Oklahoma Statutes~~ the Oklahoma Producer Licensing Act.

B. No person shall act in the capacity of a managing general agent, representing an insurer domiciled in this state with respect to risks located outside this state, unless such person is licensed as ~~an agent or broker pursuant to Section 1421 et seq. of Title 36 of the Oklahoma Statutes~~ a producer pursuant to the Oklahoma Producer Licensing Act. Provided, such license may be a nonresident license.

C. The Insurance Commissioner may require a bond in the amount acceptable to ~~him~~ the Commissioner for the protection of the insurer.

D. The Insurance Commissioner may require the managing general agent to maintain an errors and omissions policy.

SECTION 5. AMENDATORY 36 O.S. 2011, Section 1477, is amended to read as follows:

Section 1477. A. If the Insurance Commissioner finds, after a hearing conducted in accordance with Article II of the Administrative Procedures Act, ~~Section 309 et seq. of Title 75 of the Oklahoma Statutes,~~ that any person had violated any provision of ~~this act~~ the Managing General Agents Act or rules promulgated pursuant thereto, the Commissioner may order:

1. For each separate violation, a penalty in an amount of not less than One Hundred Dollars ($100.00) nor more than Five Thousand Dollars ($5,000.00) for each occurrence;

2. Revocation or suspension of the ~~agent's or broker's~~ producer's license; and

3. The managing general agent to reimburse the insurer, the rehabilitator or the liquidator of the insurer for any losses incurred by the insurer which were caused by a violation of ~~this act~~ the Managing General Agents Act committed by the managing general agent.

B. The decision, determination or order of the Commissioner pursuant to subsection A of this section shall be subject to judicial review pursuant to the Administrative Procedures Act and any applicable insurance laws and regulations.

C. Nothing contained in this section shall affect the right of the Commissioner to impose any other penalties provided for in the Oklahoma Insurance Code.

D. Nothing contained in ~~this act~~ the Managing General Agents Act is intended to or shall, in any manner, limit or restrict the rights of policyholders, claimants and auditors.

E. No insurer may continue to utilize the services of a managing general agent on or after July 1, 1991, unless such utilization is in compliance with ~~this act~~ the Managing General Agents Act.

SECTION 6. AMENDATORY 36 O.S. 2011, Section 1608, is amended to read as follows:

Section 1608. An insurer may invest in bonds, notes, warrants and other securities not in default which are the direct obligations of any state of the United States or of the District of Columbia, or of the government of Canada or any province thereof, or for which the full faith and credit of such state, district, government or province has been pledged for the payment of principal and interest. Bonds, notes, warrants and other securities classified as revenue, prerefunded or declining balances are not considered acceptable investments for this purpose.

SECTION 7. AMENDATORY 36 O.S. 2011, Section 1609, is amended to read as follows:

Section 1609. An insurer may invest in bonds, notes, warrants and other securities not in default of any county, district, incorporated city, or school district in any state of the United States, or the District of Columbia, or in any province of Canada,

which are the direct obligations of such county, district, city or school district and for payment of the principal and interest of which the county, district, city, or school district has lawful authority to levy taxes or make assessments. Bonds, notes, warrants and other securities classified as revenue, prerefunded or declining balances are not considered acceptable investments for this purpose.

SECTION 8. AMENDATORY 36 O.S. 2011, Section 1620, is amended to read as follows:

Section 1620. A. An insurer may ~~have~~ invest or deposit any of its cash funds on deposit in checking or savings accounts, under certificates of deposit, or ~~in any other form~~ in solvent banks or trust companies, which are insured by the Federal Deposit Insurance Corporation.

B. An insurer may invest or deposit any of its funds in checking, share or saving accounts under certificates of deposit or time deposits in solvent savings and loan associations which are insured by the Federal ~~Savings and Loan~~ Deposit Insurance Corporation.

C. An insurer may invest or deposit any of its cash funds in share, share draft, under certificates of deposit or ~~in any other form~~ time deposits in solvent credit unions which are insured by the National Credit Union Administration.

D. All certificates of deposits or other time deposit instruments shall be classified as negotiable and transferrable as required by Section 1703 of this title.

SECTION 9. AMENDATORY 36 O.S. 2011, Section 1703, is amended to read as follows:

Section 1703. A. All such deposits required for authority to transact insurance business in Oklahoma shall consist of cash, under negotiable~~,~~ and transferable certificates of deposit or other time deposit instruments issued by solvent insured banks, savings and loan associations, and trust companies in Oklahoma, or a combination of the foregoing and the securities described in ~~the following sections of Article 16 of this Code:~~ Sections 1607, 1608, 1609 and 1620 of this title.

B. All such deposits required pursuant to the laws of another state, province, or country, or pursuant to the retaliatory provision of Section 628 of this title, shall consist of such assets as are required or permitted by such laws, or as required pursuant to such retaliatory provision.

SECTION 10. AMENDATORY 36 O.S. 2011, Section 1707, is amended to read as follows:

Section 1707. Any deposit made in this state under ~~this~~ the Insurance Code shall be released and returned:

1. To the insurer upon extinguishment by reinsurance or otherwise of substantially all liability of the insurer for the

security of which the deposit is held upon proper request by the insurer and after financial review of the insurer proving generally acceptable financial conditions;

2. To the insurer to the extent such deposit is in excess of the amount required upon proper request by the insurer and after financial review of the insurer proving generally acceptable financial conditions; or

3. Upon proper order of a court of competent jurisdiction to the receiver, conservator, rehabilitator or liquidator of the insurer, or to any other properly designated official or officials who succeed to the management and control of the insurer's assets.

SECTION 11. AMENDATORY 36 O.S. 2011, Section 3639.1, is amended to read as follows:

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

1. Nonpayment of premium;

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

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

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

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

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

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

B. An insurer shall give to the named insured at the mailing address shown on a ~~private passenger auto or~~ homeowner's policy, a written renewal notice that shall include new premium, new deductible, new limits or coverage at least thirty (30) days prior to the expiration date of the policy. If the insurer fails to provide such notice, the premium, deductible, limits and coverage provided to the named insurer prior to the change shall remain in

effect until notice is given or until the effective date of replacement coverage obtained by the named insured, whichever occurs first. If notice is given by mail, the notice shall be deemed to have been given on the day the notice is mailed. If the insured elects not to renew, any earned premium for the period of extension of the terminated policy shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, the premium increase, if any, and other changes shall be effective the day following the prior policy's expiration or anniversary date.

SECTION 12. AMENDATORY 36 O.S. 2011, Section 4509, is amended to read as follows:

Section 4509. A. When an insured employee or a dependent whose group insurance coverage is terminated and the coverage is subject to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272, April 7, 1986, 100 Stat. 82, neither subsection B~~,~~ or C~~, or D~~ of this section applies.

B. In the case of an employee whose insurance is terminated for any reason other than termination of the group plan or termination for gross misconduct under a group policy providing hospital, medical or surgical, or Christian Science care and treatment expense benefits; or contract of hospital or medical service or indemnity; or prepaid health plan or health maintenance organization subscriber contract, such employee and the dependents of the employee shall

~~remain insured~~ be offered continuation of coverage under the group policy or contract for a period of at least sixty-three (63) days after such termination~~, unless during such period the employee and his dependents shall otherwise become entitled to similar insurance from some other source. Premiums may be charged for this period. The premiums charged shall be the premiums which would have been charged for the coverage provided under the group policy or contract had termination not occurred~~. The carrier shall notify the terminated employee of the availability of this continuation of coverage option in writing within thirty (30) days of receiving notice from the plan sponsor of the employee's termination of coverage. The terminated employee shall request in writing the continuation of group coverage not later than the thirty-first day after the date the terminated employee is given notification of the availability of this continuation of coverage option. Premiums may be charged for the continuation of coverage period. The premiums charged shall be the premiums which would have been charged for the coverage provided under the group policy or contract had termination not occurred. Continuation of coverage pursuant to this section may be terminated:

1. For employee's failure to make timely premium payments;

2. On the date the group coverage terminates in its entirety if the group coverage terminates in its entirety during the continuation of coverage period; or

3. If the employee and the dependents of the employee otherwise become entitled to similar insurance from some other source during the continuation of the coverage period.

C. If an employee has been covered for at least six (6) months under any group accident and health insurance policy delivered in this state, providing hospital, medical or surgical, or Christian Science care and treatment expense benefits, or under a contract of hospital or medical service or indemnity, and the individual employee has had his employment terminated or the group itself is terminated, then the termination shall not affect coverage of the insured or his dependents for any continuous loss which commenced while the insurance was in force. The extension of benefits beyond the period the insurance was in force may be predicated upon the continuous total disability of the person insured or his or her dependents or the expenses incurred in connection with a plan of surgical treatment, which shall include maternity care and delivery expenses, which commenced prior to the termination. The coverage for the extension of benefits shall be for the maximum benefits under the terminated policy or for a time period of not less than three (3) months in the case of basic coverage or six (6) months in the case of major medical coverage. Premium monies may be charged for the period of the extension of benefits. The premiums charged shall be the premiums which would have been charged for the coverage

provided under the group policy or contract had termination not occurred.

~~D. When an insured employee or a dependent whose group health insurance coverage is terminated due to the employee's involuntary termination from employment, the employee or his or her dependents shall have a right to continue the group health insurance coverage for four (4) months following the employee's termination from employment subject to all of the following conditions:~~

~~1. The group health insurance is provided pursuant to a group policy providing hospital, medical or surgical, or Christian Science care and treatment expense benefits; or contract of hospital or medical service or indemnity; or prepaid health plan or health maintenance organization subscriber contract; or a self-insured employer plan;~~

~~2. The coverage shall be the same coverage as was provided prior to the employee's termination;~~

~~3. Premiums shall be paid for the period of coverage. The premiums charged shall be the premiums which would have been charged for the coverage provided under the group policy or contract had termination not occurred;~~

~~4. The employee was not terminated for misconduct; and~~

~~5. This subsection shall remain in force only until the end of the period for which a premium subsidy is available pursuant to the~~

~~American Recovery and Reinvestment Act of 2009 (ARRA) or its successor.~~

SECTION 13. AMENDATORY 36 O.S. 2011, Section 6206, is amended to read as follows:

Section 6206. A. The Insurance Commissioner shall license as an adjuster only an individual who has fully complied with the provisions of the Insurance Adjusters Licensing Act, including the furnishing of evidence satisfactory to the Commissioner that the applicant:

1. Is at least eighteen (18) years of age;

2. Is a bona fide resident of this state or is a resident of a state or country which permits adjusters who are residents of this state to act as adjusters in such other state or country;

3. If a nonresident of the United States, has complied with all federal laws pertaining to employment and the transaction of business in the United States;

4. Is a trustworthy person;

5. Has had experience or special education or training of sufficient duration and extent with reference to the handling of loss claims pursuant to insurance contracts to make the applicant competent to fulfill the responsibilities of an adjuster;

6. Has successfully passed an examination as required by the Commissioner <u>within two (2) years prior to date of application,</u> or

has been exempted from examination, in accordance with the provisions of Section 6208 of this title; and

7. If the application is for a public adjuster's license, the applicant has filed the bond required by Section 6214 of this title.

B. Residence addresses and telephone listings, birth dates, and social security numbers for insurance adjusters and public adjusters on file with the Insurance Department are exempt from disclosure as public records. A separate business or mailing address as provided by the adjuster shall be considered a public record and upon request shall be disclosed. If an adjuster's residence and business address or residence and business telephone number are the same, such address or telephone number shall be considered a public record.

C. The mailing address shall appear on all licenses of the licensee, and the licensee shall promptly notify the Insurance Commissioner within thirty (30) days of any change in legal name or mailing, business or residence address of the licensee. A change in legal name or address thirty (30) days after the change must include an administrative fee of Fifty Dollars ($50.00). Failure to provide acceptable notification of a change of legal name or address to the Insurance Commissioner within forty-five (45) days of the date the administrative fee is assessed will result in penalties pursuant to Section 6220 of this title.

SECTION 14. AMENDATORY 36 O.S. 2011, Section 6217, is amended to read as follows:

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

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

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

1. Employees of the Insurance Commissioner;

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

3. An independent service whose normal business activities include the review and approval of continuing education courses and

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

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

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

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

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

~~G.~~ F. Each provider of continuing education shall, after approval by the Commissioner, submit an annual fee. A fee may be assessed for each course submission at the time it is first submitted for review and upon submission for renewal at expiration. Annual fees and course submission fees shall be set forth as a rule by the Commissioner. The fees are payable to the Insurance Commissioner and shall be deposited in the State Insurance Commissioner Revolving Fund, created in subsection C of Section 1435.23 of this title, for the purposes of fulfilling and accomplishing the conditions and purposes of the Oklahoma Producer

Licensing Act and the Insurance Adjusters Licensing Act. Public-funded educational institutions, federal agencies, nonprofit organizations, not-for-profit organizations and Oklahoma state agencies shall be exempt from this subsection.

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

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

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6222 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An adjuster shall report to the Insurance Commissioner any administrative action taken against the adjuster in another jurisdiction or by another governmental agency in this state within thirty (30) days of the final disposition of the matter. This report shall include a copy of the order, consent to order or other relevant legal documents.

B. Within thirty (30) days of the initial pretrial hearing date, an adjuster shall report to the Insurance Commissioner any criminal prosecution of the adjuster taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

SECTION 16. AMENDATORY 36 O.S. 2011, Section 6475.13, is amended to read as follows:

Section 6475.13 A. To be approved under Section ~~36~~ 6475.12 of this ~~act~~ title to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this act that include, at a minimum:

1. A quality assurance mechanism in place that:

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

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

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

d. ensures that any person employed by or under contract with the independent review organization adheres to the requirements of ~~this act~~ the Uniform Health Carrier External Review Act;

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

3. Agree to maintain and provide to the Insurance Commissioner the information set out in Section ~~39~~ 6475.15 of this ~~act~~ title.

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

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

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

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

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

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

local trade association of health benefit plans, or a national, state or local trade association of health care providers.

D. 1. In addition to the requirements set forth in subsections A, B and C of this section, to be approved pursuant to Section ~~36~~ 6475.12 of this ~~act~~ title to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

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

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

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

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

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

f. the developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.

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

E. <u>In addition to the requirements set forth in subsections A, B, C and D of this section, an independent review organization shall possess any additional minimum qualifications that the Insurance Commissioner may promulgate by rule.</u>

F. 1. An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the Commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under Section ~~36~~ 6475.12 of this ~~act~~ title. If a nationally recognized private accrediting entity has independent review accreditation standards that are substantially similar to but do not equal or exceed the minimum qualifications of this section, the Commissioner may accept the accreditation as an equivalent accreditation standard after reviewing for compliance any minimum qualifications required by this section that are not required by the national accreditation.

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

3. Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the Commissioner or the NAIC in order for the Commissioner to determine if the entity's standards

are equivalent to or exceed the minimum qualifications established under this section. The Commissioner may exclude any private accrediting entity that is not reviewed by the NAIC.

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

SECTION 17. AMENDATORY 36 O.S. 2011, Section 6608, is amended to read as follows:

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

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

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

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

3. Other pertinent information as may be required by the Commissioner.

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

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

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

3. A license fee as required pursuant to Section 6604 of this title.

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

E. 1. Any entity that claims one or more of the exclusions from the definition of service warranty provided in paragraph 14 of Section 6602 of this title shall file audited financial statements and other information as requested by the Commissioner by May 1, 2010, <u>and each year thereafter,</u> to document and verify that the

contracts of the entity are not included within the definition of service warranty.

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

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

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

SECTION 18. This act shall become effective November 1, 2012.

COMMITTEE REPORT BY: COMMITTEE ON RETIREMENT & INSURANCE, dated 3-29-12 - DO PASS.