COMMITTEE AMENDMENT

HOUSE OF REPRESENTATIVES
State of Oklahoma

SPEAKER:

CHAIR:

I move to amend HB3746
Of the printed Bill

Page _____ Section _____ Lines _____
Of the Engrossed Bill

By striking the Title, the Enacting Clause, the entire bill, and by inserting in lieu thereof the following language:

AMEND TITLE TO CONFORM TO AMENDMENTS

Amendment submitted by: Lewis Moore

Adopted: _____

_____
Reading Clerk

STATE OF OKLAHOMA

2nd Session of the 57th Legislature (2020)

PROPOSED COMMITTEE
SUBSTITUTE
FOR
HOUSE BILL NO. 3746 By: Moore

PROPOSED COMMITTEE SUBSTITUTE

An Act relating to insurance; amending 36 O.S. 2011, Section 311.4, as amended by Section 1, Chapter 275, O.S.L. 2014 (36 O.S. Supp. 2019, Section 311.4), which relates to annual statements reporting market conduct data of insurers; authorizing imposition of civil fine; amending 36 O.S. 2011, Section 615.2, which relates to Biographical Affidavits; modifying time frame for Business Character Report; amending 36 O.S. 2011, Section 638, which relates to compliance relating to examinations; updating statutory references; amending 36 O.S. 2011, Section 996, which relates to assigned risks; authorizing the Oklahoma Automobile Insurance Plan to issue certain policies; providing for liability; requiring filing of annual audited financial statement; authorizing Commissioner to establish necessary rules; amending 36 O.S. 2011, Section 1116, as amended by Section 18, Chapter 45, O.S.L. 2012 (36 O.S. Supp. 2019, Section 1116), which relates to penalties for failure to remit taxes; removing time limits; amending 36 O.S. 2011, Section 1219, which relates to claims reimbursement or denial; modifying time and manner of claim payment or denial; amending 36 O.S. 2011, Section 1250.7, as amended by Section 7, Chapter 95, O.S.L. 2018 (36 O.S. Supp. 2019, Section 1250.7), which relates to property and casualty claims; modifying time for notice; amending 36 O.S. 2011, Section 1250.8, which relates to motor vehicle total loss or damage claim; providing for electronic payment; amending 36 O.S. 2011, Section 1450, as amended by Section 6, Chapter 294, O.S.L. 2019 (36 O.S. Supp. 2019, Section 1450),

which relates to licensing procedure; modifying time for certain notification; requiring background reports; amending 36 O.S. 2011, Section 2006, as amended by Section 1, Chapter 78, O.S.L. 2014 (36 O.S. Supp. 2019, Section 2006), which relates to the Board of Directors; modifying composition of members; amending 36 O.S. 2011, Section 2023, as amended by Section 2, Chapter 384, O.S.L. 2019 (36 O.S. Supp. 2019, Section 2023), which relates to the Oklahoma Life and Health Insurance Guaranty Association; clarifying terms; amending 36 O.S. 2011, Section 3101, which relates to definitions; modifying definition; amending 36 O.S. 2011, Section 3639.1, as amended by Section 11, Chapter 44, O.S.L. 2012 (36 O.S. Supp. 2019, Section 3639.1), which relates to personal residential insurance; requiring cancellation of personal residential insurance coverage as of date certain; amending 36 O.S. 2011, Section 4103, which relates to schedule of premium rates; deleting exception; amending 36 O.S. 2011, Section 6060.12, which relates to calculation of premium costs; modifying penalty determination; prohibiting change of name of prepaid funeral benefit permit holder; requiring Insurance Commissioner approval; providing for application for change of name; authorizing waiver of approval requirement; authorizing denial of change of name application; providing for issuance of prepaid funeral benefit permit with new name; authorizing Insurance Commissioner to promulgate rules; defining term; providing for dormant captive insurance company to apply for certificate of dormancy; listing requirements for certain dormant captive insurance companies; providing exceptions; requiring certain application prior to issuing insurance policies; providing for revocation of certificate of dormancy; providing for examination; authorizing the Insurance Commissioner to promulgate rules; amending 36 O.S. 2011, Section 6552, which relates to definitions; modifying definition; amending 36 O.S. 2011, Section 6753, as amended by Section 38, Chapter 150, O.S.L. 2012 (36 O.S. Supp. 2019, Section 6753), which relates to home service contracts; modifying financial security deposit; amending 36 O.S. 2011, Section 6904, which relates to issuance of certificates; modifying time frame for issuance of certificate; amending 36 O.S. 2011, Section 6907,

which relates to reasonable standards of quality care and credentialing; modifying applicable agency; amending 36 O.S. 2011, Section 6911, which relates to grievance procedures; modifying applicable agency; amending 36 O.S. 2011, Section 6919, which relates to examination of affairs, programs, books and records; modifying applicable agency; amending 36 O.S. 2011, Section 6920, which relates to suspension or revocation of a certificate of authority; modifying applicable agency; amending 36 O.S. 2011, Section 6929, which relates to contracts with qualified persons; modifying applicable agency; 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 311.4, as amended by Section 1, Chapter 275, O.S.L. 2014 (36 O.S. Supp. 2019, Section 311.4), is amended to read as follows:

Section 311.4 A. Insurers authorized to do business under the provisions of the Oklahoma Insurance Code shall annually file with the Insurance Commissioner market conduct annual statements reporting market conduct data of insurers on the thirty-first day of December of the previous year. The statements shall report on the lines of insurance and be in such general form and context as approved by the National Association of Insurance Commissioners (NAIC), and as supplemented for additional information required by the Insurance Commissioner by rule. The statements shall be prepared in accordance with NAIC instructions, including any supplemental filings described in the NAIC instructions. If no

forms or instructions are available from the National Association of Insurance Commissioners, the statements shall be in the form and pursuant to instructions as provided by the Insurance Commissioner. Insurers not authorized by the Insurance Commissioner to provide the lines of insurance approved by the National Association or the Insurance Commissioner shall not be required to file market conduct annual statements. For good cause shown, the Insurance Commissioner may extend the time within which market conduct annual statements may be filed. The Insurance Commissioner may provide copies of market conduct annual statements, amendments, and addendums to such statements and market conduct data taken from such statements to the National Association of Insurance Commissioners only if, prior to sharing of the market conduct annual statements, amendments, addendums to such statements or market conduct data taken from such statements, the National Association of Insurance Commissioners enters into a written agreement with the Insurance Commissioner to maintain the confidentiality of the shared information.

B. The Insurance Commissioner may adopt rules implementing this section including rules that:

1. Add lines of insurance to be reported in market conduct annual statements; and

2. Require the filing of market conduct annual statements and any amendments and addendums to such statements with the National

Association of Insurance Commissioners, and the payment of applicable filing fees required by the NAIC.

C. Insurers shall pay a filing fee of Two Hundred Dollars ($200.00) to the Insurance Commissioner for the filing of the market conduct annual statement.

D. No waiver of an applicable privilege or claim of confidentiality in the documents, materials, or other information shall occur as a result of disclosure to the Insurance Commissioner or the Commissioner's designee under this section or as a result of sharing the documents, materials or other information as provided in this section.

E. Market conduct annual statements and any amendments and addendums to such statements, filed with the Insurance Commissioner pursuant to this section in electronic format or otherwise, shall be treated as working papers and documents as set out in subsection F of Section 309.4 of this title.

F. The Insurance Commissioner may use market conduct annual statements or amendments or addendums to such statements to assist in determining whether a market conduct examination or investigation of an insurer should be conducted. For purposes of completing a market conduct examination of any company under Sections 309.1 through 309.7 of this title, the Insurance Commissioner may, in the sole discretion of the Insurance Commissioner, use market conduct annual statements or amendments or addendums to such statements to

assist in determining compliance with the laws of this state and rules adopted by the Insurance Commissioner.

G. For any violation of this section, the Insurance Commissioner may, after notice and opportunity for a hearing, subject an insurer to a civil penalty of up to One Thousand Dollars ($1,000.00) for each occurrence. Such civil penalty may be enforced in the same manner in which civil judgments may be enforced.

SECTION 2. AMENDATORY 36 O.S. 2011, Section 615.2, is amended to read as follows:

Section 615.2 All domestic insurers and health maintenance organizations are required to keep biographical information current. Domestic insurers and health maintenance organizations are required to provide Biographical Affidavits within thirty (30) days of any change in officers, directors, key management or any person acquiring ten percent (10%) or more controlling interest in a domestic insurer. The information shall be on the National Association of Insurance Commissioners (NAIC) UCAA Biographical Affidavit Form. The Biographical Affidavit is to be certified by an independent third party acceptable to the Insurance Commissioner that has conducted a comprehensive review of the background of the applicant and has indicated that the Biographical Affidavit has no significantly inaccurate or conflicting information and is accepted as the Business Character Report. As used in this section, "independent third party" is one that has no affiliation with the

applicant and is in the business of providing background checks or investigations. The Business Character Report must be current and shall not be older than ~~one (1) year~~ six (6) years.

SECTION 3. AMENDATORY 36 O.S. 2011, Section 638, is amended to read as follows:

Section 638. Every ~~MEWA~~ Multiple Employer Welfare Arrangement shall comply with Articles 15 through 19 and Sections ~~308~~ 309.1 through ~~310~~ 309.7, 311.1 and 619 of ~~Title 36 of the Oklahoma Statutes~~ this title which pertain to examinations, deposits and solvency regulation.

SECTION 4. AMENDATORY 36 O.S. 2011, Section 996, is amended to read as follows:

Section 996. Assigned Risks.

A. Agreements may be made among insurers with respect to the equitable apportionment among them of costs for insurance which may be afforded applicants who are in good faith entitled to, but who are unable to procure such insurance through ordinary methods, and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements and rate modifications to be subject to the approval of the Insurance Commissioner. ~~Nothing in the Property and Casualty Competitive Loss Cost Rating Act shall permit disapproval of a residual market plan permitting an insurer to elect voluntary direct assignment.~~

B. The Oklahoma Automobile Insurance Plan is authorized to issue policies of insurance in the name of the plan, for the applicants described in subsection A of this section, and to act on behalf of all participating members in connection with said policies. Said policies shall be considered proof of financial responsibility in accordance with Section 7-600 of the Highway Safety Code.

C. The participating members shall be liable to the Plan for all costs, expenses and liabilities in proportion to its share of voluntary private passenger premium in the state.

D. The plan shall file an annual audited financial statement with the Commissioner.

E. The Commissioner is authorized to establish rules and regulations required to implement the purposes of this section.

SECTION 5. AMENDATORY 36 O.S. 2011, Section 1116, as amended by Section 18, Chapter 45, O.S.L. 2012 (36 O.S. Supp. 2019, Section 1116), is amended to read as follows:

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

Commissioner may request the Attorney General to appear in the name of the state by relation of the Commissioner.

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

SECTION 6. AMENDATORY 36 O.S. 2011, Section 1219, is amended to read as follows:

Section 1219. A. In the administration, servicing, or processing of any accident and health insurance policy, every insurer shall reimburse all clean claims of an insured, an assignee of the insured, or a health care provider within forty-five (45)

calendar days after receipt of ~~the~~ a paper claim and thirty (30) calendar days after receipt of an electronic claim by the insurer.

B. As used in this section:

1. "Accident and health insurance policy" or "policy" means any policy, certificate, contract, agreement or other instrument that provides accident and health insurance, as defined in Section 703 of this title, to any person in this state, and any subscriber certificate or any evidence of coverage issued by a health maintenance organization to any person in this state;

2. "Clean claim" means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt payment; and

3. "Insurer" means any entity that provides an accident and health insurance policy in this state, including, but not limited to, a licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a health maintenance organization, a fraternal benefit society, a multiple employer welfare arrangement, or any other entity subject to regulation by the Insurance Commissioner.

C. If a claim or any portion of a claim is determined to have defects or improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment, the insured, enrollee or subscriber, assignee of

the insured, enrollee or subscriber, and health care provider shall be notified in writing within thirty (30) calendar days after receipt of the claim by the insurer. The written notice shall specify the portion of the claim that is causing a delay in processing and explain any additional information or corrections needed. Failure of an insurer to provide the insured, enrollee or subscriber, assignee of the insured, enrollee or subscriber, and health care provider with the notice shall constitute prima facie evidence that the claim will be paid in accordance with the terms of the policy. Provided, if a claim is not submitted into the system due to a failure to meet basic Electronic Data Interchange (EDI) and/or Health Insurance Portability and Accountability Act (HIPAA) edits, electronic notification of the failure to the submitter shall be deemed compliance with this subsection. Provided further, health maintenance organizations shall not be required to notify the insured, enrollee or subscriber, or assignee of the insured, enrollee or subscriber of any claim defect or impropriety.

D. Upon receipt of the additional information or corrections which led to the claim's being delayed and a determination that the information is accurate, an insurer shall either pay or deny the claim or a portion of the claim within forty-five (45) calendar days <u>for a paper claim and thirty (30) calendar days for an electronic claim</u>.

E. Payment shall be considered made on:

1. The date a draft or other valid instrument which is equivalent to the amount of the payment is placed in the United States mail in a properly addressed, postpaid envelope; or

2. If not so posted, the date of delivery.

F. An overdue payment shall bear simple interest at the rate of ten percent (10%) per year.

G. In the event litigation should ensue based upon such a claim, the prevailing party shall be entitled to recover a reasonable attorney fee to be set by the court and taxed as costs against the party or parties who do not prevail.

H. The Insurance Commissioner shall develop a standardized prompt pay form for use by providers in reporting violations of prompt pay requirements. The form shall include a requirement that documentation of the reason for the delay in payment or documentation of proof of payment must be provided within ten (10) days of the filing of the form. The Commissioner shall provide the form to health maintenance organizations and providers.

I. The provisions of this section shall not apply to the Oklahoma Life and Health Insurance Guaranty Association or to the Oklahoma Property and Casualty Insurance Guaranty Association.

SECTION 7. AMENDATORY 36 O.S. 2011, Section 1250.7, as amended by Section 7, Chapter 95, O.S.L. 2018 (36 O.S. Supp. 2019, Section 1250.7), is amended to read as follows:

Section 1250.7 A. Within sixty (60) days after receipt by a property and casualty insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer, or if further investigation is necessary. No property and casualty insurer shall deny a claim because of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. A denial shall be given to any claimant in writing, and the claim file of the property and casualty insurer shall contain a copy of the denial. If there is a reasonable basis supported by specific information available for review by the Commissioner that the first party claimant has fraudulently caused or contributed to the loss, a property and casualty insurer shall be relieved from the requirements of this subsection. In the event of a weather-related catastrophe or a major natural disaster, as declared by the Governor, the Insurance Commissioner may extend the deadline imposed under this subsection an additional twenty (20) days.

B. If a claim is denied for reasons other than those described in subsection A of this section, and is made by any other means than writing, an appropriate notation shall be made in the claim file of the property and casualty insurer until such time as a written confirmation can be made.

C. Every property and casualty insurer shall complete investigation of a claim within sixty (60) days after notification of proof of loss unless such investigation cannot reasonably be completed within such time. If such investigation cannot be completed, or if a property and casualty insurer needs more time to determine whether a claim should be accepted or denied, it shall so notify the claimant within sixty (60) days after receipt of the proofs of loss, giving reasons why more time is needed. If the investigation remains incomplete, a property and casualty insurer shall, within sixty (60) days from the date of the initial notification, send to such claimant a letter setting forth the reasons additional time is needed for investigation. Except for an investigation of possible fraud or arson which is supported by specific information giving a reasonable basis for the investigation, the time for investigation shall not exceed one hundred twenty (120) days after receipt of proof of loss. Provided, in the event of a weather-related catastrophe or a major natural disaster, as declared by the Governor, the Insurance Commissioner may extend this deadline for investigation an additional twenty (20) days.

D. Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

E. Insurers shall not continue or delay negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney, for a length of time which causes the claimant's rights to be affected by a statute of limitations, or a policy or contract time limit, without giving the claimant written notice that the time limit is expiring and may affect the claimant's rights. Such notice shall be given to first party claimants not more than ninety (90) days and not less than thirty (30) days, and to third party claimants not more than ninety (90) days and not less than sixty (60) days, before the date on which such time limit may expire.

F. No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying a third party claimant of the provision of a statute of limitations.

G. If a lawsuit on the claim is initiated, the time limits provided for in this section shall not apply.

SECTION 8. AMENDATORY 36 O.S. 2011, Section 1250.8, is amended to read as follows:

Section 1250.8 A. If an insurance policy or insurance contract provides for the adjustment and settlement of first party motor vehicle total losses, on the basis of actual cash value or

replacement with another of like kind and quality, one of the following methods shall apply:

1. An insurer may elect to offer a replacement motor vehicle which is a specific comparable motor vehicle available to the insured, with all applicable taxes, license fees, and other fees incident to the transfer of evidence of ownership of the motor vehicle paid, at no cost to the insured other than any deductible provided in the policy. The offer and any rejection thereof shall be documented in the claim file; or

2. An insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable motor vehicle, including all applicable taxes, license fees and other fees incident to a transfer of evidence of ownership, or a comparable motor vehicle. Such cost may be determined by:

a. the cost of a comparable motor vehicle in the local market area when a comparable motor vehicle is currently or recently available in the prior ninety (90) days in the local market area,

b. one of two or more quotations obtained by an insurer from two or more qualified dealers located within the local market area when a comparable motor vehicle is not available in the local market area, or

c. the cost of a comparable motor vehicle as quoted in the latest edition of the National Automobile Dealers

Association Official Used Car Guide or monthly edition of any other nationally recognized published guidebook.

B. If a first party motor vehicle total loss is settled on a basis which deviates from the methods described in subsection A of this section, the deviation shall be supported by documentation giving particulars of the condition of the motor vehicle. Any deductions from such cost, including, but not limited to, deduction for salvage, shall be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to a first party claimant.

C. If liability for motor vehicle damages is reasonably clear, insurers shall not recommend that third party claimants make claims pursuant to the third party claimants' own policies solely to avoid paying claims pursuant to such insurer's insurance policy or insurance contract.

D. Insurers shall not require a claimant to travel unreasonably either to inspect a replacement motor vehicle, obtain a repair estimate or have the motor vehicle repaired at a specific repair shop.

E. Insurers shall, upon the request of a claimant, include the deductible of a first party claimant, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate

basis with a first party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses shall be made from a deductible recovery unless an outside attorney is retained to collect such recovery. The deduction shall then be made for only a pro rata share of the allocated loss adjustment expense.

F. If an insurer prepares an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it reasonably may be expected that the damage can be repaired satisfactorily. An insurer shall give a copy of an estimate to a claimant and may furnish to the claimant the names of one or more conveniently located repair shops, if requested by the claimant.

G. If an amount claimed is reduced because of betterment or depreciation, all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

H. An insurer or its representative shall not require a claimant to obtain motor vehicle repairs at a specific repair facility. An insurer or its representative shall not require a claimant to obtain motor vehicle glass repair or replacement at a specific motor vehicle glass repair or replacement facility. An insurer shall fully and promptly pay for the cost of the motor vehicle repair services or products, less any applicable deductible amount payable according to the terms of the policy. The claimant

shall be furnished an itemized priced statement of repairs by the repair facility at the time of acceptance of the repaired motor vehicle. Unless a cash settlement is made, if a claimant selects a motor vehicle repair or motor vehicle glass repair or replacement facility, the insurer shall provide payment to the facility or claimant based on a competitive price, as established by that insurer through market surveys or by the insured through competitive bids at the insured's option, to determine a fair and reasonable market price for similar services. Reasonable deviation from this market price is allowed based on the facts in each case.

I. An insurer shall not use as a basis for cash settlement with a first party claimant an amount which is less than the amount which an insurer would pay if repairs were made, other than in total loss situations, unless such amount is agreed to by the insured.

J. An insurer shall not force a claimant to execute a full settlement release in order to settle a property damage claim involving a personal injury.

K. All payment or satisfaction of a claim for a motor vehicle which has been transferred by title to the insurer shall be paid by check ~~or~~, draft or electronic payment, payable on demand.

L. In the event of payment of a total loss to a third party claimant, the insurer shall include any registered lienholder as copayee to the extent of the lienholder's interest.

M. As used in this section, "total loss" means that the vehicle repair costs plus the salvage value of the vehicle meets or exceeds the actual cash value of the motor vehicle prior to the loss, as provided in used automobile dealer guidebooks.

N. An insurer shall not offer a cash settlement as provided in paragraph 2 of subsection A of this section for the purchase of a comparable motor vehicle and then subsequently sell the motor vehicle which has been determined to be a total loss back to the claimant if the insurer has determined that the repair of the vehicle would not result in the vehicle being restored to operative condition as provided in Section 1111 of Title 47 of the Oklahoma Statutes unless the claimant specifies in writing or via an electronic signature that the claimant understands that the motor vehicle shall be titled as a "junked vehicle".

SECTION 9. AMENDATORY 36 O.S. 2011, Section 1450, as amended by Section 6, Chapter 294, O.S.L. 2019 (36 O.S. Supp. 2019, Section 1450), is amended to read as follows:

Section 1450. A. No person shall act as or present himself or herself to be an administrator, as defined by the provisions of the Third-party Administrator Act, in this state, unless the person holds a valid license as an administrator which is issued by the Insurance Commissioner.

B. An administrator shall not be eligible for a nonresident administrator license under this section if the administrator does

not hold a home state certificate of authority or license in a state that has adopted the Third-party Administrator Act or that applies substantially similar provisions as are contained in the Third-party Administrator Act to that administrator. If the Third-party Administrator Act in the administrator's home state does not extend to stop-loss insurance, but if the home state otherwise applies substantially similar provisions as are contained in the Third-party Administrator Act to that administrator, then that omission shall not operate to disqualify the administrator from receiving a nonresident administrator license in this state.

1. "Home state" means the United States jurisdiction that has adopted the Third-party Administrator Act or a substantially similar law governing third-party administrators and which has been designated by the administrator as its principal regulator. The administrator may designate either its state of incorporation or its principal place of business within the United States if that jurisdiction has adopted the Third-party Administrator Act or a substantially similar law governing third-party administrators. If neither the administrator's state of incorporation nor its principal place of business within the United States has adopted the Third-party Administrator Act or a substantially similar law governing third-party administrators, then the third-party administrator shall designate a United States jurisdiction in which it does business and which has adopted the Third-party Administrator Act or a

substantially similar law governing third-party administrators. For purposes of this ~~definition~~ paragraph, "United States jurisdiction" means the District of Columbia or a state or territory of the United States.

2. "Nonresident administrator" means a person who is applying for licensure or is licensed in any state other than the administrator's home state.

C. In the case of a partnership which has been licensed, each general partner shall be ~~named in the license~~ licensed and shall qualify therefore as though an individual licensee. The Commissioner shall charge a full additional license fee and a separate license shall be issued for each individual so named in such a license. The partnership shall notify the Commissioner within ~~fifteen (15)~~ thirty (30) days if any individual licensed on its behalf has been terminated, or is no longer associated with or employed by the partnership. Any ~~entity or partnership~~ person making application as an administrator or currently licensed as ~~administrators~~ an administrator under the Third-party Administrators Act shall provide a National Association of Insurance Commissioner (NAIC) Biographical ~~Affidavits~~ Affidavit and a comprehensive review of the background report by an independent third-party NAIC-approved vendor as required for domestic insurers pursuant to the insurance laws of this state.

D. An application for an administrator's license shall be in a form prescribed by the Commissioner and shall be accompanied by a fee of One Hundred Dollars ($100.00). This fee shall not be refundable if the application is denied or refused for any reason by either the applicant or the Commissioner.

E. The administrator's license shall continue in force no longer than twelve (12) months from the original month of issuance. Upon filing a renewal form prescribed by the Commissioner, accompanied by a fee of One Hundred Dollars ($100.00), the license may be renewed annually for a one-year term. Late application for renewal of a license shall require a fee of double the amount of the original license fee. The administrator shall submit, together with the application for renewal, a list of the names and addresses of the persons with whom the administrator has contracted in accordance with Section 1443 of this title. The Commissioner shall hold this information confidential except as provided in Section 1443 of this title.

F. 1. The administrator's license shall be issued or renewed by the Commissioner unless, after notice and opportunity for hearing, the Commissioner determines that the administrator is not competent, trustworthy, or financially responsible, or has had any insurance license denied for cause by any state, has been convicted or has pleaded guilty or nolo contendere to any felony or to a misdemeanor involving moral turpitude or dishonesty.

2. The administrator shall report to the Insurance Commissioner any administrative or criminal action taken against the administrator in another jurisdiction or by another governmental agency in this state within thirty (30) calendar days of the final disposition of the matter. This report shall include a copy of the order, consent to order, copy of any payment required as a result of the administrative or criminal action, or other relevant legal documents.

3. Any entity making application to the Oklahoma Insurance Department as a third party administrator (TPA) or within thirty (30) days of a change for a licensed TPA shall provide current National Association of Insurance Commissioners (NAIC) Biographical Affidavits and independent third-party background reports from a NAIC-approved vendor on behalf of all officers, directors and key managerial personnel of the TPA, and individuals with a ten percent (10%) or more beneficial ownership in the TPA and the TPA's ultimate controlling person (affiant) as required for insurers pursuant to the laws of this state.

G. After notice and opportunity for hearing, and upon determining that the administrator has violated any of the provisions of the Oklahoma Insurance Code or upon finding reasons for which the issuance or nonrenewal of such license could have been denied, the Commissioner may either suspend or revoke an administrator's license or assess a civil penalty of not more than

Five Thousand Dollars ($5,000.00) for each occurrence. The payment of the penalty may be enforced in the same manner as civil judgments may be enforced.

H. Any person who is acting as or presenting himself or herself to be an administrator without a valid license shall be subject, upon conviction, to a fine of not less than One Thousand Dollars ($1,000.00) nor more than Ten Thousand Dollars ($10,000.00) for each occurrence. This fine shall be in addition to any other penalties which may be imposed for violations of the Oklahoma Insurance Code or other laws of this state.

I. Except as provided for in subsections F and G of this section, any person convicted of violating any provisions of the Third-party Administrator Act shall be guilty of a misdemeanor and shall be subject to a fine of not more than One Thousand Dollars ($1,000.00).

SECTION 10. AMENDATORY 36 O.S. 2011, Section 2006, as amended by Section 1, Chapter 78, O.S.L. 2014 (36 O.S. Supp. 2019, Section 2006), is amended to read as follows:

Section 2006. A. The business and functions of the Oklahoma Property and Casualty Insurance Guaranty Association shall be managed and administered by a board of twelve (12) directors composed of ~~two members selected by the American Insurance Association who are member insurers; at the expiration of the terms of the members selected by the Alliance of American Insurers who are~~

~~serving on November 1, 2014, two members selected by the Property and Casualty Insurers Association of America who are member insurers; at the expiration of the terms of the members selected by the National Association of Independent Insurers who are serving on November 1, 2014, two members selected by the National Association of Mutual Insurance Companies who are member insurers; two Oklahoma domestic insurers who are member insurers; two nonaffiliated foreign or alien insurers who are member insurers; two insurance agents who shall serve as ex officio members on the board~~ domestic, foreign and alien insurers who are member insurers, including a minimum of two domestic insurers, and two insurance agents who shall serve as ex officio members. In determining candidates to fill the member insurer positions, the board shall consider whether all insurers are fairly represented, including workers' compensation insurers and other property and casualty insurers. One of the ex officio members shall be the Executive Director of the Independent Insurance Agents of Oklahoma, Inc.; the other ex officio member shall be a licensed, resident property and casualty insurance agent chosen by the Governor. Each member of the board of directors shall designate a full-time salaried employee to represent it on the board of directors. Each member except for the ex officio members shall serve for a term of two (2) years. The ex officio member who is appointed by the Governor shall serve at the pleasure of the Governor. Each appointed member insurer representative may

designate an alternate representative to represent the insurer at any meeting of the board. Any person serving as an alternate representative shall, while serving, have all the powers and responsibilities of the appointed insurer representative. The members of the board of directors except for the ex officio members shall be subject to approval by the Insurance Commissioner. Vacancies on the board except for the ex officio members shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the Commissioner. ~~If no members are selected and appointed within sixty (60) days after the effective date of this act, the Commissioner may appoint the initial members of the board of directors.~~

B. In approving selections to the board, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

C. Members of the board shall serve without compensation but may be reimbursed from the assets of the Association for expenses incurred by them as members of the board of directors.

SECTION 11. AMENDATORY 36 O.S. 2011, Section 2023, as amended by Section 2, Chapter 384, O.S.L. 2019 (36 O.S. Supp. 2019, Section 2023), is amended to read as follows:

Section 2023. A. There is created a nonprofit legal entity to be known as the Oklahoma Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the

Association as a condition of their authority to transact insurance ~~as a~~ or health maintenance organization business in this state.

B. The Association shall perform its functions under a plan of operation established and approved in accordance with this act and shall exercise its powers through the Board of Directors established in this act. For purposes of administration and assessment, the Association shall maintain three accounts:

1. The health account;

2. The life insurance account; and

3. The annuity account.

C. The Association shall come under the immediate supervision of the Insurance Commissioner and shall be subject to the applicable provisions of the insurance laws of this state.

SECTION 12. AMENDATORY 36 O.S. 2011, Section 3101, is amended to read as follows:

Section 3101. ~~The words and phrases as~~ As used in this act~~, unless a different meaning is plainly required by the context, shall have the following meanings~~:

1. "Commissioner" means the Commissioner of Insurance, his or her assistants or deputies, or other persons authorized to act for him~~.~~ or her;

2. "Company" means any person, firm, copartnership, company, association or corporation engaged in selling, furnishing or

procuring, either as principal or agent, for a consideration, motor club service~~.~~;

3. "Agent" means a limited insurance representative who solicits the purchase of service contracts or transmits for another any such contract, or application therefor, to or from the company, or acts or aids in any manner in the delivery or negotiation of any such contract, or in the renewal or continuance thereof. This, however, shall not include any person performing only work of a clerical nature in the office of the motor club~~.~~;

4. "Towing service" means any act by a company which consists of towing or moving a motor vehicle from one place to another under other than its own power~~.~~;

5. "Emergency road service" means any act by a company to adjust, repair or replace the equipment, tires or mechanical parts of a motor vehicle so it may operate under its own power; or reimbursement of expenses incurred by a member when his or her motor vehicle is unable to operate under its own power~~.~~;

6. "Insurance service" means any act to sell or give to the holder of a service contract or as a result of membership in or affiliation with a company a policy of insurance covering the holder for liability or loss for personal injury or property damage resulting from the ownership, maintenance, operation or use of a motor vehicle~~.~~;

7. "Bail bond service" means any act by a company to furnish or procure a cash deposit, bond or other undertaking required by law for any person accused of a law violation of this state, pending ~~the~~ trial~~.~~;

8. "Discount service" means any act by a company resulting in special discounts, rebates or reductions of price on gasoline, oil, repairs, insurance, parts, accessories or service for motor vehicles to holders of service contracts~~.~~;

9. "Financial service" means any act by a company to loan or otherwise advance monies, with or without security, to a service contract holder~~.~~;

10. "Buying and selling service" means any act by a company to aid the holder of a service contract in the purchase or sale of an automobile~~.~~;

11. "Theft service" means any act by a company to locate, identify or recover a stolen or missing motor vehicle owned or controlled by the holder of a service contract or to detect or apprehend the person guilty of such theft~~.~~;

12. "Map service" means any act by a company to furnish road maps without cost to holders of service contracts~~.~~;

13. "Touring service" means any act by a company to furnish touring information without cost to holders of service contracts~~.~~;

14. "Legal service" means any act by a company to furnish to a service contract holder, without cost, the services of an attorney~~.~~;

15. "Motor club service" means the rendering, furnishing or procuring of, or reimbursement for, towing service, emergency road service, insurance service, bail bond service, legal service, discount service, financial service, buying and selling service, theft service, map service, touring service, or any three or more thereof, to any person, in connection with the ownership, operation, use or maintenance of a motor vehicle by such person, that has membership, for consideration.; and

16. "Service contract" means any written agreement whereby any company, for a consideration, promises to render, furnish or procure for any person motor club service.

SECTION 13. AMENDATORY 36 O.S. 2011, Section 3639.1, as amended by Section 11, Chapter 44, O.S.L. 2012 (36 O.S. Supp. 2019, 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 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.

C. An insurer shall make the cancellation of a homeowner's insurance policy or any other personal residential insurance coverage effective as of the date of new coverage inception if the new coverage was obtained for the purpose of replacing the policy.

SECTION 14. AMENDATORY 36 O.S. 2011, Section 4103, is amended to read as follows:

Section 4103. No policy of group life insurance shall be delivered in this state ~~unless a schedule of the premium rates pertaining to the form thereof is filed with the Insurance Commissioner and~~ unless it contains in substance the following provisions, or provisions which are more favorable to the persons insured, or at least as favorable to the persons insured and more favorable to the policyholder~~,~~; provided, however, (a) that ~~provisions six (6) to ten (10) inclusive~~ paragraphs 6 through 10 shall not apply to policies issued to a creditor to insure debtors

of such creditor; (b) that the standard provisions required for individual life insurance policies shall not apply to group life insurance policies; and (c) that if the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which is or are equitable to the insured persons and to the policyholder, but nothing herein shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies:

1. A provision that the policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period~~.~~;

2. A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two (2) years from its date of issue~~;~~, and that no statement made by any person insured under the policy relating to his or her insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after

such insurance has been in force prior to the contest for a period of two (2) years during such person's lifetime nor unless it is contained in a written instrument signed by him~~.~~ or her;

3. A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or to his or her beneficiary~~.~~;

4. A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his or her coverage~~.~~;

5. A provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be used~~.~~;

6. A provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the person insured, subject to the provisions of the policy in the event there is no designated beneficiary as to all or any part of such sum, living at the death of the person insured, and subject

to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding Five Hundred Dollars ($500.00) to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured~~.~~;

7. A provision that the insurer will issue to the policyholder for delivery to each person insured an individual certificate setting forth a statement as to the insurance protection to which he is entitled, to whom the insurance benefits are payable, and the rights and conditions set forth in paragraphs ~~(8)~~, ~~(9)~~ and ~~(10)~~ of this section~~:~~.

8. A provision that if the insurance, or any portion of it, on a person covered under the policy ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, such person shall be entitled to have issued to him or her by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, provided an application for the individual policy shall be made, and the first premium paid to the insurer, within thirty-one (31) days after such termination, and provided further that: ~~(a)~~

a. the individual policy shall, at the option of such person, be on any one of the forms, except term

insurance, then customarily issued by the insurer at the age and for the amount applied for~~;~~, ~~(b)~~

b. the individual policy shall be in an amount not in excess of the amount of life insurance which ceases because of such termination, less, in the case of a person whose membership in the class or classes eligible for coverage terminates but who continues in employment in another class, the amount of any life insurance for which such person is or becomes eligible within thirty-one (31) days after such termination under any other group policy; provided that any amount of insurance which shall have matured on or before the date of such termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this ~~provision~~ subparagraph, be included in the amount which is considered to cease because of such termination~~;~~, and ~~(c)~~

c. the premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to his or her age attained on the effective date of the individual policy~~.~~;

9. A provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured thereunder at the date of such termination whose insurance terminates and who has been so insured for at least five (5) years prior to such termination date shall be entitled to have issued to him or her by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by paragraph ~~(~~8~~)~~ of this section, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of: ~~(a)~~

a. the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he or she is or becomes eligible under any group policy issued or reinstated by the same or another insurer within thirty-one (31) days after such termination, and ~~(b)~~

b. Ten Thousand Dollars ($10,000.00)~~.~~;

10. A provision that if a person insured under the group policy dies during the period within which he would have been entitled to have an individual policy issued to him or her in accordance with paragraph ~~(~~8~~)~~ or ~~(~~9~~)~~ of this section and before such an individual policy shall have become effective, the amount of life insurance which he would have been entitled to have issued to him or her under

such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made~~.~~; and

11. In the case of a policy issued to a creditor to insure debtors of such creditor, a provision that the insurer will furnish to the policyholder for delivery to each debtor insured under the policy a form which shall contain a statement that the life of the debtor is insured under the policy and that any death benefit paid thereunder by reason of his or her death shall be applied to reduce or extinguish the indebtedness.

SECTION 15. AMENDATORY 36 O.S. 2011, Section 6060.12, is amended to read as follows:

Section 6060.12 ~~A.~~ 1. A health benefit plan that, at the end of its base period, experiences a greater than two percent (2%) increase in premium costs pursuant to providing benefits for treatment of severe mental illness shall be exempt from the provisions of Section ~~2~~ 6060.11 of this ~~act~~ title.

2. To calculate base-period-premium costs, the health benefit plan shall subtract from premium costs incurred during the base period, both the premium costs incurred during the period immediately preceding the base period and any premium cost increases attributable to factors unrelated to benefits for treatment of severe mental illness.

3. a. To claim the exemption provided for in ~~subsection A~~ paragraph 1 of this section a health benefit plan shall provide to the Insurance Commissioner a written request signed by an actuary stating the reasons and actuarial assumptions upon which the request is based.

b. The Commissioner shall verify the information provided and shall approve or disapprove the request within thirty (30) days of receipt.

c. If, upon investigation, the Commissioner finds that any statement of fact in the request is found to be knowingly false, the health benefit plan may be subject to suspension or loss of license or any other penalty as determined by the Commissioner~~, or the State Commissioner of Health~~ with regard to health maintenance organizations.

SECTION 16. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6124.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. No prepaid funeral benefit permit holder shall change the name under which the permit holder operates except as provided in this section. The prepaid funeral benefit permit holder shall obtain approval from the Insurance Commissioner at least thirty (30) days prior to changing the name of the permit holder. The application for change of name of a prepaid funeral benefit permit

holder shall be in a form provided by the Insurance Commissioner and shall contain, at a minimum, the following information:

1. The name of the permit holder;

2. The proposed new name of the permit holder; and

3. The date the name change will become effective.

B. The Insurance Commissioner may waive the approval requirement provided for in subsection A of this section upon good cause shown.

C. The Insurance Commissioner may deny the change of name of the prepaid funeral benefit permit holder upon good cause shown.

D. Upon approval of a change of name, the Insurance Commissioner shall issue a prepaid funeral benefit permit with the new name. The prepaid funeral benefit permit holder shall display in a conspicuous place at all times on the premises of the organization all permits issued pursuant to the provisions of this section. No organization may consent to or allow the use or display of the permit by a person other than the persons authorized to represent the organization in contracting prepaid funeral benefits.

E. The Insurance Commissioner may prescribe rules concerning matters incidental to this section.

SECTION 17. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6470.35 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in this section, "dormant captive insurance company" means a captive insurance company that has:

1. Ceased transacting the business of insurance, including the issuance of insurance policies; and

2. No remaining liabilities associated with insurance business transactions or insurance policies issued prior to the filing of its application for a certificate of dormancy under this section.

B. A dormant captive insurance company domiciled in this state that meets the criteria of subsection A of this section may apply to the Insurance Commissioner for a certificate of dormancy. The certificate of dormancy shall be subject to renewal every five (5) years and shall be forfeited if not renewed within such time.

C. A dormant captive insurance company that has been issued a certificate of dormancy shall:

1. Possess and thereafter maintain unimpaired, paid-in capital and surplus of not less than Twenty-five Thousand Dollars ($25,000.00);

2. Submit on or before March 1 of each year to the Insurance Commissioner a report of its financial condition, verified by an oath of two of its executive officers, in a form prescribed by the Insurance Commissioner; and

3. Pay a nonrefundable renewal fee of Five Hundred Dollars ($500.00).

D. A dormant captive insurance company shall not be subject to or liable for the payment of any tax under Section 19 of this act.

E. A dormant captive insurance company shall apply to the Insurance Commissioner for approval to surrender its certificate of dormancy and resume conducting the business of insurance prior to issuing any insurance policies.

F. A certificate of dormancy shall be revoked if a dormant captive insurance company no longer meets the criteria of subsection A of this section.

G. A dormant captive insurance company may be subject to examination under Section 6470.13 of Title 36 of the Oklahoma Statutes for any year when it did not qualify as a dormant captive insurance company. The Insurance Commissioner may examine a dormant captive insurance company pursuant to Section 6470.13 of Title 36 of the Oklahoma Statutes.

H. The Insurance Commissioner may promulgate and adopt rules and regulations implementing the provisions of this section.

SECTION 18. AMENDATORY 36 O.S. 2011, Section 6552, is amended to read as follows:

Section 6552. As used in the Hospital and Medical Services Utilization Review Act:

1. "Utilization review" means a system for prospectively, concurrently and retrospectively reviewing the appropriate and efficient allocation of hospital resources and medical services

given or proposed to be given to a patient or group of patients. It does not include an insurer's normal claim review process to determine compliance with the specific terms and conditions of the insurance policy;

2. "Private review agent" means a person or entity who performs utilization review on behalf of:

a. an employer in this state, or

b. a third party that provides or administers hospital and medical benefits to citizens of this state, including, but not limited to:

(1) a health maintenance organization issued a license pursuant to Section 2501 et seq. of Title 63 of the Oklahoma Statutes, unless the health maintenance organization is federally regulated and licensed and has on file with the Insurance Commissioner ~~of Health~~ a plan of utilization review carried out by health care professionals and providing for complaint and appellate procedures for claims, or

(2) a health insurer, not-for-profit hospital service or medical plan, health insurance service organization, or preferred provider organization or other entity offering health insurance policies, contracts or benefits in this state;

3. "Utilization review plan" means a description of utilization review procedures;

4. "Commissioner" means the Insurance Commissioner;

5. "Certificate" means a certificate of registration granted by the Insurance Commissioner to a private review agent; and

6. "Health care provider" means any person, firm, corporation or other legal entity that is licensed, certified, or otherwise authorized by the laws of this state to provide health care services, procedures or supplies in the ordinary course of business or practice of a profession.

SECTION 19. AMENDATORY 36 O.S. 2011, Section 6753, as amended by Section 38, Chapter 150, O.S.L. 2012 (36 O.S. Supp. 2019, Section 6753), is amended to read as follows:

Section 6753. A. Home service contracts shall not be issued, sold or offered for sale in this state unless the provider has:

1. Provided a receipt for, or other written evidence of, the purchase of the home service contract to the contract holder; and

2. Provided a copy of the home service contract to the service contract holder within a reasonable period of time from the date of purchase.

B. Each provider of home service contracts sold in this state shall file a registration with, and on a form prescribed by, the Insurance Commissioner consisting of their name, full corporate physical street address, telephone number, contact person and a

designated person in this state for service of process. Each provider shall pay to the Commissioner a fee in the amount of One Thousand Two Hundred Dollars ($1,200.00) upon initial registration and every three (3) years thereafter. Each provider shall pay to the Commissioner an Antifraud Assessment Fee of Two Thousand Two Hundred Fifty Dollars ($2,250.00) upon initial registration and every three (3) years thereafter. The registration need only be updated by written notification to the Commissioner if material changes occur in the registration on file. A proper registration is de facto a license to conduct business in Oklahoma and may be suspended as provided in Section 6755 of this title. Fees received from home service contract providers shall not be subject to any premium tax, but shall be subject to an administrative fee equal to two percent (2%) of the gross fees received on the sale of all home service contracts issued in this state during the preceding calendar quarter. The fees shall be paid quarterly to the Commissioner and submitted along with a report on a form prescribed by the Commissioner. However, service contract providers may elect to pay an annual administrative fee of Three Thousand Dollars ($3,000.00) in lieu of the two-percent administrative fee, if the provider maintains an insurance policy as provided in paragraph 3 of subsection C of this section.

C. In order to assure the faithful performance of a provider's obligations to its contract holders, each provider shall be

responsible for complying with the requirements of paragraph 1, 2 or 3 of this subsection:

1. a. maintain a funded reserve account for its obligations under its contracts issued and outstanding in this state. The reserves shall not be less than forty percent (40%) of gross consideration received, less claims paid, on the sale of the service contract for all in-force contracts. The reserve account shall be subject to examination and review by the Commissioner, and

b. place in trust with the Commissioner a financial security deposit, having a value of not less than five percent (5%) of the gross consideration received, less claims paid, on the sale of the service contract for all service contracts issued and in force, but not less than Twenty-five Thousand Dollars ($25,000.00), consisting of one of the following:

(1) a surety bond issued by an authorized surety,

(2) securities of the type eligible for deposit by authorized insurers in this state,

(3) ~~cash,~~

~~(4)~~ a letter of credit issued by a qualified financial institution, or

~~(5)~~ (4) another form of security prescribed by rule promulgated by the Commissioner;

2. a. maintain, or together with its parent company maintain, a net worth or stockholders' equity of Twenty-five Million Dollars ($25,000,000.00), excluding goodwill, intangible assets, customer lists and affiliated receivables, and

b. upon request, provide the Commissioner with a copy of the provider's or the provider's parent company's most recent Form 10-K or Form 20-F filed with the Securities and Exchange Commission (SEC) within the last calendar year, or if the company does not file with the SEC, a copy of the company's financial statements, which shows a net worth of the provider or its parent company of at least Twenty-five Million Dollars ($25,000,000.00) based upon Generally Accepted Accounting Principles (GAAP) accounting standards. If the provider's parent company's Form 10-K, Form 20-F, or financial statements are filed to meet the provider's financial stability requirement, then the parent company shall agree to guarantee the obligations of the provider relating to service contracts sold by the provider in this state; or

3. Purchase an insurance policy which demonstrates to the satisfaction of the Insurance Commissioner that one hundred percent (100%) of its claim exposure is covered by such policy. The insurance shall be obtained from an insurer that is licensed, registered, or otherwise authorized to do business in this state, that is rated B++ or better by A.M. Best Company, Inc., and that meets the requirements of subsection D of this section. For the purposes of this paragraph, the insurance policy shall contain the following provisions:

a. in the event that the provider is unable to fulfill its obligation under contracts issued in this state for any reason, including insolvency, bankruptcy, or dissolution, the insurer shall pay losses and unearned premiums under such plans directly to the person making the claim under the contract,

b. the insurer issuing the insurance policy shall assume full responsibility for the administration of claims in the event of the inability of the provider to do so, and

c. the policy shall not be canceled or not renewed by either the insurer or the provider unless sixty (60) days' written notice thereof has been given to the Commissioner by the insurer before the date of such cancellation or nonrenewal.

D. The insurer providing the insurance policy used to satisfy the financial responsibility requirements of paragraph 3 of subsection C of this section shall meet one of the following standards:

1. The insurer shall, at the time the policy is filed with the Commissioner, and continuously thereafter:

a. maintain surplus as to policyholders and paid-in capital of at least Fifteen Million Dollars ($15,000,000.00), and

b. annually file copies of the audited financial statements of the insurer, its National Association of Insurance Commissioners (NAIC) Annual Statement, and the actuarial certification required by and filed in the state of domicile of the insurer; or

2. The insurer shall, at the time the policy is filed with the Commissioner, and continuously thereafter:

a. maintain surplus as to policyholders and paid-in capital of less than Fifteen Million Dollars ($15,000,000.00),

b. demonstrate to the satisfaction of the Commissioner that the company maintains a ratio of net written premiums, wherever written, to surplus as to policyholders and paid-in capital of not greater than three to one, and

c. annually file copies of the audited financial statements of the insurer, its NAIC Annual Statement, and the actuarial certification required by and filed in the state of domicile of the insurer.

E. Except for the registration requirements in subsection B of this section, providers, administrators and other persons marketing, selling or offering to sell home service contracts are exempt from any licensing requirements of this state and shall not be subject to other registration information or security requirements. Home service contract providers as defined in Section 6752 of this title and properly registered under this law are exempt from any treatment pursuant to the Service Warranty Act. Home service contract providers applying for registration under the Oklahoma Home Service Contract Act that have not been registered in the preceding twelve (12) months under the Oklahoma Home Service Contract Act may be subject to a thirty-day prior review before their registration is deemed complete. Said applications shall be deemed complete after thirty (30) days unless the Commissioner takes action in that period under Section 6755 of this title, for cause shown, to suspend their registration.

F. The marketing, sale, offering for sale, issuance, making, proposing to make and administration of home service contracts by providers and related service contract sellers, administrators, and

other persons, including but not limited to real estate licensees, shall be exempt from all other provisions of the Insurance Code.

SECTION 20. AMENDATORY 36 O.S. 2011, Section 6904, is amended to read as follows:

Section 6904. A. ~~1.~~ Upon receipt of an application for issuance of a certificate of authority, the Insurance Commissioner shall ~~forthwith transmit copies of such application and accompanying documents to the State Commissioner of Health.~~

~~2. The State Commissioner of Health shall~~ within forty-five (45) days determine whether the applicant ~~for a certificate of authority~~, with respect to health care services to be furnished, has complied with the provisions of Section ~~7~~ 6907 of this ~~act~~ title.

~~3. Within forty-five (45) days of receipt of an application for issuance of a certificate of authority from the Insurance Commissioner, the State Commissioner of Health shall certify to the Insurance Commissioner that the proposed health maintenance organization meets the requirements of Section 7 of this act, or shall notify the Insurance Commissioner that the proposed health maintenance organization does not meet such requirements and shall specify in what respects the applicant is deficient.~~

B. The Insurance Commissioner shall, within forty-five (45) days of ~~receipt of a certification of~~ determining compliance or ~~notice of~~ deficiency ~~from the State Commissioner of Health~~, issue a certificate of authority to a person filing a completed application

upon receipt of the prescribed fees and upon the Insurance Commissioner's being satisfied that:

1. The persons responsible for the conduct of the affairs of the applicant are competent and trustworthy, and possess good reputations;

2. Any deficiency identified ~~by the State Commissioner of Health~~ has been corrected and ~~the State Commissioner of Health has certified to~~ the Insurance Commissioner has determined that the health maintenance organization's proposed plan of operation meets the requirements of Section ~~7~~ 6907 of this ~~act~~ title;

3. The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments or deductibles, or both; and

4. The health maintenance organization is in compliance with the provisions of Sections ~~13~~ 6913 and ~~15~~ 6914 of this ~~act~~ title.

C. A certificate of authority shall be denied only after the Insurance Commissioner complies with the requirements of Section ~~20~~ 6920 of this act title. No other criteria may be used to deny a certificate of authority.

SECTION 21. AMENDATORY 36 O.S. 2011, Section 6907, is amended to read as follows:

Section 6907. A. Every health maintenance organization shall establish procedures that ensure that health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. The procedures shall include mechanisms to assure availability, accessibility and continuity of care.

B. The health maintenance organization shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services and ancillary and preventive health care services across all institutional and noninstitutional settings. The program shall include, but need not be limited to, the following:

1. A written statement of goals and objectives that emphasizes improved health status in evaluating the quality of care rendered to enrollees;

2. A written quality assurance plan that describes the following:

a. the health maintenance organization's scope and purpose in quality assurance,

b. the organizational structure responsible for quality assurance activities,

c. contractual arrangements, where appropriate, for delegation of quality assurance activities,

d. confidentiality policies and procedures,

e. a system of ongoing evaluation activities,

f. a system of focused evaluation activities,

g. a system for credentialing and recredentialing providers, and performing peer review activities, and

h. duties and responsibilities of the designated physician responsible for the quality assurance activities;

3. A written statement describing the system of ongoing quality assurance activities including:

a. problem assessment, identification, selection and study,

b. corrective action, monitoring, evaluation and reassessment, and

c. interpretation and analysis of patterns of care rendered to individual patients by individual providers;

4. A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies method of topic selection, study, data collection, analysis, interpretation and report format; and

5. Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program,

inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

C. The organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available to the ~~State~~ Insurance Commissioner ~~of Health~~.

D. The organization shall ensure the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization's evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

E. Enrollee clinical records shall be available to the ~~State~~ Insurance Commissioner ~~of Health~~ or an authorized designee for examination and review to ascertain compliance with this section, or as deemed necessary by the ~~State~~ Insurance Commissioner ~~of Health~~.

F. The organization shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

G. The organization shall be required to establish a mechanism under which physicians participating in the plan may provide input into the plan's medical policy including, but not limited to, coverage of new technology and procedures, utilization review

criteria and procedures, quality, credentialing and recredentialing criteria, and medical management procedures.

H. As used in this section "credentialing" or "recredentialing", as applied to physicians and other health care providers, means the process of accessing and validating the qualifications of such persons to provide health care services to the beneficiaries of a health maintenance organization. "Credentialing" or "recredentialing" may include, but need not be limited to, an evaluation of licensure status, education, training, experience, competence and professional judgment. Credentialing or recredentialing is a prerequisite to the final decision of a health maintenance organization to permit initial or continued participation by a physician or other health care provider.

1. Physician credentialing and recredentialing shall be based on criteria as provided in the uniform credentialing application required by Section 1-106.2 of Title 63 of the Oklahoma Statutes, with input from physicians and other health care providers.

2. Organizations shall make information on credentialing and recredentialing criteria available to physician applicants and other health care providers, participating physicians, and other participating health care providers and shall provide applicants with a checklist of materials required in the application process.

3. When economic considerations are part of the credentialing and recredentialing decision, objective criteria shall be used and

shall be available to physician applicants and participating physicians. When graduate medical education is a consideration in the credentialing and recredentialing process, equal recognition shall be given to training programs accredited by the Accrediting Council on Graduate Medical Education and by the American Osteopathic Association. When graduate medical education is considered for optometric physicians, consideration shall be given for educational accreditation by the Council on Optometric Education.

4. Physicians or other health care providers under consideration to provide health care services under a managed care plan in this state shall apply for credentialing and recredentialing on the uniform credentialing application and provide the documentation as outlined by the plan's checklist of materials required in the application process.

5. A health maintenance organization (HMO) shall determine whether a credentialing or recredentialing application is complete. If an application is determined to be incomplete, the plan shall notify the applicant in writing within ten (10) calendar days of receipt of the application. The written notice shall specify the portion of the application that is causing a delay in processing and explain any additional information or corrections needed.

6. In reviewing the application, the health maintenance organization (HMO) shall evaluate each application according to the plan's checklist of materials required in the application process.

7. When an application is deemed complete, the HMO shall initiate requests for primary source verification and malpractice history within seven (7) calendar days.

8. A malpractice carrier shall have twenty-one (21) calendar days within which to respond after receipt of an inquiry from a health maintenance organization (HMO). Any malpractice carrier that fails to respond to an inquiry within the allotted time frame may be assessed an administrative penalty by the ~~State~~ Insurance Commissioner ~~of Health~~.

9. Upon receipt of primary source verification and malpractice history by the HMO, the HMO shall determine if the application is a clean application. If the application is deemed clean, the HMO shall have forty-five (45) calendar days within which to credential or recredential a physician or other health care provider. As used in this paragraph, "clean application" means an application that has no defect, misstatement of facts, improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing or recredentialing.

10. If a health maintenance organization is unable to credential or recredential a physician or other health care provider

due to an application's not being clean, the HMO may extend the credentialing or recredentialing process for sixty (60) calendar days. At the end of sixty (60) calendar days, if the HMO is awaiting documentation to complete the application, the physician or other health care provider shall be notified of the delay by certified mail. The physician or other health care provider may extend the sixty-day period upon written notice to the HMO within ten (10) calendar days; otherwise the application shall be deemed withdrawn.

11. In no event shall the entire credentialing or recredentialing process exceed one hundred eighty (180) calendar days.

12. A health maintenance organization shall be prohibited from solely basing a denial of an application for credentialing or recredentialing on the lack of board certification or board eligibility and from adding new requirements solely for the purpose of delaying an application.

13. Any HMO that violates the provisions of this subsection may be assessed an administrative penalty by the ~~State~~ Insurance Commissioner ~~of Health~~.

I. Health maintenance organizations shall not discriminate against enrollees with expensive medical conditions by excluding practitioners with practices containing a substantial number of these patients.

J. Health maintenance organizations shall, upon request, provide to a physician whose contract is terminated or not renewed for cause the reasons for termination or nonrenewal. Health maintenance organizations shall not contractually prohibit such requests.

K. No HMO shall engage in the practice of medicine or any other profession except as provided by law nor shall an HMO include any provision in a provider contract that precludes or discourages a health maintenance organization's providers from:

1. Informing a patient of the care the patient requires, including treatments or services not provided or reimbursed under the patient's HMO; or

2. Advocating on behalf of a patient before the HMO.

L. Decisions by a health maintenance organization to authorize or deny coverage for an emergency service shall be based on the patient presenting symptoms arising from any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in serious:

1. Jeopardy to the health of the patient;

2. Impairment of bodily function; or

3. Dysfunction of any bodily organ or part.

M. Health maintenance organizations shall not deny an otherwise covered emergency service based solely upon lack of notification to the HMO.

N. Health maintenance organizations shall compensate a provider for patient screening, evaluation, and examination services that are reasonably calculated to assist the provider in determining whether the condition of the patient requires emergency service. If the provider determines that the patient does not require emergency service, coverage for services rendered subsequent to that determination shall be governed by the HMO contract.

O. If within a period of thirty (30) minutes after receiving a request from a hospital emergency department for a specialty consultation, a health maintenance organization fails to identify an appropriate specialist who is available and willing to assume the care of the enrollee, the emergency department may arrange for emergency services by an appropriate specialist that are medically necessary to attain stabilization of an emergency medical condition, and the HMO shall not deny coverage for the services due to lack of prior authorization.

P. The reimbursement policies and patient transfer requirements of a health maintenance organization shall not, directly or indirectly, require a hospital emergency department or provider to violate the federal Emergency Medical Treatment and Active Labor Act. If a member of an HMO is transferred from a hospital emergency

department facility to another medical facility, the HMO shall reimburse the transferring facility and provider for services provided to attain stabilization of the emergency medical condition of the member in accordance with the federal Emergency Medical Treatment and Active Labor Act.

SECTION 22. AMENDATORY 36 O.S. 2011, Section 6911, is amended to read as follows:

Section 6911. A. Every health maintenance organization shall establish and maintain a grievance procedure that has been approved by the Insurance Commissioner~~, after consultation with the State Commissioner of Health,~~ to provide for the resolution of grievances initiated by enrollees. Such grievance procedure shall be approved by the Insurance Commissioner within thirty (30) days of submission. The health maintenance organization shall maintain a record of grievances received since the date of its last examination of grievances.

B. The Insurance Commissioner ~~or the State Commissioner of Health~~ may examine the grievance procedures.

C. Health maintenance organizations shall comply with the requirements of an insurer as set out in Sections 1250.1 through 1250.16 of ~~Title 36 of the Oklahoma Statutes~~ this title.

SECTION 23. AMENDATORY 36 O.S. 2011, Section 6919, is amended to read as follows:

Section 6919. A. The Insurance Commissioner may make an examination of the affairs of any health maintenance organization, producers and providers with whom the organization has contracts, agreements or other arrangements pursuant to the provisions of Sections 309.1 through 309.7 of ~~Title 36 of the Oklahoma Statutes~~ this title.

B. The ~~State~~ Insurance Commissioner ~~of Health~~ may require a health maintenance organization to contract for an examination concerning the quality assurance program of the health maintenance organization and of any providers with whom the organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state, but not less frequently than once every three (3) years.

C. Every health maintenance organization and provider shall submit its books and records for examination and in every way facilitate the completion of an examination. For the purpose of an examination, the Insurance Commissioner ~~and the State Commissioner of Health~~ may administer oaths to, and examine the officers and agents of the health maintenance organization and the principals of the providers concerning their business.

D. Any health maintenance organization examined shall pay the proper charges incurred in such examination, including the actual expense of the Insurance Commissioner ~~or State Commissioner of~~

~~Health~~ or the expenses and compensation of any authorized representative and the expense and compensation of assistants and examiners employed therein. All expenses incurred in such examination shall be verified by affidavit and a copy shall be filed in the office of the Insurance Commissioner ~~or the State Commissioner of Health~~.

E. In lieu of an examination, the Insurance Commissioner ~~or State Commissioner of Health~~ may accept the report of an examination made by the health maintenance organization regulatory entity of another state.

SECTION 24. AMENDATORY 36 O.S. 2011, Section 6920, is amended to read as follows:

Section 6920. A. A certificate of authority issued under the Health Maintenance Organization Act of 2003 may be suspended or revoked, and an application for a certificate of authority may be denied, if the Insurance Commissioner finds that any of the following conditions exist:

1. The health maintenance organization (HMO) is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under Section ~~3~~ 6903 of this ~~act~~ title, unless amendments to those submissions have been filed with and approved by the Insurance Commissioner;

2. The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services that does not comply with the requirements of Sections ~~8~~ 6908 and ~~16~~ 6916 of this ~~act~~ title;

3. The health maintenance organization does not provide or arrange for basic health care services;

4. The ~~State Commissioner of Health certifies to the~~ Insurance Commissioner determines that:

a. the health maintenance organization does not meet the requirements of Section ~~7~~ 6907 of this ~~act~~ title, or

b. the health maintenance organization is unable to fulfill its obligations to furnish health care services;

5. The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

6. The health maintenance organization has failed to correct, within the time frame prescribed by subsection C of this section, any deficiency occurring due to the health maintenance organization's prescribed minimum net worth being impaired;

7. The health maintenance organization has failed to implement the grievance procedures required by Section ~~11~~ 6911 of this ~~act~~ title in a reasonable manner to resolve valid complaints;

8. The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

9. The continued operation of the health maintenance organization would be hazardous to its enrollees or to the public; or

10. The health maintenance organization has otherwise failed to comply with the provisions of the Health Maintenance Organization Act of 2003~~,~~ or applicable rules promulgated by the Insurance Commissioner pursuant thereto~~, or rules promulgated by the State Board of Health pursuant to the provisions of Section 7 of the Health Maintenance Organization Act of 2003~~.

B. In addition to or in lieu of suspension or revocation of a certificate of authority pursuant to the provisions of this section, an applicant or health maintenance organization who knowingly violates the provisions of this section may be subject to an administrative penalty of Five Thousand Dollars ($5,000.00) for each occurrence.

C. The following shall apply when insufficient net worth is maintained:

1. Whenever the Insurance Commissioner finds that the net worth maintained by any health maintenance organization subject to the provisions of this act is less than the minimum net worth required to be maintained by Section ~~13~~ 6913 of this ~~act~~ title, the Insurance

Commissioner shall give written notice to the health maintenance organization of the amount of the deficiency and require filing with the Insurance Commissioner a plan for correction of the deficiency that is acceptable to the Insurance Commissioner, and correction of the deficiency within a reasonable time, not to exceed sixty (60) days, unless an extension of time, not to exceed sixty (60) additional days, is granted by the Insurance Commissioner. A deficiency shall be deemed an impairment, and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the certificate of authority or for placing the health maintenance organization in conservation, rehabilitation or liquidation; or

2. Unless allowed by the Insurance Commissioner, no health maintenance organization or person acting on its behalf may, directly or indirectly, renew, issue or deliver any certificate, agreement or contract of coverage in this state, for which a premium is charged or collected, when the health maintenance organization writing the coverage is impaired, and the fact of impairment is known to the health maintenance organization or to the person; provided, however, the existence of an impairment shall not prevent the issuance or renewal of a certificate, agreement or contract when the enrollee exercises an option granted under the plan to obtain a new, renewed or converted coverage.

D. A certificate of authority shall be suspended or revoked or an application or a certificate of authority denied or an administrative penalty imposed only after compliance with the requirements of this section.

1. Suspension or revocation of a certificate of authority, denial of an application, or imposition of an administrative penalty by the Insurance Commissioner, pursuant to the provisions of this section, shall be by written order and shall be sent to the health maintenance organization or applicant by certified or registered mail ~~and to the State Commissioner of Health~~. The written order shall state the grounds, charges or conduct on which the suspension, revocation or denial or administrative penalty is based. The health maintenance organization or applicant may, in writing, request a hearing within thirty (30) days from the date of mailing of the order. If no written request is made, the order shall be final upon the expiration of thirty (30) days.

2. If the health maintenance organization or applicant requests a hearing pursuant to the provisions of this section, the Insurance Commissioner shall issue a written notice of hearing and send such notice to the health maintenance organization or applicant by certified or registered mail ~~and to the State Commissioner of Health~~ stating:

a. a specific time for the hearing, which may not be less than twenty (20) nor more than thirty (30) days after mailing of the notice of hearing, and

b. that any hearing shall be held at the office of the Insurance Commissioner.

~~If a hearing is requested, the State Commissioner of Health or a designee shall be in attendance and shall participate in the proceedings. The recommendations and findings of the State Commissioner of Health with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension or revocation of a certificate of authority, shall be conclusive and binding upon the Insurance Commissioner.~~ After the hearing, or upon failure of the health maintenance organization to appear at the hearing, the Insurance Commissioner shall take whatever action is deemed necessary based on written findings. The Insurance Commissioner shall mail the decision to the health maintenance organization or applicant ~~and a copy to the State Commissioner of Health~~.

E. The provisions of the Administrative Procedures Act shall apply to proceedings under this section to the extent they are not in conflict with the provisions of Section 313 of ~~Title 36 of the Oklahoma Statutes~~ this title.

F. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall

not, during the period of suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

G. If the certificate of authority of a health maintenance organization is revoked, the HMO shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. The HMO shall engage in no further advertising or solicitation whatsoever. The Insurance Commissioner may, by written order, permit further operation of the HMO if found to be in the best interests of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

SECTION 25. AMENDATORY 36 O.S. 2011, Section 6929, is amended to read as follows:

Section 6929. The ~~State~~ Insurance Commissioner ~~of Health~~, in carrying out his or her obligations under the Health Maintenance Organization Act of 2003, may contract with qualified persons to make recommendations concerning the determinations required to be made by the ~~State~~ Insurance Commissioner ~~of Health~~. The recommendations may be accepted in full or in part by the ~~State~~ Insurance Commissioner ~~of Health~~. The ~~State~~ Insurance Commissioner

~~of Health~~ shall adopt procedures to ensure that such persons are not subject to a conflict of interest that would impair their ability to make recommendations in an impartial manner.

SECTION 26. This act shall become effective November 1, 2020.

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