SENATE CHAMBER

STATE OF OKLAHOMA

DISPOSITION

☐ FLOOR AMENDMENT No. _____ _____

☐ COMMITTEE AMENDMENT _____

(Date)

Mr./Madame President:

I move to amend Senate Bill No. 887, by substituting the attached floor substitute for the title, enacting clause and entire body of the measure.

Submitted by:

_____

Senator Quinn

Quinn-CB-FS-Req#1969
3/9/2021 3:36 PM

(Floor Amendments Only) Date and Time Filed: _____

☐ Untimely ☐ Amendment Cycle Extended ☐ Secondary Amendment

STATE OF OKLAHOMA

1st Session of the 58th Legislature (2021)

FLOOR SUBSTITUTE
FOR
SENATE BILL NO. 887 By: Quinn of the Senate

and

Sneed of the House

FLOOR SUBSTITUTE

[insurance - annual statements reporting market conduct data of insurers - credit information - property and casualty claims - electronic payments - duties of the Association – repealer - codification - emergency]

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. 2020, 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) months.

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

A. Notwithstanding any other law or regulation, an insurer that uses credit information shall, upon written request from an applicant for insurance coverage or an insured upon a form provided by the Insurance Commissioner, provide reasonable exceptions to the rate of the insurer, rating classifications, company or tier placement or underwriting rules or guidelines for a consumer who has

experienced and whose credit information has been directly influenced by any of the following events:

1. Catastrophic event declared by the federal or state government;

2. Serious illness or injury, or serious illness or injury to an immediate family member;

3. Death of an immediate family member;

4. Divorce or involuntary interruption of legally owed alimony or support payments;

5. Identity theft;

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

7. Military deployment overseas; and

8. Other events, as determined by the Insurance Commissioner.

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

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

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

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

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

5. Grant an exception to requiring a written request where the consumer asks for a consideration of repeated events or the insurer has considered this event previously.

C. An insurer is in compliance with any other provision of law or Insurance Department rule relating to underwriting, rating or rate filing notwithstanding the granting an exception under this section. Nothing in this section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

D. The insurer shall provide notice to consumers, either at the time of acceptance of an insurance application or at policy renewal, that reasonable exceptions are available and information about how the consumer may inquire further.

SECTION 5. 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 the policies. The 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 market premium for the types of policies written under the plan in this 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 6. AMENDATORY 36 O.S. 2011, Section 1116, as amended by Section 18, Chapter 45, O.S.L. 2012 (36 O.S. Supp. 2020, 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, per policy. 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 7. 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 for a paper claim and thirty (30) calendar days for an electronic claim.

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 8. AMENDATORY 36 O.S. 2011, Section 1250.5, as amended by Section 1, Chapter 105, O.S.L. 2012 (36 O.S. Supp. 2020, Section 1250.5), is amended to read as follows:

Section 1250.5. Any of the following acts by an insurer, if committed in violation of Section 1250.3 of this title, constitutes an unfair claim settlement practice exclusive of paragraph 16 of this section which shall be applicable solely to health benefit plans:

1. Failing to fully disclose to first party claimants, benefits, coverages, or other provisions of any insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim;

2. Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;

3. Failing to adopt and implement reasonable standards for prompt investigations of claims arising under its insurance policies or insurance contracts;

4. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

5. Failing to comply with the provisions of Section 1219 of this title;

6. Denying a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so;

7. Except where there is a time limit specified in the policy, making statements, written or otherwise, which require a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if the time limit is not complied with unless the failure to comply with the time limit prejudices the rights of an insurer;

8. Requesting a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment;

9. Issuing checks ~~or~~, drafts or electronic payment in partial settlement of a loss or claim under a specified coverage which contain language releasing an insurer or its insured from its total liability;

10. Denying payment to a claimant on the grounds that services, procedures, or supplies provided by a treating physician or a hospital were not medically necessary unless the health insurer or administrator, as defined in Section 1442 of this title, first obtains an opinion from any provider of health care licensed by law and preceded by a medical examination or claim review, to the effect that the services, procedures or supplies for which payment is being denied were not medically necessary. Upon written request of a

claimant, treating physician, or hospital, the opinion shall be set forth in a written report, prepared and signed by the reviewing physician. The report shall detail which specific services, procedures, or supplies were not medically necessary, in the opinion of the reviewing physician, and an explanation of that conclusion. A copy of each report of a reviewing physician shall be mailed by the health insurer, or administrator, postage prepaid, to the claimant, treating physician or hospital requesting same within fifteen (15) days after receipt of the written request. As used in this paragraph, "physician" means a person holding a valid license to practice medicine and surgery, osteopathic medicine, podiatric medicine, dentistry, chiropractic, or optometry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes;

11. Compensating a reviewing physician, as defined in paragraph 10 of this subsection, on the basis of a percentage of the amount by which a claim is reduced for payment;

12. Violating the provisions of the Health Care Fraud Prevention Act;

13. Compelling, without just cause, policyholders to institute suits to recover amounts due under its insurance policies or insurance contracts by offering substantially less than the amounts ultimately recovered in suits brought by them, when the policyholders have made claims for amounts reasonably similar to the amounts ultimately recovered;

14. Failing to maintain a complete record of all complaints which it has received during the preceding three (3) years or since the date of its last financial examination conducted or accepted by the Commissioner, whichever time is longer. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For the purposes of this paragraph, "complaint" means any written communication primarily expressing a grievance;

15. Requesting a refund of all or a portion of a payment of a claim made to a claimant or health care provider more than twenty-four (24) months after the payment is made. This paragraph shall not apply:

a. if the payment was made because of fraud committed by the claimant or health care provider, or

b. if the claimant or health care provider has otherwise agreed to make a refund to the insurer for overpayment of a claim;

16. Failing to pay, or requesting a refund of a payment, for health care services covered under the policy if a health benefit plan, or its agent, has provided a preauthorization or precertification and verification of eligibility for those health care services. This paragraph shall not apply if:

a. the claim or payment was made because of fraud committed by the claimant or health care provider,

b. the subscriber had a preexisting exclusion under the policy related to the service provided, or

c. the subscriber or employer failed to pay the applicable premium and all grace periods and extensions of coverage have expired; or

17. Denying or refusing to accept an application for life insurance, or refusing to renew, cancel, restrict or otherwise terminate a policy of life insurance, or charge a different rate based upon the lawful travel destination of an applicant or insured as provided in Section 4024 of this title.

SECTION 9. AMENDATORY 36 O.S. 2011, Section 1250.7, as amended by Section 7, Chapter 95, O.S.L. 2018 (36 O.S. Supp. 2020, 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 ~~thirty (30) days,~~ and ~~to~~ third party claimants ~~sixty (60) days, before the date on which such time limit may expire~~ one year after the date of the loss.

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 10. 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 11. AMENDATORY 36 O.S. 2011, Section 1435.20, as last amended by Section 1, Chapter 263, O.S.L. 2019 (36 O.S. Supp. 2020, Section 1435.20), is amended to read as follows:

Section 1435.20. A. A limited lines producer may receive qualification for a license in one or more of the following categories:

1. Prepaid legal liability insurance, which means the assumption of an enforceable contractual obligation to provide specified legal services or to reimburse policyholders for specified legal expenses, pursuant to the provisions of a group or individual policy;

2. Crop - insurance providing protection against damage to crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation, disease or other yield-reducing conditions or perils provided by the private insurance market, or that is subsidized by the Federal Crop Insurance Corporation, including Multi-Peril Crop Insurance;

3. Car rental - insurance offered, sold or solicited in connection with and incidental to the rental of rental cars for a period of two (2) years, whether at the rental office or by

preselection of coverage in master, corporate, group or individual agreements that:

a. is nontransferable,

b. applies only to the rental car that is the subject of the rental agreement, and

c. is limited to the following kinds of insurance:

(1) personal accident insurance for renters and other rental car occupants, for accidental death or dismemberment, and for medical expenses resulting from an accident that occurs with the rental car during the rental period,

(2) liability insurance that provides protection to the renters and other authorized drivers of a rental car for liability arising from the operation or use of the rental car during the rental period,

(3) personal effects insurance that provides coverage to renters and other vehicle occupants for loss of, or damage to, personal effects in the rental car during the rental period,

(4) roadside assistance and emergency sickness protection insurance, or

(5) any other coverage designated by the Insurance Commissioner.

A car rental limited lines license issued to a rental or leasing company shall authorize any employee or authorized representative of the rental or leasing company to sell or offer coverage at each location at which the rental or leasing company operates. Employees or authorized representatives are not required to be individually licensed;

4. Credit - credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance, or any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation and that is designated by the Insurance Commissioner as limited line credit insurance;

5. Surety - insurance or bond that covers obligations to pay the debts of, or answer for the default of another, including faithlessness in a position of public or private trust. For purpose of limited line licensing, surety does not include surety bail bonds;

6. Travel; ~~and~~

7. Self-service storage insurance, pursuant to Section ~~2 of this act~~ 1435.20a of this title; and

8. Motor Service Club limited lines producer, pursuant to Sections 3101 et seq. of this title.

B. 1. An insurance producer or limited lines producer may solicit applications for and issue travel accident policies or baggage insurance by means of mechanical vending machines supervised by the insurance producer or limited lines producer only if the Insurance Commissioner shall determine that the form of policy to be sold is reasonably suited for sale and issuance through vending machines, that use of vending machines for the sale of policies would be of convenience to the public, and that the type of vending machine to be used is reasonably suitable and practical for the sale and issuance of policies. Policies so sold do not have to be countersigned.

2. The Commissioner shall issue to the insurance agent or limited insurance representative a special vending machine license for each such machine to be used. The license shall specify the name and address of the insurer and licensee, the kind of insurance and type of policy to be sold, and the place where the machine is to be in operation. The license shall expire, be renewable, and be suspended or revoked coincidentally with the insurance agent license or limited representative license of the licensee. The license fee for each vending machine shall be that stated in the provisions of Section 1435.23 of this title. Proof of existence of the license shall be displayed on or about each machine in such manner as the Commissioner may reasonably require.

SECTION 12. AMENDATORY 36 O.S. 2011, Section 1445, is amended to read as follows:

Section 1445. A. All insurance charges or premiums collected by an administrator for an insurer or trust and all return premiums received from the insurer or trust shall be held by the administrator in a fiduciary capacity. These funds shall be immediately remitted to the person entitled to the funds or shall be deposited promptly in a fiduciary bank account established and maintained by the administrator.

B. If charges or premiums deposited in a fiduciary account have been collected for more than one insurer or trust, the administrator shall keep records showing the deposits to and withdrawals from the account for each insurer or trust. The administrator, upon request of an insurer or trust, shall furnish copies of the records pertaining to deposits to and withdrawals from the account for that insurer or trust.

C. The administrator shall not pay any claim by withdrawals from a fiduciary account unless provisions for said withdrawals are included in the written agreement between the insurer or trust and the administrator. The written agreement shall authorize withdrawals by the administrator from the fiduciary account only for:

1. ~~remittance~~ Remittance to an insurer or trust entitled to a remittance; or

2. ~~deposit~~ Deposit in an account maintained in the name of an insurer or trust; or

3. ~~transfer~~ Transfer to and deposit in an account established for payment of claims, as provided for by subsection D of this section; or

4. ~~payment~~ Payment to a group policyholder for remittance to the insurer or trust entitled to such remittance; or

5. ~~payment~~ Payment of commission, fees, or charges to the administrator; or

6. ~~remittance~~ Remittance of return premiums to the person entitled to such return premiums.

D. All claims paid by the administrator from funds collected on behalf of the insurer or trust shall be paid on drafts ~~or~~, checks or electronic payment authorized by the insurer or trust.

SECTION 13. AMENDATORY 36 O.S. 2011, Section 1450, as amended by Section 6, Chapter 294, O.S.L. 2019 (36 O.S. Supp. 2020, 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 14. AMENDATORY 36 O.S. 2011, Section 2004, is amended to read as follows:

Section 2004. As used in the Oklahoma Property and Casualty Insurance Guaranty Association Act:

1. "Affiliate" means a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person on December 31 of the year next preceding the date the insurer becomes an insolvent insurer;

2. "Association" means the Oklahoma Property and Casualty Insurance Guaranty Association as created in Section 2005 of this title;

3. "Assumed claims transaction" means:

a. policy obligations that have been assumed by the insolvent insurer, prior to the entry of a final order of liquidation, pursuant to a plan, approved by a domestic commissioner of the assuming insurer, which transfers the direct policy obligations and future policy renewals from one insurer to another insurer, or

b. an assumption reinsurance transaction in which all of the following have occurred:

(1) the insolvent insurer assumed, prior to the entry of a final order of liquidation, the claim or policy obligations of another insurer under the claims or policies,

(2) the assumption of the claim or policy obligations has been approved, if an approval is required, by the appropriate regulatory authorities, and

(3) as a result of the assumption, the claim or policy obligations became the direct obligations

of the insolvent insurer through novation of the claims or policies;

4. "Claimant" means any person instituting a covered claim; provided that no person who is an affiliate of the insolvent insurer may be a claimant;

5. "Commissioner" means the Insurance Commissioner of Oklahoma;

6. "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact;

7. "Covered claim" means:

a. an unpaid claim, including one of unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this act applies, if the insurer becomes an insolvent insurer

after the effective date of this act and the policy was issued by the insurer, and:

(1) the claimant or insured is a resident of this state at the time of the insured event, provided that for entities other than an individual, the residence of a claimant or insured is the state in which its principal place of business is located at the time of the insured event, or

(2) the property from which the claim arises is permanently located in this state,

b. "Covered claim" shall not include:

(1) any amount awarded as punitive or exemplary damages,

(2) any amount sought as a return of premium under any retrospective rating plan,

(3) any amount due any reinsurer, insurer, insurance pool, or underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No claim for any amount due any reinsurer, insurer, insurance pool, or underwriting association, health

maintenance organization, hospital plan corporation, professional health service corporation or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent the claim exceeds the association obligation limitations set for in Section 2007 of this title,

(4) any claims excluded pursuant to Section 15 of this act due to the high net worth of an insured,

(5) any first party claims by an insured that is an affiliate of the insolvent company,

(6) any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods and services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent,

(7) any fee or other amount sought by or on behalf of any attorney or other provider of goods and services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the Association,

(8) any claims for interest, ~~or~~

(9) any claim filed with the association or a liquidator for protection afforded under the policy of the insured for incurred-but-not-reported losses, or

(10) notwithstanding any other provision of this act or any other law to the contrary, a claim that is filed with the association on a date that is later than eighteen (18) months after the date of the order of liquidation or that is unknown and unreported as of said date; provided, however, that this shall not include any claim for workers' compensation benefits pursuant to Title 85A of the Oklahoma Statutes and the applicable rules of OAC Title 810;

8. "Insolvent insurer" means an insurer that is licensed to transact insurance in this state either at the time the policy was issued, when the obligation with respect to the covered claim was assumed under an assumed claims transaction, or when the insured event occurred and against whom a final order of liquidation has been entered after the effective date of this act with a finding of insolvency by a court of competent jurisdiction in the state of domicile of the insurer;

9. "Insured" means any named insured, any additional insured, any vendor, lessor or any other party identified as an insured under the policy;

10. a. "Member insurer" means any person who:

(1) writes any kind of insurance to which the Oklahoma Property and Casualty Insurance Guaranty Association Act applies pursuant to Section 2003 of this title, including the exchange of reciprocal or inter-insurance contracts, and

(2) is licensed to transact insurance in this state, except those insurers enumerated in Section 110 of this title or those insurers that are otherwise exempted by law or order of the Commissioner.

b. An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its license to transact the kinds of insurance to which the Oklahoma Property and Casualty Insurance Guaranty Association Act applies; however, the insurer shall be liable as a member insurer for any and all obligations, including but not limited to obligations for assessments levied after the termination or expiration, which relate to any insurer that becomes an insolvent insurer prior to the

termination or expiration of the license of the insurer;

11. "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this act applies, including but not limited to policy and membership fees, less the following amounts:

a. return premiums,

b. premiums on policies not taken, and

c. dividends paid or credited to policyholders on direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers;

12. "Novation" means that the assumed claim or policy obligations became the direct obligations of the insolvent insurer through consent of the policyholder and that thereafter the ceding insurer or entity initially obligated under the claims or policies is released by the policyholder from performing its claim or policy obligations. Consent shall be express and an implied novation shall not be allowed for the purposes, implementation and application of the Oklahoma Property and Casualty Insurance Guaranty Association Act;

13. "Person" means the individual or other entities as defined in Section 104 of this title;

14. "Receiver" means liquidator, rehabilitator, conservator or ancillary receiver, as the context requires; and

15. "Self-insurer" means a person who covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.

SECTION 15. AMENDATORY 36 O.S. 2011, Section 2006, as amended by Section 1, Chapter 78, O.S.L. 2014 (36 O.S. Supp. 2020, 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 16. AMENDATORY 36 O.S. 2011, Section 2007, is amended to read as follows:

Section 2007. A. The Oklahoma Property and Casualty Insurance Guaranty Association shall:

1. Be obligated to pay the covered claims existing prior to the determination of insolvency if the claims arise within thirty (30) days after the determination of insolvency, or before the policy expiration date if less than thirty (30) days after the determination, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the determination. The obligation shall be satisfied by paying to the claimant an amount as follows:

a. the full amount of a covered claim for benefits under a workers' compensation insurance coverage,

b. an amount not exceeding Ten Thousand Dollars ($10,000.00) per policy for a covered claim for the return of unearned premium, and

c. an amount not exceeding One Hundred Fifty Thousand Dollars ($150,000.00) per claimant for all other covered claims.

In no event shall the Association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises or in excess of the limits of the obligation of the Association existing on the date on which the order of liquidation is filed with the court clerk;

2. Any obligation of the association to defend an insured shall cease upon the payment or tender by the association of an amount equal to the lesser of the covered claim obligation limit of the association or the applicable policy limit;

3. ~~Be deemed the insurer to the extent of the obligations on covered claims and to that extent subject to the limitations provided in the Oklahoma Property and Casualty Insurance Guaranty Association Act shall~~ As payor of last resort, have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent~~,~~ including, but not limited to, the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association. The

association shall not be deemed the insolvent insurer for the purpose of conferring jurisdiction;

4. Allocate claims paid and expenses incurred among the three accounts set out in Section 2005 of this title separately, and assess member insurers separately for each account amounts necessary to pay the obligations of the Association under this section subsequent to a member insurer becoming an insolvent insurer, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by the Oklahoma Property and Casualty Insurance Guaranty Association Act, Sections 2001 through 2020 of this title and Sections ~~14~~ 2020.1 and ~~15~~ 2020.2 of this ~~act~~ title. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment on the kinds of insurance in the account bear to the net direct written premiums of all participating insurers for the calendar year preceding the assessment on the kinds of insurance in the account. Each member insurer shall be notified in writing of the assessment not later than thirty (30) days before it is due. No member insurer may be assessed in any year an amount greater than two percent (2%) of the net direct written premiums of that member or one percent (1%) of that surplus of the member insurer as regards policyholders for the calendar year preceding the assessment on the kinds of insurance in the account, whichever is less. If the maximum assessment, together

with the other assets of the Association, does not provide in any one (1) year in any account an amount sufficient to make all necessary payments from that account, the funds available may be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The Association shall pay claims in any order which it deems reasonable, including the payment of claims as the claims are received from the claimants or in groups or categories of claims. The Association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the financial statement of the member insurer to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. During the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payments will not reduce capital or surplus below required minimums. The payments may be refunded to those companies receiving larger assessments by virtue of the deferment, or, at the election of any company credited against future assessments. Each member insurer serving as a servicing facility may set off against any assessment authorized payments made on covered claims and expenses incurred in the payment of covered claims by a member insurer if they are chargeable to the account for which the assessment is made;

5. Investigate claims brought against the Association and adjust, compromise, settle and pay covered claims to the extent of the obligation of the Association and deny all other claims. The Association shall pay claims in any order that it may deem reasonable, including, but not limited to, the payment of claims as they are received from claimants or in groups of categories of claims. The Association shall have the right to select and to direct legal counsel under liability insurance policies for the defense of covered claims;

6. Notify claimants in this state as deemed necessary by the Commissioner and upon the request of the Commissioner, to the extent records are available to the Association. Notification may include, but shall not be limited to, a legal posting on the website of the Association;

7. a. Handle claims through employees or through one or more insurers or other persons ~~incorporated and resident in the State of Oklahoma~~ designated as servicing facilities. Designation of a servicing facility is subject to approval of the Commissioner, but such designation may be declined by a member insurer.

b. The Association shall have the right to review and contest as set forth in this paragraph, settlements, releases, compromises, waivers and judgments to which the insolvent insurer or its insureds were parties

prior to the entry of the order of liquidation. In an action to enforce settlements, releases and judgments to which the insolvent insurer or its insureds were parties prior to the entry of the order of liquidation, the Association shall have the right to assert the following defenses:

(1) the Association shall not be bound by a settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment entered against the insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise waiver or judgment was:

(a) executed or entered within one hundred twenty (120) days prior to the entry of an order of liquidation, and the insured or the insurer did not use reasonable care in entering into the settlement, release, compromise, waiver or judgment, or did not pursue all reasonable appeals of an adverse judgment, or

(b) executed by or taken against an insured or the insurer based on default, fraud,

collusion or the failure of the insurer to defend,

(2) if a court of competent jurisdiction finds that the Association is not bound by a settlement, release, compromise, waiver or judgment for the releases provided for in division (1) of subparagraph b of this paragraph, the settlement, release, compromise, waiver or judgment shall be set aside and the Association shall be permitted to defend any covered claim on the merits. The settlement, release, compromise, waiver or judgment shall not be considered as evidence of liability in connection with any claim brought against the Association or any other party pursuant to the Oklahoma Property and Casualty Insurance Guaranty Association Act, and

(3) the Association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise or waiver executed by an insured or the insurer, or any judgment taken against the insured or the insurer.

c. As to any covered claims arising from a judgment under any decision, verdict or finding based on the default

of the insolvent insurer or its failure to defend, the Association, either on its own behalf or on behalf of an insured, may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator that entered the judgment, claim, decision, verdict or finding and shall be permitted to defend on the merits;

8. Reimburse each servicing facility for obligations of the Association paid by the facility and for reasonable expenses incurred by the facility while handling claims on behalf of the Association and pay the other expenses of the Association authorized by the Oklahoma Property and Casualty Insurance Guaranty Association Act; ~~and~~

9. Have standing to appear before any court of this state which has jurisdiction over an impaired or insolvent insurer for whom the Association is or may become obligated pursuant to the provisions of the Oklahoma Property and Casualty Insurance Guaranty Association Act. Standing shall extend to all matters germane to the powers and duties of the Association including, but not limited to, proposals for rehabilitation, acquisition, merger, reinsuring, or guaranteeing the covered policies of the impaired or insolvent insurer, and the determination of covered policies and contractual obligations of the impaired or insolvent insurer; and

10. Notwithstanding any other provision of the Oklahoma Property and Casualty Insurance Guaranty Association Act, an insurance policy issued by a member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of another insurer pursuant to any provision of law providing for the division of an insurance company, or the statutory assumption or transfer of designated policies under which there is no remaining obligation to the transferring entity, shall be considered to have been issued by a member insurer which is an insolvent insurer for the purposes of this Act in the event that the insurer to which the policy has been allocated, transferred, assumed or otherwise made the sole responsibility of is placed in liquidation. An insurance policy that was issued by an insurer who is not a member insurer and subsequently allocated, transferred, assumed by or otherwise made the sole responsibility of a member insurer under any provision of law providing for the division of an insurance company shall not be considered to have been issued by a member insurer pursuant to this Act.

B. The Association may:

1. Employ or retain persons as are necessary to handle claims and perform other duties of the Association;

2. Borrow funds necessary to effect the purposes of the Oklahoma Property and Casualty Insurance Guaranty Association Act in accordance with the plan of operation;

3. Sue or be sued;

4. Negotiate and become a party to contracts as are necessary to carry out the purpose of the Oklahoma Property and Casualty Insurance Guaranty Association Act;

5. Refund to member insurers in proportion to the contribution of each member insurer that amount by which the assets of the Association exceed its liabilities, if at the end of any calendar year the board of directors finds that the assets of the Association exceed the liabilities as estimated by the board of directors for the coming year;

6. Lend monies to an insurer declared to be impaired by the Commissioner. The Association, with approval of the Commissioner, shall approve the amount, length and terms of the loan. "Impaired Insurer" for purposes of this ~~paragraph~~ section shall mean an insurer potentially unable to fulfill its contractual obligations, but shall not mean an insolvent insurer;

7. Perform other acts as are necessary or proper to effectuate the purpose of the Oklahoma Property and Casualty Insurance Guaranty Association Act;

8. Intervene as a party in interest in any supervision, conservation, liquidation, rehabilitation, impairment or receivership in which policyholders' interests and interests of the Association may be or are affected; and

9. Be designated or may contract as a servicing facility for any entity which may be recommended by the board of directors of the Association and shall be approved by the Commissioner.

SECTION 17. AMENDATORY 36 O.S. 2011, Section 2008, is amended to read as follows:

Section 2008. A. The Oklahoma Property and Casualty Insurance Guaranty Association shall submit to the Commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the Association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the Commissioner.

B. If the Association fails to submit a suitable plan of operation within ninety (90) days following ~~the effective date of this act~~ June 27, 1980, or if at any time thereafter the Association fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate reasonable rules as are necessary or advisable to effectuate the provisions of ~~this act~~ Section 2001 et seq. of this title. Any rules promulgated shall continue in force until modified by the Commissioner or superseded by a plan submitted by the Association and approved by the Commissioner. All member insurers shall comply with the plan of operation.

C. The plan of operation shall:

1. Establish the procedures whereby all the powers and duties of the Association under this act will be performed;

2. Establish procedures for handling assets of the Association;

3. Require the amount and method of reimbursing members of the board of directors under Section 2006 of this title;

4. Establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims;

5. Establish regular places and times for meetings of the board of directors;

6. Require that the written procedures be established for records to be kept of all financial transactions of the Association, its agents and the board of directors;

7. Provide that any member insurer aggrieved by any final action or decision of the Association may appeal to the Commissioner within thirty (30) days after the action or decision;

8. Establish the procedures whereby selections for the board of directors will be submitted to the Commissioner; and

9. Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

D. The plan of operation may provide that any or all powers and duties of the Association, except those under paragraph 3 of subsection A and paragraph 2 of subsection B of Section 2007 of this title, are delegated to a corporation, association or other

organization ~~incorporated and resident in the State of Oklahoma~~ which performs or will perform functions similar to those of this Association, or its equivalent. The corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the Association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the Commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by ~~this act~~ Section 2001 et seq. of this title.

SECTION 18. AMENDATORY 36 O.S. 2011, Section 2023, as amended by Section 2, Chapter 384, O.S.L. 2019 (36 O.S. Supp. 2020, 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 19. 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~~ producer, for a consideration, motor club service~~.~~;

3. ~~"Agent"~~ "Producer" 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 20. AMENDATORY 36 O.S. 2011, Section 3105, is amended to read as follows:

Section 3105. A. Each motor service club operating in this state pursuant to certificate of authority issued hereunder shall file with the Commissioner, within ten (10) days of the date of employment, a notice of appointment of any ~~agent~~ limited lines producer, resident or nonresident, appointed by the automobile club to sell memberships in the motor service club to the public. This notification shall be upon such form as the Commissioner may prescribe and shall contain the name, address, age, sex, and Social Security number of such club ~~agent~~ producer, and shall also contain proof satisfactory to the Commissioner that such applicant is not less than eighteen (18) years of age, is of good reputation, and has received training from the club or is otherwise qualified in the field of motor service club service contracts and knowledgeable of the laws of this state pertaining thereto~~. Upon termination of any agent's employment by the motor service club, such motor service club shall notify the Commissioner, in writing, within five (5) days of such termination~~.

B. A ~~registration~~ licensing fee for ~~agents~~ limited lines producers, resident or nonresident, shall be ~~Twenty Dollars ($20.00)~~

~~annually, and such registration shall expire on July 1 of each year unless sooner revoked or suspended as provided for in this section~~ Forty Dollars ($40.00) biennially.

C. Upon notice and hearing, the Commissioner may suspend ~~for not over twelve (12) months~~, censure, revoke, or refuse to renew any ~~agent's~~ license of a producer if he finds as to the licensee that any one or more of the following causes exist:

1. Any violation of or noncompliance with any provision of this act;

2. Obtaining or attempting to obtain any such license through misrepresentation or fraud;

3. Oral or written misrepresentation of the terms, conditions, benefits, or privileges of any motor service club service contract issued or to be issued by the motor service club he represents or any other motor service club;

4. Misappropriation or conversion to his own use or illegal holding of monies, belonging to members or others, received in the conduct of business under his license;

5. Pleading nolo contendere or guilty to a felony or conviction by final judgment of a felony;

6. Demonstration of incompetence sufficient in the opinion of the Commissioner to make the ~~agent~~ producer a source of injury and loss to the public;

7. Fraudulent or dishonest practices;

8. Willful solicitation of membership from an individual who is or has been a member of another motor service club by giving said person credit for his years of membership with the other motor service club;

9. Waiving the enrollment fee or otherwise reducing the usual fees and charges for a new member when soliciting membership from an individual who is or has been a member of another motor service club.

D. In addition to the penalties provided for in this section, a fine of not less than One Hundred Dollars ($100.00) nor more than One Thousand Dollars ($1,000.00) for each occurrence may be levied.

SECTION 21. AMENDATORY 36 O.S. 2011, Section 3108, is amended to read as follows:

Section 3108. A motor service club or an officer or ~~agent~~ producer thereof shall not in any manner misrepresent the terms, benefits or privileges of any service contract issued or to be issued by it or by another motor service club.

SECTION 22. AMENDATORY 36 O.S. 2011, Section 3639.1, as amended by Section 11, Chapter 44, O.S.L. 2012 (36 O.S. Supp. 2020, 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. In the event an insured cancels a homeowner's insurance policy or any other personal residential insurance coverage, notice shall be provided to the prior insurer and shall include the date of the policy cancellation and the date of policy inception of the new policy.

D. An insurer canceling a policy under subsection C of this section shall not be liable for claims arising after the date of cancellation.

SECTION 23. AMENDATORY 36 O.S. 2011, Section 4030, is amended to read as follows:

Section 4030. A. Except as may be otherwise approved by the Insurance Commissioner, no single premium policy of life insurance or single premium annuity contract shall be delivered or issued for delivery in Oklahoma for a consideration other than cash, cashier's check, check, bank draft, money order, ~~or~~ premium note or electronic payment. This act shall not apply to the transfer of securities to an insurer pursuant to the insuring of a pension or profit sharing plan qualified under the Federal Internal Revenue Code.

B. This act shall not be held to repeal or alter any law now in effect, but shall be construed as cumulative with and supplemental to other laws and acts now in effect or enacted hereafter.

SECTION 24. AMENDATORY 36 O.S. 2011, Section 4030.1, is amended to read as follows:

Section 4030.1. A. Within ten (10) days after an insurer receives written notification of the death of a person covered by a policy of life insurance, the insurer shall provide to the claimant the necessary forms to be completed to establish proof of the death of the insured and, if required by the policy, the interest of the claimant. If the policy contains a provision requiring surrender of the policy prior to settlement, the insurer shall include a written statement to that effect with the forms to be completed. Forms to establish proof of death and proof of the interest of the claimant shall be approved by the Insurance Commissioner.

B. An insurer shall pay the proceeds of any benefits under a policy of life insurance not more than thirty (30) days after the insurer has received proof of death of the insured. If the proceeds are not paid within this period, the insurer shall pay interest on the proceeds, at a rate which is not less than the current rate of interest on death proceeds on deposit with the insurer, from the date of death of the insured to the date when the proceeds are paid. Should the insurer hold its deposits in a noninterest bearing account, the rate of interest to be paid shall be the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year, as certified to the Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two (2) percentage points, which shall accrue from the thirty-first day after receipt of proof of loss until the proceeds are paid. Payment shall be deemed to have been made on the date an electronic payment is made or the date a check, draft or other valid instrument which is equivalent to payment was placed in the U.S. mails in a properly addressed, postpaid envelope; or, if not so posted, on the date of delivery of such instrument to the beneficiary.

C. Subsection B of this section shall not apply to any life insurance policy issued before October 1, 1978, which contains specific provisions to the contrary.

SECTION 25. AMENDATORY 36 O.S. 2011, Section 4055.7, is amended to read as follows:

Section 4055.7. A. 1. The Insurance Commissioner may conduct an examination under the Viatical Settlements Act of 2008 of a licensee as often as the Commissioner in his or her discretion deems appropriate after considering the factors set forth in this paragraph. In scheduling and determining the nature, scope, and frequency of the examinations, the Commissioner shall consider such matters as the consumer complaints, results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, report of independent certified public accountants, and other relevant criteria as determined by the Commissioner.

2. For purposes of completing an examination of a licensee under the Viatical Settlements Act of 2008, the Commissioner may examine or investigate any person, or the business of any person, insofar as the examination or investigation is, in the sole discretion of the Commissioner, necessary or material to the examination of the licensee.

3. In lieu of an examination under the Viatical Settlements Act of 2008 of any foreign or alien licensee licensed in this state, the Commissioner may, at the Commissioner's discretion, accept an examination report on the licensee as prepared by the Commissioner for the licensee's state of domicile or port-of-entry state.

4. As far as practical, the examination of a foreign or alien licensee shall be made in cooperation with the insurance supervisory officials of other states in which the licensee transacts business.

B. 1. A person required to be licensed by the Viatical Settlements Act of 2008 shall for five (5) years for all settled policies and for two (2) years for all policies which are not settled retain copies of all:

a. proposed, offered or executed contracts, purchase agreements, underwriting documents, policy forms, and applications from the date of the proposal, offer or execution of the contract or purchase agreement, whichever is later,

b. all checks, drafts, electronic payment or other evidence and documentation related to the payment, transfer, deposit or release of funds from the date of the transaction, and

c. all other records and documents related to the requirements of the Viatical Settlements Act of 2008.

2. This subsection does not relieve a person of the obligation to produce these documents to the Commissioner after the retention period has expired if the person has retained the documents.

3. Records required to be retained by this subsection must be legible and complete and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any

process that accurately reproduces or forms a durable medium for the reproduction of a record.

C. 1. Upon determining that an examination should be conducted, the Commissioner shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the Examiners Handbook adopted by the National Association of Insurance Commissioners (NAIC). The Commissioner may also employ such other guidelines or procedures as the Commissioner may deem appropriate.

2. Every licensee or person from whom information is sought, its officers, directors and agents shall provide to the examiners timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets and computer or other recordings relating to the property, assets, business and affairs of the licensee being examined. The officers, directors, employees and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the Commissioner shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the licensee to engage in the viatical

settlement business or other business subject to the Commissioner's jurisdiction. Any proceedings for suspension, revocation or refusal of any license or authority shall be conducted in accordance with the Administrative Procedures Act.

3. The Commissioner shall have the power to issue subpoenas, to administer oaths and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the Commissioner may petition a court of competent jurisdiction, and upon proper showing, the Court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court.

4. When making an examination under the Viatical Settlements Act of 2008, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners, the reasonable cost of which shall be borne by the licensee that is the subject of the examination.

5. Nothing contained in the Viatical Settlements Act of 2008 shall be construed to limit the Commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

6. Nothing contained in the Viatical Settlements Act of 2008 shall be construed to limit the Commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or licensee workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the Commissioner may, in his or her sole discretion, deem appropriate.

D. 1. Examination reports shall be comprised of only facts appearing upon the books, records or other documents of the licensee, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

2. No later than sixty (60) days following completion of the examination, the examiner in charge shall file with the Commissioner a verified written report of examination under oath. Upon receipt of the verified report, the Commissioner shall transmit the report to the licensee examined, together with a notice that shall afford the licensee examined a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to any matters contained in the examination report.

3. In the event the Commissioner determines that regulatory action is appropriate as a result of an examination, the Commissioner may initiate any proceedings or actions provided by law.

E. 1. Names and individual identification data for all viators shall be considered private and confidential information and shall not be disclosed by the Commissioner, unless required by law.

2. Except as otherwise provided in the Viatical Settlements Act of 2008, all examination reports, working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the Commissioner or any other person in the course of an examination made under the Viatical Settlements Act of 2008, or in the course of analysis or investigation by the Commissioner of the financial condition or market conduct of a licensee shall be confidential by law and privileged, shall not be subject to the Oklahoma Open Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties.

3. Documents, materials or other information, including, but not limited to, all working papers, and copies thereof, in the possession or control of the NAIC and its affiliates and

subsidiaries shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action if they are:

a. created, produced or obtained by or disclosed to the NAIC and its affiliates and subsidiaries in the course of assisting an examination made under this act, or assisting a Commissioner in the analysis or investigation of the financial condition or market conduct of a licensee, or

b. disclosed to the NAIC and its affiliates and subsidiaries under paragraph 4 of this subsection by a Commissioner.

For the purposes of paragraph 2 of this subsection, "act" means the law of another state or jurisdiction that is substantially similar to the Viatical Settlements Act of 2008.

4. Neither the Commissioner nor any person that received the documents, material or other information while acting under the authority of the Commissioner, including the NAIC and its affiliates and subsidiaries, shall be permitted to testify in any private civil action concerning any confidential documents, materials or information subject to paragraph 1 of this subsection.

5. In order to assist in the performance of the Commissioner's duties, the Commissioner:

a. may share documents, materials or other information, including the confidential and privileged documents, materials or information subject to paragraph 1 of this subsection, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication or other information, and

b. may receive documents, materials, communications or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

6. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Commissioner under this

section or as a result of sharing as authorized in paragraph 5 of this subsection.

7. A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this state.

8. Nothing contained in the Viatical Settlements Act of 2008 shall prevent or be construed as prohibiting the Commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the Commissioner of any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time or to the NAIC, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with the Viatical Settlements Act of 2008.

F. 1. An examiner may not be appointed by the Commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under the Viatical Settlements Act of 2008. This section shall not be construed to automatically preclude an examiner from being:

a. a viator,

b. an insured in a viaticated insurance policy, or

c. a beneficiary in an insurance policy that is proposed to be viaticated.

2. Notwithstanding the requirements of this paragraph, the Commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under the Viatical Settlements Act of 2008.

G. 1. No cause of action shall arise nor shall any liability be imposed against the Commissioner, the Commissioner's authorized representatives or any examiner appointed by the Commissioner for any statements made or conduct performed in good faith while carrying out the provisions of the Viatical Settlements Act of 2008.

2. No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the Commissioner or the Commissioner's authorized representative or examiner pursuant to an examination made under the Viatical Settlements Act of 2008, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This paragraph does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in paragraph 1 of this subsection.

3. A person identified in paragraph 1 or 2 of this subsection shall be entitled to an award of attorney fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this act and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

H. The Commissioner may investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

SECTION 26. AMENDATORY 36 O.S. 2011, Section 4055.9, is amended to read as follows:

Section 4055.9. A. 1. A viatical settlement provider entering into a viatical settlement contract shall first obtain:

a. if the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract, and

b. a document in which the insured consents to the release of his or her medical records to a licensed viatical settlement provider, viatical settlement broker and the insurance company that issued the life insurance policy covering the life of the insured.

2. Within twenty (20) days after a viator executes documents necessary to transfer any rights under an insurance policy or within twenty (20) days of entering any agreement, option, promise or any other form of understanding, expressed or implied, to viaticate the policy, the viatical settlement provider shall give written notice to the insurer that issued that insurance policy that the policy has or will become a viaticated policy. The notice shall be accompanied by the documents required by paragraph 3 of this subsection.

3. Within twenty (20) days after a viator executes documents necessary to transfer any rights under an insurance policy or within twenty (20) days of entering any agreement, option, promise or any other form of understanding, expressed or implied, to viaticate the policy, the viatical provider shall deliver a copy of the medical release required under subparagraph b of paragraph 1 of this subsection, a copy of the viator's application for the viatical settlement contract, the notice required under paragraph 2 of this subsection and a request for verification of coverage to the insurer that issued the life policy that is the subject of the viatical transaction. The National Association of Insurance Commissioner's (NAIC's) form for verification of coverage shall be used unless another form is developed and approved by the Insurance Commissioner.

4. The insurer shall respond to a request for verification of coverage submitted on an approved form by a viatical settlement

provider or viatical settlement broker within thirty (30) calendar days of the date the request is received and shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract or possible fraud. The insurer shall accept a request for verification of coverage made on an NAIC form, any form agreed upon by the insurer and the requestor, or any other form approved by the Commissioner. The insurer shall accept an original or facsimile or electronic copy of such request and any accompanying authorization signed by the viator. Failure by the insurer to meet its obligations under this subsection shall be a violation of subsection C of Section 10 and Section 15 of Enrolled Senate Bill No. 1980 of the 2nd Session of the 51st Oklahoma Legislature.

5. Prior to or at the time of execution of the viatical settlement contract, the viatical settlement provider shall obtain a witnessed document in which the viator consents to the viatical settlement contract, represents that the viator has a full and complete understanding of the viatical settlement contract, that he or she has a full and complete understanding of the benefits of the life insurance policy, acknowledges that he or she is entering into the viatical settlement contract freely and voluntarily and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and

that the terminal or chronic illness or condition was diagnosed after the life insurance policy was issued.

6. The insurer shall not unreasonably delay effecting change of ownership or beneficiary with any life settlement contract entered into in this state or with a resident of this state.

7. If a viatical settlement broker performs any of these activities required of the viatical settlement provider, the provider is deemed to have fulfilled the requirements of this section.

B. All medical information solicited or obtained by any licensee shall be subject to the applicable provisions of state law relating to confidentiality of medical information.

C. All viatical settlement contracts entered into in this state shall provide the viator with an absolute right to rescind the contract before the earlier of thirty (30) calendar days after the date upon which the viatical settlement contract is executed by all parties or fifteen (15) calendar days after the viatical settlement proceeds have been sent to the viator. Rescission by the viator may be conditioned upon the viator both giving notice and repaying to the viatical settlement provider within the rescission period all proceeds of the settlement and any premiums, loans and loan interest paid by or on behalf of the viatical settlement provider in connection with or as a consequence of the viatical settlement. If the insured dies during the rescission period, the viatical

settlement contract shall be deemed to have been rescinded, subject to repayment to the viatical settlement provider or purchaser of all viatical settlement proceeds, and any premiums, loans and loan interest that have been paid by the viatical settlement provider or purchaser, which shall be paid within sixty (60) calendar days of the death of the insured. In the event of any rescission, if the viatical settlement provider has paid commissions or other compensation to a viatical settlement broker in connection with the rescinded transaction, the viatical settlement broker shall refund all such commissions and compensation to the viatical settlement provider within five (5) business days following receipt of written demand from the viatical settlement provider, which demand shall be accompanied by either the viator's notice of rescission if rescinded at the election of the viator, or notice of the death of the insured if rescinded by reason of the death of the insured within the applicable rescission period.

D. The viatical settlement provider shall instruct the viator to send the executed documents required to effect the change in ownership, assignment or change in beneficiary directly to the independent escrow agent. Within three (3) business days after the date the escrow agent receives the document or from the date the viatical settlement provider receives the documents, if the viator erroneously provides the documents directly to the provider, the provider shall pay or transfer the proceeds of the viatical

settlement into an escrow or trust account maintained in a state- or federally-chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment or change in beneficiary forms to the viatical settlement provider or related provider trust or other designated representative of the viatical settlement provider. Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment or designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the viator.

E. Failure to tender consideration to the viator for the viatical settlement contract within the time set forth in the disclosure pursuant to paragraph 7 of subsection A of Section 8 of Enrolled Senate Bill No. 1980 of the 2nd Session of the 51st Oklahoma Legislature renders the viatical settlement contract voidable by the viator for lack of consideration until the time consideration is tendered to and accepted by the viator. Funds shall be deemed sent by a viatical settlement provider to a viator as of the date that the escrow agent either releases funds for wire transfer to the viator ~~or~~, places a check for delivery to the viator via United States Postal Service or other nationally recognized delivery service or make an electronic payment to the viator.

F. In order to assure that a viator, at the time of the viatical settlement has a life expectancy of less than two (2) years, receives reasonable return for viaticating an insurance policy, the following shall be minimum discounts:

Insured's Life Expectancy	Minimum Percentage of Face Value Less Outstanding Loans Received By Viator
Less than six (6) months	80%
At least six (6) but less than twelve (12) months	70%
At least twelve (12) but less than eighteen (18) months	65%
At least eighteen (18) months but less than twenty-four (24) months	60%

G. Contacts with the insured for the purpose of determining the health status of the insured by the viatical settlement provider or viatical settlement broker after the viatical settlement has occurred shall only be made by a viatical settlement provider or broker licensed in this state or its authorized representatives and shall be limited to once every three (3) months for insureds with a life expectancy of more than one (1) year, and to no more than once per month for insureds with a life expectancy of one (1) year or less. The provider or broker shall explain the procedure for these contacts at the time the viatical settlement contract is entered

into. The limitations set forth in this subsection shall not apply to any contacts with an insured for reasons other than determining the insured's health status. Viatical settlement providers and viatical settlement brokers shall be responsible for the actions of their authorized representatives.

SECTION 27. AMENDATORY 36 O.S. 2011, Section 4103, is amended to read as follows:

Section 4103. A. 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~~:

1. Paragraphs 6 through 10 of this section shall not apply to policies issued to a creditor to insure debtors of such creditor;

~~(b) that~~

2. That the standard provisions required for individual life insurance policies shall not apply to group life insurance policies; and

~~(c) that~~

3. 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.~~ B. 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.~~ C. 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.~~ D. 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.~~ E. 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.~~ F. 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.~~ G. 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.~~ H. 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.~~ I. 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.~~ J. 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)~~ 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.~~ K. A provision that if a person insured under the group policy dies during the period within which he or she would have been entitled to have an individual policy issued to him or her in accordance with paragraph ~~(8)~~ I or ~~(9)~~ J of this section and before such an individual policy shall have become effective, the amount of life insurance which he or she 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.

~~11.~~ L. 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 28. AMENDATORY 36 O.S. 2011, Section 4112, is amended to read as follows:

Section 4112. An insurer shall pay the proceeds of any benefits under group life insurance policy not more than thirty (30) days after the insurer has received proof of death of the insured. If the proceeds are not paid within this period, the insurer shall pay interest on the proceeds, at a rate which is not less than the current rate of interest on death proceeds on deposit with the insurer, from the date of death of the insured to the date when the proceeds are paid. Payment shall be deemed to have been made on the date an electronic payment is made or a check, draft or other valid instrument which is equivalent to payment was placed in the U.S. mails in a properly addressed, postpaid envelope; or, if not so

posted, on the date of delivery of such instrument to the beneficiary.

SECTION 29. AMENDATORY 36 O.S. 2011, Section 6060.11, as amended by Section 2, Chapter 75, O.S.L. 2020 (36 O.S. Supp. 2020, Section 6060.11), is amended to read as follows:

Section 6060.11. A. Subject to the limitations set forth in this section and Sections 6060.12 and 6060.13 of this title, any health benefit plan that is offered, issued, or renewed in this state on or after the effective date of this act shall provide benefits for treatment of mental health and substance use disorders.

B. 1. Benefits for mental health and substance use disorders shall be equal to benefits for treatment of and shall be subject to the same preauthorization and utilization review mechanisms and other terms and conditions as all other physical diseases and disorders including, but not limited to:

a. coverage of inpatient hospital services for either twenty-six (26) days or the limit for other covered illnesses, whichever is greater,

b. coverage of outpatient services,

c. coverage of medication,

d. maximum lifetime benefits,

e. copayments,

f. coverage of home health visits,

g. individual and family deductibles, and

h. coinsurance.

2. Treatment limitations applicable to mental health or substance use disorder benefits shall be no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan. There shall be no separate treatment limitations that are applicable only with respect to mental health or substance abuse disorder benefits.

C. A health benefit plan shall not impose a nonquantitative treatment limitation with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health benefit plan as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the nonquantitative treatment limitation to mental health disorders in the classification are comparable to and applied no more stringently than to medical and surgical benefits in the same classification.

D. All health benefit plans must meet the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal guidance or regulations issued under these acts including 45 CFR 146.136, 45 CFR 147.160 and 45 CFR 156.115(a)(3).

E. Beginning on or after the effective date of this act, each insurer that offers, issues or renews any individual or group health benefit plan providing mental health or substance use disorder

benefits shall submit an annual report to the Insurance Commissioner on or before April 1 of each year that contains the following:

1. A description of the process used to develop or select the medical necessity criteria for mental health and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

2. Identification of all nonquantitative treatment limitations applied to both mental health and substance use disorder benefits and medical and surgical benefits within each classification of benefits; and

3. The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph 1 of this subsection and for each nonquantitative treatment limitation identified in paragraph 2 of this subsection, as written and in operation, the processes, strategies, evidentiary standards or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to mental health and substance use disorder benefits within each classification of benefits are comparable to and are applied no more stringently than to medical and surgical in the same classification of benefits. At a minimum, the results of the analysis shall:

a. identify the factors used to determine that a nonquantitative treatment limitation will apply to a

benefit including factors that were considered but rejected,

b. identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation,

c. provide the comparative analyses including the results of the analyses performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as written processes and strategies used to apply the nonquantitative treatment limitation to mental health and substance use disorder benefits are comparable to and applied no more stringently than the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as written processes and strategies used to apply the nonquantitative treatment limitation to medical and surgical benefits,

d. provide the comparative analyses including the results of the analyses performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental health and substance use disorder benefits

are comparable to and applied no more stringently than the processes or strategies used to apply each nonquantitative treatment limitation for medical and surgical benefits in the same classification of benefits, and

e. disclose the specific findings and conclusions reached by the insurer that the results of the analyses required by this subsection indicate that the insurer is in compliance with this section and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and its implementing and related regulations including 45 CFR 146.136, 45 CFR 147.160 and 45 CFR 156.115(a)(3).

F. The Commissioner shall implement and enforce any applicable provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal guidance or regulations issued under these acts including 45 CFR 146.136, 45 CFR 147.136, 45 CFR 147.160 and 45 CFR 156.115(a)(3).

G. No later than ~~June 1, 2021~~ December 31, 2021, and by ~~June 1~~ December 31 of each year thereafter, the Commissioner shall make available to the public the reports submitted by insurers, as required in subsection E of this section, during the most recent annual cycle; provided, however, that any information that is confidential or a trade secret shall be redacted.

1. The Commissioner shall identify insurers that have failed in whole or in part to comply with the full extent of reporting required in this section and shall make a reasonable attempt to obtain missing reports or information by June 1 of the following year.

2. The reports submitted by insurers and the identification by the Commissioner of noncompliant insurers shall be made available to the public by posting on the Internet website of the Insurance Department.

H. The Commissioner shall promulgate rules pursuant to the provisions of this section and any provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, that relate to the business of insurance.

SECTION 30. AMENDATORY 36 O.S. 2011, Section 6060.12, as amended by Section 3, Chapter 75, O.S.L. 2020 (36 O.S. Supp. 2020, Section 6060.12), is amended to read as follows:

Section 6060.12. 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 mental health and substance use disorders shall be exempt from the provisions of Section 6060.11 of this 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 mental health and substance use disorders.

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 31. 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 32. AMENDATORY 36 O.S. 2011, Section 6216.1, is amended to read as follows:

Section 6216.1. No insurance company authorized to transact insurance in this state shall make payment of any insurance claim, or any portion of a claim, to a public adjuster on account of services rendered by a public adjuster to an insured unless the name of the insured is added as a joint payee on any claim check ~~or~~, draft or electronic payment. The payment, whether by check, draft, electronic payment or otherwise, shall be sent to the address or electronic mail address designated by the insured.

SECTION 33. AMENDATORY 36 O.S. 2011, Section 6217, as last amended by Section 14, Chapter 269, O.S.L. 2013 (36 O.S. Supp. 2020, Section 6217), is amended to read as follows:

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

B. Any licensee applying for renewal of a license as an adjuster shall have completed not less than twenty-four (24) clock hours of continuing insurance education, of which three (3) hours shall be in ethics, within the previous twenty-four (24) months

prior to renewal of the license. The Insurance Commissioner shall approve courses and providers of continuing education for insurance adjusters as required by this section.

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

1. Employees of the Insurance Commissioner;

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

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

C. An adjuster who, during the time period prior to renewal, participates in an approved professional designation program shall be deemed to have met the biennial requirement for continuing education. Each course in the curriculum for the program shall

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

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

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

F. 1. Each provider of continuing education shall, after approval by the Commissioner, submit an annual fee. A fee may be

assessed for each course submission at the time it is first submitted for review and upon submission for renewal at expiration. Annual fees and course submission fees shall be set forth as a rule by the Commissioner. The fees are payable to the Insurance Commissioner and shall be deposited in the State Insurance Commissioner Revolving Fund, created in Section 307.3 of this title, for the purposes of fulfilling and accomplishing the conditions and purposes of the Oklahoma Producer Licensing Act and the Insurance Adjusters Licensing Act. Public-funded educational institutions, federal agencies, nonprofit organizations, not-for-profit organizations and Oklahoma state agencies shall be exempt from this subsection.

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

G. Subject to the right of the Commissioner to suspend, revoke, or refuse to renew a license of an adjuster, any such license may be renewed by filing on the form prescribed by the Commissioner on or before the expiration date a written request by or on behalf of the licensee for such renewal and proof of completion of the continuing

education requirement set forth in subsection B of this section, accompanied by payment of the renewal fee.

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

SECTION 34. 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 6753 of Title 36 of the Oklahoma Statutes.

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 35. 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 36. AMENDATORY 36 O.S. 2011, Section 6753, as amended by Section 38, Chapter 150, O.S.L. 2012 (36 O.S. Supp. 2020, 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 37. 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~~ 6915 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 38. 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 39. 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 40. 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 41. 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 42. 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 43. REPEALER 36 O.S. 2011, Sections 1435.40, as amended by Section 1, Chapter 23, O.S.L. 2016 (36 O.S. Supp. 2020, Sections 1435.40), 1612.1, 6221 and 6522, are hereby repealed.

SECTION 44. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

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