HOUSE OF REPRESENTATIVES - FLOOR VERSION

STATE OF OKLAHOMA

2nd Session of the 58th Legislature (2022)

ENGROSSED SENATE
BILL NO. 1240 By: Quinn of the Senate

and

Sneed of the House

An Act relating insurance; amending 36 O.S. 2021, Sections 1106.1, 3101, 3105, 3623.1, 5122, 5123, 5124, 6060.21, 6454, 6470.35, 6475.1, 6475.5, 6475.6, 6475.7, 6475.8, 6475.9, 6475.10, 6475.12, and 6475.15, which relate to consumer price index, motor service clubs, policy and membership fees, Credit for Reinsurance Act, coverage for individuals with autism spectrum disorder, Oklahoma Risk Retention Act, Oklahoma Captive Insurance Company Act, and Uniform Health Carrier External Review Act; updating definition to statutory requirement; conforming definitions; conforming language; updating statutory reference; deleting obsolete language; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2021, Section 1106.1, is amended to read as follows:

Section 1106.1. A. A surplus lines licensee or broker is not required to make a due diligence search to determine whether the full amount or type of insurance can be obtained from admitted insurers when the surplus lines licensee or broker is seeking to

procure or place nonadmitted insurance for an exempt commercial purchaser, provided:

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

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

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

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

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

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

a. the person possesses a net worth in excess of ~~Twenty Million Dollars ($20,000,000.00)~~ Twenty-Four Million Dollars ($24,000,000.00), as such amount is adjusted pursuant to paragraph 4 of this subsection,

b. the person generates annual revenues in excess of ~~Fifty Million Dollars ($50,000,000.00)~~ Sixty Million Dollars ($60,000,000.00), as such amount is adjusted pursuant to paragraph 4 of this subsection,

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

d. the person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least ~~Thirty Million Dollars ($30,000,000.00)~~ Thirty-Six Million Dollars ($36,000,000.00), as such amount is adjusted pursuant to paragraph 4 of this subsection, or

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

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

SECTION 2. AMENDATORY 36 O.S. 2021, Section 3101, is amended to read as follows:

Section 3101. As used in this act:

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 producer, for a consideration, motor club service;

3. "Producer" means an insurance producer or a limited ~~insurance representative~~ lines producer 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 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 club" means the rendering, furnishing or procuring of, or reimbursement for~~,~~ three or more of the following: towing service, emergency road service, insurance service, bail bond service, legal service, discount service, financial service, buying and selling service, theft service, map service, and 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 3. AMENDATORY 36 O.S. 2021, 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 insurance producer or

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 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.

B. A licensing fee for insurance producers and limited lines producers, resident or nonresident, shall be ~~Forty Dollars ($40.00) biennially~~ in accordance with Section 1435.23 of this title.

C. Upon notice and hearing, the Commissioner may suspend, censure, revoke, or refuse to renew any 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 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 4. AMENDATORY 36 O.S. 2021, Section 3623.1, is amended to read as follows:

Section 3623.1. A. Nothing in this Code shall be construed to prevent an insurer from charging and collecting in this state separate initial membership fees, policy fees and any other fees as defined in subsection C of this section in addition to premiums for insurance, and such fees shall not be considered premium within the definition of this Code, but shall be subject to premium tax as provided in this Code. An insurer shall fully disclose all fees to its customers.

B. A minimum premium charge is considered premium within the definition of this Code, and shall be subject to premium tax as provided in this Code.

C. 1. Fees are defined as a flat amount added to the basic premium rate to reflect the cost of establishing the required records, sending premium notices and other related expenses and include, but are not limited to, the following: Installment fees, service charges, financing fees, membership fees, return check fees, policy fees, motor vehicle record fees, inspection fees, late fees, electronic transfer fees, credit score fees and expense load fees.

2. The fee passed on to the consumer must be the actual expense incurred by the insurance company, insurance agency or insurance producer.

D. Minimum premium charge is the smallest acceptable premium for which an insurance company will write a policy. This minimum charge is necessary to cover fixed expenses, other than those

expenses defined as fees above, in placing the policy on the books. A minimum premium charge includes, but is not limited to, minimum earned premium and minimum retained premium.

E. An ~~insurance consultant,~~ insurance producer, limited lines producer, managing general agent, or surplus lines insurance broker cannot charge a duplicate fee or minimum premium charge.

SECTION 5. AMENDATORY 36 O.S. 2021, Section 5122, is amended to read as follows:

Section 5122. A. Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subsection B, C, D, E, F, G or H of this section; provided, further, that the Commissioner may adopt by regulation pursuant to subsection B of Section 5124 of this title, specific additional requirements relating to or setting forth the valuation of assets or reserve credits, the amount and forms of security supporting reinsurance arrangements described in subsection B of Section 5124 of this title and the circumstances pursuant to which credit will be reduced or eliminated. Credit shall be allowed under subsection B, C or D of this section only as respects cessions of those kinds or classes of business in which the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and

licensed to transact insurance or reinsurance. Credit shall be allowed under subsection D or E of this section only if the applicable requirements of subsection I have been satisfied.

B. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

C. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited by the Insurance Commissioner as a reinsurer in this state. An accredited reinsurer is one that:

1. Files with the Insurance Commissioner evidence of its submission to this state's jurisdiction;

2. Submits to this state's authority to examine its books and records;

3. Is licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer is entered through and licensed to transact insurance or reinsurance in at least one state;

4. Files annually with the Insurance Commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

5. Demonstrates to the satisfaction of the Insurance Commissioner that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume

reinsurance from domestic insurers. An assuming insurer is deemed to meet this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than Twenty Million Dollars ($20,000,000.00) and its accreditation has not been denied by the Insurance Commissioner within ninety (90) days after submission of its application.

D. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is domiciled in, or in the case of a United States branch of an alien assuming insurer is entered through, a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this statute and the assuming insurer or United States branch of an alien assuming insurer:

1. Maintains a surplus as regards policyholders in an amount not less than Twenty Million Dollars ($20,000,000.00); and

2. Submits to the authority of this state to examine its books and records.

The requirement of paragraph 1 of this subsection does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

E. 1. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in Section 5123.1 of this title, for the payment of the valid claims of its United States

ceding insurers, their assigns and successors in interest. To enable the Insurance Commissioner to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the Insurance Commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners Annual Statement form by licensed insurers. The assuming insurer shall submit to examination of its books and records by the Commissioner and bear the expense of examination.

2. Credit for reinsurance shall not be granted under this subsection unless the form of the trust and any amendments to the trust have been approved by:

a. the Commissioner of the state where the trust is domiciled, or

b. the Commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

3. The form of the trust and any trust amendments also shall be filed with the Insurance Commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers, their assigns and

successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the Insurance Commissioner.

4. The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

5. No later than February 28 of each year the trustee of the trust shall report to the Insurance Commissioner in writing the balance of the trust and listing the trust's investments at the preceding year end and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the following December 31.

6. The following requirements apply to the following categories of assuming insurer:

a. the trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than Twenty Million Dollars ($20,000,000.00), except as provided in subparagraph b of this paragraph,

b. at any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three (3) full years, the

Commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review~~,~~ including an independent analysis of reserves and cash flows, and shall consider all material risk factors~~,~~ including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus shall not be reduced to an amount less than thirty percent (30%) of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust,

c. (1) in the case of a group including incorporated and individual unincorporated underwriters:

(a) for reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after January 1, 1993,

the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by United States-domiciled ceding insurers to any underwriter of the group,

(b) for reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of the Credit for Reinsurance Act, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States, and

(c) in addition to these trusts, the group shall maintain in trust a trusteed surplus of which One Hundred Million Dollars ($100,000,000.00) shall be held jointly for the benefit of the United States-domiciled ceding insurers of any member of the group for all years of account,

(2) the incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members, and

(3) within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the Commissioner an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group, and

d. in the case of a group of incorporated underwriters under common administration, the group shall:

(1) have continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to making application for accreditation,

(2) maintain aggregate policyholders' surplus of at least Ten Billion Dollars ($10,000,000,000.00),

(3) maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by United States-domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group,

(4) in addition, maintain a joint trusteed surplus of which One Hundred Million Dollars ($100,000,000.00) shall be held jointly for the benefit of United States-domiciled ceding insurers of any member of the group as additional security for these liabilities, and

(5) within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, make available to the Commissioner an annual certification of each underwriter member's solvency by the member's domiciliary regulator and financial statements of each underwriter member of the group prepared by its independent public accountant.

F. Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the Commissioner as a reinsurer in this state and secures its obligations in accordance with the requirements of this subsection.

1. In order to be eligible for certification, the assuming insurer shall meet the following requirements:

a. the assuming insurer shall be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the Commissioner pursuant to paragraph 3 of this subsection,

b. the assuming insurer shall maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the Commissioner pursuant to regulation,

c. the assuming insurer shall maintain financial strength ratings from two or more rating agencies deemed acceptable by the Commissioner pursuant to regulation,

d. the assuming insurer shall agree to submit to the jurisdiction of this state, appoint the Commissioner as its agent for service of process in this state and agree to provide security for one hundred percent (100%) of the assuming insurer’s liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment,

e. the assuming insurer shall agree to meet applicable information filing requirements as determined by the Commissioner, both with respect to an initial

application for certification and on an ongoing basis, and

f. the assuming insurer shall satisfy any other requirements for certification deemed relevant by the Commissioner.

2. An association~~,~~ including incorporated and individual unincorporated underwriters, may be a certified reinsurer. In order to be eligible for certification, in addition to satisfying requirements of paragraph 1 of this subsection:

a. the association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents (net of liabilities) of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the Commissioner to provide adequate protection,

b. the incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members, and

c. within ninety (90) days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the Commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

3. The Commissioner shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the Commissioner as a certified reinsurer.

a. In order to determine whether the domiciliary jurisdiction of a non-United-States assuming insurer is eligible to be recognized as a qualified jurisdiction, the Commissioner shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-United-States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction shall agree to share

information and cooperate with the Commissioner with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction shall not be recognized as a qualified jurisdiction if the Commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the Commissioner.

b. A list of qualified jurisdictions shall be published through the National Association of Insurance Commissioners (NAIC) Committee Process. The Commissioner shall consider this list in determining qualified jurisdictions. If the Commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the Commissioner shall provide thoroughly documented justification in accordance with criteria to be developed under regulations.

c. United States jurisdictions that meet the requirement for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.

d. If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the Commissioner may at his or her discretion suspend the reinsurer's certification indefinitely, in lieu of revocation.

4. The Commissioner shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the Commissioner pursuant to regulation. The Commissioner shall publish a list of all certified reinsurers and their ratings.

5. A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subsection at a level consistent with its rating, as specified in regulations promulgated by the Commissioner.

a. In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the Commissioner and consistent with the provisions of Section 5123 of this title, or in a multibeneficiary trust in accordance with subsection E of this section, except as otherwise provided in this subsection.

b. If a certified reinsurer maintains a trust to fully secure its obligations subject to subsection E of this

section, and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subsection or comparable laws of other United States jurisdictions and for its obligations subject to subsection E of this section. It shall be a condition to the grant of certification under this subsection that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the Commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.

c. The minimum trusteed surplus requirements provided in subsection E of this section are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection, except that such trust shall maintain a minimum trusteed surplus of Ten Million Dollars ($10,000,000.00).

d. With respect to obligations incurred by a certified reinsurer under this subsection, if the security is insufficient, the Commissioner shall reduce the allowable credit by an amount proportionate to the deficiency, and may at his or her discretion impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

6. If an applicant for certification has been certified as a reinsurer in an NAIC-accredited jurisdiction, the Commissioner may at his or her discretion defer to that jurisdiction's certification, and may in his or her discretion defer to the rating assigned by that jurisdiction, and such assuming insurer shall be considered to be a certified reinsurer in this state.

7. A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this subsection, and the Commissioner shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

8. For purposes of this subsection:

a. a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure one hundred percent (100%) of its obligations, and

b. the term "terminated" refers to revocation, suspension, voluntary surrender and inactive status. If the Commissioner continues to assign a higher rating as permitted by this section, the requirement to secure one hundred percent (100%) of its obligations shall not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

G. 1. Credit shall be allowed when the reinsurance is ceded to an assuming insurer meeting all of the following conditions:

a. the assuming insurer shall have its head office or be domiciled, as applicable, and licensed in a reciprocal jurisdiction. For purposes of this subparagraph, "reciprocal jurisdiction" is a jurisdiction that is one of the following:

(1) a non-United States jurisdiction that is subject to an in-force, covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member

state of the European Union. For purposes of this subparagraph, a "covered agreement" is an agreement entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. Sections 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance,

(2) a United States jurisdiction that meets the requirements for accreditation under the National Association of Insurance Commissioners financial standards and accreditation program, or

(3) a qualified jurisdiction, as determined by the Commissioner pursuant to ~~subparagraph a of~~ paragraph 3 of subsection F of this section, that is not otherwise described in division 1 or 2 of subparagraph a of paragraph 1 of this subsection and meets additional requirements consistent with the terms and conditions of in-force, covered

agreements, as specified by the Commissioner in rules,

b. the assuming insurer shall have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be set forth in Insurance Department rules. If the assuming insurer is an association including incorporated and individual unincorporated underwriters, it shall have and maintain, on an ongoing basis, minimum capital and surplus equivalents (net of liabilities), calculated according to the methodology applicable in its domiciliary jurisdiction, and a central fund containing a balance in amounts to be set forth in Department rules,

c. the assuming insurer shall have and maintain, on an ongoing basis, a minimum solvency or capital ratio, as applicable, which will be set forth in Department rules. If the assuming insurer is an association including incorporated and individual unincorporated underwriters, it shall have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer

has its head office or is domiciled and is also licensed,

d. the assuming insurer shall agree and provide adequate assurance to the Insurance Commissioner, in a form specified by the Commissioner, as follows:

(1) the assuming insurer shall provide prompt written notice and explanation to the Commissioner if it falls below the minimum requirements set forth in subparagraph b or c of this paragraph, or if any regulatory action is taken against it for serious noncompliance with applicable law,

(2) the assuming insurer shall consent in writing to the jurisdiction of the courts of this state and to the appointment of the Commissioner as agent for service of process. The Commissioner may require that consent for service of process be provided to the Commissioner and included in each reinsurance agreement. Nothing in this provision shall be construed to limit, or in any way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws,

(3) the assuming insurer shall consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained,

(4) each reinsurance agreement shall include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent (100%) of the liabilities of the assuming insurer attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate, and

(5) the assuming insurer shall confirm that it is not presently participating in any solvent scheme of arrangement that involves the ceding insurers of this state, and agree to notify the ceding insurer and the Commissioner and to provide security in an amount equal to one hundred percent (100%) of the liabilities of the assuming

insurer to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement. The security shall be in a form consistent with the provisions of subsection ~~H~~ F of Section 5122 and Section 5123 of this title, specified by the Commissioner in rule,

e. the assuming insurer or its legal successor shall provide, on behalf of itself and any legal predecessors, any additional documentation requested by the Commissioner in regulation,

f. the assuming insurer shall maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth in rule,

g. the supervisory authority of the assuming insurer shall confirm to the Commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements set forth in subparagraphs b and c of this paragraph, and

h. nothing in this provision shall be construed to preclude an assuming insurer from providing the Commissioner with information on a voluntary basis.

2. The Commissioner shall timely create and publish a list of reciprocal jurisdictions.

a. A list of reciprocal jurisdictions is published through the National Association of Insurance Commissioners Committee Process. The list shall include any reciprocal jurisdiction as defined under subparagraph a of paragraph 1 of this subsection and shall consider any other reciprocal jurisdiction included on the National Association of Insurance Commissioners list. The Commissioner may approve a jurisdiction that does not appear on the list of reciprocal jurisdictions in accordance with criteria to be developed through rules issued by the Commissioner.

b. The Commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set forth in rules issued by the Commissioner, except that the Commissioner shall not remove from the list a reciprocal jurisdiction as defined under subparagraph a of paragraph 1 of this subsection. Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance ceded to an assuming

insurer that has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to this act.

3. The Commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this subsection and to which cessions shall be granted credit in accordance with this subsection. The Commissioner may add an assuming insurer to such list if a National Association of Insurance Commissioners accredited jurisdiction has added the assuming insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the Commissioner as required under subparagraph d of paragraph 1 of this subsection and complies with any additional requirements that the Commissioner may impose by regulation, except to the extent that they conflict with an applicable covered agreement.

4. If the Commissioner determines that an assuming insurer no longer meets one or more of the requirements under this subsection, the Commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this subsection in accordance with procedures set forth in Department rules.

a. While the eligibility of an assuming insurer is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the

obligations of the assuming insurer under the contract are secured in accordance with the provisions of Section 5123 of this title.

b. If the eligibility of an assuming insurer is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer including reinsurance agreements entered into prior to the date of revocation, except to the extent that the obligations of the assuming insurer under the contract are secured in a form acceptable to the Commissioner.

5. If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer or its representative may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

6. Nothing in this subsection shall be construed to limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this act or other applicable law or rule.

7. Credit may be taken under this subsection only for reinsurance agreements entered into, amended or renewed on or after the effective date of this act, and only with respect to losses incurred and reserves reported on or after the later of (1) the date on which the assuming insurer has met all eligibility requirements pursuant to paragraph 1 of this subsection, and (2) the effective date of the new reinsurance agreement, amendment or renewal.

a. This paragraph does not alter or impair the right of a ceding insurer to take credit for reinsurance, to the extent that credit is not available under this subsection, as long as the reinsurance qualifies for credit under any other applicable provision of this act.

b. Nothing in this subsection shall be construed to authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement, except as permitted by the terms of the agreement.

c. Nothing in this subsection shall be construed to limit, or in any way alter, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

H. Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subsection B, C, D, E, F or G of this section but only as the insurance of risks located

in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

I. If the assuming insurer is not licensed, accredited or certified to transact insurance or reinsurance in this state, the credit permitted by subsections D and E of this section shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

1. That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction, and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

2. To designate the Insurance Commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding insurer. This subsection is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.

J. If the assuming insurer does not meet the requirements of subsection B, C, ~~or~~ D, or G of this section, the credit permitted by

subsection E or F of this section shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

1. Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by paragraph 6 of subsection E of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the Commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the Commissioner with regulatory oversight all of the assets of the trust fund;

2. The assets shall be distributed by and claims shall be filed with and valued by the Commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies;

3. If the Commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be

returned by the Commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement; and

4. The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this provision.

K. If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the Commissioner may suspend or revoke the reinsurer's accreditation or certification.

1. The Commissioner shall give the reinsurer notice and opportunity for hearing. The suspension or revocation shall not take effect until after the Commissioner's order on hearing, unless:

a. the reinsurer waives its right to hearing,

b. the Commissioner's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under paragraph 6 of subsection F of this section, or

c. the Commissioner finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the Commissioner's action~~;~~.

2. While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the

effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with Section 5123 of this title. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance shall be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with paragraph 5 of subsection F of this section or Section 5123 of this title.

L. Concentration Risk.

1. A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business. A domestic ceding insurer shall notify the Commissioner within thirty (30) days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceeds fifty percent (50%) of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

2. A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the Commissioner within thirty (30) days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more

than twenty percent (20%) of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

SECTION 6. AMENDATORY 36 O.S. 2021, Section 5123, is amended to read as follows:

Section 5123. An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section 5122 of this title shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer; provided, further, that the Commissioner may adopt by regulation pursuant to subsection B of Section 5124 of this title, specific additional requirements relating to or setting forth: the valuation of assets or reserve credits, the amount and forms of security supporting reinsurance arrangements described in subsection B of Section 5124 of this title and the circumstances pursuant to which credit will be reduced or eliminated. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer~~,~~ including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and

under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution, as defined in subsection B of Section ~~3 of this act~~ 5123.1 of this title. This security may be in the form of:

1. Cash;

2. Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners~~,~~ including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office and qualifying as admitted assets;

3. a. Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in subsection A of Section ~~3~~ 5123.1 of this ~~act~~ title, effective no later than December 31 of the year for which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement.

b. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration,

extension, renewal, modification or amendment, whichever first occurs; or

4. Any other form of security acceptable to the Insurance Commissioner.

SECTION 7. AMENDATORY 36 O.S. 2021, Section 5124, is amended to read as follows:

Section 5124. A. The Insurance Commissioner may promulgate and adopt rules and regulations implementing the provisions of the Credit for Reinsurance Act.

B. The Insurance Commissioner is further authorized to adopt rules and regulations applicable to reinsurance arrangements described in paragraph 1 of this subsection.

1. A regulation adopted pursuant to this subsection may apply only to reinsurance relating to:

a. life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits,

b. universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period,

c. variable annuities with guaranteed death or living benefits,

d. long-term care insurance policies, or

e. such other life and health insurance and annuity products as to which the National Association of

Insurance Commissioners (NAIC) adopts model regulatory requirements with respect to credit for reinsurance.

2. A regulation adopted pursuant to this subsection which is applicable to policies listed in subparagraph a or b of paragraph 1 of this subsection may apply to any treaty containing:

a. policies issued on or after January 1, 2015, and

b. policies issued prior to January 1, 2015, if risk pertaining to such pre-2015 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015, unless the NAIC Accounting Practices and Procedures Manual in effect as of December 31, 2015, excluded such pre-2015 policies from the requirements concerning the amounts and forms of security supporting reinsurance arrangements that would otherwise be applicable to such policies.

3. A regulation adopted pursuant to this subsection may require the ceding insurer, in calculating the amounts or forms of security required to be held under regulations promulgated under this authority, to use the Valuation Manual adopted by the NAIC under Section 11B (1) of the NAIC Standard Valuation Law~~,~~ including all amendments adopted by the NAIC and in effect on the date as of which the calculation is made, to the extent applicable.

4. A regulation adopted pursuant to this subsection shall not apply to cessions to an assuming insurer that:

a. meets the conditions set forth in ~~this section~~ subsection G of Section 5122 of this title,

b. is certified in this state, or

c. maintains at least Two Hundred Fifty Million Dollars ($250,000,000.00) in capital and surplus when determined in accordance with the NAIC Accounting Practices and Procedures Manual~~,~~ including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices, and is:

(1) licensed in at least twenty-six states, or

(2) licensed in at least ten states, and licensed or accredited in a total of at least thirty-five states.

5. The authority to adopt regulations pursuant to this subsection does not limit the Commissioner's general authority to adopt regulations pursuant to subsection A of this section.

SECTION 8. AMENDATORY 36 O.S. 2021, Section 6060.21, is amended to read as follows:

Section 6060.21. A. For all plans issued or renewed on or after November 1, 2016, a health benefit plan and the Oklahoma Employees Health Insurance Plan shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in individuals ~~less than nine (9) years of age, or if an individual is~~

~~not diagnosed or treated until after three (3) years of age, coverage shall be provided for at least six (6) years, provided that the individual continually and consistently shows sufficient progress and improvement as determined by the health care provider~~. No insurer shall terminate coverage, or refuse to deliver, execute, issue, amend, adjust or renew coverage to an individual solely because the individual is diagnosed with or has received treatment for an autism spectrum disorder.

B. ~~Except as provided in subsection E of this section, coverage~~ Coverage under this section shall be subject to the provisions set forth in Section 6060.11 of this title; provided, however, that coverage shall not be subject to any limits on the number of visits an individual may make for treatment of autism spectrum disorder.

C. Coverage under this section shall not be subject to dollar limits, deductibles or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles or coinsurance provisions that apply to substantially all medical and surgical benefits under the health benefit plan~~, except as otherwise provided in subsection E of this section~~.

D. This section shall not be construed as limiting benefits that are otherwise available to an individual under a health benefit plan.

~~E. Coverage for applied behavior analysis shall be subject to a maximum benefit of twenty-five (25) hours per week and no more than~~

~~Twenty-five Thousand Dollars ($25,000.00) per year. Beginning January 1, 2018, the Oklahoma Insurance Commissioner shall, on an annual basis, adjust the maximum benefit for inflation by using the Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers (CPI-U). The Commissioner shall submit the adjusted maximum benefit for publication annually before January 1, 2018, and before the first day of January of each calendar year thereafter, and the published adjusted maximum benefit shall be applicable in the following calendar year to the Oklahoma Employees Health Insurance Plan and health benefit plans subject to this section. Payments made by an insurer on behalf of a covered individual for treatment other than applied behavior analysis shall not be applied toward any maximum benefit established under this section.~~

~~F.~~ E. Coverage for applied behavior analysis shall include the services provided or supervised by a board-certified behavior analyst, a board-certified assistant behavior analyst or a licensed doctoral-level psychologist.

~~G.~~ F. Except for inpatient services, if an insured is receiving treatment for an autism spectrum disorder, an insurer shall have the right to review the treatment plan annually, unless the insurer and the insured's treating physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall apply only to

a particular insured being treated for an autism spectrum disorder and shall not apply to all individuals being treated for autism spectrum disorder by a physician or psychologist. The cost of obtaining any review or treatment plan shall be borne by the insurer.

~~H.~~ G. This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program or an individualized service plan.

~~I. Nothing in this section shall apply to nongrandfathered plans in the individual and small group markets that are required to include essential health benefits under the federal Patient Protection and Affordable Care Act, Public Law 111-148, or to Medicare supplement, accident-only, specified disease, hospital indemnity, disability income, long-term care or other limited benefit hospital insurance policies.~~

~~J.~~ H. As used in this section:

1. "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior~~,~~ including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior;

2. "Autism spectrum disorder" means any of the pervasive developmental disorders or autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the edition that was in effect at the time of diagnosis;

3. "Behavioral health treatment" means counseling and treatment programs~~,~~ including applied behavior analysis, that are:

a. necessary to develop, maintain or restore, to the maximum extent practicable, the functioning of an individual, and

b. provided or supervised by a board-certified behavior analyst, a board-certified assistant behavior analyst or by a licensed doctoral-level psychologist so long as the services performed are commensurate with the psychologist's university training and experience;

4. "Diagnosis of autism spectrum disorder" means medically necessary assessment, evaluations or tests to diagnose whether an individual has an autism spectrum disorder;

5. "Health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of Title 36 of the Oklahoma Statutes;

6. "Oklahoma Employees Health Insurance Plan" means "Health Insurance Plan" as defined in Section 1303 of Title 74 of the Oklahoma Statutes;

7. "Pharmacy care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications;

8. "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

9. "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

10. "Therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists or physical therapists; and

11. "Treatment for autism spectrum disorder" means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed doctoral-level psychologist who determines the care to be medically necessary~~.~~ including, but not limited to:

a. behavioral health treatment,

b. pharmacy care,

c. psychiatric care,

d. psychological care, and

e. therapeutic care.

SECTION 9. AMENDATORY 36 O.S. 2021, Section 6454, is amended to read as follows:

Section 6454. A. 1. A risk retention group seeking to be chartered for domicile in this state shall be chartered and licensed only to write liability insurance pursuant to the insurance laws of this state and, except as provided elsewhere in the Oklahoma Risk Retention Act, shall comply with all of the laws, rules, regulations, and requirements applicable to such insurers chartered and licensed in this state ~~pursuant to~~ including Section 6455 of this title to the extent such requirements are not a limitation on the laws, rules, regulations and requirements in this state.

2. Notwithstanding any other provision of law, all risk retention groups chartered in this state shall file with the Insurance Department and the National Association of Insurance Commissioners an annual statement in a form prescribed by the Association and in electronic form, if required by the Insurance Commissioner and completed in accordance with its instructions and the Practices and Procedures Manual of the Association.

B. Before it may offer insurance in any state, each risk retention group licensed in this state shall submit for approval to the Insurance Commissioner of this state a plan of operation or a feasibility study. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study within ten (10) days of the change. The group shall not offer any additional kinds of liability insurance in this state or in any other state

until a revision of the plan or study is approved by the Commissioner. At the time of filing its application for charter, the risk retention group shall provide to the Commissioner a summary of the following information: the identity of the initial members of the group or who organized the group, the identity of those individuals who will provide administrative services or otherwise influence or control the activities of the group, the amount and nature of initial capitalization, the coverages to be afforded, and the states in which the group intends to operate. Upon receipt of this information, the Commissioner shall transmit the information to the National Association of Insurance Commissioners. Transmitting this information shall be sufficient to satisfy the requirements of Section 6455 of this section.

SECTION 10. AMENDATORY 36 O.S. 2021, Section 6470.35, is amended to read as follows:

Section 6470.35. 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~~ annual 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~~ 6470 of this title ~~Title 36 of the Oklahoma Statutes~~ for the initial five-year dormancy.

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~~ this title 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~~ this title.

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

SECTION 11. AMENDATORY 36 O.S. 2021, Section 6475.1, is amended to read as follows:

Section 6475.1. Sections ~~25~~ 6475.1 through ~~41~~ 6475.17 of this ~~act~~ title shall be known and may be cited as the "Uniform Health Carrier External Review Act".

SECTION 12. AMENDATORY 36 O.S. 2021, Section 6475.5, is amended to read as follows:

Section 6475.5. A. 1. A health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to Section ~~32, 33 or 34 of this act~~ 6475.8, 6475.9, or 6475.10 of this title and include the appropriate statements and information set forth in subsection B of

this section at the same time the health carrier sends written notice of:

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

b. a final adverse determination.

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

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

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

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

(1) if the covered person has a medical condition where the time frame for completion of an expedited review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to Section ~~34~~ 6475.10 of this ~~act~~ title, or Section ~~35~~ 6475.11 of this ~~act~~ title if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination, but

that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review, and

(2) the covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process, but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within thirty (30) days following the date the covered person or the covered person's authorized representative files the grievance with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to Section ~~30~~ 6475.6 of this ~~act~~ title and shall be considered to have exhausted the health carrier's internal grievance process

for purposes of Section ~~31~~ 6475.7 of this ~~act~~ title, and

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

(1) if the covered person has a medical condition where the time frame for completion of a standard external review pursuant to Section ~~32~~ 6475.8 of this ~~act~~ title would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to Section ~~33~~ 6475.9 of this ~~act~~ title, or

(2) if the final adverse determination concerns:

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

pursuant to Section ~~33~~ 6475.9 of this ~~act~~ title, or

(b) a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or the covered person's authorized representative may file a request for a standard external review to be conducted pursuant to Section ~~34~~ 6475.10 of this ~~act~~ title or if the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, the covered person or the covered person's authorized representative may request an expedited external review to be conducted under Section ~~34~~ 6475.10 of this ~~act~~ title.

2. In addition to the information to be provided pursuant to paragraph 1 of this subsection, the health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant

to Section ~~41~~ 6475.17 of this ~~act~~ title, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

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

SECTION 13. AMENDATORY 36 O.S. 2021, Section 6475.6, is amended to read as follows:

Section 6475.6. A. 1. Except for a request for an expedited external review as set forth in Section ~~33~~ 6475.9 of this ~~act~~ title, all requests for external review shall be made in writing to the Insurance Commissioner.

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

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

SECTION 14. AMENDATORY 36 O.S. 2021, Section 6475.7, is amended to read as follows:

Section 6475.7. A. 1. Except as provided in subsection B of this section, a request for an external review pursuant to Section ~~42, 43 or 44~~ 6475.8, 6475.9, or 6475.10 of this ~~act~~ title shall not be made until the covered person has exhausted the health carrier's internal grievance process.

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

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

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

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

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

(1) under Section ~~33~~ 6475.9 of this ~~act~~ title if the covered person has a medical condition where the time frame for completion of an expedited review of the grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, or

(2) under Section ~~34~~ 6475.10 of this ~~act~~ title if the adverse determination involves a denial of

coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

b. Upon receipt of a request for an expedited external review under subparagraph a of this paragraph, the independent review organization conducting the external review in accordance with the provisions of Section ~~33~~ 6475.9 or ~~34~~ 6475.10 of this ~~act~~ title shall determine whether the covered person shall be required to complete the expedited review process before it conducts the expedited external review.

c. Upon a determination made pursuant to subparagraph b of this paragraph that the covered person must first complete the expedited grievance review process, the independent review organization immediately shall notify the covered person and, if applicable, the covered person's authorized representative of this determination and that it will not proceed with the

expedited external review set forth in Section ~~33~~ 6475.9 of this ~~act~~ title until completion of the expedited grievance review process and the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

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

C. If the requirement to exhaust the health carrier's internal grievance procedures is waived under paragraph 2 of subsection B of this section, the covered person or the covered person's authorized representative may file a request in writing for a standard external review as set forth in Section ~~32~~ 6475.8 or ~~34~~ 6475.10 of this ~~act~~ title.

SECTION 15. AMENDATORY 36 O.S. 2021, Section 6475.8, is amended to read as follows:

Section 6475.8. A. 1. Within four (4) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section ~~29~~ 6475.5 of this ~~act~~ title, a covered person or the covered person's authorized representative may file a request for an external review with the Insurance Commissioner.

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

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

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

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

3. The covered person has exhausted the health carrier's internal grievance process unless the covered person is not required

to exhaust the health carrier's internal grievance process pursuant to Section ~~31~~ 6475.7 of this ~~act~~ title; and

4. The covered person has provided all the information and forms required to process an external review~~,~~ including the release form provided under subsection B of Section ~~29~~ 6475.5 of this ~~act~~ title.

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

a. the request is complete, and

b. the request is eligible for external review.

2. If the request:

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

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

include in the notice the reasons for its ineligibility.

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

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

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

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

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

a. assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Section ~~36~~ 6475.12 of this ~~act~~ title to conduct the external review and notify the health carrier of the name of the assigned independent review organization, and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The covered person's medical records;

2. The attending health care professional's recommendation;

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

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

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

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

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

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

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

a. the covered person,

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

c. the health carrier, and

d. the Commissioner.

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

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

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

c. the date the external review was conducted,

d. the date of its decision,

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

f. the rationale for its decision, and

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

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

J. The assignment by the Commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances~~,~~ including conflict of interest concerns pursuant to subsection D of Section ~~37~~ 6475.13 of this ~~act~~ title.

SECTION 16. AMENDATORY 36 O.S. 2021, Section 6475.9, is amended to read as follows:

Section 6475.9. A. Except as provided in subsection F of this section, a covered person or the covered person's authorized representative may make a request for an expedited external review

with the Insurance Commissioner at the time the covered person receives:

1. An adverse determination if:

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

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

2. A final adverse determination:

a. if the covered person has a medical condition where the time frame for completion of a standard external review pursuant to Section ~~32~~ 6475.8 of this ~~act~~ title would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, or

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

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

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

2. Immediately upon receipt of the request pursuant to paragraph 1 of this subsection, the health carrier shall determine whether the request meets the reviewability requirements set forth in subsection B of Section ~~32~~ 6475.8 of this ~~act~~ title. The health carrier shall immediately notify the Commissioner and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.

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

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

4. a. The Commissioner may determine that a request is eligible for external review under subsection B of Section ~~32~~ 6475.8 of this ~~act~~ title notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

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

5. Upon receipt of the notice that the request meets the reviewability requirements, the Commissioner immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Section ~~36~~ 6475.12 of this ~~act~~ title. The Commissioner shall immediately notify the health carrier of the name of the assigned independent review organization.

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

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

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

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

1. The covered person's pertinent medical records;

2. The attending health care professional's recommendation;

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

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

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

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

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

E. 1. As expeditiously as the covered person's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in subsection B of Section ~~32~~ 6475.8 of this ~~act~~ title, the assigned independent review organization shall:

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

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

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

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

b. include the information set forth in paragraph 2 of subsection I of Section ~~32~~ 6475.8 of this ~~act~~ title.

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

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

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

accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances~~,~~ including conflict of interest concerns pursuant to subsection D of Section ~~37~~ 6475.13 of this ~~act~~ title.

SECTION 17. AMENDATORY 36 O.S. 2021, Section 6475.10, is amended to read as follows:

Section 6475.10. A. 1. Within four (4) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section ~~29~~ 6475.5 of this ~~act~~ title that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the Insurance Commissioner.

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

the subject of the request would be significantly less effective if not promptly initiated.

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

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

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

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

determination that the external review request is ineligible for review may be appealed to the Commissioner.

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

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

e. Upon receipt of the notice that the expedited external review request meets the reviewability requirements of paragraph 2 of subsection B of this section, the Commissioner immediately shall assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Section ~~36~~ 6475.12 of this

~~act~~ title and notify the health carrier of the name of the assigned independent review organization.

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

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

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

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

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

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

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

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

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

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

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

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

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

d. the covered person's treating physician:

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

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

e. the covered person has exhausted the health carrier's internal grievance process unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section ~~31~~ 6475.7 of this ~~act~~ title, and

f. the covered person has provided all the information and forms required by the Commissioner that are necessary to process an external review~~,~~ including the release form provided under subsection B of Section ~~29~~ 6475.5 of this ~~act~~ title.

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

a. the request is complete, and

b. the request is eligible for external review.

2. If the request:

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

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

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

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

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

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

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

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

a. assign an independent review organization to conduct the external review from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Section ~~36~~ 6475.12 of this ~~act~~ title and notify the health carrier of the name of the assigned independent review organization, and

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

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

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

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

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

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

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

4. a. In selecting clinical reviewers pursuant to subparagraph a of paragraph 3 of this subsection, the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in Section ~~37~~ 6475.13 of this ~~act~~ title and, through clinical experience in the past three (3) years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. a description and analysis of any medical or scientific evidence, as that term is defined in Section ~~27~~ 6475.3 of this ~~act~~ title, considered in reaching the opinion,

d. a description and analysis of any evidence-based standard, as that term is defined in Section ~~27~~ 6475.3 of this ~~act~~ title, and

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

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

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

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

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

1. The covered person's pertinent medical records;

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

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

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

5. Whether:

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

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

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

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

(1) the covered person,

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

(3) the health carrier, and

(4) the Commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

d. the date the external review was conducted,

e. the date of its decision,

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

g. the rationale for its decision.

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

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

accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances~~,~~ including conflict of interest concerns pursuant to subsection D of Section ~~37~~ 6475.13 of this ~~act~~ title.

SECTION 18. AMENDATORY 36 O.S. 2021, Section 6475.12, is amended to read as follows:

Section 6475.12. A. The Insurance Commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under the Uniform Health Carrier External Review Act.

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

1. Except as otherwise provided in this section, shall be accredited by a nationally recognized private accrediting entity that the Commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under Section ~~37~~ 6475.13 of this ~~act~~ title; and

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

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

D. 1. Any independent review organization wishing to be approved to conduct external reviews under this act shall submit the application form and include with the form all documentation and information necessary for the Commissioner to determine if the independent review organization satisfies the minimum qualifications established under Section ~~37~~ 6475.13 of this ~~act~~ title.

2. a. Subject to subparagraph b of this paragraph, an independent review organization is eligible for approval under this section only if it is accredited by a nationally recognized private accrediting entity that the Commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under Section ~~37~~ 6475.13 of this ~~act~~ title.

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

entities providing independent review organization accreditation.

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

E. 1. An approval is effective for two (2) years, unless the Commissioner determines before its expiration that the independent review organization is not satisfying the minimum qualifications established under Section ~~38~~ 6475.14 of this ~~act~~ title.

2. Whenever the Commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under Section ~~38~~ 6475.14 of this ~~act~~ title, the Commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under the Uniform Health Carrier External Review Act that is maintained by the Commissioner pursuant to subsection F of this section.

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

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

SECTION 19. AMENDATORY 36 O.S. 2021, Section 6475.15, is amended to read as follows:

Section 6475.15. A. 1. An independent review organization assigned pursuant to Section ~~32~~ 6475.8, ~~33~~ 6475.9, or ~~34~~ 6475.10 of this ~~act~~ title to conduct an external review shall maintain written records in the aggregate by state and by health carrier on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the Insurance Commissioner, as required under paragraph 2 of this subsection.

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

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

a. the total number of requests for external review,

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

c. the average length of time for resolution,

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

e. the number of external reviews pursuant to subsection G of Section ~~32~~ 6475.8 of this ~~act~~ title that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative, and

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

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

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

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

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

a. the total number of requests for external review,

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

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

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

SECTION 20. This act shall become effective November 1, 2022.

COMMITTEE REPORT BY: COMMITTEE ON INSURANCE, dated 04/06/2022 - DO PASS.