

1 **HOUSE OF REPRESENTATIVES - FLOOR VERSION**

2 STATE OF OKLAHOMA

3 2nd Session of the 58th Legislature (2022)

4 ENGROSSED SENATE
5 BILL NO. 1240

By: Quinn of the Senate

and

Sneed of the House

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8
9 An Act relating insurance; amending 36 O.S. 2021,
10 Sections 1106.1, 3101, 3105, 3623.1, 5122, 5123,
11 5124, 6060.21, 6454, 6470.35, 6475.1, 6475.5, 6475.6,
12 6475.7, 6475.8, 6475.9, 6475.10, 6475.12, and
13 6475.15, which relate to consumer price index, motor
14 service clubs, policy and membership fees, Credit for
15 Reinsurance Act, coverage for individuals with autism
16 spectrum disorder, Oklahoma Risk Retention Act,
17 Oklahoma Captive Insurance Company Act, and Uniform
18 Health Carrier External Review Act; updating
19 definition to statutory requirement; conforming
20 definitions; conforming language; updating statutory
21 reference; deleting obsolete language; and providing
22 an effective date.

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

24 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Section 3101. As used in this act:

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

5 2. "Company" means any person, firm, copartnership, company,
6 association or corporation engaged in selling, furnishing or
7 procuring, either as principal or producer, for a consideration,
8 motor club service;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 SECTION 3. AMENDATORY 36 O.S. 2021, Section 3105, is
20 amended to read as follows:

21 Section 3105. A. Each motor service club operating in this
22 state pursuant to certificate of authority issued hereunder shall
23 file with the Commissioner, within ten (10) days of the date of
24 employment, a notice of appointment of any insurance producer or

1 limited lines producer, resident or nonresident, appointed by the
2 automobile club to sell memberships in the motor service club to the
3 public. This notification shall be upon such form as the
4 Commissioner may prescribe and shall contain the name, address, age,
5 sex, and Social Security number of such club producer, and shall
6 also contain proof satisfactory to the Commissioner that such
7 applicant is not less than eighteen (18) years of age, is of good
8 reputation, and has received training from the club or is otherwise
9 qualified in the field of motor service club service contracts and
10 knowledgeable of the laws of this state pertaining thereto.

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

14 C. Upon notice and hearing, the Commissioner may suspend,
15 censure, revoke, or refuse to renew any license of a producer if he
16 finds as to the licensee that any one or more of the following
17 causes exist:

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

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

22 3. Oral or written misrepresentation of the terms, conditions,
23 benefits, or privileges of any motor service club service contract
24

1 issued or to be issued by the motor service club he represents or
2 any other motor service club;

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

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

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

11 7. Fraudulent or dishonest practices;

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

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

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

23 SECTION 4. AMENDATORY 36 O.S. 2021, Section 3623.1, is
24 amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Commissioner with principal regulatory oversight of
2 the trust may authorize a reduction in the required
3 trusted surplus, but only after a finding, based on
4 an assessment of the risk, that the new required
5 surplus level is adequate for the protection of United
6 States ceding insurers, policyholders and claimants in
7 light of reasonably foreseeable adverse loss
8 development. The risk assessment may involve an
9 actuarial review, including an independent analysis of
10 reserves and cash flows, and shall consider all
11 material risk factors, including when applicable the
12 lines of business involved, the stability of the
13 incurred loss estimates and the effect of the surplus
14 requirements on the assuming insurer's liquidity or
15 solvency. The minimum required trusted surplus shall
16 not be reduced to an amount less than thirty percent
17 (30%) of the assuming insurer's liabilities
18 attributable to reinsurance ceded by United States
19 ceding insurers covered by the trust,

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

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

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

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

18 (c) in addition to these trusts, the group shall
19 maintain in trust a trusteeed surplus of
20 which One Hundred Million Dollars
21 (\$100,000,000.00) shall be held jointly for
22 the benefit of the United States-domiciled
23 ceding insurers of any member of the group
24 for all years of account,

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

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

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

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

22 (2) maintain aggregate policyholders' surplus of at
23 least Ten Billion Dollars (\$10,000,000,000.00),
24

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

7 (4) in addition, maintain a joint trusteed surplus of
8 which One Hundred Million Dollars
9 (\$100,000,000.00) shall be held jointly for the
10 benefit of United States-domiciled ceding
11 insurers of any member of the group as additional
12 security for these liabilities, and

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

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

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

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

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

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

13 d. the assuming insurer shall agree to submit to the
14 jurisdiction of this state, appoint the Commissioner
15 as its agent for service of process in this state and
16 agree to provide security for one hundred percent
17 (100%) of the assuming insurer's liabilities
18 attributable to reinsurance ceded by United States
19 ceding insurers if it resists enforcement of a final
20 United States judgment,

21 e. the assuming insurer shall agree to meet applicable
22 information filing requirements as determined by the
23 Commissioner, both with respect to an initial
24

1 application for certification and on an ongoing basis,
2 and

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

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

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

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

24

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

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

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

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

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

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

24

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

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

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

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

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

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

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

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

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

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

24 8. For purposes of this subsection:

- 1 a. a certified reinsurer whose certification has been
2 terminated for any reason shall be treated as a
3 certified reinsurer required to secure one hundred
4 percent (100%) of its obligations, and
- 5 b. the term "terminated" refers to revocation,
6 suspension, voluntary surrender and inactive status.
7 If the Commissioner continues to assign a higher
8 rating as permitted by this section, the requirement
9 to secure one hundred percent (100%) of its
10 obligations shall not apply to a certified reinsurer
11 in inactive status or to a reinsurer whose
12 certification has been suspended.

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

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

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

1 state of the European Union. For purposes of
2 this subparagraph, a "covered agreement" is an
3 agreement entered into pursuant to Dodd-Frank
4 Wall Street Reform and Consumer Protection Act,
5 31 U.S.C. Sections 313 and 314, that is currently
6 in effect or in a period of provisional
7 application and addresses the elimination, under
8 specified conditions, of collateral requirements
9 as a condition for entering into any reinsurance
10 agreement with a ceding insurer domiciled in this
11 state or for allowing the ceding insurer to
12 recognize credit for reinsurance,

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

17 (3) a qualified jurisdiction, as determined by the
18 Commissioner pursuant to ~~subparagraph a of~~
19 paragraph 3 of subsection F of this section, that
20 is not otherwise described in division 1 or 2 of
21 subparagraph a of paragraph 1 of this subsection
22 and meets additional requirements consistent with
23 the terms and conditions of in-force, covered
24

1 agreements, as specified by the Commissioner in
2 rules,

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

16 c. the assuming insurer shall have and maintain, on an
17 ongoing basis, a minimum solvency or capital ratio, as
18 applicable, which will be set forth in Department
19 rules. If the assuming insurer is an association
20 including incorporated and individual unincorporated
21 underwriters, it shall have and maintain, on an
22 ongoing basis, a minimum solvency or capital ratio in
23 the reciprocal jurisdiction where the assuming insurer
24

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

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

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

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

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

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

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

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

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

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

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

21 h. nothing in this provision shall be construed to
22 preclude an assuming insurer from providing the
23 Commissioner with information on a voluntary basis.
24

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 3. If the Commissioner with regulatory oversight determines
21 that the assets of the trust fund or any part thereof are not
22 necessary to satisfy the claims of the United States ceding insurers
23 of the grantor of the trust, the assets or part thereof shall be
24

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

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

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

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

- 12 a. the reinsurer waives its right to hearing,
13 b. the Commissioner's order is based on regulatory action
14 by the reinsurer's domiciliary jurisdiction or the
15 voluntary surrender or termination of the reinsurer's
16 eligibility to transact insurance or reinsurance
17 business in its domiciliary jurisdiction or in the
18 primary certifying state of the reinsurer under
19 paragraph 6 of subsection F of this section, or
20 c. the Commissioner finds that an emergency requires
21 immediate action and a court of competent jurisdiction
22 has not stayed the Commissioner's action.

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

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

9 L. Concentration Risk.

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

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

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

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

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

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

5 1. Cash;

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

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

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

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

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

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

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

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

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

- 15 a. life insurance policies with guaranteed nonlevel gross
16 premiums or guaranteed nonlevel benefits,
- 17 b. universal life insurance policies with provisions
18 resulting in the ability of a policyholder to keep a
19 policy in force over a secondary guarantee period,
- 20 c. variable annuities with guaranteed death or living
21 benefits,
- 22 d. long-term care insurance policies, or
- 23 e. such other life and health insurance and annuity
24 products as to which the National Association of

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

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

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

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

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

- 1 a. meets the conditions set forth in ~~this section~~
2 subsection G of Section 5122 of this title,
3 b. is certified in this state, or
4 c. maintains at least Two Hundred Fifty Million Dollars
5 (\$250,000,000.00) in capital and surplus when
6 determined in accordance with the NAIC Accounting
7 Practices and Procedures Manual, including all
8 amendments thereto adopted by the NAIC, excluding the
9 impact of any permitted or prescribed practices, and
10 is:
11 (1) licensed in at least twenty-six states, or
12 (2) licensed in at least ten states, and licensed or
13 accredited in a total of at least thirty-five
14 states.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24

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

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

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

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

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

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

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

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

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

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

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

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

- 18 a. behavioral health treatment,
- 19 b. pharmacy care,
- 20 c. psychiatric care,
- 21 d. psychological care, and
- 22 e. therapeutic care.

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

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

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

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

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

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

16 Section 6470.35. A. As used in this section, "dormant captive
17 insurance company" means a captive insurance company that has:

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

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

23 B. A dormant captive insurance company domiciled in this state
24 that meets the criteria of subsection A of this section may apply to

1 the Insurance Commissioner for a certificate of dormancy. The
2 certificate of dormancy shall be subject to renewal every five (5)
3 years and shall be forfeited if not renewed within such time.

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

6 1. Possess and thereafter maintain unimpaired, paid-in capital
7 and surplus of not less than Twenty-five Thousand Dollars
8 (\$25,000.00);

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

13 3. Pay a nonrefundable ~~renewal~~ annual fee of Five Hundred
14 Dollars (\$500.00).

15 D. A dormant captive insurance company shall not be subject to
16 or liable for the payment of any tax under Section ~~6753~~ 6470 of this
17 title ~~Title 36 of the Oklahoma Statutes~~ for the initial five-year
18 dormancy.

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

23

24

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

4 G. A dormant captive insurance company may be subject to
5 examination under Section 6470.13 of ~~Title 36 of the Oklahoma~~
6 ~~Statutes~~ this title for any year when it did not qualify as a
7 dormant captive insurance company. The Insurance Commissioner may
8 examine a dormant captive insurance company pursuant to Section
9 6470.13 of ~~Title 36 of the Oklahoma Statutes~~ this title.

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

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

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

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

19 Section 6475.5. A. 1. A health carrier shall notify the
20 covered person in writing of the covered person's right to request
21 an external review to be conducted pursuant to Section ~~32, 33 or 34~~
22 ~~of this act~~ 6475.8, 6475.9, or 6475.10 of this title and include the
23 appropriate statements and information set forth in subsection B of
24

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

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

7 b. a final adverse determination.

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

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

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

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

1 (1) if the covered person has a medical condition
2 where the time frame for completion of an
3 expedited review of a grievance involving an
4 adverse determination would seriously jeopardize
5 the life or health of the covered person or would
6 jeopardize the covered person's ability to regain
7 maximum function, the covered person or the
8 covered person's authorized representative may
9 file a request for an expedited external review
10 to be conducted pursuant to Section ~~34~~ 6475.10 of
11 this ~~act~~ title, or Section ~~35~~ 6475.11 of this ~~act~~
12 title if the adverse determination involves a
13 denial of coverage based on a determination that
14 the recommended or requested health care service
15 or treatment is experimental or investigational
16 and the covered person's treating physician
17 certifies in writing that the recommended or
18 requested health care service or treatment that
19 is the subject of the adverse determination would
20 be significantly less effective if not promptly
21 initiated, at the same time the covered person or
22 the covered person's authorized representative
23 files a request for an expedited review of a
24 grievance involving an adverse determination, but

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

7 (2) the covered person or the covered person's
8 authorized representative may file a grievance
9 under the health carrier's internal grievance
10 process, but if the health carrier has not issued
11 a written decision to the covered person or the
12 covered person's authorized representative within
13 thirty (30) days following the date the covered
14 person or the covered person's authorized
15 representative files the grievance with the
16 health carrier and the covered person or the
17 covered person's authorized representative has
18 not requested or agreed to a delay, the covered
19 person or the covered person's authorized
20 representative may file a request for external
21 review pursuant to Section ~~30~~ 6475.6 of this ~~act~~
22 title and shall be considered to have exhausted
23 the health carrier's internal grievance process
24

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

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

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

16 (2) if the final adverse determination concerns:

17 (a) an admission, availability of care,
18 continued stay or health care service for
19 which the covered person received emergency
20 services, but has not been discharged from a
21 facility, the covered person or the covered
22 person's authorized representative may
23 request an expedited external review
24

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

3 (b) a denial of coverage based on a
4 determination that the recommended or
5 requested health care service or treatment
6 is experimental or investigational, the
7 covered person or the covered person's
8 authorized representative may file a request
9 for a standard external review to be
10 conducted pursuant to Section ~~34~~ 6475.10 of
11 this ~~act~~ title or if the covered person's
12 treating physician certifies in writing that
13 the recommended or requested health care
14 service or treatment that is the subject of
15 the request would be significantly less
16 effective if not promptly initiated, the
17 covered person or the covered person's
18 authorized representative may request an
19 expedited external review to be conducted
20 under Section ~~34~~ 6475.10 of this ~~act~~ title.

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

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

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

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

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

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

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

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

6 Section 6475.7. A. 1. Except as provided in subsection B of
7 this section, a request for an external review pursuant to Section
8 ~~42, 43 or 44~~ 6475.8, 6475.9, or 6475.10 of this ~~act~~ title shall not
9 be made until the covered person has exhausted the health carrier's
10 internal grievance process.

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

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

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

24

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

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

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

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

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

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

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

1 expedited external review set forth in Section ~~33~~
2 6475.9 of this ~~act~~ title until completion of the
3 expedited grievance review process and the covered
4 person's grievance at the completion of the expedited
5 grievance review process remains unresolved.

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

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

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

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

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

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

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

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

22 3. The covered person has exhausted the health carrier's
23 internal grievance process unless the covered person is not required
24

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

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

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

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

13 2. If the request:

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

24

1 include in the notice the reasons for its
2 ineligibility.

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

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

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

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

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

- 6 a. assign an independent review organization from the
7 list of approved independent review organizations
8 compiled and maintained by the Commissioner pursuant
9 to Section ~~36~~ 6475.12 of this ~~act~~ title to conduct the
10 external review and notify the health carrier of the
11 name of the assigned independent review organization,
12 and
- 13 b. notify in writing the covered person and, if
14 applicable, the covered person's authorized
15 representative of the request's eligibility and
16 acceptance for external review.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 H. In addition to the documents and information provided
22 pursuant to subsection E of this section, the assigned independent
23 review organization, to the extent the information or documents are
24

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

- 3 1. The covered person's medical records;
- 4 2. The attending health care professional's recommendation;
- 5 3. Consulting reports from appropriate health care

6 professionals and other documents submitted by the health carrier,
7 covered person, the covered person's authorized representative, or
8 the covered person's treating provider;

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

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

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

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

24

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

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

- 8 a. the covered person,
- 9 b. if applicable, the covered person's authorized
10 representative,
- 11 c. the health carrier, and
- 12 d. the Commissioner.

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

- 15 a. a general description of the reason for the request
16 for external review,
- 17 b. the date the independent review organization received
18 the assignment from the Commissioner to conduct the
19 external review,
- 20 c. the date the external review was conducted,
- 21 d. the date of its decision,
- 22 e. the principal reason or reasons for its decision,
23 including what applicable, if any, evidence-based
24 standards were a basis for its decision,

- 1 f. the rationale for its decision, and
2 g. references to the evidence or documentation, including
3 the evidence-based standards, considered in reaching
4 its decision.

5 3. Upon receipt of a notice of a decision pursuant to paragraph
6 1 of this subsection reversing the adverse determination or final
7 adverse determination, the health carrier immediately shall approve
8 the coverage that was the subject of the adverse determination or
9 final adverse determination.

10 J. The assignment by the Commissioner of an approved
11 independent review organization to conduct an external review in
12 accordance with this section shall be done on a random basis among
13 those approved independent review organizations qualified to conduct
14 the particular external review based on the nature of the health
15 care service that is the subject of the adverse determination or
16 final adverse determination and other circumstances, including
17 conflict of interest concerns pursuant to subsection D of Section ~~37~~
18 6475.13 of this ~~act~~ title.

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

21 Section 6475.9. A. Except as provided in subsection F of this
22 section, a covered person or the covered person's authorized
23 representative may make a request for an expedited external review
24

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

3 1. An adverse determination if:

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

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

15 2. A final adverse determination:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 18 1. The covered person's pertinent medical records;
- 19 2. The attending health care professional's recommendation;
- 20 3. Consulting reports from appropriate health care
21 professionals and other documents submitted by the health carrier,
22 covered person, the covered person's authorized representative or
23 the covered person's treating provider;

24

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

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

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

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

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

24

- 1 a. make a decision to uphold or reverse the adverse
2 determination or final adverse determination, and
3 b. notify the covered person, if applicable, the covered
4 person's authorized representative, the health
5 carrier, and the Commissioner of the decision.

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

- 10 a. provide written confirmation of the decision to the
11 covered person, if applicable, the covered person's
12 authorized representative, the health carrier, and the
13 Commissioner, and
14 b. include the information set forth in paragraph 2 of
15 subsection I of Section ~~32~~ 6475.8 of this ~~act~~ title.

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

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

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

1 accordance with this section shall be done on a random basis among
2 those approved independent review organizations qualified to conduct
3 the particular external review based on the nature of the health
4 care service that is the subject of the adverse determination or
5 final adverse determination and other circumstances, including
6 conflict of interest concerns pursuant to subsection D of Section ~~37~~
7 6475.13 of this ~~act~~ title.

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

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

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

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

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

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

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

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

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

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

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

16 e. Upon receipt of the notice that the expedited external
17 review request meets the reviewability requirements of
18 paragraph 2 of subsection B of this section, the
19 Commissioner immediately shall assign an independent
20 review organization to review the expedited request
21 from the list of approved independent review
22 organizations compiled and maintained by the
23 Commissioner pursuant to Section ~~36~~ 6475.12 of this
24

1 ~~aet~~ title and notify the health carrier of the name of
2 the assigned independent review organization.

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

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

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

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

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

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

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

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

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

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

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

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

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

5 d. the covered person's treating physician:

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

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

24

1 e. the covered person has exhausted the health carrier's
2 internal grievance process unless the covered person
3 is not required to exhaust the health carrier's
4 internal grievance process pursuant to Section ~~31~~
5 6475.7 of this ~~act~~ title, and

6 f. the covered person has provided all the information
7 and forms required by the Commissioner that are
8 necessary to process an external review, including the
9 release form provided under subsection B of Section ~~29~~
10 6475.5 of this ~~act~~ title.

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

- 15 a. the request is complete, and
16 b. the request is eligible for external review.

17 2. If the request:

- 18 a. is not complete, the health carrier shall inform in
19 writing the Commissioner and the covered person and,
20 if applicable, the covered person's authorized
21 representative and include in the notice what
22 information or materials are needed to make the
23 request complete, or
24

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

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

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

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

24

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

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

11 D. 1. Within one (1) business day after the receipt of the
12 notice from the health carrier that the external review request is
13 eligible for external review pursuant to subparagraph d of paragraph
14 2 of subsection A of this section or paragraph 5 of subsection C of
15 this section, the Commissioner shall:

- 16 a. assign an independent review organization to conduct
17 the external review from the list of approved
18 independent review organizations compiled and
19 maintained by the Commissioner pursuant to Section ~~36~~
20 6475.12 of this ~~act~~ title and notify the health
21 carrier of the name of the assigned independent review
22 organization, and
- 23 b. notify in writing the covered person and, if
24 applicable, the covered person's authorized

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

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

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

- 18 a. select one or more clinical reviewers, as it
19 determines is appropriate, pursuant to paragraph 4 of
20 this subsection to conduct the external review, and
21 b. based on the opinion of the clinical reviewer, or
22 opinions if more than one clinical reviewer has been
23 selected to conduct the external review, make a
24

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

3 4. a. In selecting clinical reviewers pursuant to
4 subparagraph a of paragraph 3 of this subsection, the
5 assigned independent review organization shall select
6 physicians or other health care professionals who meet
7 the minimum qualifications described in Section ~~37~~
8 6475.13 of this ~~act~~ title and, through clinical
9 experience in the past three (3) years, are experts in
10 the treatment of the covered person's condition and
11 knowledgeable about the recommended or requested
12 health care service or treatment.

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

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

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

1 6565 of ~~Title 36 of the Oklahoma Statutes~~ this title or the health
2 carrier's internal grievance process.

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

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

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

21 b. Immediately upon making the decision under
22 subparagraph a of this paragraph, the independent
23 review organization shall notify the covered person,
24

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 d. a description and analysis of any evidence-based
21 standard, as that term is defined in Section ~~27~~ 6475.3
22 of this ~~act~~ title, and
23
24

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

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

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

19 I. In addition to the documents and information provided
20 pursuant to paragraph 2 of subsection A of this section or
21 subsection E of this section, each clinical reviewer selected
22 pursuant to subsection D of this section, to the extent the
23 information or documents are available and the reviewer considers
24

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

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

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

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

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

17 5. Whether:

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

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

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

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

- 15 (1) the covered person,
- 16 (2) if applicable, the covered person's authorized
17 representative,
- 18 (3) the health carrier, and
- 19 (4) the Commissioner.

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

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

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

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

20 b. If a majority of the clinical reviewers recommend that
21 the recommended or requested health care service or
22 treatment should not be covered, the independent
23 review organization shall make a decision to uphold
24

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

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

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

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

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

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

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

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

13 d. the date the external review was conducted,

14 e. the date of its decision,

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

16 g. the rationale for its decision.

17 4. Upon receipt of a notice of a decision pursuant to paragraph
18 1 of this subsection reversing the adverse determination or final
19 adverse determination, the health carrier immediately shall approve
20 coverage of the recommended or requested health care service or
21 treatment that was the subject of the adverse determination or final
22 adverse determination.

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

1 accordance with this section shall be done on a random basis among
2 those approved independent review organizations qualified to conduct
3 the particular external review based on the nature of the health
4 care service that is the subject of the adverse determination or
5 final adverse determination and other circumstances, including
6 conflict of interest concerns pursuant to subsection D of Section ~~37~~
7 6475.13 of this ~~act~~ title.

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

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

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

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

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

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

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

12 2. a. Subject to subparagraph b of this paragraph, an
13 independent review organization is eligible for
14 approval under this section only if it is accredited
15 by a nationally recognized private accrediting entity
16 that the Commissioner has determined has independent
17 review organization accreditation standards that are
18 equivalent to or exceed the minimum qualifications for
19 independent review organizations under Section ~~37~~
20 6475.13 of this ~~act~~ title.

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

1 entities providing independent review organization
2 accreditation.

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

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

10 2. Whenever the Commissioner determines that an independent
11 review organization has lost its accreditation or no longer
12 satisfies the minimum requirements established under Section ~~38~~
13 6475.14 of this ~~act~~ title, the Commissioner shall terminate the
14 approval of the independent review organization and remove the
15 independent review organization from the list of independent review
16 organizations approved to conduct external reviews under the Uniform
17 Health Carrier External Review Act that is maintained by the
18 Commissioner pursuant to subsection F of this section.

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

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

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

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

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

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

- 16 a. the total number of requests for external review,
- 17 b. the number of requests for external review resolved
18 and, of those resolved, the number resolved upholding
19 the adverse determination or final adverse
20 determination and the number resolved reversing the
21 adverse determination or final adverse determination,
- 22 c. the average length of time for resolution,

23
24

- 1 d. a summary of the types of coverages or cases for which
2 an external review was sought, as provided in the
3 format required by the Commissioner,
4 e. the number of external reviews pursuant to subsection
5 G of Section ~~32~~ 6475.8 of this ~~act~~ title that were
6 terminated as the result of a reconsideration by the
7 health carrier of its adverse determination or final
8 adverse determination after the receipt of additional
9 information from the covered person or the covered
10 person's authorized representative, and
11 f. any other information the Commissioner may request or
12 require.

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

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

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

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

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

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

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

13
14 COMMITTEE REPORT BY: COMMITTEE ON INSURANCE, dated 04/06/2022 - DO
15 PASS.
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