

An Act

ENROLLED SENATE
BILL NO. 1485

By: Brown of the Senate

and

Moore of the House

An Act relating to insurance; amending 36 O.S. 2011, Sections 321, as amended by Section 2, Chapter 275, O.S.L. 2014, 1106, as last amended by Section 1, Chapter 415, O.S.L. 2014, 1441.1, as amended by Section 8, Chapter 298, O.S.L. 2015, 1250.4, as amended by Section 20, Chapter 254, O.S.L. 2013, 1605, 3102, 1250.7, 3629, 4424, as amended by Section 1, Chapter 264, O.S.L. 2016, 6453 and 6470.12, as last amended by Section 18, Chapter 298, O.S.L. 2015 (36 O.S. Supp. 2017, Sections 321, 1106, 1441.1, 1250.4, 4424 and 6470.12), which relate to fees and licenses, surplus lines, the Third Party Administrator Act, claim files, investments in any one person, issuance of certificates, property and casualty insurers, forms of proof of loss, Long-Term Care Insurance Act, definitions and actuarial opinion; modifying certain fee; modifying requirements for obtaining surplus lines license; clarifying list of persons required to submit response to certain inquiries; modifying certain exception; modifying actions required for issuance of certain certificate; modifying timeline for certain responses by insurer; modifying definitions; modifying requirements for filing certain actuarial opinions; updating language; updating statutory references; and providing an effective date.

SUBJECT: Insurance

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

SECTION 1. AMENDATORY 36 O.S. 2011, Section 321, as amended by Section 2, Chapter 275, O.S.L. 2014 (36 O.S. Supp. 2017, Section 321), is amended to read as follows:

Section 321. A. The Insurance Commissioner shall collect in advance the following fees:

1. For filing charter documents:

Original charter documents,
articles of incorporation, bylaws,
or record of organization of alien
or foreign insurers, or certified
copies thereof.....\$50.00

2. Certificate of Authority or Certificate of Approval:

(a) Issuance:

.....\$150.00

(b) Renewal:

.....\$150.00

3. For filing appointment of Insurance
Commissioner as agent for service
of process.....\$10.00

4. Miscellaneous:

(a) Copies of records, per page.....\$0.40

(b) Amended charter documents,
articles of incorporation or
bylaws of domestic, alien or
foreign insurers or health
maintenance organizations.....\$50.00

- (c) Certificate of Commissioner,
under seal.....\$5.00
- (d) For filing Merger and
Acquisition Forms (Domestic
Insurers).....\$1,000.00
- (e) For filing Variable Product
Forms.....\$200.00
- (f) For filing a Life, Accident
and Health Policy and Health
Maintenance Organization
contract.....\$50.00
- (g) For filing an advertisement or
rider application to a Life,
Accident and Health Policy and
Health Maintenance
Organization contract.....\$25.00
- (h) Pending Company Review.....\$1,000.00
- (i) For filing a Viatical
Settlement Contract or Life
Settlement.....\$50.00
- (j) For filing an advertisement
for Viatical Settlement or
Life Settlement.....\$25.00
- (k) For filing application for
Viatical Settlement or Life
Settlement Contract.....\$25.00
- (l) Miscellaneous form filing.....\$25.00

B. There shall be assessed an annual fee of Five Hundred Dollars (\$500.00) payable by each insurer, health maintenance organization, fraternal benefit society, hospital service and medical indemnity corporation, or charitable and benevolent

corporation licensed to do business in this state, or United States surplus lines insurance companies licensed approved to do business in this state, to pay for the filing, processing, and reviewing of ~~annual and quarterly~~ financial statements by personnel of the Office of the State Insurance Commissioner.

SECTION 2. AMENDATORY 36 O.S. 2011, Section 1106, as last amended by Section 1, Chapter 415, O.S.L. 2014 (36 O.S. Supp. 2017, Section 1106), is amended to read as follows:

Section 1106. If insurance required to protect the interest of the insured for the amount of insurance, coverage terms and solvency requirements of the insured cannot be procured from admitted insurers after inquiry in the market available to the insurance producer, then insurance may be procured from surplus lines insurers subject to the following conditions:

1. The surplus lines insurer shall meet the requirements of the Unauthorized Insurers and Surplus Lines Insurance Act and the following conditions:

- a. the insurer has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which equals the greater of:
 - (1) the minimum capital and surplus requirements under the laws of this state for nonadmitted insurers, or
 - (2) Fifteen Million Dollars (\$15,000,000.00),
- b. the requirements of subparagraph a of this paragraph may be satisfied by an insurer's possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the Insurance Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and reputation within the industry. In no event shall the Insurance Commissioner make an affirmative finding of acceptability when the

nonadmitted insurer's capital and surplus is less than Four Million Five Hundred Thousand Dollars (\$4,500,000.00), and

- c. the insurer, if an alien insurer, is listed on the National Association of Insurance Commissioners Nonadmitted Insurers Quarterly Listing; and

2. The insurance shall be procured through a licensed surplus lines licensee or broker licensed in the insurer's home state. An Oklahoma surplus lines license is required only where Oklahoma is the home state of the ~~insurer~~ insured.

For the purposes of carrying out the provisions of the Nonadmitted and Reinsurance Reform Act of 2010, the Insurance Commissioner is authorized to utilize the national insurance producer database of the National Association of Insurance Commissioners, or any other equivalent uniform national database, for the licensure of an individual or entity as a surplus lines licensee or broker and for renewal of such license.

SECTION 3. AMENDATORY 36 O.S. 2011, Section 1441.1, as amended by Section 8, Chapter 298, O.S.L. 2015 (36 O.S. Supp. 2017, Section 1441.1), is amended to read as follows:

Section 1441.1. The provisions of Section 1441 et seq. of this title shall not apply to administrators of group self-insurance associations created pursuant to Section ~~399~~ 103 of Title ~~85~~ 85A of the Oklahoma Statutes.

SECTION 4. AMENDATORY 36 O.S. 2011, Section 1250.4, as amended by Section 20, Chapter 254, O.S.L. 2013 (36 O.S. Supp. 2017, Section 1250.4), is amended to read as follows:

Section 1250.4. A. An insurer's claim files shall be subject to examination by the Insurance Commissioner or by duly appointed designees. Such files shall contain all notes and work papers pertaining to a claim in such detail that pertinent events and the dates of such events can be reconstructed. In addition, the Insurance Commissioner, authorized employees and examiners shall have access to any of an insurer's files that may relate to a

particular complaint under investigation or to an inquiry or examination by the Insurance Department.

B. ~~Every agent, adjuster, administrator, insurance company representative, or insurer~~ Any person subject to the jurisdiction of the Commissioner, upon receipt of any inquiry from the Commissioner shall, within thirty (30) days from the date of the inquiry, furnish the Commissioner with an adequate response to the inquiry.

C. Every insurer, upon receipt of any pertinent written communication including but not limited to e-mail or other forms of written electronic communication, or documentation by the insurer of a verbal communication from a claimant which reasonably suggests that a response is expected, shall, within thirty (30) days after receipt thereof, furnish the claimant with an adequate response to the communication.

D. Any violation by an insurer of this section shall subject the insurer to discipline including a civil penalty of not less than One Hundred Dollars (\$100.00) nor more than Five Thousand Dollars (\$5,000.00).

SECTION 5. AMENDATORY 36 O.S. 2011, Section 1605, is amended to read as follows:

Section 1605. An insurer shall not, except with the consent of the Insurance Commissioner, have at any one time any combination of checking account moneys, investments in or loans upon the security of the obligations, property, or securities of any one person, institution, corporation, or municipal corporation, aggregating an amount exceeding ten percent (10%) of the insurer's admitted assets. This restriction shall not apply to investments in or loans upon the security of general obligations of the United States or any state of the United States or include policy loans made under Section 1619 of this title, or investments made under Section 1616 of this title.

SECTION 6. AMENDATORY 36 O.S. 2011, Section 3102, is amended to read as follows:

Section 3102. A. No company shall sell, or offer for sale, any motor club service without first having deposited with the Commissioner the sum of Fifty Thousand Dollars (\$50,000.00), in cash

or securities approved by the Commissioner, or, in lieu thereof, a corporate surety bond, approved by the Commissioner, in the form described by the Commissioner, payable to the State of Oklahoma, in the sum of One Hundred Thousand Dollars (\$100,000.00), and conditioned upon the faithful performance in the sale or rendering of motor club service and payment of any fines or penalties levied against it for failure to comply with the provisions of ~~this act~~ Section 3101 et seq. of this title. Provided, however, that the aggregate liability of the surety for all breaches of the conditions of the bond and for the payment of all fines and penalties shall, in no event, exceed the amount of ~~said~~ the bond.

B. No Certificate of Authority shall be issued by the Commissioner until the company has filed with him the following:

1. A formal application for the certificate in such form and detail as the Commissioner requires, executed under oath by its president or another principal officer of the company;

2. A certified copy of its charter or articles of incorporation and its bylaws, if any;

3. A certificate from the Secretary of State, State of Oklahoma, in the event that it is a domestic corporation, signifying that the company is in compliance with the corporation laws of the State of Oklahoma;

4. A copy of its latest financial statement, or report of independent audit, as the Commissioner may require; or, in the event that neither is available, its most recent audited and certified operating statement and balance sheet. Any such certified operating statement, audit or audited and certified operating statement and balance sheet shall be verified by the person compiling or making the same and by an executive officer of the applicant;

5. A certificate from its domiciliary state regulatory authority, in the event that it is a foreign corporation, to be executed not more than thirty (30) days before the filing of its application, signifying that it is duly authorized to do motor club business in that state;

6. An explanation of its plan of doing business and copies of the following:

- a. its application for membership,
- b. the proposed membership certificate or identification card and any proposed addendum thereto,
- c. any individual insurance policy and any group master policy and individual certificates thereunder to be offered, and
- d. any service contract to be issued; and

7. Such other information as the Commissioner may find necessary in order to determine the applicant's qualifications.

C. No Certificate of Authority shall be issued by the Commissioner until the company has:

1. Paid an initial filing fee of Two Hundred Fifty Dollars (\$250.00) to the General Fund of the State of Oklahoma State Insurance Commissioner Revolving Fund, pursuant to Section 307.3 of this title;

2. Paid an annual license fee of One Hundred Dollars (\$100.00) to the General Fund of the State of Oklahoma State Insurance Commissioner Revolving Fund, pursuant to Section 307.3 of this title;

3. Had its name approved by the Commissioner under the provisions of Title 36 of the Oklahoma Statutes, Sections 620 and 2104 of this title, the provisions of which are hereby made applicable to motor clubs, after electronic submission of its name request on a form prescribed by the Commissioner;

4. Proved by affidavits of its officers, directors, managers and individual owners of more than ten percent (10%), on a form prescribed by the Commissioner, that it is not disqualified under any provisions contained in this act Section 3101 et seq. of this title or contained in the Insurance Code; and

5. Proved to the Commissioner's satisfaction that it is a separate legal entity capable of being examined by the Commissioner as provided in ~~this act~~ Section 3101 et seq. of this title.

D. Certificates of Authority issued hereunder shall expire annually on July 1, unless sooner revoked or suspended, as hereinafter provided.

SECTION 7. AMENDATORY 36 O.S. 2011, Section 1250.7, is amended to read as follows:

Section 1250.7. A. Within ~~forty-five (45)~~ sixty (60) days after receipt by a property and casualty insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer, or if further investigation is necessary. No property and casualty insurer shall deny a claim because of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. A denial shall be given to any claimant in writing, and the claim file of the property and casualty insurer shall contain a copy of the denial. If there is a reasonable basis supported by specific information available for review by the Commissioner that the first party claimant has fraudulently caused or contributed to the loss, a property and casualty insurer shall be relieved from the requirements of this subsection. In the event of a weather-related catastrophe or a major natural disaster, as declared by the Governor, the Insurance Commissioner may extend the deadline imposed under this subsection an additional twenty (20) days.

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

C. Every property and casualty insurer shall complete investigation of a claim within sixty (60) days after notification of proof of loss unless such investigation cannot reasonably be completed within such time. If such investigation cannot be completed, or if a property and casualty insurer needs more time to determine whether a claim should be accepted or denied, it shall so

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

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

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

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

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

SECTION 8. AMENDATORY 36 O.S. 2011, Section 3629, is amended to read as follows:

Section 3629. A. An insurer shall furnish, upon written request of any insured claiming to have a loss under an insurance contract issued by such insurer, forms of proof of loss for completion by such person, but such insurer shall not, by reason of the requirement so to furnish forms, have any responsibility for or with reference to the completion of such proof or the manner of any such completion or attempted completion.

B. It shall be the duty of the insurer, receiving a proof of loss, to submit a written offer of settlement or rejection of the claim to the insured within ~~ninety (90)~~ sixty (60) days of receipt of that proof of loss. Upon a judgment rendered to either party, costs and attorney fees shall be allowable to the prevailing party. For purposes of this section, the prevailing party is the insurer in those cases where judgment does not exceed written offer of settlement. In all other judgments the insured shall be the prevailing party. If the insured is the prevailing party, the court in rendering judgment shall add interest on the verdict at the rate of fifteen percent (15%) per year from the date the loss was payable pursuant to the provisions of the contract to the date of the verdict. This provision shall not apply to uninsured motorist coverage.

SECTION 9. AMENDATORY 36 O.S. 2011, Section 4424, as amended by Section 1, Chapter 264, O.S.L. 2016 (36 O.S. Supp. 2017, Section 4424), is amended to read as follows:

Section 4424. Unless the context requires otherwise, the definitions in this section apply throughout the Long-Term Care Insurance Act.

1. a. "Long-term care insurance" means any insurance policy, certificate or rider, including qualified long-term care insurance contracts and long-term care partnership program contracts, which are advertised, marketed, offered or designed primarily to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance,

or personal care services, provided in a setting other than an acute care unit of a hospital.

- b. This term includes group and individual health policies or riders or group and individual life policies or annuities or riders which provide, directly or as a supplement, coverage for long-term care, whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, life care communities, or any similar organization.
- c. This term also includes a policy or rider which provides for payment of long-term care benefits based upon cognitive impairment or the loss of functional capacity.
- d. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage or related asset-protection coverage, catastrophic coverage, comprehensive coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.
- e. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

- f. Notwithstanding any other provision contained herein, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of ~~this act~~ the Long-Term Care Act.

2. "Applicant" means:

- a. in the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits, and
- b. in the case of a group long-term care insurance policy, the proposed certificate holder.

3. "Certificate" means any certificate issued under a group long-term care insurance policy, which certificate has been delivered, or issued for delivery, in this state.

4. "Group long-term care insurance" means a long-term care insurance policy which is delivered, or issued for delivery, in this state and issued to:

- a. one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof or for members or former members, or a combination thereof, of the labor organizations, or
- b. any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:
 - (1) is composed of individuals, all of whom are or were actively engaged in the same profession, trade or occupation, and
 - (2) has been maintained in good faith for purposes other than insurance, or

- c. an association, a trust, or the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the Insurance Commissioner that the association or associations shall have at the outset of transacting long-term care insurance in this state a minimum of one hundred (100) persons in the association or associations and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least one (1) year; and shall have a constitution and bylaws which provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees. Thirty (30) days after such filing the association or associations shall be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements, or
- d. a group other than as described in subparagraphs a, b and c of this paragraph, subject to a finding by the Commissioner that:
- (1) the issuance of the group policy is not contrary to the best interest of the public,
 - (2) the issuance of the group policy would result in economies of acquisition or administration, and
 - (3) the benefits are reasonable in relation to the premiums charged.

5. "Not-for-Profit Life care community" within the meaning of Section 1-853.1 of Title 63 of the Oklahoma Statutes means any not-for-profit organization that enters into an arrangement pursuant to which a person contracts for a place of residence and personal care services, including but not limited to services which progress from independent living to semi-dependent nursing care to acute nursing care, in consideration of an endowed prepayment, license or entry fee which has been actuarially established to meet the cost of the promised services and accommodations. For communities commencing operations after January 1, 2016, the amount of the endowed prepayment must be independently, actuarially determined, in compliance with the Actuarial Board Standards of Practice promulgated by the Actuarial Standards Board of the American Academy of Actuaries, prior to opening the community and annually thereafter to ensure that sufficient payments are collected to meet the future services of the residents. The actuarial study shall take into consideration projected or actual project costs, resident fees and charges, resident contract provisions and any other factors affecting the operation of the facility. It shall contain mortality and morbidity data and an actuary's signed opinion that the proposed is feasible and that the study has been prepared in accordance with standards adopted by the American Academy of Actuaries. A not-for-profit life care community shall not include the following:

- a. traditional landlord and tenant agreements utilizing periodic rental and security deposit payments,
- b. residential care homes licensed pursuant to the Oklahoma Residential Care Act,
- c. assisted living centers and continuum of care facilities licensed pursuant to the Oklahoma Continuum of Care and Assisted Living Act,
- d. facilities licensed pursuant to the Oklahoma Nursing Home Care Act, or
- e. any facility where the endowed prepayment, license or entry fee is less than Fifty Thousand Dollars (\$50,000.00).

6. "Policy" means any policy, contract, certificate, subscriber agreement, rider or endorsement delivered, or issued for delivery, in this state by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization, life care community, or any similar organization.

7. "Qualified long-term care insurance contract" means any:

a. individual or group insurance contract if the contract meets the requirements of Section 7702(B) of the Internal Revenue Code, as amended, and if:

- (1) the only insurance protection provided under the contract is coverage of qualified long-term care services,
- (2) the contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to contracts where Medicare is a secondary payor, or where the contract makes per diem or other periodic payments without regard to expenses,
- (3) the contract is guaranteed renewable,
- (4) the contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed. All refunds of premiums and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund of the aggregate premium paid under the contract may be allowed in the event of death of the insured or a complete surrender or cancellation of the contract, and

- (5) the contract contains the consumer protection provisions set forth in Section 7702(B)(g) of the Internal Revenue Code, or
- b. life insurance contract which provides long-term care coverage by rider or as part of the contract if the contract complies with the applicable provisions of Section 7702(B) of the Internal Revenue Code, as amended.

8. "Qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance for personal care services for which an insured is eligible under a qualified long-term care insurance contract, and which are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

SECTION 10. AMENDATORY 36 O.S. 2011, Section 6453, is amended to read as follows:

Section 6453. As used in the Oklahoma Risk Retention Act:

1. "Commissioner" means the Insurance Commissioner of this state or the Commissioner, Director, or Superintendent of insurance in any other state;

2. "Completed operations liability" means liability arising out of the installation, maintenance, or repair of any product at a site which is not owned or controlled by:

- a. any person who performs that work, or
- b. any person who hires an independent contractor to perform that work,

and shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability;

3. "Domicile", for purposes of determining the state in which a purchasing group is domiciled, means:

- a. for a corporation, the state in which the purchasing group is incorporated, and
- b. for an unincorporated entity, the state of its principal place of business;

4. "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able:

- a. to meet obligations to policyholders with respect to known claims and reasonably anticipated claims, or
- b. to pay other obligations in the normal course of business;

5. "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this state;

6. "Liability":

- a. means legal liability for damages, including but not limited to, costs of defense, legal costs and fees, and other claims expenses, because of injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from or arising out of:
 - (1) any business, trade, product, services, premises, or operations, or
 - (2) any activity of any state or local government, or any agency or political subdivision thereof, and
- b. does not include personal risk liability and the liability of an employer to employees, other than legal liability under the Federal Employers' Liability Act, 45 U.S.C. 51 et seq.;

7. "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities rather than from responsibilities or activities referred to in paragraph 6 of this section;

8. "Plan of operation or feasibility study" means an analysis which presents the expected activities and results of a risk retention group including, but not limited to:

- a. the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer,
- b. historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available,
- c. pro forma financial statements and projections,
- d. appropriate opinions by a qualified, ~~independent~~ casualty actuary, as defined in paragraph 11 of this section, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition,
- e. identification of management procedures, underwriting procedures, managerial oversight methods, investment policies, and reinsurance agreements,
- f. information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations,
- g. identification of each state in which the risk retention group has obtained, or sought to obtain, a

charter and license, and a description of its status in each such state, and

- h. such other matters as may be prescribed by the Commissioner, for liability insurance companies authorized by the insurance laws of the state in which the risk retention group is chartered;

9. "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage, including but not limited to damages resulting from the loss of use of property, arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred;

10. "Purchasing group" means any group which:

- a. has as one of its purposes the purchase of liability insurance on a group basis for its members to cover their similar or related liability exposure,
- b. is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations, and
- c. is domiciled in any state;

11. "Qualified actuary" means an individual who is a member of the American Academy of Actuaries and who has met the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinions in the United States promulgated by the American Academy of Actuaries;

12. "Risk retention group" means any corporation or other limited liability association formed under the laws of any state, Bermuda, or the Cayman Islands, to assume and spread all, or any portion of, the liability exposure of its group members, and which:

- a. (1) is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state, or
- (2) before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the Insurance Commissioner of at least one state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability, as such terms were defined in the federal Product Liability Risk Retention Act of 1981, before the date of the enactment of the federal Liability Risk Retention Act of 1986,
- b. does not exclude any person from membership in the group solely to provide for members of such group a competitive advantage over such person,
- c. (1) has as its members only persons who have an ownership interest in the group and who are provided insurance by the risk retention group, or
- (2) has as its sole member and sole owner an organization which is owned by persons who are provided insurance by the risk retention group,
- d. has as its members persons or organizations which are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar, or common business trade, product, services, premises, or operations,

- e. does not provide insurance coverage other than:
 - (1) liability insurance for assuming and spreading all or any portion of the liability of its group members, and
 - (2) reinsurance with respect to the liability of any other risk retention group, or any members of such other group, and
- f. the name of which includes the phrase, "Risk Retention Group"; and

~~12.~~ 13. "State" means any state of the United States or the District of Columbia.

SECTION 11. AMENDATORY 36 O.S. 2011, Section 6470.12, as last amended by Section 18, Chapter 298, O.S.L. 2015 (36 O.S. Supp. 2017, Section 6470.12), is amended to read as follows:

Section 6470.12. A. Upon written application, accompanied by such information as the Commissioner requires, the Insurance Commissioner may grant permission to a sponsored captive insurance company or a special purpose captive insurance company to discount loss and loss adjustment expense reserves at treasury rates applied to the applicable payments projected through the use of the expected payment pattern associated with the reserves.

B. A sponsored captive insurance company and a special purpose captive insurance company, and any captive insurer, at the Commissioner's discretion, shall file annually an actuarial opinion on the company's loss and loss adjustment expense reserves provided by an independent actuary or life and health policy and claim reserves, as applicable. The actuary may not be an employee individual who prepares the Statement of Actuarial Opinion must be independent of the captive company or and its affiliates.

C. The Insurance Commissioner may disallow the discounting of reserves if a captive insurance company violates a provision of this title.

SECTION 12. This act shall become effective November 1, 2018.

Passed the Senate the 6th day of March, 2018.

Presiding Officer of the Senate

Passed the House of Representatives the 17th day of April, 2018.

Presiding Officer of the House
of Representatives

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this _____

day of _____, 20_____, at _____ o'clock _____ M.

By: _____

Approved by the Governor of the State of Oklahoma this _____

day of _____, 20_____, at _____ o'clock _____ M.

Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _____

day of _____, 20_____, at _____ o'clock _____ M.

By: _____