

1 **HOUSE OF REPRESENTATIVES - FLOOR VERSION**

2 STATE OF OKLAHOMA

3 2nd Session of the 57th Legislature (2020)

4 COMMITTEE SUBSTITUTE
5 FOR
6 HOUSE BILL NO. 3746

By: Moore

7
8 COMMITTEE SUBSTITUTE

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

1 which relates to licensing procedure; modifying time
2 for certain notification; requiring background
3 reports; amending 36 O.S. 2011, Section 2006, as
4 amended by Section 1, Chapter 78, O.S.L. 2014 (36
5 O.S. Supp. 2019, Section 2006), which relates to the
6 Board of Directors; modifying composition of members;
7 amending 36 O.S. 2011, Section 2023, as amended by
8 Section 2, Chapter 384, O.S.L. 2019 (36 O.S. Supp.
9 2019, Section 2023), which relates to the Oklahoma
10 Life and Health Insurance Guaranty Association;
11 clarifying terms; amending 36 O.S. 2011, Section
12 3101, which relates to definitions; modifying
13 definition; amending 36 O.S. 2011, Section 3639.1, as
14 amended by Section 11, Chapter 44, O.S.L. 2012 (36
15 O.S. Supp. 2019, Section 3639.1), which relates to
16 personal residential insurance; requiring
17 cancellation of personal residential insurance
18 coverage as of date certain; amending 36 O.S. 2011,
19 Section 4103, which relates to schedule of premium
20 rates; deleting exception; amending 36 O.S. 2011,
21 Section 6060.12, which relates to calculation of
22 premium costs; modifying penalty determination;
23 prohibiting change of name of prepaid funeral benefit
24 permit holder; requiring Insurance Commissioner
approval; providing for application for change of
name; authorizing waiver of approval requirement;
authorizing denial of change of name application;
providing for issuance of prepaid funeral benefit
permit with new name; authorizing Insurance
Commissioner to promulgate rules; defining term;
providing for dormant captive insurance company to
apply for certificate of dormancy; listing
requirements for certain dormant captive insurance
companies; providing exceptions; requiring certain
application prior to issuing insurance policies;
providing for revocation of certificate of dormancy;
providing for examination; authorizing the Insurance
Commissioner to promulgate rules; amending 36 O.S.
2011, Section 6552, which relates to definitions;
modifying definition; amending 36 O.S. 2011, Section
6753, as amended by Section 38, Chapter 150, O.S.L.
2012 (36 O.S. Supp. 2019, Section 6753), which
relates to home service contracts; modifying
financial security deposit; amending 36 O.S. 2011,
Section 6904, which relates to issuance of
certificates; modifying time frame for issuance of
certificate; amending 36 O.S. 2011, Section 6907,

1 which relates to reasonable standards of quality care
2 and credentialing; modifying applicable agency;
3 amending 36 O.S. 2011, Section 6911, which relates to
4 grievance procedures; modifying applicable agency;
5 amending 36 O.S. 2011, Section 6919, which relates to
6 examination of affairs, programs, books and records;
7 modifying applicable agency; amending 36 O.S. 2011,
8 Section 6920, which relates to suspension or
9 revocation of a certificate of authority; modifying
10 applicable agency; amending 36 O.S. 2011, Section
11 6929, which relates to contracts with qualified
12 persons; modifying applicable agency; providing for
13 codification; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2011, Section 311.4, as
amended by Section 1, Chapter 275, O.S.L. 2014 (36 O.S. Supp. 2019,
Section 311.4), is amended to read as follows:

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

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

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

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

22 2. Require the filing of market conduct annual statements and
23 any amendments and addendums to such statements with the National
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1 Association of Insurance Commissioners, and the payment of
2 applicable filing fees required by the NAIC.

3 C. Insurers shall pay a filing fee of Two Hundred Dollars
4 (\$200.00) to the Insurance Commissioner for the filing of the market
5 conduct annual statement.

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

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

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

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

3 G. For any violation of this section, the Insurance
4 Commissioner may, after notice and opportunity for a hearing,
5 subject an insurer to a civil penalty of up to One Thousand Dollars
6 (\$1,000.00) for each occurrence. Such civil penalty may be enforced
7 in the same manner in which civil judgments may be enforced.

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

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

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

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

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

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

13 Section 996. Assigned Risks.

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

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

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

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

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

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

18 Section 1116. A. Any surplus lines licensee or broker who
19 fails to remit the surplus line tax provided for by Section 1115 of
20 this title ~~for more than sixty (60) days after it is due~~ shall be
21 liable for a civil penalty ~~of~~ not to exceed Twenty-five Dollars
22 (\$25.00) for each ~~additional~~ day of delinquency. The Insurance
23 Commissioner shall collect the tax by distraint and shall recover
24 the penalty by an action in the name of the State of Oklahoma. The

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

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

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

20 Section 1219. A. In the administration, servicing, or
21 processing of any accident and health insurance policy, every
22 insurer shall reimburse all clean claims of an insured, an assignee
23 of the insured, or a health care provider within forty-five (45)
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1 calendar days after receipt of ~~the~~ a paper claim and thirty (30)
2 calendar days after receipt of an electronic claim by the insurer.

3 B. As used in this section:

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

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

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

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

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

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

24 E. Payment shall be considered made on:

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

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

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

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

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

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

21 SECTION 7. AMENDATORY 36 O.S. 2011, Section 1250.7, as
22 amended by Section 7, Chapter 95, O.S.L. 2018 (36 O.S. Supp. 2019,
23 Section 1250.7), is amended to read as follows:
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1 Section 1250.7 A. Within sixty (60) days after receipt by a
2 property and casualty insurer of properly executed proofs of loss,
3 the first party claimant shall be advised of the acceptance or
4 denial of the claim by the insurer, or if further investigation is
5 necessary. No property and casualty insurer shall deny a claim
6 because of a specific policy provision, condition, or exclusion
7 unless reference to such provision, condition, or exclusion is
8 included in the denial. A denial shall be given to any claimant in
9 writing, and the claim file of the property and casualty insurer
10 shall contain a copy of the denial. If there is a reasonable basis
11 supported by specific information available for review by the
12 Commissioner that the first party claimant has fraudulently caused
13 or contributed to the loss, a property and casualty insurer shall be
14 relieved from the requirements of this subsection. In the event of
15 a weather-related catastrophe or a major natural disaster, as
16 declared by the Governor, the Insurance Commissioner may extend the
17 deadline imposed under this subsection an additional twenty (20)
18 days.

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

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

21 D. Insurers shall not fail to settle first party claims on the
22 basis that responsibility for payment should be assumed by others
23 except as may otherwise be provided by policy provisions.
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1 E. Insurers shall not continue or delay negotiations for
2 settlement of a claim directly with a claimant who is neither an
3 attorney nor represented by an attorney, for a length of time which
4 causes the claimant's rights to be affected by a statute of
5 limitations, or a policy or contract time limit, without giving the
6 claimant written notice that the time limit is expiring and may
7 affect the claimant's rights. Such notice shall be given to first
8 party claimants not more than ninety (90) days and not less than
9 thirty (30) days, and to third party claimants not more than ninety
10 (90) days and not less than sixty (60) days, before the date on
11 which such time limit may expire.

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

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

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

21 Section 1250.8 A. If an insurance policy or insurance contract
22 provides for the adjustment and settlement of first party motor
23 vehicle total losses, on the basis of actual cash value or
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1 replacement with another of like kind and quality, one of the
2 following methods shall apply:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 3. Any entity making application to the Oklahoma Insurance
10 Department as a third party administrator (TPA) or within thirty
11 (30) days of a change for a licensed TPA shall provide current
12 National Association of Insurance Commissioners (NAIC) Biographical
13 Affidavits and independent third-party background reports from a
14 NAIC-approved vendor on behalf of all officers, directors and key
15 managerial personnel of the TPA, and individuals with a ten percent
16 (10%) or more beneficial ownership in the TPA and the TPA's ultimate
17 controlling person (affiant) as required for insurers pursuant to
18 the laws of this state.

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

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

4 H. Any person who is acting as or presenting himself or herself
5 to be an administrator without a valid license shall be subject,
6 upon conviction, to a fine of not less than One Thousand Dollars
7 (\$1,000.00) nor more than Ten Thousand Dollars (\$10,000.00) for each
8 occurrence. This fine shall be in addition to any other penalties
9 which may be imposed for violations of the Oklahoma Insurance Code
10 or other laws of this state.

11 I. Except as provided for in subsections F and G of this
12 section, any person convicted of violating any provisions of the
13 Third-party Administrator Act shall be guilty of a misdemeanor and
14 shall be subject to a fine of not more than One Thousand Dollars
15 (\$1,000.00).

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

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

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

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

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

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

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

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

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

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

- 8 1. The health account;
- 9 2. The life insurance account; and
- 10 3. The annuity account.

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

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

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

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

22 2. "Company" means any person, firm, copartnership, company,
23 association or corporation engaged in selling, furnishing or
24

1 procuring, either as principal or agent, for a consideration, motor
2 club service-;i

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 SECTION 13. AMENDATORY 36 O.S. 2011, Section 3639.1, as
13 amended by Section 11, Chapter 44, O.S.L. 2012 (36 O.S. Supp. 2019,
14 Section 3639.1), is amended to read as follows:

15 Section 3639.1 A. No insurer shall cancel, refuse to renew or
16 increase the premium of a homeowner's insurance policy or any other
17 personal residential insurance coverage, which has been in effect
18 more than forty-five (45) days, solely because the insured filed a
19 first claim against the policy. The provisions of this section
20 shall not be construed to prevent the cancellation, nonrenewal or
21 increase in premium of a homeowner's insurance policy for the
22 following reasons:

23 1. Nonpayment of premium;
24

1 2. Discovery of fraud or material misrepresentation in the
2 procurement of the insurance or with respect to any claims submitted
3 thereunder;

4 3. Discovery of willful or reckless acts or omissions on the
5 part of the named insured which increase any hazard insured against;

6 4. A change in the risk which substantially increases any
7 hazard insured against after insurance coverage has been issued or
8 renewed;

9 5. Violation of any local fire, health, safety, building, or
10 construction regulation or ordinance with respect to any insured
11 property or the occupancy thereof which substantially increases any
12 hazard insured against;

13 6. A determination by the Insurance Commissioner that the
14 continuation of the policy would place the insurer in violation of
15 the insurance laws of this state; or

16 7. Conviction of the named insured of a crime having as one of
17 its necessary elements an act increasing any hazard insured against.

18 B. An insurer shall give to the named insured at the mailing
19 address shown on a homeowner's policy, a written renewal notice that
20 shall include new premium, new deductible, new limits or coverage at
21 least thirty (30) days prior to the expiration date of the policy.
22 If the insurer fails to provide such notice, the premium,
23 deductible, limits and coverage provided to the named insurer prior
24 to the change shall remain in effect until notice is given or until

1 the effective date of replacement coverage obtained by the named
2 insured, whichever occurs first. If notice is given by mail, the
3 notice shall be deemed to have been given on the day the notice is
4 mailed. If the insured elects not to renew, any earned premium for
5 the period of extension of the terminated policy shall be calculated
6 pro rata at the lower of the current or previous year's rate. If
7 the insured accepts the renewal, the premium increase, if any, and
8 other changes shall be effective the day following the prior
9 policy's expiration or anniversary date.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 b. Ten Thousand Dollars (\$10,000.00) ~~;-i~~

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

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

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

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

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

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

- 1 3. a. To claim the exemption provided for in ~~subsection A~~
2 paragraph 1 of this section a health benefit plan
3 shall provide to the Insurance Commissioner a written
4 request signed by an actuary stating the reasons and
5 actuarial assumptions upon which the request is based.
- 6 b. The Commissioner shall verify the information provided
7 and shall approve or disapprove the request within
8 thirty (30) days of receipt.
- 9 c. If, upon investigation, the Commissioner finds that
10 any statement of fact in the request is found to be
11 knowingly false, the health benefit plan may be
12 subject to suspension or loss of license or any other
13 penalty as determined by the Commissioner, ~~or the~~
14 ~~State Commissioner of Health~~ with regard to health
15 maintenance organizations.

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

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

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

1. The name of the permit holder;
2. The proposed new name of the permit holder; and
3. The date the name change will become effective.

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

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

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

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

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

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

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

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

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

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

15 1. Possess and thereafter maintain unimpaired, paid-in capital
16 and surplus of not less than Twenty-five Thousand Dollars
17 (\$25,000.00);

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

22 3. Pay a nonrefundable renewal fee of Five Hundred Dollars
23 (\$500.00).
24

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

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

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

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

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

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

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

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

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

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

- 7 a. an employer in this state, or
8 b. a third party that provides or administers hospital
9 and medical benefits to citizens of this state,
10 including, but not limited to:

11 (1) a health maintenance organization issued a
12 license pursuant to Section 2501 et seq. of Title
13 63 of the Oklahoma Statutes, unless the health
14 maintenance organization is federally regulated
15 and licensed and has on file with the Insurance
16 Commissioner ~~of Health~~ a plan of utilization
17 review carried out by health care professionals
18 and providing for complaint and appellate
19 procedures for claims, or

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

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

3 4. "Commissioner" means the Insurance Commissioner;

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

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

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

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

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

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

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

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

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

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

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

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

18 (1) a surety bond issued by an authorized surety,
19 (2) securities of the type eligible for deposit by
20 authorized insurers in this state,

21 (3) ~~cash,~~

22 ~~(4)~~ a letter of credit issued by a qualified
23 financial institution, or
24

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

2.
 - a. maintain, or together with its parent company maintain, a net worth or stockholders' equity of Twenty-five Million Dollars (\$25,000,000.00), excluding goodwill, intangible assets, customer lists and affiliated receivables, and
 - b. upon request, provide the Commissioner with a copy of the provider's or the provider's parent company's most recent Form 10-K or Form 20-F filed with the Securities and Exchange Commission (SEC) within the last calendar year, or if the company does not file with the SEC, a copy of the company's financial statements, which shows a net worth of the provider or its parent company of at least Twenty-five Million Dollars (\$25,000,000.00) based upon Generally Accepted Accounting Principles (GAAP) accounting standards. If the provider's parent company's Form 10-K, Form 20-F, or financial statements are filed to meet the provider's financial stability requirement, then the parent company shall agree to guarantee the obligations of the provider relating to service contracts sold by the provider in this state; or

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

- 10 a. in the event that the provider is unable to fulfill
11 its obligation under contracts issued in this state
12 for any reason, including insolvency, bankruptcy, or
13 dissolution, the insurer shall pay losses and unearned
14 premiums under such plans directly to the person
15 making the claim under the contract,
- 16 b. the insurer issuing the insurance policy shall assume
17 full responsibility for the administration of claims
18 in the event of the inability of the provider to do
19 so, and
- 20 c. the policy shall not be canceled or not renewed by
21 either the insurer or the provider unless sixty (60)
22 days' written notice thereof has been given to the
23 Commissioner by the insurer before the date of such
24 cancellation or nonrenewal.

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

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

7 a. maintain surplus as to policyholders and paid-in
8 capital of at least Fifteen Million Dollars
9 (\$15,000,000.00), and

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

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

17 a. maintain surplus as to policyholders and paid-in
18 capital of less than Fifteen Million Dollars
19 (\$15,000,000.00),

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

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

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

21 F. The marketing, sale, offering for sale, issuance, making,
22 proposing to make and administration of home service contracts by
23 providers and related service contract sellers, administrators, and
24

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

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

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

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

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

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

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

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

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

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

16 4. The health maintenance organization is in compliance with
17 the provisions of Sections ~~13~~ 6913 and ~~15~~ 6915 of this ~~act~~ title.

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

22 SECTION 21. AMENDATORY 36 O.S. 2011, Section 6907, is
23 amended to read as follows:
24

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

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

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

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

- 19 a. the health maintenance organization's scope and
20 purpose in quality assurance,
- 21 b. the organizational structure responsible for quality
22 assurance activities,
- 23 c. contractual arrangements, where appropriate, for
24 delegation of quality assurance activities,

- d. confidentiality policies and procedures,
- e. a system of ongoing evaluation activities,
- f. a system of focused evaluation activities,
- g. a system for credentialing and recredentialing providers, and performing peer review activities, and
- h. duties and responsibilities of the designated physician responsible for the quality assurance activities;

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

- a. problem assessment, identification, selection and study,
- b. corrective action, monitoring, evaluation and reassessment, and
- c. interpretation and analysis of patterns of care rendered to individual patients by individual providers;

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

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

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

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

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

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

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

20 G. The organization shall be required to establish a mechanism
21 under which physicians participating in the plan may provide input
22 into the plan's medical policy including, but not limited to,
23 coverage of new technology and procedures, utilization review
24

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 1. Jeopardy to the health of the patient;

22 2. Impairment of bodily function; or

23 3. Dysfunction of any bodily organ or part.

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

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

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

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

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

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

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

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

19 C. Health maintenance organizations shall comply with the
20 requirements of an insurer as set out in Sections 1250.1 through
21 1250.16 of ~~Title 36 of the Oklahoma Statutes~~ this title.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 1. Whenever the Insurance Commissioner finds that the net worth
22 maintained by any health maintenance organization subject to the
23 provisions of this act is less than the minimum net worth required
24 to be maintained by Section ~~43~~ 6913 of this ~~act~~ title, the Insurance

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

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

24

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

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

17 2. If the health maintenance organization or applicant requests
18 a hearing pursuant to the provisions of this section, the Insurance
19 Commissioner shall issue a written notice of hearing and send such
20 notice to the health maintenance organization or applicant by
21 certified or registered mail ~~and to the State Commissioner of Health~~
22 stating:
23
24

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

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

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

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

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

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

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

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

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

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

4 SECTION 26. This act shall become effective November 1, 2020.
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6 COMMITTEE REPORT BY: COMMITTEE ON INSURANCE, dated 02/26/2020 - DO
7 PASS, As Amended.
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