STATE OF OKLAHOMA

1st Session of the 55th Legislature (2015)

SENATE BILL 455 By: Brown

AS INTRODUCED

An Act relating to insurance; amending 36 O.S. 2011, Section 309.4, which relates to examination reports; eliminating requirement that insurance companies deliver certain reports and orders; amending 36 O.S. 2011, Section 348.1, as amended by Section 3, Chapter 275, O.S.L. 2014 (36 O.S. Supp. 2014, Section 348.1), which relates to fees and licenses; updating citation; amending 36 O.S. 2011, Sections 608 and 609, which relate to authorization of insurers; updating citation; deleting citation referencing repealed provision; amending 36 O.S. 2011, Section 903.2, as amended by Section 16, Chapter 254, O.S.L. 2013 (36 O.S. Supp. 2014, Section 903.2), which relates to the Oklahoma Insurance Rating Act; deleting citation referencing repealed provision; amending 36 O.S. 2011, Section 1435.2, which relates to the Oklahoma Producer Licensing Act; updating definition; updating citations; amending 36 O.S. 2011, Section 1441.1, which relates to the Third-Party Administrator Act; updating citations; amending 36 O.S. 2011, Section 1524, as amended by Section 6, Chapter 269, O.S.L. 2013 (36 O.S. Supp. 2014, Section 1524), which relates to the Risk-based Capital for Insurers Act; modifying required contents of certain required plan; amending 36 O.S. 2011, Section 1674, which relates to the Business Transacted with Producer Controlled Insurer Act; updating reference; amending 36 O.S. 2011, Section 4502, which relates to group accident and health insurance policies; modifying required policy provisions; amending 36 O.S. 2011, Section 6041, which relates to payments for emergency living expenses; expanding authorized forms of payments; amending 36 O.S. 2011, Section 6811, which relates to the Medical Professional Liability Insurance Closed Claim Reports Act; authorizing the Insurance Commissioner to require

certain filings; adding entity required to file certain report; modifying time certain report must be filed; eliminating requirement that certain claims be reported; repealing 36 O.S. 2011, Sections 924.4, as amended by Section 1, Chapter 44, O.S.L. 2012 and 924.5, as amended by Section 2, Chapter 44, O.S.L. 2012 (36 O.S. Supp. 2014, Sections 924.4 and 924.5), which relate to affidavits of exempt status; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2011, Section 309.4, is amended to read as follows:

Section 309.4 A. All examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the company, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from such facts.

B. No later than thirty (30) days following completion of the examination, the examiner in charge shall file with the Insurance Department a verified written report of examination under oath. Upon receipt of the verified report, the Department shall transmit the report to the company examined, together with a notice which shall afford such company examined a reasonable opportunity of not more than twenty (20) days to make a written submission or written

rebuttal with respect to any matters contained in the examination report.

C. Within twenty (20) days of the end of the period allowed for the receipt of written submissions or written rebuttals, the Insurance Commissioner shall fully consider and review the report, together with any written submissions or written rebuttals and any relevant portions of the examiners' work papers and enter an order:

1. Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the Commissioner, the Commissioner may order the company to take any action the Commissioner considers necessary and appropriate to cure such violation;

2. Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and refiling pursuant to subsection A of this section; or

3. Calling for an investigatory hearing with notice pursuant to the Administrative Procedures Act to the company for purposes of obtaining additional documentation, data, information and testimony.

D. 1. All orders entered pursuant to paragraph 1 of subsection C of this section shall be accompanied by findings and conclusions resulting from the Commissioner's consideration and review of the examination report, relevant examiner work papers and any written

submissions or rebuttals. Any such order shall be considered a final administrative decision and may be appealed pursuant to the Administrative Procedures Act, and shall be served upon the company by certified mail, together with a copy of the adopted examination report. Within thirty (30) days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders. ~~Upon proper order of the Commissioner, the company shall deliver by mail or otherwise, within thirty (30) days of the date of the order, a copy of the adopted report and related orders to all states and jurisdictions in which the company is licensed to transact the business of insurance.~~

2. Any hearing conducted pursuant to paragraph 3 of subsection C of this section by the Commissioner or authorized representative, shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the Commissioner's review of relevant work papers or by the written submission or rebuttal of the company. Within thirty (30) days of the conclusion of any such hearing, the Commissioner shall enter an order pursuant to paragraph 1 of subsection C of this section.

3. The Commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The Commissioner

or a representative of the Commissioner may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation whether under the control of the Department, the company or other persons. The documents produced shall be included in the record, and testimony taken by the Commissioner or representative of the Commissioner shall be under oath and preserved for the record.

4. Nothing contained in this section shall require the Department to disclose any information or records which would indicate or show the existence or content of any investigation or activity of a criminal justice agency.

5. The hearing shall proceed with the Commissioner or a representative of the Commissioner posing questions to the persons subpoenaed. Thereafter the company and the Department may present testimony relevant to the investigation. The company and the Department shall be permitted to make closing statements and may be represented by counsel of their choice.

E. 1. Upon the adoption of the examination report under paragraph 1 of subsection C of this section, the Commissioner shall continue to hold the content of the examination report as private and confidential information for a period of two (2) days except to the extent provided in subsection B of this section and subsection F of Section 309.3 of this title. Thereafter, the Commissioner may

open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

2. Nothing contained in Sections 309.1 through 309.7 of this title shall prevent or be construed as prohibiting the Commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with Sections 309.1 through 309.7 of this title.

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

F. All working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the Commissioner or any other person in the course of an examination made under Sections 309.1 through 309.7 of this title, or in the course of analysis by the Commissioner or any other person of the financial condition or market conduct of a company, shall be given confidential treatment and are not subject to subpoena and may not be made public by the Commissioner or any other person, except to

the extent provided in subsection E of this section and subsection F of Section 309.3 of this title. Access may also be granted to the National Association of Insurance Commissioners. Such parties shall agree in writing prior to receiving the information to provide to it the same confidential treatment as required by this section, unless the prior written consent of the company to which it pertains has been obtained.

SECTION 2. AMENDATORY 36 O.S. 2011, Section 348.1, as amended by Section 3, Chapter 275, O.S.L. 2014 (36 O.S. Supp. 2014, Section 348.1), is amended to read as follows:

Section 348.1 A. The Insurance Commissioner shall collect the following fees and licenses for the Property and Casualty Division:

1. Rating organizations, statistical agents and advisory organizations:

a. Application fee for issuance of license.....$200.00

b. License fee.....$500.00

2. Miscellaneous:

a. Certificate of Insurance Commissioner, under seal.....$ 20.00

b. Upon each transaction of filing of documents required pursuant to Section 3610 of this title and the Service Warranty Act, as contained in Sections

141.1 through 141.32 of Title 15 of the Oklahoma Statutes:

(1) For an individual insurer.....$ 50.00

(2) For an approved joint underwriting association, or rating or advisory organization:

(a) Basic fee.....$ 50.00

(b) Additional fee for each member or subscriber insurer.....$ 10.00, not to exceed.....$500.00.

3. For each rate, loss cost and rule filing request pursuant to the ~~provisions of Sections 6821 and 981 et seq. of this title~~ Property and Casualty Competitive Loss Cost Rating Act:

a. For an individual insurer.....$100.00

b. For an approved joint underwriting association, rating or advisory organization:

(1) Basic fee.....$100.00

(2) Additional fee for each member or subscriber insurer.....$ 10.00, not to exceed.....$500.00.

B. The fees, licenses, and taxes imposed by the Commissioner upon persons, firms, associations, or corporations licensed pursuant to this section shall be payment in full with respect thereto of and

in lieu of all demands for any and all state, county, district, and municipal license fees, license taxes, business privilege taxes, business privilege fees, and charges of every kind now or hereafter imposed upon all such persons, firms, associations, or corporations. This subsection shall not affect other fees, licenses and taxes imposed by the Insurance Code.

C. Any costs incurred by the Commissioner in the process of review and analysis of a filing shall be assessed against the company or organization making the filing.

SECTION 3. AMENDATORY 36 O.S. 2011, Section 608, is amended to read as follows:

Section 608. A. A casualty insurer shall not be authorized to transact workers' compensation insurance in this state without first complying with the applicable provisions of Title ~~85~~ 85A of the Oklahoma Statutes.

B. A claims adjuster for any insurer duly authorized to transact workers' compensation insurance in Oklahoma shall be licensed pursuant to the Insurance Adjusters Licensing Act.

SECTION 4. AMENDATORY 36 O.S. 2011, Section 609, is amended to read as follows:

Section 609. An insurer which otherwise qualifies therefor may be authorized to transact any one kind or combination of kinds of insurance as defined in Section 701 et seq. of this title, except:

1. A life insurer shall not be authorized to transact any other kind of insurance except accident and health and workers' compensation and employer liability equivalent insurance if otherwise qualified to do so on or after September 1, 1994, ~~pursuant to the provisions of Section 65 of Title 85 of the Oklahoma Statutes~~ or if immediately prior to the effective date of this Code any life insurer lawfully held a subsisting certificate of authority granting it the right to transact in Oklahoma additional kinds of insurance other than accident and health, so long as the insurer is otherwise in compliance with this Code the Insurance Commissioner shall continue to authorize such insurer to transact the same kinds of insurance as those specified in such prior certificate of authority;

2. A reciprocal insurer shall not transact life insurance;

3. A Lloyd's insurer shall not transact life insurance;

4. A title insurer shall be a stock insurer and shall not transact any other kind of insurance; and

5. No insurer shall issue for delivery or deliver in this state any contract of insurance which imposes contingent or assessment liability upon a resident of this state.

SECTION 5. AMENDATORY 36 O.S. 2011, Section 903.2, as amended by Section 16, Chapter 254, O.S.L. 2013 (36 O.S. Supp. 2014, Section 903.2) is amended to read as follows:

Section 903.2 No insurance company shall request and the Insurance Commissioner shall not approve an increase for the expense

portion of insurance company rate filings based upon the requirements of Section 6701 of this title ~~and Section 355 of Title 85 of the Oklahoma Statutes~~.

SECTION 6. AMENDATORY 36 O.S. 2011, Section 1435.2, is amended to read as follows:

Section 1435.2 As used in the Oklahoma Producer Licensing Act:

1. "Commissioner" means the Insurance Commissioner;

2. "Business entity" means a corporation, association, partnership, limited liability company, limited partnership, or other legal entity;

3. "Customer service representative" means an individual appointed by an insurance producer, surplus lines insurance broker, managing general agent, or insurance agency to assist the insurance producer, broker, or agency in transacting the business of insurance from the office of the insurance producer, broker, or agency and whose salary may vary based on the production or volume of applications or premiums;

4. "Home state" means the District of Columbia and any state or territory of the United States in which an insurance producer maintains the producer's principal place of residence or principal place of business and is licensed to act as an insurance producer;

5. "Insurance" means any of the lines of authority in ~~Title 36 of the Oklahoma Statutes~~ this title, including workers' compensation insurance. Any insurer approved to offer workers' compensation

~~equivalent~~ insurance ~~pursuant to the provisions of Section 65 of Title 85 of the Oklahoma Statutes~~ may appoint ~~property and casualty~~ insurance producers. All producers appointed for workers' compensation ~~equivalent~~ insurance products must be licensed as ~~property and casualty~~ insurance producers by the Oklahoma Insurance Department;

6. "Insurance consultant" means an individual or legal entity who, for a fee, is held out to the public as engaged in the business of offering any advice, counsel, opinion or service with respect to the benefits, advantages, or disadvantages promised under any policy of insurance that could be issued or delivered in this state;

7. "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance. Any person not duly licensed as an insurance producer, surplus lines insurance broker, or limited lines producer who solicits a policy of insurance on behalf of an insurer shall be deemed to be acting as an insurance agent within the meaning of the Oklahoma Producer Licensing Act, and shall thereby become liable for all the duties, requirements, liabilities, and penalties to which an insurance producer of the company is subject, and the company by issuing the policy of insurance shall thereby accept and acknowledge the person as its agent in the transaction. For purposes of the laws of this state and the Oklahoma Insurance Code, the term

"insurance agent" shall have the same meaning as the term "insurance producer";

8. "Insurer" has the meaning set out in Section 103 of this title;

9. "License" means a document issued by the Insurance Commissioner of this state authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier;

10. "Limited line credit insurance" includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance, known as "gap" insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation that the Insurance Commissioner determines should be designated a form of limited line credit insurance;

11. "Limited line credit insurance producer" means a person who sells, solicits or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group or individual policy;

12. "Limited lines insurance" means limited line credit and those lines of insurance defined in Section ~~20~~ 1435.20 of this ~~act~~ title or any other line of insurance the Insurance Commissioner deems necessary to recognize for the purposes of complying with subsection E of Section ~~9~~ 1435.9 of this ~~act~~ title;

13. "Limited lines producer" means a person who is authorized by the Commissioner to sell, solicit or negotiate limited lines insurance. For purposes of the laws of this state and the Oklahoma Insurance Code, the term "limited insurance representative" shall have the same meaning as the term "limited lines producer";

14. "Managing general agent" means an individual or legal entity appointed, as an independent contractor, by one or more insurers to exercise general supervision over the business of the insurer in this state, with authority to appoint insurance producers for the insurer, and to terminate appointments for the insurer;

15. "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchaser;

16. "Person" means an individual or a business entity;

17. "Sell" means to exchange a contract of insurance, by any means, for money or its equivalent, on behalf of an insurance company;

18. "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company;

19. "Surplus lines insurance broker" means an individual or legal entity who solicits, negotiates, or procures a policy of insurance in an insurance company not licensed to transact business in this state which cannot be procured from insurers licensed to do business in this state. All transactions under such license shall be subject to Article 11 of the Oklahoma Insurance Code;

20. "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance;

21. "Uniform Business Entity Application" means the current version of the National Association of Insurance Commissioners (NAIC) Uniform Business Entity Application for resident and nonresident business entities; and

22. "Uniform Application" means the current version of the NAIC Uniform Application for resident and nonresident producer licensing.

SECTION 7. AMENDATORY 36 O.S. 2011, Section 1441.1, is amended to read as follows:

Section 1441.1 The provisions of Section 1441 et seq. of ~~Title 36 of the Oklahoma Statutes~~ this title shall not apply to administrators of group self-insurance associations created pursuant to Section ~~149.2~~ 399 of Title 85 of the Oklahoma Statutes.

SECTION 8. AMENDATORY 36 O.S. 2011, Section 1524, as amended by Section 6, Chapter 269, O.S.L. 2013 (36 O.S. Supp. 2014, Section 1524), is amended to read as follows:

Section 1524. A. "Company Action Level Event" means any of the following events:

1. The filing of ~~an RBC~~ a Risk-Based Capital Report (RBC) by an insurer which indicates that:

a. the insurer's Total Adjusted Capital is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC,

b. if a life or health insurer, the insurer or fraternal benefit society has Total Adjusted Capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and has a negative trend, or

c. if a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 and triggers the trend test determined in accordance

with the trend test calculation included in the Property and Casualty RBC instructions;

2. The notification by the Insurance Commissioner to the insurer of an Adjusted RBC Report that indicates an event described in paragraph 1 of this subsection, provided the insurer does not challenge the Adjusted RBC Report under Section 1528 of this title; or

3. If, pursuant to Section 1528 of this title, an insurer challenges an Adjusted RBC Report that indicates the event described in paragraph 1 of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after opportunity for a hearing, rejected the insurer's challenge.

B. In the event of a Company Action Level Event, the insurer shall, unless otherwise directed by the Commissioner, prepare and submit to the Commissioner an RBC Plan which shall include the following five elements:

1. Conditions which contribute to the Company Action Level Event;

2. Proposals of corrective actions which the insurer intends to take and which would be expected to result in the elimination of the Company Action Level Event;

3. Projections of the insurer's financial results in the current year and at least the four (4) succeeding years, both in the absence of proposed corrective actions and giving effect to the

proposed corrective actions, including projections of statutory operating income, net income~~, or~~ and capital and surplus. Unless the Commissioner otherwise directs, the projections for both new and renewal business shall include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

4. The key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

5. The quality of, and problems associated with, the insurer's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

C. The RBC Plan shall be submitted:

1. Within forty-five (45) days of the Company Action Level Event; or

2. If the insurer challenges an Adjusted RBC Report pursuant to Section 1528 of this title, within forty-five (45) days after notification to the insurer that the Commissioner has, after opportunity for a hearing, rejected the insurer's challenge.

D. Within sixty (60) days after the submission by an insurer of an RBC Plan to the Commissioner, the Commissioner shall notify the insurer whether the RBC Plan shall be implemented or is, in the judgment of the Commissioner, unsatisfactory. If the Commissioner

determines the RBC Plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC Plan satisfactory, in the judgment of the Commissioner. Upon notification from the Commissioner, the insurer shall prepare a Revised RBC Plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the Revised RBC Plan to the Commissioner:

1. Within forty-five (45) days after the notification from the Commissioner; or

2. If the insurer challenges the notification from the Commissioner under Section 1528 of this title, within forty-five (45) days after a notification to the insurer that the Commissioner has, after opportunity for a hearing, rejected the insurer's challenge.

E. In the event of a notification by the Commissioner to an insurer that the insurer's RBC Plan or Revised RBC Plan is unsatisfactory, the Commissioner may at the Commissioner's discretion, subject to the insurer's right to a hearing under Section 1528 of this title, specify in the notification that the notification constitutes a Regulatory Action Level Event.

F. Every domestic insurer that files an RBC Plan or Revised RBC Plan with the Commissioner shall file a copy of the RBC Plan or

Revised RBC Plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

1. The state has an RBC provision substantially similar to subsection A of Section 1531 of this title; and

2. The insurance commissioner of that state has notified the insurer of its request for the filing in writing. If such a request is made, the insurer shall file a copy of the RBC Plan or Revised RBC Plan in that state no later than the later of:

a. fifteen (15) days after the receipt of the request to file a copy of its RBC Plan or Revised RBC Plan with the state, or

b. the date on which the RBC Plan or Revised RBC Plan is filed under subsections C and D of this section.

SECTION 9. AMENDATORY 36 O.S. 2011, Section 1674, is amended to read as follows:

Section 1674. A. Applicability of section.

1. The provisions of this section shall apply if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling producer is equal to or greater than five percent (5%) of the admitted assets of the controlled insurer, as reported in the controlled insurers' quarterly statement filed as of September 30 of the prior year.

2. Notwithstanding paragraph 1 of this subsection, the provisions of this section shall not apply if:

a. the controlling producer:

(1) places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate or subsidiary and receives no compensation based upon the amount of premiums written in connection with such insurance, and

(2) accepts insurance placements only from nonaffiliated subproducers, and not directly from insureds, and

b. the controlled insurer, except for insurance business written through a residual market facility, accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer.

B. Required contract provisions. A controlled insurer shall not accept business from a controlling producer and a controlling producer shall not place business with a controlled insurer unless there is a written contract between the controlling producer and the insurer specifying the responsibilities of each party, which

contract has been approved by the board of directors of the insurer and contains the following minimum provisions:

1. The controlled insurer may terminate the contract for cause, upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination;

2. The controlling producer shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to, the controlling producer;

3. The controlling producer shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that premiums or installments thereof collected shall be remitted no later than ninety (90) days after the effective date of any policy placed with the controlled insurer under this contract;

4. All funds collected for the controlled insurer's account shall be held by the controlling producer in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the Federal Reserve System, in accordance with the provisions of the insurance law as applicable. However, funds of a controlling producer not required to be licensed in this state shall

be maintained in compliance with the requirements of the controlling producer's domiciliary jurisdiction;

5. The controlling producer shall maintain separately identifiable records of business written for the controlled insurer;

6. The contract shall not be assigned in whole or in part by the controlling producer;

7. The controlled insurer shall provide the controlling producer with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates and conditions. The standards, rules, procedures, rates and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer;

8. The rate and terms of the controlling producer's commissions, charges or other fees and the purposes for those charges or fees. The rates of the commissions, charges and other fees shall be no greater than those applicable to comparable business placed with the controlled insurer by producers other than controlling producers. For purposes of this paragraph and paragraph 7 of this subsection, examples of "comparable business" include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business;

9. If the contract provides that the controlling producer, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then such compensation shall not be determined and paid until at least five (5) years after the premiums on liability insurance are earned and at least one (1) year after the premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to subsection ~~C~~ D of this section;

10. A limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings. The insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and shall not accept business from the controlling producer if the limit is reached. The controlling producer shall not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached; and

11. The controlling producer may negotiate but shall not bind reinsurance on behalf of the controlled insurer on business the controlling producer places with the controlled insurer, except that the controlling producer may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with

the controlled insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts of percentages that may be reinsured and commission schedules.

C. Audit Committee. Every controlled insurer shall have an Audit Committee of the Board of Directors composed of independent directors. The Audit Committee shall annually meet with management, the insurer's licensed public accountant or a certified public accountant holding a permit to practice in this state and an independent casualty actuary or other independent loss reserve specialist acceptable to the Commissioner to review the adequacy of the insurer's loss reserves.

D. Reporting requirements.

1. In addition to any other required loss reserve certification, the controlled insurer shall annually, on April 1 of each year, file with the Commissioner an opinion of an independent casualty actuary, or such other independent loss reserve specialist acceptable to the Commissioner, reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end, including incurred but not reported losses, on business placed by the producer; and

2. The controlled insurer shall annually report to the Commissioner the amount of commissions paid to the producer, the percentage such amount represents of the net premiums written and comparable amounts and percentage paid to noncontrolling producers for placements of the same kinds of insurance.

SECTION 10. AMENDATORY 36 O.S. 2011, Section 4502, is amended to read as follows:

Section 4502. A. Each group accident and health policy shall contain in substance the following provisions:

1. A provision that, in the absence of fraud, all statements made by the policyholder or by any insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary~~.~~;

2. A provision that the insurer will furnish to the policyholder, for delivery to each employee or member of the insured group, an individual certificate setting forth in summary form a statement of the essential features of the insurance coverage of such employee or member and to whom benefits are payable. If dependents or family members are included in the coverage additional

certificates need not be issued for delivery to such dependents or family members.; and

3. A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

B. Each group health policy certificate subject to the provisions of the Federal Health Insurance Portability and Accountability Act, Public Law 104-191, (HIPAA) laws shall contain in substance the following provisions, which shall be in addition to the provisions required by subsection A of this section.

1. A provision that a health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition;

2. A provision that a health benefit plan shall not define a preexisting condition more restrictively than:

a. a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage,

b. pregnancy and genetic information shall not be considered preexisting conditions,

c. a health benefit plan may exclude a preexisting condition for late enrollees for a period not to exceed eighteen (18) months from the date the individual enrolls for coverage,

d. the period of any such preexisting condition exclusion shall be reduced by the aggregate of the periods of creditable coverage as defined in the Federal HIPAA laws,

e. a period of creditable coverage shall not be counted if after such period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage,

f. "enrollment date" means the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment, and

g. "late enrollee" means a participant or beneficiary who enrolls under the plan other than during the first period in which the individual is eligible to enroll under the plan or a special enrollment period;

3. A provision that individuals losing other coverage shall be permitted to enroll for coverage under the terms of the plan if each of the following conditions is met:

a. the employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent,

b. the employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer required such a statement at such time and provided the employee with notice of such requirement, and the consequences of such requirement, at such time,

c. the employee's or dependent's coverage was under a COBRA continuation provision and the coverage under such provision was exhausted; or was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions toward such coverage were terminated, and

d. under the terms of the plan, the employee requests such enrollment not later than thirty (30) days after the date of exhaustion of coverage;

4. A provision that for any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period, that period shall not be taken into account in determining the continuous period of creditable coverage. "Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period;

5. A provision that preexisting condition exclusions will not apply to newborns, who, as the last day of the thirty-day period beginning with the date of birth, are covered under creditable coverage;

6. A provision that preexisting condition exclusions will not apply to a child who is adopted or placed for adoption before attaining eighteen (18) years of age;

7. A provision that dependents are eligible for a special enrollment period if the group health plan makes coverage available with respect to a dependent of an individual, and the individual is a participant under the plan, or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a

previous enrollment period, and a person becomes such a dependent of the individual through marriage, birth or adoption or placement for adoption. The special enrollment period shall apply to that person or, if not otherwise enrolled, the individual, the dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

a. The dependent special enrollment period shall be a period of not less than thirty (30) days and shall begin on the later of the date dependent coverage is made available, or the date of the marriage, birth, or adoption or placement for adoption.

b. There is no waiting period if an individual seeks to enroll a dependent during the first thirty (30) days of such a dependent special enrollment period.

c. The coverage for the dependent shall become effective in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received, in the case of a dependent's birth, as of the date of such birth, in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption;

8. A provision that eligibility or continued eligibility of any individual will not be based on any of the following health-status-related factors in relation to the individual or a dependent of the individual: health status, medical condition, including both physical and mental illnesses, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, including conditions arising out of acts of domestic violence or disability.

a. Carriers are not required to provide particular benefits other than those provided under the terms of the plan or coverage.

b. Carriers may establish limitations or restrictions on the amount, level, extent, and nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage; and

9. A provision that the group health plan is guaranteed renewable, except as provided pursuant to the federal provisions found in HIPAA, which are as follows:

a. nonpayment of premium,

b. fraud,

c. violation of participation and/or contribution rules,

d. termination of coverage:

(1) in any case in which an issuer decides to discontinue offering a particular type of group

health insurance coverage offered in the large or small group market, coverage of such type may be discontinued by the issuer only if: the issuer provides notice to each plan sponsor provided coverage of this type in such market, and participants and beneficiaries covered under such coverage, of such discontinuation at least ninety (90) days prior to the date of the discontinuation of such coverage and makes available the option to purchase all or, in the case of the large group market, any other health insurance coverage currently being offered by the issuer to a group health plan in such market and in exercising the option to discontinue coverage of this type and in offering the option of coverage pursuant to this provision, the issuer acts uniformly without regard to the claims experience of those sponsors or any health-status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage,

(2) in any case in which an issuer decides to discontinue offering a particular type of group

health insurance coverage offered in the large or small group market, coverage of such type may be discontinued by the issuer only if: the issuer provides notice to the Oklahoma Insurance Department and to each plan sponsor and participants and beneficiaries covered under such coverage of such discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of such coverage; and all health insurance issued or delivered for issuance in the state in such market or markets are discontinued and coverage under such health insurance coverage in such market or markets is not renewed, and

(3) in the case of a discontinuation under division (2) of this subparagraph in a market, the issuer shall not provide for the issuance of any health insurance coverage in the market and in this state during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed,

e. movement outside the service area, and

f. association membership ceases~~; and~~

~~10. A provision that certification of creditable coverage will be issued individuals covered:~~

~~a. at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,~~

~~b. in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and~~

~~c. on the request on behalf of an individual made not later than twenty-four (24) months after the date of cessation of the coverage described in subparagraph a or b of this paragraph, whichever is later.~~

~~The certification described in this paragraph is a written certification of the period of creditable coverage of the individual under such plan and the coverage, if any, under such COBRA continuation provision, and the waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under such plan~~.

SECTION 11. AMENDATORY 36 O.S. 2011, Section 6041, is amended to read as follows:

Section 6041. ~~A.~~ Payment or each periodic payment not exceeding One Thousand Dollars ($1,000.00) for emergency living expenses made to any policyholder or his dependents or beneficiaries under an insurance policy for:

1. Fire insurance;

2. Casualty insurance;

3. Property insurance, including what may be termed a homeowner's policy; or

4. Any other type of policy that insures against personal loss as a consequence of loss of or damage to real or personal property; which provides for payment or periodic payments for emergency living expenses; and payments made under workers' compensation or employers' liability insurance as defined in Section 707 of ~~Title 36 of the Oklahoma Statutes~~ this title, shall be made through the use of United States legal tender, or through a means acceptable to the recipient of the payment, including, but not limited to, electronic funds transfer, prepaid cards, negotiable instruments payable on demand or negotiable drafts.

SECTION 12. AMENDATORY 36 O.S. 2011, Section 6811, is amended to read as follows:

Section 6811. A. ~~An~~ The Insurance Commissioner may require that an insuring entity or self-insured entity shall file~~, between January 1 and March 15 of each year,~~ a closed claim report. These reports shall be filed within thirty (30) days after the Commissioner's request and shall include data for all claims closed in the preceding calendar year and ~~any adjustments to data reported in prior years~~ other information required by the Commissioner.

B. Any violation by an insurer of the Medical Professional Liability Insurance Closed Claim Reports Act shall subject the insurer to discipline including a civil penalty of not less than Five Thousand Dollars ($5,000.00).

C. ~~Every insuring entity or self-insurer that provides medical professional liability insurance to any facility or provider in this state shall report each medical professional liability closed claim to the Insurance Commissioner.~~

~~D.~~ A closed claim that is covered under a primary policy and one or more excess policies shall be reported only by the insuring entity that issued the primary policy. The insuring entity that issued the primary policy shall report the total amount, if any, paid with respect to the closed claim, including any amount paid under an excess policy, any amount paid by the facility or provider, and any amount paid by any other person on behalf of the facility or provider.

~~E.~~ D. If a claim is not covered by an insuring entity or self-insurer, the facility or provider named in the claim shall report it to the Commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties. Instances in which a claim may not be covered by an insuring entity or self-insurer include situations in which:

1. The facility or provider did not buy insurance or maintained a self-insured retention that was larger than the final judgment or settlement;

2. The claim was denied by an insuring entity or self-insurer because it did not fall within the scope of the insurance coverage agreement; or

3. The annual aggregate coverage limits had been exhausted by other claim payments.

~~F.~~ E. If a claim is covered by an insuring entity or self-insurer that fails to report the claim to the Commissioner, the facility or provider named in the claim shall report it to the Commissioner after a final claim disposition has occurred due to a court proceeding or a settlement by the parties.

1. If a facility or provider is insured by a risk retention group and the risk retention group refuses to report closed claims and asserts that the federal Liability Risk Retention Act (95 Stat. 949; 15 U.S.C. Sec. 3901 et seq.) preempts state law, the facility or provider shall report all data required by the Medical Professional Liability Insurance Closed Claim Reports Act on behalf of the risk retention group.

2. If a facility or provider is insured by an unauthorized insurer and the unauthorized insurer refuses to report closed claims and asserts a federal exemption or other jurisdictional preemption, the facility or provider shall report all data required by the

Medical Professional Liability Insurance Closed Claim Reports Act on behalf of the unauthorized insurer.

3. If a facility or provider is insured by a captive insurer and the captive insurer refuses to report closed claims and asserts a federal exemption or other jurisdictional preemption, the facility or provider shall report all data required by the Medical Professional Liability Insurance Closed Claim Reports Act on behalf of the captive insurer.

SECTION 13. REPEALER 36 O.S. 2011, Sections 924.4, as amended by Section 1, Chapter 44, O.S.L. 2012 and 924.5, as amended by Section 2, Chapter 44, O.S.L. 2012 (36 O.S. Supp. 2014, Sections 924.4 and 924.5), are hereby repealed.

SECTION 14. This act shall become effective November 1, 2015.

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