

1 ENGROSSED HOUSE AMENDMENTS

TO

2 ENGROSSED SENATE BILL NO. 887

By: Quinn of the Senate

3 and

4 Sneed of the House

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An Act relating to insurance \*\*\*\* Biographical Affidavits; modifying time frame for Business Character Report \*\*\*\* Oklahoma Automobile Insurance Plan to issue certain policies \*\*\*\* acts by an insurer constituting unfair claim settlement practices \*\*\*\* licensing procedure \*\*\*\* Oklahoma Property and Casualty Insurance Guaranty Association \*\*\*\* Oklahoma Life and Health Insurance Guaranty Association \*\*\*\* Viatical Settlements Act of 2008 \*\*\*\* Insurance Commissioner to prescribe rules \*\*\*\* home service contracts; modifying type of authorized financial security deposit \*\*\*\* grievance procedures \*\*\*\* applicants for licensure, property for employees, Advisory Board to the Insurance Commissioner, and the Oklahoma Small Employer Health Reinsurance Program; providing for codification; and declaring an emergency.

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18 AMENDMENT NO. 1. Page 68, Line 20, after the "comma" and before the  
19 word "notice" insert the word "written"

20 AMENDMENT NO. 2. Page 68, Lines 21-23, by deleting all language  
21 beginning with the word "to" on Line 21 through  
22 the word "policy" on Line 23, insert the following  
language:

23 "by the insured to the insurer that provided the  
24 coverage being canceled. The notice of  
cancellation shall provide the date of the  
cancellation of the policy and the insurer shall

1                    reimburse the insured for any premiums paid for  
2                    coverage beyond the date of cancellation of the  
3                    policy"

4                    and amend title to conform

5                    Passed the House of Representatives the 21st day of April, 2021.

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7                    \_\_\_\_\_  
8                    Presiding Officer of the House of  
                         Representatives

9                    Passed the Senate the \_\_\_\_ day of \_\_\_\_\_, 2021.

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12                    \_\_\_\_\_  
                         Presiding Officer of the Senate

1 ENGROSSED SENATE  
2 BILL NO. 887

By: Quinn of the Senate

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7 An Act relating to insurance; amending 36 O.S. 2011,  
8 Section 311.4, as amended by Section 1, Chapter 275,  
9 O.S.L. 2014 (36 O.S. Supp. 2020, Section 311.4),  
10 which relates to annual statements reporting market  
11 conduct data of insurers; authorizing imposition of  
12 civil fine; amending 36 O.S. 2011, Section 615.2,  
13 which relates to Biographical Affidavits; modifying  
14 time frame for Business Character Report; amending 36  
15 O.S. 2011, Section 638, which relates to compliance  
16 relating to examinations; updating statutory  
17 references; requiring insurer using credit  
18 information to provide certain exceptions to how  
19 credit information is used; specifying exceptions;  
20 authorizing insurer to require certain information  
21 for granting of exception; declaring insurer in  
22 compliance with law in certain situation; construing  
23 provision; requiring insurer to provide notice of  
24 exceptions; amending 36 O.S. 2011, Section 996, which  
relates to assigned risks; removing prohibition on  
disapproval of certain market plans; authorizing the  
Oklahoma Automobile Insurance Plan to issue certain  
policies; declaring policies as proof of certain  
required financial responsibility; providing for  
liability; requiring filing of annual audited  
financial statement; authorizing Commissioner 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. 2020, Section 1116), which  
relates to penalties for failure to remit taxes;  
removing time limits; specifying application of  
certain penalty; 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 1250.5, as amended by  
Section 1, Chapter 105, O.S.L. 2012 (36 O.S. Supp.

1 2020, Section 1250.5), which relates to acts by an  
2 insurer constituting unfair claim settlement  
3 practices; authorizing certain method of payment;  
4 amending 36 O.S. 2011, Section 1250.7, as amended by  
5 Section 7, Chapter 95, O.S.L. 2018 (36 O.S. Supp.  
6 2020, Section 1250.7), which relates to property and  
7 casualty claims; modifying time for notice; amending  
8 36 O.S. 2011, Section 1250.8, which relates to motor  
9 vehicle total loss or damage claim; providing for  
10 electronic payment; amending 36 O.S. 2011, Section  
11 1435.20, as last amended by Section 1, Chapter 263,  
12 O.S.L. 2019 (36 O.S. Supp. 2020, Section 1435.20),  
13 which relates to limited lines producers; updating  
14 language; adding type of license limited lines  
15 producer may receive; amending 36 O.S. 2011, Section  
16 1445, which relates to fiduciary capacity;  
17 authorizing electronic payments in certain  
18 circumstances; amending 36 O.S. 2011, Section 1450,  
19 as amended by Section 6, Chapter 294, O.S.L. 2019 (36  
20 O.S. Supp. 2020, Section 1450), which relates to  
21 licensing procedure; modifying time for certain  
22 notification; requiring background reports by certain  
23 persons; amending 36 O.S. 2011, Sections 2004, 2006,  
24 as amended by Section 1, Chapter 78, O.S.L. 2014,  
2007 and 2008 (36 O.S. Supp. 2020, Section 2006),  
which relate to the Oklahoma Property and Casualty  
Insurance Guaranty Association; modifying definition;  
modifying composition of Board of Directors;  
modifying obligations of certain insurers; specifying  
entity responsible for issuance of certain policies;  
adding method of certain notification; authorizing  
insurer Board representative to designate alternate  
member with duties of insurer; removing authority of  
Commissioner to appoint Board members in certain  
circumstances; modifying duties of the Association;  
removing residency requirement for certain entities;  
amending 36 O.S. 2011, Section 2023, as amended by  
Section 2, Chapter 384, O.S.L. 2019 (36 O.S. Supp.  
2020, Section 2023), which relates to the Oklahoma  
Life and Health Insurance Guaranty Association;  
clarifying terms; amending 36 O.S. 2011, Section  
3101, which relates to definitions; modifying  
definition; amending 36 O.S. Supp. 2011, Section  
3105, which relates to motor service club agents;  
updating language; clarifying persons who may be  
appointed; removing requirement of certain  
notification; modifying certain fee for producers;

1 modifying length Commissioner may suspend certain  
2 license; amending 36 O.S. 2011, Section 3108, which  
3 relates to misrepresentation; updating language;  
4 amending 36 O.S. 2011, Section 3639.1, as amended by  
5 Section 11, Chapter 44, O.S.L. 2012 (36 O.S. Supp.  
6 2020, Section 3639.1), which relates to personal  
7 residential insurance; requiring insured provide  
8 certain notification for cancellation; providing that  
9 insurer not liable after date of cancellation;  
10 amending 36 O.S. 2011, Sections 4030 and 4030.1,  
11 which relate to paying premiums for single life  
12 policies and payment of proceeds; amending 36 O.S.  
13 2011, Section 4055.7, which relates to the Viatical  
14 Settlements Act of 2008; amending 36 O.S. Section  
15 4055.9, which relates to viatical settlements;  
16 amending 36 O.S. 2011, Section 4103, which relates to  
17 schedule of premium rates; deleting exception;  
18 amending 36 O.S. 2011, Section 4112, which relates to  
19 payment of proceeds; amending 36 O.S. 2011, Section  
20 6060.11, as amended by Section 2, Chapter 75, O.S.L.  
21 2020 (36 O.S. Supp. 2020, Section 6060.11), which  
22 relates to mental health and substance use disorders;  
23 modifying certain deadline for Commissioner  
24 reporting; amending 36 O.S. 2011, Section 6060.12, as  
amended by Section 3, Chapter 75, O.S.L. 2020 (36  
O.S. Supp. 2020, Section 6060.12), which relates to  
calculation of premium costs; modifying penalty  
determination; prohibiting change of name of prepaid  
funeral benefit 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 prescribe rules; amending  
36 O.S. 2011, Section 6216.1, which relates to  
payment of claims to public adjuster; amending 36  
O.S. 2011, Section 6217, as last amended by Section  
14, Chapter 269, O.S.L. 2013 (36 O.S. Supp. 2020,  
Section 6217), which relates to continuing education;  
eliminating continuing education advisory committee;  
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

1 certificate of dormancy; providing for examination;  
2 authorizing the Insurance Commissioner to promulgate  
3 rules; amending 36 O.S. 2011, Section 6552, which  
4 relates to definitions; modifying definition;  
5 amending 36 O.S. 2011, Section 6753, as amended by  
6 Section 38, Chapter 150, O.S.L. 2012 (36 O.S. Supp.  
7 2020, Section 6753), which relates to home service  
8 contracts; modifying type of authorized financial  
9 security deposit; amending 36 O.S. 2011, Section  
10 6904, which relates to issuance of certificates;  
11 modifying agency responsible for determining certain  
12 compliance; removing duty and notification  
13 requirements of State Commissioner of Health;  
14 modifying time frame for issuance of certificate;  
15 amending 36 O.S. 2011, Section 6907, which relates to  
16 reasonable standards of quality care and  
17 credentialing; modifying applicable agency; amending  
18 36 O.S. 2011, Section 6911, which relates to  
19 grievance procedures; modifying responsible agency;  
20 amending 36 O.S. 2011, Section 6919, which relates to  
21 examination of affairs, programs, books and records;  
22 amending 36 O.S. 2011, Section 6920, which relates to  
23 suspension or revocation of a certificate of  
24 authority; eliminating role of State Commissioner of  
Health in certain hearings and determinations;  
modifying conditions in which Commissioner may revoke  
certain license; amending 36 O.S. 2011, Section 6929,  
which relates to contracts with qualified persons;  
repealing 36 O.S. 2011, Sections 1435.40, as amended  
by Section 1, Chapter 23, O.S.L. 2016 (O.S. Supp.  
2020, Section 1435.40), 1612.1, 6221, and 6522 which  
relate to applicants for licensure, property for  
employees, Advisory Board to the Insurance  
Commissioner, and the Oklahoma Small Employer Health  
Reinsurance Program; providing for codification; and  
declaring an emergency.

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

1 SECTION 1. AMENDATORY 36 O.S. 2011, Section 311.4, as  
2 amended by Section 1, Chapter 275, O.S.L. 2014 (36 O.S. Supp. 2020,  
3 Section 311.4), is amended to read as follows:

4 Section 311.4. A. Insurers authorized to do business under the  
5 provisions of the Oklahoma Insurance Code shall annually file with  
6 the Insurance Commissioner market conduct annual statements  
7 reporting market conduct data of insurers on the thirty-first day of  
8 December of the previous year. The statements shall report on the  
9 lines of insurance and be in such general form and context as  
10 approved by the National Association of Insurance Commissioners  
11 (NAIC), and as supplemented for additional information required by  
12 the Insurance Commissioner by rule. The statements shall be  
13 prepared in accordance with NAIC instructions, including any  
14 supplemental filings described in the NAIC instructions. If no  
15 forms or instructions are available from the National Association of  
16 Insurance Commissioners, the statements shall be in the form and  
17 pursuant to instructions as provided by the Insurance Commissioner.  
18 Insurers not authorized by the Insurance Commissioner to provide the  
19 lines of insurance approved by the National Association or the  
20 Insurance Commissioner shall not be required to file market conduct  
21 annual statements. For good cause shown, the Insurance Commissioner  
22 may extend the time within which market conduct annual statements  
23 may be filed. The Insurance Commissioner may provide copies of  
24 market conduct annual statements, amendments, and addendums to such

1 statements and market conduct data taken from such statements to the  
2 National Association of Insurance Commissioners only if, prior to  
3 sharing of the market conduct annual statements, amendments,  
4 addendums to such statements or market conduct data taken from such  
5 statements, the National Association of Insurance Commissioners  
6 enters into a written agreement with the Insurance Commissioner to  
7 maintain the confidentiality of the shared information.

8 B. The Insurance Commissioner may adopt rules implementing this  
9 section including rules that:

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

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

16 C. Insurers shall pay a filing fee of Two Hundred Dollars  
17 (\$200.00) to the Insurance Commissioner for the filing of the market  
18 conduct annual statement.

19 D. No waiver of an applicable privilege or claim of  
20 confidentiality in the documents, materials, or other information  
21 shall occur as a result of disclosure to the Insurance Commissioner  
22 or the Commissioner's designee under this section or as a result of  
23 sharing the documents, materials or other information as provided in  
24 this section.



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

6 F. The Insurance Commissioner may use market conduct annual  
7 statements or amendments or addendums to such statements to assist  
8 in determining whether a market conduct examination or investigation  
9 of an insurer should be conducted. For purposes of completing a  
10 market conduct examination of any company under Sections 309.1  
11 through 309.7 of this title, the Insurance Commissioner may, in the  
12 sole discretion of the Insurance Commissioner, use market conduct  
13 annual statements or amendments or addendums to such statements to  
14 assist in determining compliance with the laws of this state and  
15 rules adopted by the Insurance Commissioner.

16 G. For any violation of this section, the Insurance  
17 Commissioner may, after notice and opportunity for a hearing,  
18 subject an insurer to a civil penalty of up to One Thousand Dollars  
19 (\$1,000.00) for each occurrence. Such civil penalty may be enforced  
20 in the same manner in which civil judgments may be enforced.

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

23 Section 615.2. All domestic insurers and health maintenance  
24 organizations are required to keep biographical information current.

1 Domestic insurers and health maintenance organizations are required  
2 to provide Biographical Affidavits within thirty (30) days of any  
3 change in officers, directors, key management or any person  
4 acquiring ten percent (10%) or more controlling interest in a  
5 domestic insurer. The information shall be on the National  
6 Association of Insurance Commissioners (NAIC) UCAA Biographical  
7 Affidavit Form. The Biographical Affidavit is to be certified by an  
8 independent third party acceptable to the Insurance Commissioner  
9 that has conducted a comprehensive review of the background of the  
10 applicant and has indicated that the Biographical Affidavit has no  
11 significantly inaccurate or conflicting information and is accepted  
12 as the Business Character Report. As used in this section,  
13 "independent third party" is one that has no affiliation with the  
14 applicant and is in the business of providing background checks or  
15 investigations. The Business Character Report must be current and  
16 shall not be older than ~~one (1) year~~ six (6) months.

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

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

24

1           SECTION 4.           NEW LAW           A new section of law to be codified  
2 in the Oklahoma Statutes as Section 953.1 of Title 36, unless there  
3 is created a duplication in numbering, reads as follows:

4           A. Notwithstanding any other law or regulation, an insurer that  
5 uses credit information shall, upon written request from an  
6 applicant for insurance coverage or an insured upon a form provided  
7 by the Insurance Commissioner, provide reasonable exceptions to the  
8 rate of the insurer, rating classifications, company or tier  
9 placement or underwriting rules or guidelines for a consumer who has  
10 experienced and whose credit information has been directly  
11 influenced by any of the following events:

12           1. Catastrophic event declared by the federal or state  
13 government;

14           2. Serious illness or injury, or serious illness or injury to  
15 an immediate family member;

16           3. Death of an immediate family member;

17           4. Divorce or involuntary interruption of legally owed alimony  
18 or support payments;

19           5. Identity theft;

20           6. Temporary loss of employment for a period of three (3)  
21 months or more, if it results from involuntary termination;

22           7. Military deployment overseas; and

23           8. Other events, as determined by the Insurance Commissioner.  
24

1 B. If an applicant or insured submits a request for an  
2 exception as provided in subsection A of this section, an insurer  
3 may, in its sole discretion:

4 1. Require the consumer to provide reasonable written and  
5 independently verifiable documentation of the event;

6 2. Require the consumer to demonstrate that the event had  
7 direct and meaningful impact on the credit information of the  
8 consumer;

9 3. Require the request be made no more than sixty (60) days  
10 from the date of the application for insurance or the policy  
11 renewal;

12 4. Grant an exception despite the consumer not providing the  
13 initial request for an exception in writing; or

14 5. Grant an exception to requiring a written request where the  
15 consumer asks for a consideration of repeated events or the insurer  
16 has considered this event previously.

17 C. An insurer is in compliance with any other provision of law  
18 or Insurance Department rule relating to underwriting, rating or  
19 rate filing notwithstanding the granting an exception under this  
20 section. Nothing in this section shall be construed to provide a  
21 consumer or other insured with a cause of action that does not exist  
22 in the absence of this section.

23 D. The insurer shall provide notice to consumers, either at the  
24 time of acceptance of an insurance application or at policy renewal,

1 that reasonable exceptions are available and information about how  
2 the consumer may inquire further.

3 SECTION 5. AMENDATORY 36 O.S. 2011, Section 996, is  
4 amended to read as follows:

5 Section 996. Assigned Risks. A. Agreements may be made among  
6 insurers with respect to the equitable apportionment among them of  
7 costs for insurance which may be afforded applicants who are in good  
8 faith entitled to, but who are unable to procure, such insurance  
9 through ordinary methods, and such insurers may agree among  
10 themselves on the use of reasonable rate modifications for such  
11 insurance, such agreements and rate modifications to be subject to  
12 the approval of the Insurance Commissioner. ~~Nothing in the Property~~  
13 ~~and Casualty Competitive Loss Cost Rating Act shall permit~~  
14 ~~disapproval of a residual market plan permitting an insurer to elect~~  
15 ~~voluntary direct assignment.~~

16 B. The Oklahoma Automobile Insurance Plan is authorized to  
17 issue policies of insurance in the name of the plan for the  
18 applicants described in subsection A of this section and to act on  
19 behalf of all participating members in connection with the policies.  
20 The policies shall be considered proof of financial responsibility  
21 in accordance with Section 7-600 of the Highway Safety Code.

22 C. The participating members shall be liable to the plan for  
23 all costs, expenses and liabilities in proportion to its share of  
24

1 voluntary market premium for the types of policies written under the  
2 plan in this state.

3 D. The plan shall file an annual audited financial statement  
4 with the Commissioner.

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

7 SECTION 6. AMENDATORY 36 O.S. 2011, Section 1116, as  
8 amended by Section 18, Chapter 45, O.S.L. 2012 (36 O.S. Supp. 2020,  
9 Section 1116), is amended to read as follows:

10 Section 1116. A. Any surplus lines licensee or broker who  
11 fails to remit the surplus line tax provided for by Section 1115 of  
12 this title ~~for more than sixty (60) days after it is due~~ shall be  
13 liable for a civil penalty ~~of~~ not to exceed Twenty-five Dollars  
14 (\$25.00) for each ~~additional~~ day of delinquency, per policy. The  
15 Insurance Commissioner shall collect the tax by distraint and shall  
16 recover the penalty by an action in the name of the State of  
17 Oklahoma. The Commissioner may request the Attorney General to  
18 appear in the name of the state by relation of the Commissioner.

19 B. If any person, association or legal entity procuring or  
20 accepting any insurance coverage from a surplus lines insurer where  
21 Oklahoma is the home state of the insured, otherwise than through a  
22 surplus lines licensee or broker, fails to remit the surplus line  
23 tax provided for by Section 1115 of this title, the person,  
24 association or legal entity shall, in addition to the tax, be liable

1 to a civil penalty in an amount equal to one percent (1%) of the  
2 premiums paid or agreed to be paid for the policy or policies of  
3 insurance for each calendar month of delinquency or a civil penalty  
4 in the amount of Twenty-five Dollars (\$25.00) whichever shall be the  
5 greater. The Insurance Commissioner shall collect the tax by  
6 distraint and shall recover the civil penalty in an action in the  
7 name of the State of Oklahoma. The Commissioner may request the  
8 Attorney General to appear in the name of the state by relation of  
9 the Commissioner.

10 SECTION 7. AMENDATORY 36 O.S. 2011, Section 1219, is  
11 amended to read as follows:

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

18 B. As used in this section:

19 1. "Accident and health insurance policy" or "policy" means any  
20 policy, certificate, contract, agreement or other instrument that  
21 provides accident and health insurance, as defined in Section 703 of  
22 this title, to any person in this state, and any subscriber  
23 certificate or any evidence of coverage issued by a health  
24 maintenance organization to any person in this state;

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

5           3. "Insurer" means any entity that provides an accident and  
6 health insurance policy in this state, including, but not limited  
7 to, a licensed insurance company, a not-for-profit hospital service  
8 and medical indemnity corporation, a health maintenance  
9 organization, a fraternal benefit society, a multiple employer  
10 welfare arrangement, or any other entity subject to regulation by  
11 the Insurance Commissioner.

12           C. If a claim or any portion of a claim is determined to have  
13 defects or improprieties, including a lack of any required  
14 substantiating documentation, or particular circumstance requiring  
15 special treatment, the insured, enrollee or subscriber, assignee of  
16 the insured, enrollee or subscriber, and health care provider shall  
17 be notified in writing within thirty (30) calendar days after  
18 receipt of the claim by the insurer. The written notice shall  
19 specify the portion of the claim that is causing a delay in  
20 processing and explain any additional information or corrections  
21 needed. Failure of an insurer to provide the insured, enrollee or  
22 subscriber, assignee of the insured, enrollee or subscriber, and  
23 health care provider with the notice shall constitute prima facie  
24 evidence that the claim will be paid in accordance with the terms of



1 the policy. Provided, if a claim is not submitted into the system  
2 due to a failure to meet basic Electronic Data Interchange (EDI)  
3 and/or Health Insurance Portability and Accountability Act (HIPAA)  
4 edits, electronic notification of the failure to the submitter shall  
5 be deemed compliance with this subsection. Provided further, health  
6 maintenance organizations shall not be required to notify the  
7 insured, enrollee or subscriber, or assignee of the insured,  
8 enrollee or subscriber of any claim defect or impropriety.

9 D. Upon receipt of the additional information or corrections  
10 which led to the claim's being delayed and a determination that the  
11 information is accurate, an insurer shall either pay or deny the  
12 claim or a portion of the claim within forty-five (45) calendar days  
13 for a paper claim and thirty (30) calendar days for an electronic  
14 claim.

15 E. Payment shall be considered made on:

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

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

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

22 G. In the event litigation should ensue based upon such a  
23 claim, the prevailing party shall be entitled to recover a  
24

1 reasonable attorney fee to be set by the court and taxed as costs  
2 against the party or parties who do not prevail.

3 H. The Insurance Commissioner shall develop a standardized  
4 prompt pay form for use by providers in reporting violations of  
5 prompt pay requirements. The form shall include a requirement that  
6 documentation of the reason for the delay in payment or  
7 documentation of proof of payment must be provided within ten (10)  
8 days of the filing of the form. The Commissioner shall provide the  
9 form to health maintenance organizations and providers.

10 I. The provisions of this section shall not apply to the  
11 Oklahoma Life and Health Insurance Guaranty Association or to the  
12 Oklahoma Property and Casualty Insurance Guaranty Association.

13 SECTION 8. AMENDATORY 36 O.S. 2011, Section 1250.5, as  
14 amended by Section 1, Chapter 105, O.S.L. 2012 (36 O.S. Supp. 2020,  
15 Section 1250.5), is amended to read as follows:

16 Section 1250.5. Any of the following acts by an insurer, if  
17 committed in violation of Section 1250.3 of this title, constitutes  
18 an unfair claim settlement practice exclusive of paragraph 16 of  
19 this section which shall be applicable solely to health benefit  
20 plans:

21 1. Failing to fully disclose to first party claimants,  
22 benefits, coverages, or other provisions of any insurance policy or  
23 insurance contract when the benefits, coverages or other provisions  
24 are pertinent to a claim;

- 1        2. Knowingly misrepresenting to claimants pertinent facts or  
2 policy provisions relating to coverages at issue;
- 3        3. Failing to adopt and implement reasonable standards for  
4 prompt investigations of claims arising under its insurance policies  
5 or insurance contracts;
- 6        4. Not attempting in good faith to effectuate prompt, fair and  
7 equitable settlement of claims submitted in which liability has  
8 become reasonably clear;
- 9        5. Failing to comply with the provisions of Section 1219 of  
10 this title;
- 11       6. Denying a claim for failure to exhibit the property without  
12 proof of demand and unfounded refusal by a claimant to do so;
- 13       7. Except where there is a time limit specified in the policy,  
14 making statements, written or otherwise, which require a claimant to  
15 give written notice of loss or proof of loss within a specified time  
16 limit and which seek to relieve the company of its obligations if  
17 the time limit is not complied with unless the failure to comply  
18 with the time limit prejudices the rights of an insurer;
- 19       8. Requesting a claimant to sign a release that extends beyond  
20 the subject matter that gave rise to the claim payment;
- 21       9. Issuing checks ~~or~~, drafts or electronic payment in partial  
22 settlement of a loss or claim under a specified coverage which  
23 contain language releasing an insurer or its insured from its total  
24 liability;

1           10. Denying payment to a claimant on the grounds that services,  
2 procedures, or supplies provided by a treating physician or a  
3 hospital were not medically necessary unless the health insurer or  
4 administrator, as defined in Section 1442 of this title, first  
5 obtains an opinion from any provider of health care licensed by law  
6 and preceded by a medical examination or claim review, to the effect  
7 that the services, procedures or supplies for which payment is being  
8 denied were not medically necessary. Upon written request of a  
9 claimant, treating physician, or hospital, the opinion shall be set  
10 forth in a written report, prepared and signed by the reviewing  
11 physician. The report shall detail which specific services,  
12 procedures, or supplies were not medically necessary, in the opinion  
13 of the reviewing physician, and an explanation of that conclusion.  
14 A copy of each report of a reviewing physician shall be mailed by  
15 the health insurer, or administrator, postage prepaid, to the  
16 claimant, treating physician or hospital requesting same within  
17 fifteen (15) days after receipt of the written request. As used in  
18 this paragraph, "physician" means a person holding a valid license  
19 to practice medicine and surgery, osteopathic medicine, podiatric  
20 medicine, dentistry, chiropractic, or optometry, pursuant to the  
21 state licensing provisions of Title 59 of the Oklahoma Statutes;

22           11. Compensating a reviewing physician, as defined in paragraph  
23 10 of this subsection, on the basis of a percentage of the amount by  
24 which a claim is reduced for payment;

1 12. Violating the provisions of the Health Care Fraud  
2 Prevention Act;

3 13. Compelling, without just cause, policyholders to institute  
4 suits to recover amounts due under its insurance policies or  
5 insurance contracts by offering substantially less than the amounts  
6 ultimately recovered in suits brought by them, when the  
7 policyholders have made claims for amounts reasonably similar to the  
8 amounts ultimately recovered;

9 14. Failing to maintain a complete record of all complaints  
10 which it has received during the preceding three (3) years or since  
11 the date of its last financial examination conducted or accepted by  
12 the Commissioner, whichever time is longer. This record shall  
13 indicate the total number of complaints, their classification by  
14 line of insurance, the nature of each complaint, the disposition of  
15 each complaint, and the time it took to process each complaint. For  
16 the purposes of this paragraph, "complaint" means any written  
17 communication primarily expressing a grievance;

18 15. Requesting a refund of all or a portion of a payment of a  
19 claim made to a claimant or health care provider more than twenty-  
20 four (24) months after the payment is made. This paragraph shall  
21 not apply:

22 a. if the payment was made because of fraud committed by  
23 the claimant or health care provider, or  
24

1           b.    if the claimant or health care provider has otherwise  
2                    agreed to make a refund to the insurer for overpayment  
3                    of a claim;

4           16.   Failing to pay, or requesting a refund of a payment, for  
5 health care services covered under the policy if a health benefit  
6 plan, or its agent, has provided a preauthorization or  
7 precertification and verification of eligibility for those health  
8 care services. This paragraph shall not apply if:

- 9           a.    the claim or payment was made because of fraud  
10                   committed by the claimant or health care provider,  
11           b.    the subscriber had a preexisting exclusion under the  
12                   policy related to the service provided, or  
13           c.    the subscriber or employer failed to pay the  
14                   applicable premium and all grace periods and  
15                   extensions of coverage have expired; or

16           17.   Denying or refusing to accept an application for life  
17 insurance, or refusing to renew, cancel, restrict or otherwise  
18 terminate a policy of life insurance, or charge a different rate  
19 based upon the lawful travel destination of an applicant or insured  
20 as provided in Section 4024 of this title.

21           SECTION 9.        AMENDATORY        36 O.S. 2011, Section 1250.7, as  
22 amended by Section 7, Chapter 95, O.S.L. 2018 (36 O.S. Supp. 2020,  
23 Section 1250.7), is amended to read as follows:

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.

24

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.

24



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 ~~thirty (30) days,~~ and to third party claimants ~~sixty~~  
9 ~~(60) days, before the date on which such time limit may expire~~ one  
10 year after the date of the loss.

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

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

18 SECTION 10. AMENDATORY 36 O.S. 2011, Section 1250.8, is  
19 amended to read as follows:

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

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

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

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

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

21           c. the cost of a comparable motor vehicle as quoted in  
22 the latest edition of the National Automobile Dealers  
23 Association Official Used Car Guide or monthly edition  
24

1 of any other nationally recognized published  
2 guidebook.

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

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

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

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

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

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

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

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

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

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

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

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

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

23 M. As used in this section, "total loss" means that the vehicle  
24 repair costs plus the salvage value of the vehicle meets or exceeds

1 the actual cash value of the motor vehicle prior to the loss, as  
2 provided in used automobile dealer guidebooks.

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

13 SECTION 11. AMENDATORY 36 O.S. 2011, Section 1435.20, as  
14 last amended by Section 1, Chapter 263, O.S.L. 2019 (36 O.S. Supp.  
15 2020, Section 1435.20), is amended to read as follows:

16 Section 1435.20. A. A limited lines producer may receive  
17 qualification for a license in one or more of the following  
18 categories:

19 1. Prepaid legal liability insurance, which means the  
20 assumption of an enforceable contractual obligation to provide  
21 specified legal services or to reimburse policyholders for specified  
22 legal expenses, pursuant to the provisions of a group or individual  
23 policy;

24

1           2. Crop - insurance providing protection against damage to  
2 crops from unfavorable weather conditions, fire or lightning, flood,  
3 hail, insect infestation, disease or other yield-reducing conditions  
4 or perils provided by the private insurance market, or that is  
5 subsidized by the Federal Crop Insurance Corporation, including  
6 Multi-Peril Crop Insurance;

7           3. Car rental - insurance offered, sold or solicited in  
8 connection with and incidental to the rental of rental cars for a  
9 period of two (2) years, whether at the rental office or by  
10 preselection of coverage in master, corporate, group or individual  
11 agreements that:

- 12           a. is nontransferable,
- 13           b. applies only to the rental car that is the subject of  
14           the rental agreement, and
- 15           c. is limited to the following kinds of insurance:
  - 16           (1) personal accident insurance for renters and other  
17           rental car occupants, for accidental death or  
18           dismemberment, and for medical expenses resulting  
19           from an accident that occurs with the rental car  
20           during the rental period,
  - 21           (2) liability insurance that provides protection to  
22           the renters and other authorized drivers of a  
23           rental car for liability arising from the  
24

1 operation or use of the rental car during the  
2 rental period,

3 (3) personal effects insurance that provides coverage  
4 to renters and other vehicle occupants for loss  
5 of, or damage to, personal effects in the rental  
6 car during the rental period,

7 (4) roadside assistance and emergency sickness  
8 protection insurance, or

9 (5) any other coverage designated by the Insurance  
10 Commissioner.

11 A car rental limited lines license issued to a rental or leasing  
12 company shall authorize any employee or authorized representative of  
13 the rental or leasing company to sell or offer coverage at each  
14 location at which the rental or leasing company operates. Employees  
15 or authorized representatives are not required to be individually  
16 licensed;

17 4. Credit - credit life, credit disability, credit property,  
18 credit unemployment, involuntary unemployment, mortgage life,  
19 mortgage guaranty, mortgage disability, guaranteed automobile  
20 protection insurance, or any other form of insurance offered in  
21 connection with an extension of credit that is limited to partially  
22 or wholly extinguishing that credit obligation and that is  
23 designated by the Insurance Commissioner as limited line credit  
24 insurance;



1           5. Surety - insurance or bond that covers obligations to pay  
2 the debts of, or answer for the default of another, including  
3 faithlessness in a position of public or private trust. For purpose  
4 of limited line licensing, surety does not include surety bail  
5 bonds;

6           6. Travel; ~~and~~

7           7. Self-service storage insurance, pursuant to Section ~~2 of~~  
8 ~~this act~~ 1435.20a of this title; and

9           8. Motor Service Club limited lines producer, pursuant to  
10 Sections 3101 et seq. of this title.

11           B. 1. An insurance producer or limited lines producer may  
12 solicit applications for and issue travel accident policies or  
13 baggage insurance by means of mechanical vending machines supervised  
14 by the insurance producer or limited lines producer only if the  
15 Insurance Commissioner shall determine that the form of policy to be  
16 sold is reasonably suited for sale and issuance through vending  
17 machines, that use of vending machines for the sale of policies  
18 would be of convenience to the public, and that the type of vending  
19 machine to be used is reasonably suitable and practical for the sale  
20 and issuance of policies. Policies so sold do not have to be  
21 countersigned.

22           2. The Commissioner shall issue to the insurance agent or  
23 limited insurance representative a special vending machine license  
24 for each such machine to be used. The license shall specify the

1 name and address of the insurer and licensee, the kind of insurance  
2 and type of policy to be sold, and the place where the machine is to  
3 be in operation. The license shall expire, be renewable, and be  
4 suspended or revoked coincidentally with the insurance agent license  
5 or limited representative license of the licensee. The license fee  
6 for each vending machine shall be that stated in the provisions of  
7 Section 1435.23 of this title. Proof of existence of the license  
8 shall be displayed on or about each machine in such manner as the  
9 Commissioner may reasonably require.

10 SECTION 12. AMENDATORY 36 O.S. 2011, Section 1445, is  
11 amended to read as follows:

12 Section 1445. A. All insurance charges or premiums collected  
13 by an administrator for an insurer or trust and all return premiums  
14 received from the insurer or trust shall be held by the  
15 administrator in a fiduciary capacity. These funds shall be  
16 immediately remitted to the person entitled to the funds or shall be  
17 deposited promptly in a fiduciary bank account established and  
18 maintained by the administrator.

19 B. If charges or premiums deposited in a fiduciary account have  
20 been collected for more than one insurer or trust, the administrator  
21 shall keep records showing the deposits to and withdrawals from the  
22 account for each insurer or trust. The administrator, upon request  
23 of an insurer or trust, shall furnish copies of the records  
24

1 pertaining to deposits to and withdrawals from the account for that  
2 insurer or trust.

3 C. The administrator shall not pay any claim by withdrawals  
4 from a fiduciary account unless provisions for said withdrawals are  
5 included in the written agreement between the insurer or trust and  
6 the administrator. The written agreement shall authorize  
7 withdrawals by the administrator from the fiduciary account only  
8 for:

9 1. ~~remittance~~ Remittance to an insurer or trust entitled to a  
10 remittance; or

11 2. ~~deposit~~ Deposit in an account maintained in the name of an  
12 insurer or trust; or

13 3. ~~transfer~~ Transfer to and deposit in an account established  
14 for payment of claims, as provided for by subsection D of this  
15 section; or

16 4. ~~payment~~ Payment to a group policyholder for remittance to  
17 the insurer or trust entitled to such remittance; or

18 5. ~~payment~~ Payment of commission, fees, or charges to the  
19 administrator; or

20 6. ~~remittance~~ Remittance of return premiums to the person  
21 entitled to such return premiums.

22 D. All claims paid by the administrator from funds collected on  
23 behalf of the insurer or trust shall be paid on drafts ~~or~~, checks or  
24 electronic payment authorized by the insurer or trust.

1 SECTION 13. AMENDATORY 36 O.S. 2011, Section 1450, as  
2 amended by Section 6, Chapter 294, O.S.L. 2019 (36 O.S. Supp. 2020,  
3 Section 1450), is amended to read as follows:

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

9 B. An administrator shall not be eligible for a nonresident  
10 administrator license under this section if the administrator does  
11 not hold a home state certificate of authority or license in a state  
12 that has adopted the Third-party Administrator Act or that applies  
13 substantially similar provisions as are contained in the Third-party  
14 Administrator Act to that administrator. If the Third-party  
15 Administrator Act in the administrator's home state does not extend  
16 to stop-loss insurance, but if the home state otherwise applies  
17 substantially similar provisions as are contained in the Third-party  
18 Administrator Act to that administrator, then that omission shall  
19 not operate to disqualify the administrator from receiving a  
20 nonresident administrator license in this state.

21 1. "Home state" means the United States jurisdiction that has  
22 adopted the Third-party Administrator Act or a substantially similar  
23 law governing third-party administrators and which has been  
24 designated by the administrator as its principal regulator. The

1 administrator may designate either its state of incorporation or its  
2 principal place of business within the United States if that  
3 jurisdiction has adopted the Third-party Administrator Act or a  
4 substantially similar law governing third-party administrators. If  
5 neither the administrator's state of incorporation nor its principal  
6 place of business within the United States has adopted the Third-  
7 party Administrator Act or a substantially similar law governing  
8 third-party administrators, then the third-party administrator shall  
9 designate a United States jurisdiction in which it does business and  
10 which has adopted the Third-party Administrator Act or a  
11 substantially similar law governing third-party administrators. For  
12 purposes of this ~~definition~~ paragraph, "United States jurisdiction"  
13 means the District of Columbia or a state or territory of the United  
14 States.

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

18 C. In the case of a partnership which has been licensed, each  
19 general partner shall be ~~named in the license~~ licensed and shall  
20 qualify therefore as though an individual licensee. The  
21 Commissioner shall charge a full additional license fee and a  
22 separate license shall be issued for each individual so named in  
23 such a license. The partnership shall notify the Commissioner  
24 within ~~fifteen (15)~~ thirty (30) days if any individual licensed on

1 its behalf has been terminated, or is no longer associated with or  
2 employed by the partnership. Any ~~entity or partnership~~ person  
3 making application as an administrator or currently licensed as  
4 administrators an administrator under the Third-party Administrators  
5 Act shall provide a National Association of Insurance Commissioner  
6 (NAIC) Biographical Affidavits Affidavit and a comprehensive review  
7 of the background report by an independent third-party NAIC-approved  
8 vendor as required for domestic insurers pursuant to the insurance  
9 laws of this state.

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

15 E. The administrator's license shall continue in force no  
16 longer than twelve (12) months from the original month of issuance.  
17 Upon filing a renewal form prescribed by the Commissioner,  
18 accompanied by a fee of One Hundred Dollars (\$100.00), the license  
19 may be renewed annually for a one-year term. Late application for  
20 renewal of a license shall require a fee of double the amount of the  
21 original license fee. The administrator shall submit, together with  
22 the application for renewal, a list of the names and addresses of  
23 the persons with whom the administrator has contracted in accordance  
24 with Section 1443 of this title. The Commissioner shall hold this

1 information confidential except as provided in Section 1443 of this  
2 title.

3 F. 1. The administrator's license shall be issued or renewed  
4 by the Commissioner unless, after notice and opportunity for  
5 hearing, the Commissioner determines that the administrator is not  
6 competent, trustworthy, or financially responsible, or has had any  
7 insurance license denied for cause by any state, has been convicted  
8 or has pleaded guilty or nolo contendere to any felony or to a  
9 misdemeanor involving moral turpitude or dishonesty.

10 2. The administrator shall report to the Insurance Commissioner  
11 any administrative or criminal action taken against the  
12 administrator in another jurisdiction or by another governmental  
13 agency in this state within thirty (30) calendar days of the final  
14 disposition of the matter. This report shall include a copy of the  
15 order, consent to order, copy of any payment required as a result of  
16 the administrative or criminal action, or other relevant legal  
17 documents.

18 3. Any entity making application to the Oklahoma Insurance  
19 Department as a third-party administrator (TPA) or within thirty  
20 (30) days of a change for a licensed TPA shall provide current  
21 National Association of Insurance Commissioners (NAIC) Biographical  
22 Affidavits and independent third-party background reports from a  
23 NAIC-approved vendor on behalf of all officers, directors and key  
24 managerial personnel of the TPA, and individuals with a ten percent

1 (10%) or more beneficial ownership in the TPA and the TPA's ultimate  
2 controlling person (affiant) as required for insurers pursuant to  
3 the laws of this state.

4 G. After notice and opportunity for hearing, and upon  
5 determining that the administrator has violated any of the  
6 provisions of the Oklahoma Insurance Code or upon finding reasons  
7 for which the issuance or nonrenewal of such license could have been  
8 denied, the Commissioner may either suspend or revoke an  
9 administrator's license or assess a civil penalty of not more than  
10 Five Thousand Dollars (\$5,000.00) for each occurrence. The payment  
11 of the penalty may be enforced in the same manner as civil judgments  
12 may be enforced.

13 H. Any person who is acting as or presenting himself or herself  
14 to be an administrator without a valid license shall be subject,  
15 upon conviction, to a fine of not less than One Thousand Dollars  
16 (\$1,000.00) nor more than Ten Thousand Dollars (\$10,000.00) for each  
17 occurrence. This fine shall be in addition to any other penalties  
18 which may be imposed for violations of the Oklahoma Insurance Code  
19 or other laws of this state.

20 I. Except as provided for in subsections F and G of this  
21 section, any person convicted of violating any provisions of the  
22 Third-party Administrator Act shall be guilty of a misdemeanor and  
23 shall be subject to a fine of not more than One Thousand Dollars  
24 (\$1,000.00).



1 SECTION 14. AMENDATORY 36 O.S. 2011, Section 2004, is  
2 amended to read as follows:

3 Section 2004. As used in the Oklahoma Property and Casualty  
4 Insurance Guaranty Association Act:

5 1. "Affiliate" means a person who directly or indirectly,  
6 through one or more intermediaries, controls, is controlled by, or  
7 is under common control with another person on December 31 of the  
8 year next preceding the date the insurer becomes an insolvent  
9 insurer;

10 2. "Association" means the Oklahoma Property and Casualty  
11 Insurance Guaranty Association as created in Section 2005 of this  
12 title;

13 3. "Assumed claims transaction" means:

14 a. policy obligations that have been assumed by the  
15 insolvent insurer, prior to the entry of a final  
16 order of liquidation, pursuant to a plan, approved by  
17 a domestic commissioner of the assuming insurer,  
18 which transfers the direct policy obligations and  
19 future policy renewals from one insurer to another  
20 insurer, or

21 b. an assumption reinsurance transaction in which all of  
22 the following have occurred:

23 (1) the insolvent insurer assumed, prior to the  
24 entry of a final order of liquidation, the claim

1 or policy obligations of another insurer under  
2 the claims or policies,

3 (2) the assumption of the claim or policy  
4 obligations has been approved, if an approval is  
5 required, by the appropriate regulatory  
6 authorities, and

7 (3) as a result of the assumption, the claim or  
8 policy obligations became the direct obligations  
9 of the insolvent insurer through novation of the  
10 claims or policies;

11 4. "Claimant" means any person instituting a covered claim;  
12 provided that no person who is an affiliate of the insolvent insurer  
13 may be a claimant;

14 5. "Commissioner" means the Insurance Commissioner of Oklahoma;

15 6. "Control" means the possession, direct or indirect, of the  
16 power to direct or cause the direction of the management and  
17 policies of a person, whether through the ownership of voting  
18 securities, by contract other than a commercial contract for goods  
19 or nonmanagement services, or otherwise, unless the power is the  
20 result of an official position with or corporate office held by the  
21 person. Control shall be presumed to exist if a person, directly or  
22 indirectly, owns, controls, holds with the power to vote, or holds  
23 proxies representing ten percent (10%) or more of the voting  
24

1 securities of any other person. This presumption may be rebutted by  
2 a showing that control does not exist in fact;

3 7. "Covered claim" means:

4 a. an unpaid claim, including one of unearned premiums,  
5 submitted by a claimant, which arises out of and is  
6 within the coverage and is subject to the applicable  
7 limits of an insurance policy to which this act  
8 applies, if the insurer becomes an insolvent insurer  
9 after the effective date of this act and the policy  
10 was issued by the insurer, and:

11 (1) the claimant or insured is a resident of this  
12 state at the time of the insured event, provided  
13 that for entities other than an individual, the  
14 residence of a claimant or insured is the state  
15 in which its principal place of business is  
16 located at the time of the insured event, or

17 (2) the property from which the claim arises is  
18 permanently located in this state,

19 b. "Covered claim" shall not include:

20 (1) any amount awarded as punitive or exemplary  
21 damages,

22 (2) any amount sought as a return of premium under  
23 any retrospective rating plan,  
24

1 (3) any amount due any reinsurer, insurer, insurance  
2 pool, or underwriting association, health  
3 maintenance organization, hospital plan  
4 corporation, professional health service  
5 corporation or self-insurer as subrogation  
6 recoveries, reinsurance recoveries, contribution,  
7 indemnification or otherwise. No claim for any  
8 amount due any reinsurer, insurer, insurance  
9 pool, or underwriting association, health  
10 maintenance organization, hospital plan  
11 corporation, professional health service  
12 corporation or self-insurer may be asserted  
13 against a person insured under a policy issued by  
14 an insolvent insurer other than to the extent the  
15 claim exceeds the association obligation  
16 limitations set for in Section 2007 of this  
17 title,

18 (4) any claims excluded pursuant to Section 15 of  
19 this act due to the high net worth of an insured,

20 (5) any first party claims by an insured that is an  
21 affiliate of the insolvent company,

22 (6) any fee or other amount relating to goods or  
23 services sought by or on behalf of any attorney  
24 or other provider of goods and services retained

1 by the insolvent insurer or an insured prior to  
2 the date it was determined to be insolvent,

3 (7) any fee or other amount sought by or on behalf of  
4 any attorney or other provider of goods and  
5 services retained by any insured or claimant in  
6 connection with the assertion or prosecution of  
7 any claim, covered or otherwise, against the  
8 Association,

9 (8) any claims for interest, ~~or~~

10 (9) any claim filed with the association or a  
11 liquidator for protection afforded under the  
12 policy of the insured for incurred-but-not-  
13 reported losses, or

14 (10) notwithstanding any other provision of this act  
15 or any other law to the contrary, a claim that is  
16 filed with the association on a date that is  
17 later than eighteen (18) months after the date of  
18 the order of liquidation or that is unknown and  
19 unreported as of said date; provided, however,  
20 that this shall not include any claim for  
21 workers' compensation benefits pursuant to Title  
22 85A of the Oklahoma Statutes and the applicable  
23 rules of OAC Title 810;  
24

1       8. "Insolvent insurer" means an insurer that is licensed to  
2 transact insurance in this state either at the time the policy was  
3 issued, when the obligation with respect to the covered claim was  
4 assumed under an assumed claims transaction, or when the insured  
5 event occurred and against whom a final order of liquidation has  
6 been entered after the effective date of this act with a finding of  
7 insolvency by a court of competent jurisdiction in the state of  
8 domicile of the insurer;

9       9. "Insured" means any named insured, any additional insured,  
10 any vendor, lessor or any other party identified as an insured under  
11 the policy;

12       10. a. "Member insurer" means any person who:

13               (1) writes any kind of insurance to which the  
14               Oklahoma Property and Casualty Insurance Guaranty  
15               Association Act applies pursuant to Section 2003  
16               of this title, including the exchange of  
17               reciprocal or inter-insurance contracts, and

18               (2) is licensed to transact insurance in this state,  
19               except those insurers enumerated in Section 110  
20               of this title or those insurers that are  
21               otherwise exempted by law or order of the  
22               Commissioner.

23       b. An insurer shall cease to be a member insurer  
24       effective on the day following the termination or

1 expiration of its license to transact the kinds of  
2 insurance to which the Oklahoma Property and Casualty  
3 Insurance Guaranty Association Act applies; however,  
4 the insurer shall be liable as a member insurer for  
5 any and all obligations, including but not limited to  
6 obligations for assessments levied after the  
7 termination or expiration, which relate to any insurer  
8 that becomes an insolvent insurer prior to the  
9 termination or expiration of the license of the  
10 insurer;

11 11. "Net direct written premiums" means direct gross premiums  
12 written in this state on insurance policies to which this act  
13 applies, including but not limited to policy and membership fees,  
14 less the following amounts:

- 15 a. return premiums,
- 16 b. premiums on policies not taken, and
- 17 c. dividends paid or credited to policyholders on direct  
18 business. "Net direct written premiums" does not  
19 include premiums on contracts between insurers or  
20 reinsurers;

21 12. "Novation" means that the assumed claim or policy  
22 obligations became the direct obligations of the insolvent insurer  
23 through consent of the policyholder and that thereafter the ceding  
24 insurer or entity initially obligated under the claims or policies

1 is released by the policyholder from performing its claim or policy  
2 obligations. Consent shall be express and an implied novation shall  
3 not be allowed for the purposes, implementation and application of  
4 the Oklahoma Property and Casualty Insurance Guaranty Association  
5 Act;

6 13. "Person" means the individual or other entities as defined  
7 in Section 104 of this title;

8 14. "Receiver" means liquidator, rehabilitator, conservator or  
9 ancillary receiver, as the context requires; and

10 15. "Self-insurer" means a person who covers its liability  
11 through a qualified individual or group self-insurance program or  
12 any other formal program created for the specific purpose of  
13 covering liabilities typically covered by insurance.

14 SECTION 15. AMENDATORY 36 O.S. 2011, Section 2006, as  
15 amended by Section 1, Chapter 78, O.S.L. 2014 (36 O.S. Supp. 2020,  
16 Section 2006), is amended to read as follows:

17 Section 2006. A. The business and functions of the Oklahoma  
18 Property and Casualty Insurance Guaranty Association shall be  
19 managed and administered by a board of twelve (12) directors  
20 composed of ~~two members selected by the American Insurance~~  
21 ~~Association who are member insurers; at the expiration of the terms~~  
22 ~~of the members selected by the Alliance of American Insurers who are~~  
23 ~~serving on November 1, 2014, two members selected by the Property~~  
24 ~~and Casualty Insurers Association of America who are member~~



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

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

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

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

17 SECTION 16. AMENDATORY 36 O.S. 2011, Section 2007, is  
18 amended to read as follows:

19 Section 2007. A. The Oklahoma Property and Casualty Insurance  
20 Guaranty Association shall:

21 1. Be obligated to pay the covered claims existing prior to the  
22 determination of insolvency if the claims arise within thirty (30)  
23 days after the determination of insolvency, or before the policy  
24 expiration date if less than thirty (30) days after the

1 determination, or before the insured replaces the policy or causes  
2 its cancellation, if the insured does so within thirty (30) days of  
3 the determination. The obligation shall be satisfied by paying to  
4 the claimant an amount as follows:

- 5 a. the full amount of a covered claim for benefits under  
6 a workers' compensation insurance coverage,
- 7 b. an amount not exceeding Ten Thousand Dollars  
8 (\$10,000.00) per policy for a covered claim for the  
9 return of unearned premium, and
- 10 c. an amount not exceeding One Hundred Fifty Thousand  
11 Dollars (\$150,000.00) per claimant for all other  
12 covered claims.

13 In no event shall the Association be obligated to pay a claimant  
14 an amount in excess of the obligation of the insolvent insurer under  
15 the policy or coverage from which the claim arises or in excess of  
16 the limits of the obligation of the Association existing on the date  
17 on which the order of liquidation is filed with the court clerk;

18 2. Any obligation of the association to defend an insured shall  
19 cease upon the payment or tender by the association of an amount  
20 equal to the lesser of the covered claim obligation limit of the  
21 association or the applicable policy limit;

22 3. ~~Be deemed the insurer to the extent of the obligations on~~  
23 ~~covered claims and to that extent subject to the limitations~~  
24 ~~provided in the Oklahoma Property and Casualty Insurance Guaranty~~

1 ~~Association Act shall~~ As payor of last resort, have all rights,  
2 duties and obligations of the insolvent insurer as if the insurer  
3 had not become insolvent, ~~including,~~ but not limited to, the right  
4 to pursue and retain salvage and subrogation recoverable on covered  
5 claim obligations to the extent paid by the association. The  
6 association shall not be deemed the insolvent insurer for the  
7 purpose of conferring jurisdiction;

8 4. Allocate claims paid and expenses incurred among the three  
9 accounts set out in Section 2005 of this title separately, and  
10 assess member insurers separately for each account amounts necessary  
11 to pay the obligations of the Association under this section  
12 subsequent to a member insurer becoming an insolvent insurer, the  
13 expenses of handling covered claims subsequent to an insolvency, and  
14 other expenses authorized by the Oklahoma Property and Casualty  
15 Insurance Guaranty Association Act, Sections 2001 through 2020 of  
16 this title and Sections ~~14~~ 2020.1 and ~~15~~ 2020.2 of this ~~act~~ title.  
17 The assessments of each member insurer shall be in the proportion  
18 that the net direct written premiums of the member insurer for the  
19 calendar year preceding the assessment on the kinds of insurance in  
20 the account bear to the net direct written premiums of all  
21 participating insurers for the calendar year preceding the  
22 assessment on the kinds of insurance in the account. Each member  
23 insurer shall be notified in writing of the assessment not later  
24 than thirty (30) days before it is due. No member insurer may be

1 assessed in any year an amount greater than two percent (2%) of the  
2 net direct written premiums of that member or one percent (1%) of  
3 that surplus of the member insurer as regards policyholders for the  
4 calendar year preceding the assessment on the kinds of insurance in  
5 the account, whichever is less. If the maximum assessment, together  
6 with the other assets of the Association, does not provide in any  
7 one (1) year in any account an amount sufficient to make all  
8 necessary payments from that account, the funds available may be  
9 prorated and the unpaid portion shall be paid as soon thereafter as  
10 funds become available. The Association shall pay claims in any  
11 order which it deems reasonable, including the payment of claims as  
12 the claims are received from the claimants or in groups or  
13 categories of claims. The Association may exempt or defer, in whole  
14 or in part, the assessment of any member insurer, if the assessment  
15 would cause the financial statement of the member insurer to reflect  
16 amounts of capital or surplus less than the minimum amounts required  
17 for a certificate of authority by any jurisdiction in which the  
18 member insurer is authorized to transact insurance. During the  
19 period of deferment, no dividends shall be paid to shareholders or  
20 policyholders. Deferred assessments shall be paid when the payments  
21 will not reduce capital or surplus below required minimums. The  
22 payments may be refunded to those companies receiving larger  
23 assessments by virtue of the deferment, or, at the election of any  
24 company credited against future assessments. Each member insurer

1 serving as a servicing facility may set off against any assessment  
2 authorized payments made on covered claims and expenses incurred in  
3 the payment of covered claims by a member insurer if they are  
4 chargeable to the account for which the assessment is made;

5 5. Investigate claims brought against the Association and  
6 adjust, compromise, settle and pay covered claims to the extent of  
7 the obligation of the Association and deny all other claims. The  
8 Association shall pay claims in any order that it may deem  
9 reasonable, including, but not limited to, the payment of claims as  
10 they are received from claimants or in groups of categories of  
11 claims. The Association shall have the right to select and to  
12 direct legal counsel under liability insurance policies for the  
13 defense of covered claims;

14 6. Notify claimants in this state as deemed necessary by the  
15 Commissioner and upon the request of the Commissioner, to the extent  
16 records are available to the Association. Notification may include,  
17 but shall not be limited to, a legal posting on the website of the  
18 Association;

19 7. a. Handle claims through employees or through one or more  
20 insurers or other persons ~~incorporated and resident in~~  
21 ~~the State of Oklahoma~~ designated as servicing  
22 facilities. Designation of a servicing facility is  
23 subject to approval of the Commissioner, but such  
24 designation may be declined by a member insurer.

1           b.    The Association shall have the right to review and  
2                contest as set forth in this paragraph, settlements,  
3                releases, compromises, waivers and judgments to which  
4                the insolvent insurer or its insureds were parties  
5                prior to the entry of the order of liquidation. In an  
6                action to enforce settlements, releases and judgments  
7                to which the insolvent insurer or its insureds were  
8                parties prior to the entry of the order of  
9                liquidation, the Association shall have the right to  
10              assert the following defenses:

11           (1)   the Association shall not be bound by a  
12                settlement, release, compromise or waiver  
13                executed by an insured or the insurer, or any  
14                judgment entered against the insured or the  
15                insurer by consent or through a failure to  
16                exhaust all appeals, if the settlement, release,  
17                compromise waiver or judgment was:

18           (a)   executed or entered within one hundred  
19                twenty (120) days prior to the entry of an  
20                order of liquidation, and the insured or the  
21                insurer did not use reasonable care in  
22                entering into the settlement, release,  
23                compromise, waiver or judgment, or did not  
24

1                   pursue all reasonable appeals of an adverse  
2                   judgment, or

3                   (b) executed by or taken against an insured or  
4                   the insurer based on default, fraud,  
5                   collusion or the failure of the insurer to  
6                   defend,

7                   (2) if a court of competent jurisdiction finds that  
8                   the Association is not bound by a settlement,  
9                   release, compromise, waiver or judgment for the  
10                  releases provided for in division (1) of  
11                  subparagraph b of this paragraph, the settlement,  
12                  release, compromise, waiver or judgment shall be  
13                  set aside and the Association shall be permitted  
14                  to defend any covered claim on the merits. The  
15                  settlement, release, compromise, waiver or  
16                  judgment shall not be considered as evidence of  
17                  liability in connection with any claim brought  
18                  against the Association or any other party  
19                  pursuant to the Oklahoma Property and Casualty  
20                  Insurance Guaranty Association Act, and

21                  (3) the Association shall have the right to assert  
22                  any statutory defenses or rights of offset  
23                  against any settlement, release, compromise or  
24                  waiver executed by an insured or the insurer, or



1 any judgment taken against the insured or the  
2 insurer.

3 c. As to any covered claims arising from a judgment under  
4 any decision, verdict or finding based on the default  
5 of the insolvent insurer or its failure to defend, the  
6 Association, either on its own behalf or on behalf of  
7 an insured, may apply to have the judgment, order,  
8 decision, verdict or finding set aside by the same  
9 court or administrator that entered the judgment,  
10 claim, decision, verdict or finding and shall be  
11 permitted to defend on the merits;

12 8. Reimburse each servicing facility for obligations of the  
13 Association paid by the facility and for reasonable expenses  
14 incurred by the facility while handling claims on behalf of the  
15 Association and pay the other expenses of the Association authorized  
16 by the Oklahoma Property and Casualty Insurance Guaranty Association  
17 Act; and

18 9. Have standing to appear before any court of this state which  
19 has jurisdiction over an impaired or insolvent insurer for whom the  
20 Association is or may become obligated pursuant to the provisions of  
21 the Oklahoma Property and Casualty Insurance Guaranty Association  
22 Act. Standing shall extend to all matters germane to the powers and  
23 duties of the Association including, but not limited to, proposals  
24 for rehabilitation, acquisition, merger, reinsuring, or guaranteeing

1 the covered policies of the impaired or insolvent insurer, and the  
2 determination of covered policies and contractual obligations of the  
3 impaired or insolvent insurer; and

4 10. Notwithstanding any other provision of the Oklahoma  
5 Property and Casualty Insurance Guaranty Association Act, an  
6 insurance policy issued by a member insurer and later allocated,  
7 transferred, assumed by or otherwise made the sole responsibility of  
8 another insurer pursuant to any provision of law providing for the  
9 division of an insurance company, or the statutory assumption or  
10 transfer of designated policies under which there is no remaining  
11 obligation to the transferring entity, shall be considered to have  
12 been issued by a member insurer which is an insolvent insurer for  
13 the purposes of this Act in the event that the insurer to which the  
14 policy has been allocated, transferred, assumed or otherwise made  
15 the sole responsibility of is placed in liquidation. An insurance  
16 policy that was issued by an insurer who is not a member insurer and  
17 subsequently allocated, transferred, assumed by or otherwise made  
18 the sole responsibility of a member insurer under any provision of  
19 law providing for the division of an insurance company shall not be  
20 considered to have been issued by a member insurer pursuant to this  
21 Act.

22 B. The Association may:

23 1. Employ or retain persons as are necessary to handle claims  
24 and perform other duties of the Association;

- 1        2. Borrow funds necessary to effect the purposes of the  
2 Oklahoma Property and Casualty Insurance Guaranty Association Act in  
3 accordance with the plan of operation;
- 4        3. Sue or be sued;
- 5        4. Negotiate and become a party to contracts as are necessary  
6 to carry out the purpose of the Oklahoma Property and Casualty  
7 Insurance Guaranty Association Act;
- 8        5. Refund to member insurers in proportion to the contribution  
9 of each member insurer that amount by which the assets of the  
10 Association exceed its liabilities, if at the end of any calendar  
11 year the board of directors finds that the assets of the Association  
12 exceed the liabilities as estimated by the board of directors for  
13 the coming year;
- 14        6. Lend monies to an insurer declared to be impaired by the  
15 Commissioner. The Association, with approval of the Commissioner,  
16 shall approve the amount, length and terms of the loan. "Impaired  
17 Insurer" for purposes of this ~~paragraph~~ section shall mean an  
18 insurer potentially unable to fulfill its contractual obligations,  
19 but shall not mean an insolvent insurer;
- 20        7. Perform other acts as are necessary or proper to effectuate  
21 the purpose of the Oklahoma Property and Casualty Insurance Guaranty  
22 Association Act;
- 23        8. Intervene as a party in interest in any supervision,  
24 conservation, liquidation, rehabilitation, impairment or

1 receivership in which policyholders' interests and interests of the  
2 Association may be or are affected; and

3 9. Be designated or may contract as a servicing facility for  
4 any entity which may be recommended by the board of directors of the  
5 Association and shall be approved by the Commissioner.

6 SECTION 17. AMENDATORY 36 O.S. 2011, Section 2008, is  
7 amended to read as follows:

8 Section 2008. A. The Oklahoma Property and Casualty Insurance  
9 Guaranty Association shall submit to the Commissioner a plan of  
10 operation and any amendments thereto necessary or suitable to assure  
11 the fair, reasonable and equitable administration of the  
12 Association. The plan of operation and any amendments thereto shall  
13 become effective upon approval in writing by the Commissioner.

14 B. If the Association fails to submit a suitable plan of  
15 operation within ninety (90) days following ~~the effective date of~~  
16 ~~this act~~ June 27, 1980, or if at any time thereafter the Association  
17 fails to submit suitable amendments to the plan, the Commissioner  
18 shall, after notice and hearing, adopt and promulgate reasonable  
19 rules as are necessary or advisable to effectuate the provisions of  
20 ~~this act~~ Section 2001 et seq. of this title. Any rules promulgated  
21 shall continue in force until modified by the Commissioner or  
22 superseded by a plan submitted by the Association and approved by  
23 the Commissioner. All member insurers shall comply with the plan of  
24 operation.

1 C. The plan of operation shall:

2 1. Establish the procedures whereby all the powers and duties  
3 of the Association under this act will be performed;

4 2. Establish procedures for handling assets of the Association;

5 3. Require the amount and method of reimbursing members of the  
6 board of directors under Section 2006 of this title;

7 4. Establish procedures by which claims may be filed with the  
8 Association and establish acceptable forms of proof of covered  
9 claims;

10 5. Establish regular places and times for meetings of the board  
11 of directors;

12 6. Require that the written procedures be established for  
13 records to be kept of all financial transactions of the Association,  
14 its agents and the board of directors;

15 7. Provide that any member insurer aggrieved by any final  
16 action or decision of the Association may appeal to the Commissioner  
17 within thirty (30) days after the action or decision;

18 8. Establish the procedures whereby selections for the board of  
19 directors will be submitted to the Commissioner; and

20 9. Contain additional provisions necessary or proper for the  
21 execution of the powers and duties of the Association.

22 D. The plan of operation may provide that any or all powers and  
23 duties of the Association, except those under paragraph 3 of  
24 subsection A and paragraph 2 of subsection B of Section 2007 of this

1 title, are delegated to a corporation, association or other  
2 organization ~~incorporated and resident in the State of Oklahoma~~  
3 which performs or will perform functions similar to those of this  
4 Association, or its equivalent. The corporation, association or  
5 organization shall be reimbursed as a servicing facility would be  
6 reimbursed and shall be paid for its performance of any other  
7 functions of the Association. A delegation under this subsection  
8 shall take effect only with the approval of both the board of  
9 directors and the Commissioner, and may be made only to a  
10 corporation, association or organization which extends protection  
11 not substantially less favorable and effective than that provided by  
12 ~~this act~~ Section 2001 et seq. of this title.

13 SECTION 18. AMENDATORY 36 O.S. 2011, Section 2023, as  
14 amended by Section 2, Chapter 384, O.S.L. 2019 (36 O.S. Supp. 2020,  
15 Section 2023), is amended to read as follows:

16 Section 2023. A. There is created a nonprofit legal entity to  
17 be known as the Oklahoma Life and Health Insurance Guaranty  
18 Association. All member insurers shall be and remain members of the  
19 Association as a condition of their authority to transact insurance  
20 ~~as a~~ or health maintenance organization business in this state.

21 B. The Association shall perform its functions under a plan of  
22 operation established and approved in accordance with this act and  
23 shall exercise its powers through the Board of Directors established  
24

1 in this act. For purposes of administration and assessment, the  
2 Association shall maintain three accounts:

- 3 1. The health account;
- 4 2. The life insurance account; and
- 5 3. The annuity account.

6 C. The Association shall come under the immediate supervision  
7 of the Insurance Commissioner and shall be subject to the applicable  
8 provisions of the insurance laws of this state.

9 SECTION 19. AMENDATORY 36 O.S. 2011, Section 3101, is  
10 amended to read as follows:

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

14 1. "Commissioner" means the Commissioner of Insurance, his or  
15 her assistants or deputies, or other persons authorized to act for  
16 him- or her;

17 2. "Company" means any person, firm, copartnership, company,  
18 association or corporation engaged in selling, furnishing or  
19 procuring, either as principal or ~~agent~~ producer, for a  
20 consideration, motor club service-~~;~~

21 3. ~~"Agent"~~ "Producer" means a limited insurance representative  
22 who solicits the purchase of service contracts or transmits for  
23 another any such contract, or application therefor, to or from the  
24 company, or acts or aids in any manner in the delivery or

1 negotiation of any such contract, or in the renewal or continuance  
2 thereof. This, however, shall not include any person performing  
3 only work of a clerical nature in the office of the motor club-;

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

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

12 6. "Insurance service" means any act to sell or give to the  
13 holder of a service contract or as a result of membership in or  
14 affiliation with a company a policy of insurance covering the holder  
15 for liability or loss for personal injury or property damage  
16 resulting from the ownership, maintenance, operation or use of a  
17 motor vehicle-;

18 7. "Bail bond service" means any act by a company to furnish or  
19 procure a cash deposit, bond or other undertaking required by law  
20 for any person accused of a law violation of this state, pending ~~the~~  
21 trial-;

22 8. "Discount service" means any act by a company resulting in  
23 special discounts, rebates or reductions of price on gasoline, oil,  
24



1 repairs, insurance, parts, accessories or service for motor vehicles  
2 to holders of service contracts-; i

3 9. "Financial service" means any act by a company to loan or  
4 otherwise advance monies, with or without security, to a service  
5 contract holder-; i

6 10. "Buying and selling service" means any act by a company to  
7 aid the holder of a service contract in the purchase or sale of an  
8 automobile-; i

9 11. "Theft service" means any act by a company to locate,  
10 identify or recover a stolen or missing motor vehicle owned or  
11 controlled by the holder of a service contract or to detect or  
12 apprehend the person guilty of such theft-; i

13 12. "Map service" means any act by a company to furnish road  
14 maps without cost to holders of service contracts-; i

15 13. "Touring service" means any act by a company to furnish  
16 touring information without cost to holders of service contracts-; i

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

19 15. "Motor club service" means the rendering, furnishing or  
20 procuring of, or reimbursement for, towing service, emergency road  
21 service, insurance service, bail bond service, legal service,  
22 discount service, financial service, buying and selling service,  
23 theft service, map service, touring service, or any three or more  
24 thereof, to any person, in connection with the ownership, operation,

1 use or maintenance of a motor vehicle by such person, that has  
2 membership, for consideration; and

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

6 SECTION 20. AMENDATORY 36 O.S. 2011, Section 3105, is  
7 amended to read as follows:

8 Section 3105. A. Each motor service club operating in this  
9 state pursuant to certificate of authority issued hereunder shall  
10 file with the Commissioner, within ten (10) days of the date of  
11 employment, a notice of appointment of any ~~agent~~ limited lines  
12 producer, resident or nonresident, appointed by the automobile club  
13 to sell memberships in the motor service club to the public. This  
14 notification shall be upon such form as the Commissioner may  
15 prescribe and shall contain the name, address, age, sex, and Social  
16 Security number of such club ~~agent~~ producer, and shall also contain  
17 proof satisfactory to the Commissioner that such applicant is not  
18 less than eighteen (18) years of age, is of good reputation, and has  
19 received training from the club or is otherwise qualified in the  
20 field of motor service club service contracts and knowledgeable of  
21 the laws of this state pertaining thereto. ~~Upon termination of any~~  
22 ~~agent's employment by the motor service club, such motor service~~  
23 ~~club shall notify the Commissioner, in writing, within five (5) days~~  
24 ~~of such termination.~~

1 B. A ~~registration~~ licensing fee for ~~agents~~ limited lines  
2 producers, resident or nonresident, shall be ~~Twenty Dollars (\$20.00)~~  
3 ~~annually, and such registration shall expire on July 1 of each year~~  
4 ~~unless sooner revoked or suspended as provided for in this section~~  
5 Forty Dollars (\$40.00) biennially.

6 C. Upon notice and hearing, the Commissioner may suspend ~~for~~  
7 ~~not over twelve (12) months~~, censure, revoke, or refuse to renew any  
8 ~~agent's~~ license of a producer if he finds as to the licensee that  
9 any one or more of the following causes exist:

10 1. Any violation of or noncompliance with any provision of this  
11 act;

12 2. Obtaining or attempting to obtain any such license through  
13 misrepresentation or fraud;

14 3. Oral or written misrepresentation of the terms, conditions,  
15 benefits, or privileges of any motor service club service contract  
16 issued or to be issued by the motor service club he represents or  
17 any other motor service club;

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

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

1           6. Demonstration of incompetence sufficient in the opinion of  
2 the Commissioner to make the ~~agent~~ producer a source of injury and  
3 loss to the public;

4           7. Fraudulent or dishonest practices;

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

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

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

16           SECTION 21.           AMENDATORY           36 O.S. 2011, Section 3108, is  
17 amended to read as follows:

18           Section 3108. A motor service club or an officer or ~~agent~~  
19 producer thereof shall not in any manner misrepresent the terms,  
20 benefits or privileges of any service contract issued or to be  
21 issued by it or by another motor service club.

22           SECTION 22.           AMENDATORY           36 O.S. 2011, Section 3639.1, as  
23 amended by Section 11, Chapter 44, O.S.L. 2012 (36 O.S. Supp. 2020,  
24 Section 3639.1), is amended to read as follows:

1 Section 3639.1. A. No insurer shall cancel, refuse to renew or  
2 increase the premium of a homeowner's insurance policy or any other  
3 personal residential insurance coverage, which has been in effect  
4 more than forty-five (45) days, solely because the insured filed a  
5 first claim against the policy. The provisions of this section  
6 shall not be construed to prevent the cancellation, nonrenewal or  
7 increase in premium of a homeowner's insurance policy for the  
8 following reasons:

9 1. Nonpayment of premium;

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

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

15 4. A change in the risk which substantially increases any  
16 hazard insured against after insurance coverage has been issued or  
17 renewed;

18 5. Violation of any local fire, health, safety, building, or  
19 construction regulation or ordinance with respect to any insured  
20 property or the occupancy thereof which substantially increases any  
21 hazard insured against;

22 6. A determination by the Insurance Commissioner that the  
23 continuation of the policy would place the insurer in violation of  
24 the insurance laws of this state; or

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

3 B. An insurer shall give to the named insured at the mailing  
4 address shown on a homeowner's policy, a written renewal notice that  
5 shall include new premium, new deductible, new limits or coverage at  
6 least thirty (30) days prior to the expiration date of the policy.

7 If the insurer fails to provide such notice, the premium,  
8 deductible, limits and coverage provided to the named insurer prior  
9 to the change shall remain in effect until notice is given or until  
10 the effective date of replacement coverage obtained by the named  
11 insured, whichever occurs first. If notice is given by mail, the  
12 notice shall be deemed to have been given on the day the notice is  
13 mailed. If the insured elects not to renew, any earned premium for  
14 the period of extension of the terminated policy shall be calculated  
15 pro rata at the lower of the current or previous year's rate. If  
16 the insured accepts the renewal, the premium increase, if any, and  
17 other changes shall be effective the day following the prior  
18 policy's expiration or anniversary date.

19 C. In the event an insured cancels a homeowner's insurance  
20 policy or any other personal residential insurance coverage, notice  
21 shall be provided to the prior insurer and shall include the date of  
22 the policy cancellation and the date of policy inception of the new  
23 policy.

1        D. An insurer canceling a policy under subsection C of this  
2 section shall not be liable for claims arising after the date of  
3 cancellation.

4        SECTION 23.        AMENDATORY        36 O.S. 2011, Section 4030, is  
5 amended to read as follows:

6        Section 4030. A. Except as may be otherwise approved by the  
7 Insurance Commissioner, no single premium policy of life insurance  
8 or single premium annuity contract shall be delivered or issued for  
9 delivery in Oklahoma for a consideration other than cash, cashier's  
10 check, check, bank draft, money order, ~~or~~ premium note or electronic  
11 payment. This act shall not apply to the transfer of securities to  
12 an insurer pursuant to the insuring of a pension or profit sharing  
13 plan qualified under the Federal Internal Revenue Code.

14        B. This act shall not be held to repeal or alter any law now in  
15 effect, but shall be construed as cumulative with and supplemental  
16 to other laws and acts now in effect or enacted hereafter.

17        SECTION 24.        AMENDATORY        36 O.S. 2011, Section 4030.1, is  
18 amended to read as follows:

19        Section 4030.1. A. Within ten (10) days after an insurer  
20 receives written notification of the death of a person covered by a  
21 policy of life insurance, the insurer shall provide to the claimant  
22 the necessary forms to be completed to establish proof of the death  
23 of the insured and, if required by the policy, the interest of the  
24 claimant. If the policy contains a provision requiring surrender of

1 the policy prior to settlement, the insurer shall include a written  
2 statement to that effect with the forms to be completed. Forms to  
3 establish proof of death and proof of the interest of the claimant  
4 shall be approved by the Insurance Commissioner.

5 B. An insurer shall pay the proceeds of any benefits under a  
6 policy of life insurance not more than thirty (30) days after the  
7 insurer has received proof of death of the insured. If the proceeds  
8 are not paid within this period, the insurer shall pay interest on  
9 the proceeds, at a rate which is not less than the current rate of  
10 interest on death proceeds on deposit with the insurer, from the  
11 date of death of the insured to the date when the proceeds are paid.  
12 Should the insurer hold its deposits in a noninterest bearing  
13 account, the rate of interest to be paid shall be the same rate of  
14 interest as the average United States Treasury Bill rate of the  
15 preceding calendar year, as certified to the Insurance Commissioner  
16 by the State Treasurer on the first regular business day in January  
17 of each year, plus two (2) percentage points, which shall accrue  
18 from the thirty-first day after receipt of proof of loss until the  
19 proceeds are paid. Payment shall be deemed to have been made on the  
20 date an electronic payment is made or the date a check, draft or  
21 other valid instrument which is equivalent to payment was placed in  
22 the U.S. mails in a properly addressed, postpaid envelope; or, if  
23 not so posted, on the date of delivery of such instrument to the  
24 beneficiary.



1 C. Subsection B of this section shall not apply to any life  
2 insurance policy issued before October 1, 1978, which contains  
3 specific provisions to the contrary.

4 SECTION 25. AMENDATORY 36 O.S. 2011, Section 4055.7, is  
5 amended to read as follows:

6 Section 4055.7. A. 1. The Insurance Commissioner may conduct  
7 an examination under the Viatical Settlements Act of 2008 of a  
8 licensee as often as the Commissioner in his or her discretion deems  
9 appropriate after considering the factors set forth in this  
10 paragraph. In scheduling and determining the nature, scope, and  
11 frequency of the examinations, the Commissioner shall consider such  
12 matters as the consumer complaints, results of financial statement  
13 analyses and ratios, changes in management or ownership, actuarial  
14 opinions, report of independent certified public accountants, and  
15 other relevant criteria as determined by the Commissioner.

16 2. For purposes of completing an examination of a licensee  
17 under the Viatical Settlements Act of 2008, the Commissioner may  
18 examine or investigate any person, or the business of any person,  
19 insofar as the examination or investigation is, in the sole  
20 discretion of the Commissioner, necessary or material to the  
21 examination of the licensee.

22 3. In lieu of an examination under the Viatical Settlements Act  
23 of 2008 of any foreign or alien licensee licensed in this state, the  
24 Commissioner may, at the Commissioner's discretion, accept an

1 examination report on the licensee as prepared by the Commissioner  
2 for the licensee's state of domicile or port-of-entry state.

3 4. As far as practical, the examination of a foreign or alien  
4 licensee shall be made in cooperation with the insurance supervisory  
5 officials of other states in which the licensee transacts business.

6 B. 1. A person required to be licensed by the Viatical  
7 Settlements Act of 2008 shall for five (5) years for all settled  
8 policies and for two (2) years for all policies which are not  
9 settled retain copies of all:

10 a. proposed, offered or executed contracts, purchase  
11 agreements, underwriting documents, policy forms, and  
12 applications from the date of the proposal, offer or  
13 execution of the contract or purchase agreement,  
14 whichever is later,

15 b. all checks, drafts, electronic payment or other  
16 evidence and documentation related to the payment,  
17 transfer, deposit or release of funds from the date of  
18 the transaction, and

19 c. all other records and documents related to the  
20 requirements of the Viatical Settlements Act of 2008.

21 2. This subsection does not relieve a person of the obligation  
22 to produce these documents to the Commissioner after the retention  
23 period has expired if the person has retained the documents.

24

1           3. Records required to be retained by this subsection must be  
2 legible and complete and may be retained in paper, photograph,  
3 microprocess, magnetic, mechanical, or electronic media, or by any  
4 process that accurately reproduces or forms a durable medium for the  
5 reproduction of a record.

6           C. 1. Upon determining that an examination should be  
7 conducted, the Commissioner shall issue an examination warrant  
8 appointing one or more examiners to perform the examination and  
9 instructing them as to the scope of the examination. In conducting  
10 the examination, the examiner shall observe those guidelines and  
11 procedures set forth in the Examiners Handbook adopted by the  
12 National Association of Insurance Commissioners (NAIC). The  
13 Commissioner may also employ such other guidelines or procedures as  
14 the Commissioner may deem appropriate.

15           2. Every licensee or person from whom information is sought,  
16 its officers, directors and agents shall provide to the examiners  
17 timely, convenient and free access at all reasonable hours at its  
18 offices to all books, records, accounts, papers, documents, assets  
19 and computer or other recordings relating to the property, assets,  
20 business and affairs of the licensee being examined. The officers,  
21 directors, employees and agents of the licensee or person shall  
22 facilitate the examination and aid in the examination so far as it  
23 is in their power to do so. The refusal of a licensee, by its  
24 officers, directors, employees or agents, to submit to examination

1 or to comply with any reasonable written request of the Commissioner  
2 shall be grounds for suspension or refusal of, or nonrenewal of any  
3 license or authority held by the licensee to engage in the viatical  
4 settlement business or other business subject to the Commissioner's  
5 jurisdiction. Any proceedings for suspension, revocation or refusal  
6 of any license or authority shall be conducted in accordance with  
7 the Administrative Procedures Act.

8 3. The Commissioner shall have the power to issue subpoenas, to  
9 administer oaths and to examine under oath any person as to any  
10 matter pertinent to the examination. Upon the failure or refusal of  
11 a person to obey a subpoena, the Commissioner may petition a court  
12 of competent jurisdiction, and upon proper showing, the Court may  
13 enter an order compelling the witness to appear and testify or  
14 produce documentary evidence. Failure to obey the court order shall  
15 be punishable as contempt of court.

16 4. When making an examination under the Viatical Settlements  
17 Act of 2008, the Commissioner may retain attorneys, appraisers,  
18 independent actuaries, independent certified public accountants or  
19 other professionals and specialists as examiners, the reasonable  
20 cost of which shall be borne by the licensee that is the subject of  
21 the examination.

22 5. Nothing contained in the Viatical Settlements Act of 2008  
23 shall be construed to limit the Commissioner's authority to  
24 terminate or suspend an examination in order to pursue other legal

1 or regulatory action pursuant to the insurance laws of this state.  
2 Findings of fact and conclusions made pursuant to any examination  
3 shall be prima facie evidence in any legal or regulatory action.

4 6. Nothing contained in the Viatical Settlements Act of 2008  
5 shall be construed to limit the Commissioner's authority to use and,  
6 if appropriate, to make public any final or preliminary examination  
7 report, any examiner or licensee workpapers or other documents, or  
8 any other information discovered or developed during the course of  
9 any examination in the furtherance of any legal or regulatory action  
10 which the Commissioner may, in his or her sole discretion, deem  
11 appropriate.

12 D. 1. Examination reports shall be comprised of only facts  
13 appearing upon the books, records or other documents of the  
14 licensee, its agents or other persons examined, or as ascertained  
15 from the testimony of its officers or agents or other persons  
16 examined concerning its affairs, and such conclusions and  
17 recommendations as the examiners find reasonably warranted from the  
18 facts.

19 2. No later than sixty (60) days following completion of the  
20 examination, the examiner in charge shall file with the Commissioner  
21 a verified written report of examination under oath. Upon receipt  
22 of the verified report, the Commissioner shall transmit the report  
23 to the licensee examined, together with a notice that shall afford  
24 the licensee examined a reasonable opportunity of not more than

1 thirty (30) days to make a written submission or rebuttal with  
2 respect to any matters contained in the examination report.

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

7 E. 1. Names and individual identification data for all viators  
8 shall be considered private and confidential information and shall  
9 not be disclosed by the Commissioner, unless required by law.

10 2. Except as otherwise provided in the Viatical Settlements Act  
11 of 2008, all examination reports, working papers, recorded  
12 information, documents and copies thereof produced by, obtained by  
13 or disclosed to the Commissioner or any other person in the course  
14 of an examination made under the Viatical Settlements Act of 2008,  
15 or in the course of analysis or investigation by the Commissioner of  
16 the financial condition or market conduct of a licensee shall be  
17 confidential by law and privileged, shall not be subject to the  
18 Oklahoma Open Records Act, shall not be subject to subpoena, and  
19 shall not be subject to discovery or admissible in evidence in any  
20 private civil action. The Commissioner is authorized to use the  
21 documents, materials or other information in the furtherance of any  
22 regulatory or legal action brought as part of the Commissioner's  
23 official duties.

24

1       3. Documents, materials or other information, including, but  
2 not limited to, all working papers, and copies thereof, in the  
3 possession or control of the NAIC and its affiliates and  
4 subsidiaries shall be confidential by law and privileged, shall not  
5 be subject to subpoena, and shall not be subject to discovery or  
6 admissible in evidence in any private civil action if they are:

7           a. created, produced or obtained by or disclosed to the  
8           NAIC and its affiliates and subsidiaries in the course  
9           of assisting an examination made under this act, or  
10          assisting a Commissioner in the analysis or  
11          investigation of the financial condition or market  
12          conduct of a licensee, or

13          b. disclosed to the NAIC and its affiliates and  
14          subsidiaries under paragraph 4 of this subsection by a  
15          Commissioner.

16       For the purposes of paragraph 2 of this subsection, "act" means  
17 the law of another state or jurisdiction that is substantially  
18 similar to the Viatical Settlements Act of 2008.

19       4. Neither the Commissioner nor any person that received the  
20 documents, material or other information while acting under the  
21 authority of the Commissioner, including the NAIC and its affiliates  
22 and subsidiaries, shall be permitted to testify in any private civil  
23 action concerning any confidential documents, materials or  
24 information subject to paragraph 1 of this subsection.

1           5. In order to assist in the performance of the Commissioner's  
2 duties, the Commissioner:

- 3           a. may share documents, materials or other information,  
4 including the confidential and privileged documents,  
5 materials or information subject to paragraph 1 of  
6 this subsection, with other state, federal and  
7 international regulatory agencies, with the NAIC and  
8 its affiliates and subsidiaries, and with state,  
9 federal and international law enforcement authorities,  
10 provided that the recipient agrees to maintain the  
11 confidentiality and privileged status of the document,  
12 material, communication or other information, and
- 13           b. may receive documents, materials, communications or  
14 information, including otherwise confidential and  
15 privileged documents, materials or information, from  
16 the NAIC and its affiliates and subsidiaries, and from  
17 regulatory and law enforcement officials of other  
18 foreign or domestic jurisdictions, and shall maintain  
19 as confidential or privileged any document, material  
20 or information received with notice or the  
21 understanding that it is confidential or privileged  
22 under the laws of the jurisdiction that is the source  
23 of the document, material or information.

24



1           6. No waiver of any applicable privilege or claim of  
2 confidentiality in the documents, materials or information shall  
3 occur as a result of disclosure to the Commissioner under this  
4 section or as a result of sharing as authorized in paragraph 5 of  
5 this subsection.

6           7. A privilege established under the law of any state or  
7 jurisdiction that is substantially similar to the privilege  
8 established under this subsection shall be available and enforced in  
9 any proceeding in, and in any court of, this state.

10          8. Nothing contained in the Viatical Settlements Act of 2008  
11 shall prevent or be construed as prohibiting the Commissioner from  
12 disclosing the content of an examination report, preliminary  
13 examination report or results, or any matter relating thereto, to  
14 the Commissioner of any other state or country, or to law  
15 enforcement officials of this or any other state or agency of the  
16 federal government at any time or to the NAIC, so long as such  
17 agency or office receiving the report or matters relating thereto  
18 agrees in writing to hold it confidential and in a manner consistent  
19 with the Viatical Settlements Act of 2008.

20          F. 1. An examiner may not be appointed by the Commissioner if  
21 the examiner, either directly or indirectly, has a conflict of  
22 interest or is affiliated with the management of or owns a pecuniary  
23 interest in any person subject to examination under the Viatical  
24

1 Settlements Act of 2008. This section shall not be construed to  
2 automatically preclude an examiner from being:

- 3 a. a viator,
- 4 b. an insured in a viaticated insurance policy, or
- 5 c. a beneficiary in an insurance policy that is proposed  
6 to be viaticated.

7 2. Notwithstanding the requirements of this paragraph, the  
8 Commissioner may retain from time to time, on an individual basis,  
9 qualified actuaries, certified public accountants, or other similar  
10 individuals who are independently practicing their professions, even  
11 though these persons may from time to time be similarly employed or  
12 retained by persons subject to examination under the Viatical  
13 Settlements Act of 2008.

14 G. 1. No cause of action shall arise nor shall any liability  
15 be imposed against the Commissioner, the Commissioner's authorized  
16 representatives or any examiner appointed by the Commissioner for  
17 any statements made or conduct performed in good faith while  
18 carrying out the provisions of the Viatical Settlements Act of 2008.

19 2. No cause of action shall arise, nor shall any liability be  
20 imposed against any person for the act of communicating or  
21 delivering information or data to the Commissioner or the  
22 Commissioner's authorized representative or examiner pursuant to an  
23 examination made under the Viatical Settlements Act of 2008, if the  
24 act of communication or delivery was performed in good faith and

1 without fraudulent intent or the intent to deceive. This paragraph  
2 does not abrogate or modify in any way any common law or statutory  
3 privilege or immunity heretofore enjoyed by any person identified in  
4 paragraph 1 of this subsection.

5 3. A person identified in paragraph 1 or 2 of this subsection  
6 shall be entitled to an award of attorney fees and costs if he or  
7 she is the prevailing party in a civil cause of action for libel,  
8 slander or any other relevant tort arising out of activities in  
9 carrying out the provisions of this act and the party bringing the  
10 action was not substantially justified in doing so. For purposes of  
11 this section a proceeding is "substantially justified" if it had a  
12 reasonable basis in law or fact at the time that it was initiated.

13 H. The Commissioner may investigate suspected fraudulent  
14 viatical settlement acts and persons engaged in the business of  
15 viatical settlements.

16 SECTION 26. AMENDATORY 36 O.S. 2011, Section 4055.9, is  
17 amended to read as follows:

18 Section 4055.9. A. 1. A viatical settlement provider entering  
19 into a viatical settlement contract shall first obtain:

20 a. if the viator is the insured, a written statement from  
21 a licensed attending physician that the viator is of  
22 sound mind and under no constraint or undue influence  
23 to enter into a viatical settlement contract, and  
24

1           b.    a document in which the insured consents to the  
2                    release of his or her medical records to a licensed  
3                    viatical settlement provider, viatical settlement  
4                    broker and the insurance company that issued the life  
5                    insurance policy covering the life of the insured.

6           2.    Within twenty (20) days after a viator executes documents  
7 necessary to transfer any rights under an insurance policy or within  
8 twenty (20) days of entering any agreement, option, promise or any  
9 other form of understanding, expressed or implied, to viaticate the  
10 policy, the viatical settlement provider shall give written notice  
11 to the insurer that issued that insurance policy that the policy has  
12 or will become a viaticated policy. The notice shall be accompanied  
13 by the documents required by paragraph 3 of this subsection.

14           3.    Within twenty (20) days after a viator executes documents  
15 necessary to transfer any rights under an insurance policy or within  
16 twenty (20) days of entering any agreement, option, promise or any  
17 other form of understanding, expressed or implied, to viaticate the  
18 policy, the viatical provider shall deliver a copy of the medical  
19 release required under subparagraph b of paragraph 1 of this  
20 subsection, a copy of the viator's application for the viatical  
21 settlement contract, the notice required under paragraph 2 of this  
22 subsection and a request for verification of coverage to the insurer  
23 that issued the life policy that is the subject of the viatical  
24 transaction. The National Association of Insurance Commissioner's

1 (NAIC's) form for verification of coverage shall be used unless  
2 another form is developed and approved by the Insurance  
3 Commissioner.

4 4. The insurer shall respond to a request for verification of  
5 coverage submitted on an approved form by a viatical settlement  
6 provider or viatical settlement broker within thirty (30) calendar  
7 days of the date the request is received and shall indicate whether,  
8 based on the medical evidence and documents provided, the insurer  
9 intends to pursue an investigation at this time regarding the  
10 validity of the insurance contract or possible fraud. The insurer  
11 shall accept a request for verification of coverage made on an NAIC  
12 form, any form agreed upon by the insurer and the requestor, or any  
13 other form approved by the Commissioner. The insurer shall accept  
14 an original or facsimile or electronic copy of such request and any  
15 accompanying authorization signed by the viator. Failure by the  
16 insurer to meet its obligations under this subsection shall be a  
17 violation of subsection C of Section 10 and Section 15 of Enrolled  
18 Senate Bill No. 1980 of the 2nd Session of the 51st Oklahoma  
19 Legislature.

20 5. Prior to or at the time of execution of the viatical  
21 settlement contract, the viatical settlement provider shall obtain a  
22 witnessed document in which the viator consents to the viatical  
23 settlement contract, represents that the viator has a full and  
24 complete understanding of the viatical settlement contract, that he

1 or she has a full and complete understanding of the benefits of the  
2 life insurance policy, acknowledges that he or she is entering into  
3 the viatical settlement contract freely and voluntarily and, for  
4 persons with a terminal or chronic illness or condition,  
5 acknowledges that the insured has a terminal or chronic illness and  
6 that the terminal or chronic illness or condition was diagnosed  
7 after the life insurance policy was issued.

8       6. The insurer shall not unreasonably delay effecting change of  
9 ownership or beneficiary with any life settlement contract entered  
10 into in this state or with a resident of this state.

11       7. If a viatical settlement broker performs any of these  
12 activities required of the viatical settlement provider, the  
13 provider is deemed to have fulfilled the requirements of this  
14 section.

15       B. All medical information solicited or obtained by any  
16 licensee shall be subject to the applicable provisions of state law  
17 relating to confidentiality of medical information.

18       C. All viatical settlement contracts entered into in this state  
19 shall provide the viator with an absolute right to rescind the  
20 contract before the earlier of thirty (30) calendar days after the  
21 date upon which the viatical settlement contract is executed by all  
22 parties or fifteen (15) calendar days after the viatical settlement  
23 proceeds have been sent to the viator. Rescission by the viator may  
24 be conditioned upon the viator both giving notice and repaying to

1 the viatical settlement provider within the rescission period all  
2 proceeds of the settlement and any premiums, loans and loan interest  
3 paid by or on behalf of the viatical settlement provider in  
4 connection with or as a consequence of the viatical settlement. If  
5 the insured dies during the rescission period, the viatical  
6 settlement contract shall be deemed to have been rescinded, subject  
7 to repayment to the viatical settlement provider or purchaser of all  
8 viatical settlement proceeds, and any premiums, loans and loan  
9 interest that have been paid by the viatical settlement provider or  
10 purchaser, which shall be paid within sixty (60) calendar days of  
11 the death of the insured. In the event of any rescission, if the  
12 viatical settlement provider has paid commissions or other  
13 compensation to a viatical settlement broker in connection with the  
14 rescinded transaction, the viatical settlement broker shall refund  
15 all such commissions and compensation to the viatical settlement  
16 provider within five (5) business days following receipt of written  
17 demand from the viatical settlement provider, which demand shall be  
18 accompanied by either the viator's notice of rescission if rescinded  
19 at the election of the viator, or notice of the death of the insured  
20 if rescinded by reason of the death of the insured within the  
21 applicable rescission period.

22 D. The viatical settlement provider shall instruct the viator  
23 to send the executed documents required to effect the change in  
24 ownership, assignment or change in beneficiary directly to the

1 independent escrow agent. Within three (3) business days after the  
2 date the escrow agent receives the document or from the date the  
3 viatical settlement provider receives the documents, if the viator  
4 erroneously provides the documents directly to the provider, the  
5 provider shall pay or transfer the proceeds of the viatical  
6 settlement into an escrow or trust account maintained in a state- or  
7 federally-chartered financial institution whose deposits are insured  
8 by the Federal Deposit Insurance Corporation (FDIC). Upon payment  
9 of the settlement proceeds into the escrow account, the escrow agent  
10 shall deliver the original change in ownership, assignment or change  
11 in beneficiary forms to the viatical settlement provider or related  
12 provider trust or other designated representative of the viatical  
13 settlement provider. Upon the escrow agent's receipt of the  
14 acknowledgment of the properly completed transfer of ownership,  
15 assignment or designation of beneficiary from the insurance company,  
16 the escrow agent shall pay the settlement proceeds to the viator.

17 E. Failure to tender consideration to the viator for the  
18 viatical settlement contract within the time set forth in the  
19 disclosure pursuant to paragraph 7 of subsection A of Section 8 of  
20 Enrolled Senate Bill No. 1980 of the 2nd Session of the 51st  
21 Oklahoma Legislature renders the viatical settlement contract  
22 voidable by the viator for lack of consideration until the time  
23 consideration is tendered to and accepted by the viator. Funds  
24 shall be deemed sent by a viatical settlement provider to a viator



1 as of the date that the escrow agent either releases funds for wire  
2 transfer to the viator ~~or~~, places a check for delivery to the viator  
3 via United States Postal Service or other nationally recognized  
4 delivery service or make an electronic payment to the viator.

5 F. In order to assure that a viator, at the time of the  
6 viatical settlement has a life expectancy of less than two (2)  
7 years, receives reasonable return for viaticating an insurance  
8 policy, the following shall be minimum discounts:

Insured's Life Expectancy	Minimum Percentage of Face Value Less Outstanding Loans Received By Viator
Less than six (6) months	80%
At least six (6) but less than twelve (12) months	70%
At least twelve (12) but less than eighteen (18) months	65%
At least eighteen (18) months but less than twenty-four (24) months	60%

19 G. Contacts with the insured for the purpose of determining the  
20 health status of the insured by the viatical settlement provider or  
21 viatical settlement broker after the viatical settlement has  
22 occurred shall only be made by a viatical settlement provider or  
23 broker licensed in this state or its authorized representatives and  
24 shall be limited to once every three (3) months for insureds with a

1 life expectancy of more than one (1) year, and to no more than once  
2 per month for insureds with a life expectancy of one (1) year or  
3 less. The provider or broker shall explain the procedure for these  
4 contacts at the time the viatical settlement contract is entered  
5 into. The limitations set forth in this subsection shall not apply  
6 to any contacts with an insured for reasons other than determining  
7 the insured's health status. Viatical settlement providers and  
8 viatical settlement brokers shall be responsible for the actions of  
9 their authorized representatives.

10 SECTION 27. AMENDATORY 36 O.S. 2011, Section 4103, is  
11 amended to read as follows:

12 Section 4103. A. No policy of group life insurance shall be  
13 delivered in this state ~~unless a schedule of the premium rates~~  
14 ~~pertaining to the form thereof is filed with the Insurance~~  
15 ~~Commissioner and~~ unless it contains in substance the following  
16 provisions, or provisions which are more favorable to the persons  
17 insured, or at least as favorable to the persons insured and more  
18 favorable to the policyholder; 7i provided, however, ~~(a)~~ that  
19 ~~provisions six (6) to ten (10) inclusive;~~

20 1. Paragraphs 6 through 10 of this section shall not apply to  
21 policies issued to a creditor to insure debtors of such creditor;

22 ~~(b) that~~

23

24

1        2. That the standard provisions required for individual life  
2 insurance policies shall not apply to group life insurance policies;  
3 and

4        ~~(c) that~~

5        3. That if the group life insurance policy is on a plan of  
6 insurance other than the term plan, it shall contain a nonforfeiture  
7 provision or provisions which is or are equitable to the insured  
8 persons and to the policyholder, but nothing herein shall be  
9 construed to require that group life insurance policies contain the  
10 same nonforfeiture provisions as are required for individual life  
11 insurance policies:

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

21        ~~2.~~ C. A provision that the validity of the policy shall not be  
22 contested, except for nonpayment of premiums, after it has been in  
23 force for two (2) years from its date of issue~~+~~+, and that no  
24 statement made by any person insured under the policy relating to

1 his or her insurability shall be used in contesting the validity of  
2 the insurance with respect to which such statement was made after  
3 such insurance has been in force prior to the contest for a period  
4 of two (2) years during such person's lifetime nor unless it is  
5 contained in a written instrument signed by him or her.

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

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

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

22 ~~6.~~ G. A provision that any sum becoming due by reason of the  
23 death of the person insured shall be payable to the beneficiary  
24 designated by the person insured, subject to the provisions of the

1 policy in the event there is no designated beneficiary as to all or  
2 any part of such sum, living at the death of the person insured, and  
3 subject to any right reserved by the insurer in the policy and set  
4 forth in the certificate to pay at its option a part of such sum not  
5 exceeding Five Hundred Dollars (\$500.00) to any person appearing to  
6 the insurer to be equitably entitled thereto by reason of having  
7 incurred funeral or other expenses incident to the last illness or  
8 death of the person insured.

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

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

1           ~~(a)~~

2           a.    the individual policy shall, at the option of such  
3                    person, be on any one of the forms, except term  
4                    insurance, then customarily issued by the insurer at  
5                    the age and for the amount applied for~~†~~1

6           ~~(b)~~

7           b.    the individual policy shall be in an amount not in  
8                    excess of the amount of life insurance which ceases  
9                    because of such termination, less, in the case of a  
10                   person whose membership in the class or classes  
11                   eligible for coverage terminates but who continues in  
12                   employment in another class, the amount of any life  
13                   insurance for which such person is or becomes eligible  
14                   within thirty-one (31) days after such termination  
15                   under any other group policy; provided that any amount  
16                   of insurance which shall have matured on or before the  
17                   date of such termination as an endowment payable to  
18                   the person insured, whether in one sum or in  
19                   installments or in the form of an annuity, shall not,  
20                   for the purposes of this ~~provision~~ subparagraph, be  
21                   included in the amount which is considered to cease  
22                   because of such termination~~†~~1 and

23           ~~(c)~~

24

1           c.    the premium on the individual policy shall be at the  
2                   insurer's then customary rate applicable to the form  
3                   and amount of the individual policy, to the class of  
4                   risk to which such person then belongs, and to his or  
5                   her age attained on the effective date of the  
6                   individual policy.

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

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

24           b.    Ten Thousand Dollars (\$10,000.00).

1       ~~10.~~ K. A provision that if a person insured under the group  
2 policy dies during the period within which he or she would have been  
3 entitled to have an individual policy issued to him or her in  
4 accordance with paragraph ~~(8)~~ I or ~~(9)~~ J of this section and before  
5 such an individual policy shall have become effective, the amount of  
6 life insurance which he or she would have been entitled to have  
7 issued to him or her under such individual policy shall be payable  
8 as a claim under the group policy, whether or not application for  
9 the individual policy or the payment of the first premium therefor  
10 has been made.

11       ~~11.~~ L. In the case of a policy issued to a creditor to insure  
12 debtors of such creditor, a provision that the insurer will furnish  
13 to the policyholder for delivery to each debtor insured under the  
14 policy a form which shall contain a statement that the life of the  
15 debtor is insured under the policy and that any death benefit paid  
16 thereunder by reason of his or her death shall be applied to reduce  
17 or extinguish the indebtedness.

18       SECTION 28.       AMENDATORY       36 O.S. 2011, Section 4112, is  
19 amended to read as follows:

20       Section 4112. An insurer shall pay the proceeds of any benefits  
21 under group life insurance policy not more than thirty (30) days  
22 after the insurer has received proof of death of the insured. If  
23 the proceeds are not paid within this period, the insurer shall pay  
24 interest on the proceeds, at a rate which is not less than the



1 current rate of interest on death proceeds on deposit with the  
2 insurer, from the date of death of the insured to the date when the  
3 proceeds are paid. Payment shall be deemed to have been made on the  
4 date an electronic payment is made or a check, draft or other valid  
5 instrument which is equivalent to payment was placed in the U.S.  
6 mails in a properly addressed, postpaid envelope; or, if not so  
7 posted, on the date of delivery of such instrument to the  
8 beneficiary.

9 SECTION 29. AMENDATORY 36 O.S. 2011, Section 6060.11, as  
10 amended by Section 2, Chapter 75, O.S.L. 2020 (36 O.S. Supp. 2020,  
11 Section 6060.11), is amended to read as follows:

12 Section 6060.11. A. Subject to the limitations set forth in  
13 this section and Sections 6060.12 and 6060.13 of this title, any  
14 health benefit plan that is offered, issued, or renewed in this  
15 state on or after the effective date of this act shall provide  
16 benefits for treatment of mental health and substance use disorders.

17 B. 1. Benefits for mental health and substance use disorders  
18 shall be equal to benefits for treatment of and shall be subject to  
19 the same preauthorization and utilization review mechanisms and  
20 other terms and conditions as all other physical diseases and  
21 disorders including, but not limited to:

22 a. coverage of inpatient hospital services for either  
23 twenty-six (26) days or the limit for other covered  
24 illnesses, whichever is greater,

- b. coverage of outpatient services,
- c. coverage of medication,
- d. maximum lifetime benefits,
- e. copayments,
- f. coverage of home health visits,
- g. individual and family deductibles, and
- h. coinsurance.

2. Treatment limitations applicable to mental health or substance use disorder benefits shall be no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan. There shall be no separate treatment limitations that are applicable only with respect to mental health or substance abuse disorder benefits.

C. A health benefit plan shall not impose a nonquantitative treatment limitation with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health benefit plan as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the nonquantitative treatment limitation to mental health disorders in the classification are comparable to and applied no more stringently than to medical and surgical benefits in the same classification.

D. All health benefit plans must meet the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and

1 Addiction Equity Act of 2008, as amended, and federal guidance or  
2 regulations issued under these acts including 45 CFR 146.136, 45 CFR  
3 147.160 and 45 CFR 156.115(a) (3).

4 E. Beginning on or after the effective date of this act, each  
5 insurer that offers, issues or renews any individual or group health  
6 benefit plan providing mental health or substance use disorder  
7 benefits shall submit an annual report to the Insurance Commissioner  
8 on or before April 1 of each year that contains the following:

9 1. A description of the process used to develop or select the  
10 medical necessity criteria for mental health and substance use  
11 disorder benefits and the process used to develop or select the  
12 medical necessity criteria for medical and surgical benefits;

13 2. Identification of all nonquantitative treatment limitations  
14 applied to both mental health and substance use disorder benefits  
15 and medical and surgical benefits within each classification of  
16 benefits; and

17 3. The results of an analysis that demonstrates that for the  
18 medical necessity criteria described in paragraph 1 of this  
19 subsection and for each nonquantitative treatment limitation  
20 identified in paragraph 2 of this subsection, as written and in  
21 operation, the processes, strategies, evidentiary standards or other  
22 factors used in applying the medical necessity criteria and each  
23 nonquantitative treatment limitation to mental health and substance  
24 use disorder benefits within each classification of benefits are

1 comparable to and are applied no more stringently than to medical  
2 and surgical in the same classification of benefits. At a minimum,  
3 the results of the analysis shall:

- 4 a. identify the factors used to determine that a  
5 nonquantitative treatment limitation will apply to a  
6 benefit including factors that were considered but  
7 rejected,
- 8 b. identify and define the specific evidentiary standards  
9 used to define the factors and any other evidence  
10 relied upon in designing each nonquantitative  
11 treatment limitation,
- 12 c. provide the comparative analyses including the results  
13 of the analyses performed to determine that the  
14 processes and strategies used to design each  
15 nonquantitative treatment limitation, as written, and  
16 the as written processes and strategies used to apply  
17 the nonquantitative treatment limitation to mental  
18 health and substance use disorder benefits are  
19 comparable to and applied no more stringently than the  
20 processes and strategies used to design each  
21 nonquantitative treatment limitation, as written, and  
22 the as written processes and strategies used to apply  
23 the nonquantitative treatment limitation to medical  
24 and surgical benefits,

1 d. provide the comparative analyses including the results  
2 of the analyses performed to determine that the  
3 processes and strategies used to apply each  
4 nonquantitative treatment limitation, in operation,  
5 for mental health and substance use disorder benefits  
6 are comparable to and applied no more stringently than  
7 the processes or strategies used to apply each  
8 nonquantitative treatment limitation for medical and  
9 surgical benefits in the same classification of  
10 benefits, and

11 e. disclose the specific findings and conclusions reached  
12 by the insurer that the results of the analyses  
13 required by this subsection indicate that the insurer  
14 is in compliance with this section and the Paul  
15 Wellstone and Pete Domenici Mental Health Parity and  
16 Addiction Equity Act of 2008, as amended, and its  
17 implementing and related regulations including 45 CFR  
18 146.136, 45 CFR 147.160 and 45 CFR 156.115(a)(3).

19 F. The Commissioner shall implement and enforce any applicable  
20 provisions of the Paul Wellstone and Pete Domenici Mental Health  
21 Parity and Addiction Equity Act of 2008, as amended, and federal  
22 guidance or regulations issued under these acts including 45 CFR  
23 146.136, 45 CFR 147.136, 45 CFR 147.160 and 45 CFR 156.115(a)(3).

1 G. No later than ~~June 1, 2021~~ December 31, 2021, and by ~~June 1~~  
2 December 31 of each year thereafter, the Commissioner shall make  
3 available to the public the reports submitted by insurers, as  
4 required in subsection E of this section, during the most recent  
5 annual cycle; provided, however, that any information that is  
6 confidential or a trade secret shall be redacted.

7 1. The Commissioner shall identify insurers that have failed in  
8 whole or in part to comply with the full extent of reporting  
9 required in this section and shall make a reasonable attempt to  
10 obtain missing reports or information by June 1 of the following  
11 year.

12 2. The reports submitted by insurers and the identification by  
13 the Commissioner of noncompliant insurers shall be made available to  
14 the public by posting on the Internet website of the Insurance  
15 Department.

16 H. The Commissioner shall promulgate rules pursuant to the  
17 provisions of this section and any provisions of the Paul Wellstone  
18 and Pete Domenici Mental Health Parity and Addiction Equity Act of  
19 2008, as amended, that relate to the business of insurance.

20 SECTION 30. AMENDATORY 36 O.S. 2011, Section 6060.12, as  
21 amended by Section 3, Chapter 75, O.S.L. 2020 (36 O.S. Supp. 2020,  
22 Section 6060.12), is amended to read as follows:

23 Section 6060.12. 1. A health benefit plan that, at the end of  
24 its base period, experiences a greater than two percent (2%)

1 increase in premium costs pursuant to providing benefits for  
2 treatment of mental health and substance use disorders shall be  
3 exempt from the provisions of Section 6060.11 of this title.

4 2. To calculate base-period-premium costs, the health benefit  
5 plan shall subtract from premium costs incurred during the base  
6 period, both the premium costs incurred during the period  
7 immediately preceding the base period and any premium cost increases  
8 attributable to factors unrelated to benefits for treatment of  
9 mental health and substance use disorders.

10 3. a. To claim the exemption provided for in ~~subsection A~~  
11 paragraph 1 of this section a health benefit plan  
12 shall provide to the Insurance Commissioner a written  
13 request signed by an actuary stating the reasons and  
14 actuarial assumptions upon which the request is based.

15 b. The Commissioner shall verify the information provided  
16 and shall approve or disapprove the request within  
17 thirty (30) days of receipt.

18 c. If, upon investigation, the Commissioner finds that  
19 any statement of fact in the request is found to be  
20 knowingly false, the health benefit plan may be  
21 subject to suspension or loss of license or any other  
22 penalty as determined by the Commissioner, ~~or the~~  
23 ~~State Commissioner of Health~~ with regard to health  
24 maintenance organizations.

1           SECTION 31.           NEW LAW           A new section of law to be codified  
2 in the Oklahoma Statutes as Section 6124.2 of Title 36, unless there  
3 is created a duplication in numbering, reads as follows:

4           A. No prepaid funeral benefit permit holder shall change the  
5 name under which the permit holder operates except as provided in  
6 this section. The prepaid funeral benefit permit holder shall  
7 obtain approval from the Insurance Commissioner at least thirty (30)  
8 days prior to changing the name of the permit holder. The  
9 application for change of name of a prepaid funeral benefit permit  
10 holder shall be in a form provided by the Insurance Commissioner and  
11 shall contain, at a minimum, the following information:

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

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

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

20           D. Upon approval of a change of name, the Insurance  
21 Commissioner shall issue a prepaid funeral benefit permit with the  
22 new name. The prepaid funeral benefit permit holder shall display  
23 in a conspicuous place at all times on the premises of the  
24 organization all permits issued pursuant to the provisions of this



1 section. No organization may consent to or allow the use or display  
2 of the permit by a person other than the persons authorized to  
3 represent the organization in contracting prepaid funeral benefits.

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

6 SECTION 32. AMENDATORY 36 O.S. 2011, Section 6216.1, is  
7 amended to read as follows:

8 Section 6216.1. No insurance company authorized to transact  
9 insurance in this state shall make payment of any insurance claim,  
10 or any portion of a claim, to a public adjuster on account of  
11 services rendered by a public adjuster to an insured unless the name  
12 of the insured is added as a joint payee on any claim check ~~or,~~  
13 draft or electronic payment. The payment, whether by check, draft,  
14 electronic payment or otherwise, shall be sent to the address or  
15 electronic mail address designated by the insured.

16 SECTION 33. AMENDATORY 36 O.S. 2011, Section 6217, as  
17 last amended by Section 14, Chapter 269, O.S.L. 2013 (36 O.S. Supp.  
18 2020, Section 6217), is amended to read as follows:

19 Section 6217. A. All licenses issued pursuant to the  
20 provisions of the Insurance Adjusters Licensing Act shall continue  
21 in force not longer than twenty-four (24) months. The renewal dates  
22 for the licenses may be staggered throughout the year by notifying  
23 licensees in writing of the expiration and renewal date being

24

1 assigned to the licensees by the Insurance Commissioner and by  
2 making appropriate adjustments in the biennial licensing fee.

3 B. Any licensee applying for renewal of a license as an  
4 adjuster shall have completed not less than twenty-four (24) clock  
5 hours of continuing insurance education, of which three (3) hours  
6 shall be in ethics, within the previous twenty-four (24) months  
7 prior to renewal of the license. The Insurance Commissioner shall  
8 approve courses and providers of continuing education for insurance  
9 adjusters as required by this section.

10 The Insurance Department may use one or more of the following to  
11 review and provide a nonbinding recommendation to the Insurance  
12 Commissioner on approval or disapproval of courses and providers of  
13 continuing education:

14 1. Employees of the Insurance Commissioner;

15 2. A continuing education advisory committee. ~~The continuing~~  
16 ~~education advisory committee is separate and distinct from the~~  
17 ~~Advisory Board established by Section 6221 of this title;~~

18 3. An independent service whose normal business activities  
19 include the review and approval of continuing education courses and  
20 providers. The Commissioner may negotiate agreements with such  
21 independent service to review documents and other materials  
22 submitted for approval of courses and providers and present the  
23 Commissioner with its nonbinding recommendation. The Commissioner  
24 may require such independent service to collect the fee charged by

1 the independent service for reviewing materials provided for review  
2 directly from the course providers.

3 C. An adjuster who, during the time period prior to renewal,  
4 participates in an approved professional designation program shall  
5 be deemed to have met the biennial requirement for continuing  
6 education. Each course in the curriculum for the program shall  
7 total a minimum of twenty-four (24) hours. Each approved  
8 professional designation program included in this section shall be  
9 reviewed for quality and compliance every three (3) years in  
10 accordance with standardized criteria promulgated by rule.

11 Continuation of approved status is contingent upon the findings of  
12 the review. The list of professional designation programs approved  
13 under this subsection shall be made available to producers and  
14 providers annually.

15 D. The Insurance Department may promulgate rules providing that  
16 courses or programs offered by professional associations shall  
17 qualify for presumptive continuing education credit approval. The  
18 rules shall include standardized criteria for reviewing the  
19 professional associations' mission, membership, and other relevant  
20 information, and shall provide a procedure for the Department to  
21 disallow a presumptively approved course. Professional association  
22 courses approved in accordance with this subsection shall be  
23 reviewed every three (3) years to determine whether they continue to  
24 qualify for continuing education credit.

1 E. The active service of a licensed adjuster as a member of a  
2 continuing education advisory committee, as described in paragraph 2  
3 of subsection B of this section, shall be deemed to qualify for  
4 continuing education credit on an hour-for-hour basis.

5 F. 1. Each provider of continuing education shall, after  
6 approval by the Commissioner, submit an annual fee. A fee may be  
7 assessed for each course submission at the time it is first  
8 submitted for review and upon submission for renewal at expiration.  
9 Annual fees and course submission fees shall be set forth as a rule  
10 by the Commissioner. The fees are payable to the Insurance  
11 Commissioner and shall be deposited in the State Insurance  
12 Commissioner Revolving Fund, created in Section 307.3 of this title,  
13 for the purposes of fulfilling and accomplishing the conditions and  
14 purposes of the Oklahoma Producer Licensing Act and the Insurance  
15 Adjusters Licensing Act. Public-funded educational institutions,  
16 federal agencies, nonprofit organizations, not-for-profit  
17 organizations and Oklahoma state agencies shall be exempt from this  
18 subsection.

19 2. The Commissioner may assess a civil penalty, after notice  
20 and opportunity for hearing, against a continuing education provider  
21 who fails to comply with the requirements of the Insurance Adjusters  
22 Licensing Act, of not less than One Hundred Dollars (\$100.00) nor  
23 more than Five Hundred Dollars (\$500.00), for each occurrence. The  
24

1 civil penalty may be enforced in the same manner in which civil  
2 judgments may be enforced.

3 G. Subject to the right of the Commissioner to suspend, revoke,  
4 or refuse to renew a license of an adjuster, any such license may be  
5 renewed by filing on the form prescribed by the Commissioner on or  
6 before the expiration date a written request by or on behalf of the  
7 licensee for such renewal and proof of completion of the continuing  
8 education requirement set forth in subsection B of this section,  
9 accompanied by payment of the renewal fee.

10 H. If the request, proof of compliance with the continuing  
11 education requirement and fee for renewal of a license as an  
12 adjuster are filed with the Commissioner prior to the expiration of  
13 the existing license, the licensee may continue to act pursuant to  
14 said license, unless revoked or suspended prior to the expiration  
15 date, until the issuance of a renewal license or until the  
16 expiration of ten (10) days after the Commissioner has refused to  
17 renew the license and has mailed notice of said refusal to the  
18 licensee. Any request for renewal filed after the date of  
19 expiration may be considered by the Commissioner as an application  
20 for a new license.

21 SECTION 34. NEW LAW A new section of law to be codified  
22 in the Oklahoma Statutes as Section 6470.35 of Title 36, unless  
23 there is created a duplication in numbering, reads as follows:

24

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 6753 of Title 36  
3 of the Oklahoma Statutes.

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

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

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

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

19 SECTION 35. AMENDATORY 36 O.S. 2011, Section 6552, is  
20 amended to read as follows:

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

23 1. "Utilization review" means a system for prospectively,  
24 concurrently and retrospectively reviewing the appropriate and

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

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

8 a. an employer in this state, or

9 b. a third party that provides or administers hospital  
10 and medical benefits to citizens of this state,  
11 including, but not limited to:

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

21 (2) a health insurer, not-for-profit hospital service  
22 or medical plan, health insurance service  
23 organization, or preferred provider organization  
24



1 or other entity offering health insurance  
2 policies, contracts or benefits in this state;

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

5 4. "Commissioner" means the Insurance Commissioner;

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

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

13 SECTION 36. AMENDATORY 36 O.S. 2011, Section 6753, as  
14 amended by Section 38, Chapter 150, O.S.L. 2012 (36 O.S. Supp. 2020,  
15 Section 6753), is amended to read as follows:

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

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

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

23 B. Each provider of home service contracts sold in this state  
24 shall file a registration with, and on a form prescribed by, the

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

1 C. In order to assure the faithful performance of a provider's  
2 obligations to its contract holders, each provider shall be  
3 responsible for complying with the requirements of paragraph 1, 2 or  
4 3 of this subsection:

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

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

- 20 (1) a surety bond issued by an authorized surety,  
21 (2) securities of the type eligible for deposit by  
22 authorized insurers in this state,  
23 (3) ~~cash,~~



1 obligations of the provider relating to service  
2 contracts sold by the provider in this state; or

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

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

1 Commissioner by the insurer before the date of such  
2 cancellation or nonrenewal.

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

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

9 a. maintain surplus as to policyholders and paid-in  
10 capital of at least Fifteen Million Dollars  
11 (\$15,000,000.00), and

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

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

19 a. maintain surplus as to policyholders and paid-in  
20 capital of less than Fifteen Million Dollars  
21 (\$15,000,000.00),

22 b. demonstrate to the satisfaction of the Commissioner  
23 that the company maintains a ratio of net written  
24 premiums, wherever written, to surplus as to

1 policyholders and paid-in capital of not greater than  
2 three to one, and

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

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

23 F. The marketing, sale, offering for sale, issuance, making,  
24 proposing to make and administration of home service contracts by

1 providers and related service contract sellers, administrators, and  
2 other persons, including but not limited to real estate licensees,  
3 shall be exempt from all other provisions of the Insurance Code.

4 SECTION 37. AMENDATORY 36 O.S. 2011, Section 6904, is  
5 amended to read as follows:

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

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

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

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



1 certificate of authority to a person filing a completed application  
2 upon receipt of the prescribed fees and upon the Insurance  
3 Commissioner's being satisfied that:

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

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

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

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

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

23 SECTION 38. AMENDATORY 36 O.S. 2011, Section 6907, is  
24 amended to read as follows:

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 "reccredentialing", 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 "reccredentialing" 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 reccredentialing 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.

23

24

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.

24

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

24

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 41. 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;

24

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;

24

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 42. 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 43. REPEALER 36 O.S. 2011, Sections 1435.40, as  
5 amended by Section 1, Chapter 23, O.S.L. 2016 (36 O.S. Supp. 2020,  
6 Sections 1435.40), 1612.1, 6221 and 6522, are hereby repealed.

7 SECTION 44. It being immediately necessary for the preservation  
8 of the public peace, health or safety, an emergency is hereby  
9 declared to exist, by reason whereof this act shall take effect and  
10 be in full force from and after its passage and approval.

11 Passed the Senate the 10th day of March, 2021.

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\_\_\_\_\_  
Presiding Officer of the Senate

Passed the House of Representatives the \_\_\_\_ day of \_\_\_\_\_,  
2021.

\_\_\_\_\_  
Presiding Officer of the House  
of Representatives