

OKLAHOMA INSURANCE DEPARTMENT

2017 STATUTE & RULE CHANGES

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OKLAHOMA INSURANCE DEPARTMENT OMNIBUS REQUEST

SB 431

Effective Nov. 1, 2017

Support Staff "Compensation" – 36 O.S. § 305(A)

- The Insurance Commissioner may determine the **compensation** of any deputies, assistants, examiners, actuaries, attorneys, clerk, and employees he or she appoints.
 - Previous law referred to "salaries" rather than "compensation."
 - The Commissioner sometimes utilizes the services of an outside actuary, attorney, or examiner. These individuals are compensated for their services, but not paid a salary.

Data Call and Market Conduct Annual Statement Confidentiality – 36 O.S. § 309.4(F)

- Data calls and Market Conduct Annual Statements are expressly designated as confidential if obtained by the Commissioner in the course of an examination.
 - Data calls and MCAS have always been interpreted as being confidential under this law, but are now clearly identified as confidential.

Mortgage Loan Investments – 36 O.S. §§ 1622 & 1624

- An insurer may not invest more than 35% of its admitted assets in mortgage loans.
 - Previous limit was 25%.
- An insurer may not invest more than an aggregate of 35% of its admitted assets in mortgage loans (§1622), purchase money mortgages (§1623), and real property (§1624).
 - Specific limits for each of these investments are unchanged.
- An insurer investing in real property which is acquired for sale or lease is no longer required to sell or lease that property to a corporation. The property may be sold or leased to any lessee or purchaser who could have legally acquired the property in the first instance.

Reference Clarification – 36 O.S. § 4101.1

- Section 4101.1 is amended to fix incorrect references to Section 4101.

Medicaid-only HMO Requirements – 36 O.S. §§ 6903.1 & 6937

- Health maintenance organizations that contract with the Oklahoma Health Care Authority to provide services for Medicaid recipients but do not provide services to any other group must comply with:
 - 36 O.S. § 6913 (HMO net worth requirements), and
 - The Risk-based Capital (RBC) for Health Maintenance Organizations Act of 2003 (36 O.S. § 6937-6951).

LIFE & HEALTH

SB 478 – Health Care Choice Act

Effective August 25, 2017

36 O.S. §§ 4413-4414

- Allows accident and health insurers that are authorized to engage in the business of insurance in other states to apply for a limited exemption from Oklahoma's certificate of authority requirement to do business in Oklahoma, provided the insurer is domiciled in a state which has a legislatively approved compact with Oklahoma.

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- The Commissioner will set up an application process for these insurers, including establishing the requirements and fees for application.

§ 4414(B) Each insurer shall:

- Offer plans that contain all Oklahoma mandated benefits, as well as comply with all other applicable laws pertaining to coverage and coverage decisions,
- Keep records of each policy, which shall be subject to examination by the Commissioner for 3 years,
- File an annual statement of all insurance transacted by the insurer,
- Issue policies through a producer licensed in Oklahoma as well as in a state in which the insurer is licensed,
- Appoint a TPA licensed in Oklahoma that has adjusters licensed in Oklahoma, and
- Submit to the jurisdiction of Oklahoma, including naming the Commissioner as the insurer's agent for service of process.

§ 4414(C) The Commissioner may only grant approval to an insurer that:

- Is properly licensed and has met the requirements for solvency in its domiciliary state,
- Has met the requirements for market conduct applicable to insurers domiciled in Oklahoma, and
- Has submitted the policy form that it will issue to insureds in Oklahoma for a determination by the Commissioner that the policy form is in compliance with all laws and regulations in Oklahoma.

§ 4414(D)

- The Commissioner shall obtain written verification from the insurer's domiciliary regulator that the insurer has met the solvency requirements of its domiciliary state.

§ 4414(E)

- The Commissioner may require an out-of-state insurer to reapply as often as he or she deems prudent.

§ 4414(F)

- The Commissioner may impose on the insurer any additional requirement that he or she deems necessary.

§ 4414(G)

- The Commissioner may negotiate compacts with other states to allow insurers from those states to sell accident and health policies in Oklahoma. The compact must be approved by the Legislature.

§4414(H)

- The Commissioner may require each insurer to submit to a market conduct examination. The examination must be conducted in the same manner and under the same terms and conditions as exams of companies located in Oklahoma.

§4414(I)

- Each insurer must provide Oklahoma-mandated benefits and must comply with all other applicable laws that apply to Oklahoma A&H insurers.

§4414(J)

- The insurers must comply with the Unfair Claims Settlement Practices Act, Health Care Freedom of Choice Act, Genetic Nondiscrimination in Insurance Act, Hospital and Medical Services Utilization Review Act, and all requirements of 36 O.S. §§ 4401-4411.
- All HMO's shall be subject to and comply with the Health Maintenance Organization Act of 2003.

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§4414(K) & (L)

- Each application for purchase of a policy from an out-of-state insurer subject to this act shall contain certain disclosures.

§4414(M)

- Each insurer is subject to payment of any applicable premium taxes pursuant to 36 O.S. § 624.

§4414(N)

- Each insurer must participate in the Oklahoma Life and Health Guaranty Association Act.

§4414(O)

- Each insurer must participate in any existing or future high risk pool.

§4414(P)

- The Commissioner shall promulgate rules to implement the act.

HB 2406 – Oklahoma Individual Health Insurance Market Stabilization Act **Effective June 6, 2017**

36 O.S. § 6530.2

- Sets out definitions of terms used in the act: “agent” | “Board” | “health insurance” | “high-risk pool” | “insurer” | “market” | “market stabilization activities” | “plan” | “Program” | “reinsurer” | “reinsurance”

§ 6530.3

- Any person who is qualified for and enrolled in coverage through the Federally Facilitated Marketplace and is a permanent resident of Oklahoma is eligible for the Program.
- Individuals not eligible:
 - Any person currently receiving or entitled to receive benefits under any other federal or state health program providing financial assistance or preventative and rehabilitative social services, and
 - Any inmate incarcerated in any state penal institution or confined to any narcotic detention, treatment and rehabilitation facility

§ 6530.4

- Creates a nonprofit legal entity known as the Oklahoma Individual Health Insurance Market Stabilization Program (“Program”)
- The Program will operate under the management of a 9-member Board of Directors (“Board”) appointed by the Insurance Commissioner:
 - 2 representatives of domestic insurance companies licensed in Oklahoma,
 - 1 member from the general public who is a member of the class of individuals to which the Program would apply (i.e. a person with a chronic, expensive health condition)
 - 1 representative of an HMO,
 - 1 member from a health-related profession,
 - 1 member of the general public who is not associated with the medical profession, a hospital, or an insurer,
 - 1 representative of reinsurers, and
 - 2 representatives from the providers of individual plans licensed in Oklahoma.
- The original Board will be appointed as follows:

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- three members for a term of one year,
 - three members for a term of two years, and
 - three members for a term of three years.
- All terms after the initial term will be for three years.
- The Board shall elect one of its members as chairperson.
- Members of the Board may be reimbursed from monies of the Program for actual and necessary expenses incurred in the performance of their duties as members of the Board but shall not otherwise be compensated.
- The Board shall adopt a plan of operation and submit its articles, bylaws, and operating rules to the Commissioner for approval. If the Board fails to submit a suitable plan within 180 days, the Commissioner shall promulgate rules governing the operation of the Board. If the Board then creates any plan of operation, articles, bylaws, and operating rules that are approved by the Commissioner, the Commissioner shall revoke any prior inconsistent adopted administrative rules.
- The Board may hire an Executive Director.
- The Insurance Department will provide administrative and operational support, and will be reimbursed for any actual and direct administrative costs.
- The Board shall cause an audit to be made of the program annually.

§6530.5

- The Board shall:
 - Develop, implement, and administer the Program, which is contingent on approval for and receipt of federal funds,
 - Levy and collect all assessments from all health insurers and reinsurers,
 - Make payments to provide for the market stabilization activities and for administrative expenses,
 - Establish administrative and accounting processes and procedures for the operation of the Program and create operating rules to effectuate the provisions of the act, including but not limited to:
 - Determining eligibility of individuals under the Program,
 - Establishing standards for qualification based on health status, health conditions, prior or current insurance coverage status, or health costs as a result of utilization of consuming health care,
 - Determining the amount of the assessment on insurers and reinsurers,
 - Establishing the dollar attachment point of claims for eligible individuals after which the Program will provide payments,
 - Establishing the rate at which the Program will reimburse a health insurance plan for claims incurred above the attachment point but below the reinsurance cap,
 - Determining the threshold amount for claims costs after which the benefits are no longer eligible for reinsurance payments, and
 - Determining the health conditions of eligible individuals for which the program will provide payments, and
 - Apply for, accept, and receive federal funding for the operation of the Program.
- Federal funding sources:
 - Approval of a waiver provided by Section 1332 of the Patient Protection and Affordable Care Act (“1332 State Innovation Waiver”, authorizing federal funding to support market stabilization program payments,
 - Oklahoma’s participation in any federal grant program or programs, or
 - Any combination of the above.

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- If Oklahoma is unable to secure approval of a 1332 State Innovation Waiver or secure funding from federal grant programs within 2 years, the Program will sunset and any remaining monies will be returned to insurers on a pro rata basis.

§ 6530.6

- The Board may:
 - Exercise powers granted to insurers under the laws of Oklahoma,
 - Sue or be sued,
 - Levy interim assessments against insurers and reinsurers,
 - Request the Commissioner to check the reports, records, books and papers of the Insurance Department to determine the financial condition of an insurer for purposes of determining if the Board should defer the assessment of that insurer.

§ 6530.7

- Each insurer and reinsurer shall be assessed by the Board according to such methodology, at such time, and for such amount as the Board finds necessary.
 - “Insurer” means any individual, corporation, association, partnership, fraternal benefit society or any other entity engaged in the health insurance business, except insurance agents and brokers. Also includes not-for-profit hospital service and medical indemnity plans, health maintenance organizations, preferred provider organizations, prepaid health plans, the State and Education Employees Group Health Insurance Plan, stop-loss insurance plans, and any reinsurer reinsuring health insurance in this state.
 - "Reinsurer" means any insurer from whom any insurer providing health insurance to Oklahomans procures insurance for itself with respect to all or part of the health insurance risk of the person
- Each insurer’s or reinsurer’s proportion of participation in the Program shall be determined annually by the Board based on annual statements and other reports deemed necessary by the Board and filed with it by the insurer.
- An insurer or reinsurer may not take a credit on its premium tax return for assessments paid, but may factor the assessment into its claims cost calculation for premiums charged, and the rates shall not be deemed excessive for including such calculation.

§ 6530.8

- The Board may abate or defer, in whole or in part, the assessment of any insurer or reinsurer if determined by the Commissioner and the Board, payment of the assessment would place the insurer or reinsurer at an action control level as defined in 36 O.S. § 1522(11)(a), (b), (c), or (d), or prevent the insurer or reinsurer from fulfilling its contractual obligations.
- If an assessment is abated or deferred, the amount by which such assessment is abated or deferred may be assessed against the other insurers or reinsurers, and the insurer or reinsurer receiving the abatement or deferment shall remain liable to the Program for the deficiency for four (4) years.

§ 6530.9

- If an insurer, insurance agent, insurance broker or third-party administrator refers an individual employee to the Program, or arranges for an individual employee to apply for the Program, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment, it is an unfair practice under 36 O.S. § 1201-1220.

§6530.10

- The Oklahoma Secretary of Health and Human Services may apply to the U.S. HHS Secretary for a 1332 State Innovation Waiver for the 2018 plan year. The Secretary may

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implement a state plan meeting the waiver requirements in a manner consistent with state and federal law and as approved by the U.S. HHS Secretary.

HB 2236 - Employer Insured Health Benefit Plan Information

Effective November 1, 2017

36 O.S. § 4512

- Makes the section applicable to insured employer health benefit plans for employers with twenty (20) or more full-time or full-time-equivalent employees.
 - Previous law was fifty (50) or more.
 - If the carrier requires the employer to submit any changes to the benefit plan prior to the anniversary or annual renewal date, the carrier shall provide the information required by this section no later than sixty (60) days before the date the employer is required to submit any changes.
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HB 1819 - Coverage for Prescription Eye Drops

Effective November 1, 2017

36 O.S. § 6060.9d

- A health benefit plan providing coverage for prescription eye drops shall not deny coverage for a refill of a prescription if:
 - For a 30 day supply, the amount of time has passed after which a patient should have used 70% of the dosage units of the drug according to a practitioner's instructions, or 21 days from:
 - the original date the prescription was distributed to the insured, or
 - the date the most recent refill was distributed to the insured;
 - The prescribing practitioner indicates on the original prescription that additional quantities are needed;
 - The refill requested by the insured does not exceed the number of additional quantities needed; and
 - The prescription eye drops prescribed by the practitioner are a covered benefit under the policy or contract to the insured.
 - "Health benefit plan" means any plan or arrangement as defined in 36 O.S. § 6060.4(C).
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HB 1824 - Prescription Drug Refill Synchronization

Effective November 1, 2017

36 O.S. § 3634.5

- A health benefit plan that provides benefits for prescription drugs shall provide for synchronization of prescription drug refills on at least one occasion per insured per year, provided all of the following conditions are met:
 - The prescription drugs are covered by the plan's clinical coverage policy or have been approved by a formulary exceptions process,
 - The drugs are maintenance medications as defined by the plan and have all available refill quantities at the time of synchronization,
 - The medications are not Schedule II, III, or IV controlled substances,
 - The insured meets all utilization management criteria to the drugs at the time of synchronization,

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- The drugs are of a formulation that can be safely split into short-fill periods to achieve synchronization,
 - The drugs do not have special handling or sourcing needs as determined by the plan, contract, or agreement that require a single, designated pharmacy to fill or refill the prescription, and
 - The covered person agrees to synchronization.
 - When necessary to permit synchronization, the plan shall apply a prorated daily cost-sharing rate to any medication dispensed by a network pharmacy pursuant to this section. No dispensing fees shall be prorated, and all dispensing fees shall be based on the number of prescriptions filled or refilled.
 - “Synchronization” means the coordination of medication refills for a patient taking two or more medications for one or more chronic conditions such that the patient’s medications are refilled on the same schedule for a given time period.
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SB 726 – Telemedicine

Effective November 1, 2017

59 O.S. § 478

- Sets out definitions of terms used in the act: “store and forward technologies” & “telemedicine”

§ 478.1

- Unless otherwise prohibited by law, a valid physician-patient relationship may be established by an allopathic or osteopathic physician with a patient located in Oklahoma through telemedicine, provided that the physician:
 - Holds a license to practice medicine in Oklahoma;
 - Confirms with the patient the patient’s identity and physical location; and
 - Provides the patient with the treating physician’s identity and professional credentials.
 - Telemedicine and store and forward technology encounters shall comply with HIPAA and ensure that all patient communications and records are secure and confidential.
 - Telemedicine encounters and encounters involving store and forward technologies in Oklahoma shall not be used to establish a valid physician-patient relationship for the purpose of prescribing opiates, synthetic opiates, semisynthetic opiates, benzodiazepine or carisprodol, but may be used to prescribe opioid antagonists or partial agonists pursuant to 63 O.S. §§ 1-2506.1 & 1-2506.2.
 - A physician-patient relationship shall not be created solely based on the receipt of patient health information by a physician. The duties and obligations created by a physician-patient relationship shall not apply until the physician affirmatively:
 - Undertakes to diagnose and treat the patient; or
 - Participates in the diagnosis and treatment of the patient.
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PROPERTY & CASUALTY

HB 1720 – Discounts and Rate Reductions for FORTIFIED Homes

Effective November 1, 2017 | Provisions applicable after April 1, 2018

36 O.S. § 961

- Beginning on April 1, 2018, insurers are required to provide a premium discount or rate reduction to any owner who builds or locates a new insurable property in Oklahoma constructed in accordance with either:
 - Appendix Y of the 2015 Oklahoma Uniform Building Code (the city of Moore building code), as long as its standards are equal to or greater than the FORTIFIED Home High Wind and Hail standards as certified by the Institute for Business and Home Safety (IBHS), or
 - The FORTIFIED Home High Wind and Hail Standards adopted by IBHS.
- The discount or rate reduction shall only be required if the insurer determines the discount or rate reduction is actuarially justified and there is sufficient and credible evidence of costs savings which can be attributed to the construction standards set forth in the new law.
- Insurers may also offer additional adjustments in deductible, other risk differentials, or a combination thereof.
- If built to Appendix Y, the home must be certified as conforming to the code after inspection by a certified or licensed building inspector.
- If built to the IBHS FORTIFIED Home Standards, the home must be evaluated and certified by an evaluator certified pursuant to the FORTIFIED Home High Wind and Hail Standards.
- The owner of the property must maintain sufficient certification and construction records, including certification of compliance with one of the building standards, receipts from contractors, receipts for materials, and records for local building officials, which shall be subject to audit by the Insurance Commissioner, and shall be presented to the insurer or potential insurer of the property before the discount, rate reduction, or other adjustment becomes effective.
- Insurers writing policies subject to these requirements must submit rates and rating plans certified by their actuary as actuarially justified providing the discount or rate reductions described in this law. Only applies to policies providing wind or hail coverage and only to that portion of the premium for wind or hail coverage.
- If an insurer already offers an actuarially justified hail resistance discount, that hail-related discount shall be deemed as having met the requirements of this act as it pertains to hail-related discounts or rate reductions and no additional hail-related discount or rate reduction shall be required.
- If an insurer already offers an actuarially justified discount for IBHS FORTIFIED Home standards, that discount shall be deemed as having met the requirements of this act as it pertains to wind-related discounts or rate reductions and no additional wind-related discount or rate reduction shall be required.
- At the time of a policy renewal for which a premium discount, rate reduction, or other adjustment has previously been made, the insurer may request documentation or recertification that the FORTIFIED standards continue to be met.

36 O.S. § 962

- Beginning on April 1, 2018, insurers are required to provide a premium discount or rate reduction to any owner who retrofits his or her insurable property in Oklahoma in accordance with the FORTIFIED Home High Wind and Hail Standards adopted by IBHS. Wind-Zone-3-HUD-Code manufactured homes installed on a permanent

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foundation and retrofitted to the FORTIFIED Home High Wind and Hail standards shall be eligible for the discount or rate reduction.

- The discount or rate reduction shall only be required if the insurer determines the discount or rate reduction is actuarially justified and there is sufficient and credible evidence of costs savings which can be attributed to the construction standards set forth in the new law.
- Insurers may also offer additional adjustments in deductible, other risk differentials, or a combination thereof.
- To be eligible for the discount, rate reduction, or other adjustment, the home must be evaluated and certified by an evaluator certified pursuant to the FORTIFIED Home High Wind and Hail Standards.
- The owner of the property must maintain sufficient certification and construction records, including certification of compliance with the IBHS FORTIFIED Home High Wind and Hail standards, receipts from contractors, and receipts for materials, which shall be subject to audit by the Insurance Commissioner, and shall be presented to the insurer or potential insurer of the property before the discount, rate reduction, or other adjustment becomes effective.
- Insurers writing policies subject to these requirements must submit rates and rating plans certified by their actuary as actuarially justified providing the discount or rate reductions described in this law. Only applies to policies providing wind or hail coverage and only to that portion of the premium for wind or hail coverage.
- If an insurer already offers an actuarially justified hail resistance discount, that hail-related discount shall be deemed as having met the requirements of this act as it pertains to hail-related discounts or rate reductions and no additional hail-related discount or rate reduction shall be required.
- If an insurer already offers an actuarially justified discount for IBHS FORTIFIED Home standards, that discount shall be deemed as having met the requirements of this act as it pertains to wind-related discounts or rate reductions and no additional wind-related discount or rate reduction shall be required.
- At the time of a policy renewal for which a premium discount, rate reduction, or other adjustment has previously been made, the insurer may request documentation or recertification that the FORTIFIED standards continue to be met.

36 O.S. § 963

- “Insurable property” includes single-family residential property, as well as modular homes satisfying the codes, standards, or techniques set out in the act. Manufactured home or mobile homes are excluded, except as expressly provided.

36 O.S. § 964

- The act only applies to new insurance policies written, or existing policies renewed, on or after April 1, 2018.

36 O.S. § 965

- The Commissioner shall promulgate rules as are necessary to implement and administer the act.
 - The Commissioner may not suggest, set, or otherwise impose any standard discount amount, target, or benchmark.
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SB 495 – Rural Fire Department Subscription Dues Verification

Effective November 1, 2017

36 O.S. § 4809

- If a property and casualty insurance company provides a fire run service benefit payment within the fire insurance policy, **the company and its agents are exempt** from subsections a and c of § 4809, which prohibit companies and agents from writing a fire policy on any risk located in a rural fire protection district or in any area protected by a rural fire department at a special or reduced rate or with any rate credit based on the location of the risk in a district or area without first obtaining evidence that current dues or subscription payments have been made.
- If the agent or company remains required to obtain evidence of such payment (does not provide a fire run service benefit payment within the fire policy), they are required to obtain such evidence when initially writing the policy and once annually thereafter.
 - Previous law required evidence to be obtained at initial writing and upon any “rewrite” of the policy.

SB 631 – Transportation Network Company Insurance Requirements

Effective November 1, 2017

47 O.S. § 1025

- In order to trigger the legal requirement that a TNC driver, or the TNC on the driver’s behalf, must maintain primary auto insurance coverage, the driver must not only be logged on to the TNC’s digital network he or she must also be **available to receive transportation requests**. The requirement is also triggered if the driver is engaged in providing a prearranged ride (no change).

REGULATORY COMPLIANCE / INSURER OPERATIONS

SB 372 – Policy Document Electronic Delivery

Effective November 1, 2017

36 O.S. § 123

- Any notice or document required under law in an insurance transaction, or that is evidence of insurance coverage, may be delivered, stored, and presented by electronic means, so long as it meets the requirement of the Uniform Electronic Transactions Act (12A O.S. §§ 15-101 through 15-121).
- Electronic delivery is considered equivalent to any delivery method required under law, including first class mail; first class mail, postage prepaid; certified mail; certificate of mail; or certificate of mailing.
- “Delivered by electronic means” includes:
 - delivery to an e-mail address at which a party has consented to receive notices or documents, or
 - posting on an electronic network or site accessible via the Internet, mobile application, computer, mobile device, tablet or any other electronic device, together with separate notice of the posting which shall be provided by e-mail to the address at which the party has consented to receive notice, or by any other delivery method that has been consented to by the party.
- A notice or document may be delivered by electronic means by an insurer to a party if:

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- The party has affirmatively consented to that method of delivery and has not withdrawn the consent; or
- The party, before giving consent, is provided with a clear and conspicuous statement informing the party of:
 - o the right of the party to withdraw consent to have a notice or document delivered by electronic means, at any time, and any conditions or consequences imposed in the event consent is withdrawn,
 - o the types of notices and documents to which the party's consent would apply,
 - o the right of a party to have a notice or document delivered in paper form, and
 - o the procedures a party must follow to withdraw consent to have a notice or document delivered by electronic means and to update the party's electronic mail address;
- The party:
 - o before giving consent, is provided with a statement of the hardware and software requirements for access to and retention of a notice or document delivered by electronic means, and
 - o consents electronically, or confirms consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means as to which the party has given consent;
- The insurer takes measures reasonably calculated to ensure that delivery by electronic means results in receipt of the notice or document by the party; and
- After consent of the party is given, the insurer, in the event a change in the hardware or software requirements needed to access or retain a notice or document delivered by electronic means creates a material risk that the party will not be able to access or retain a subsequent notice or document to which the consent applies:
 - o provides the party with a statement that describes:
 - the revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means, and
 - the right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed at the time of initial consent, and
 - o complies with 36 O.S. § 123(D)(2).
- Requirements related to the timing or content of a notice or documents are unchanged.
- If a law requires verification or acknowledgement of receipt of the notice or document, it may be delivered by electronic means only if the method used provides for verification of acknowledgement of receipt.
- The legal effectiveness, validity, or enforceability of any contract or policy of insurance executed by a party may not be denied solely because of the failure to obtain electronic consent or confirmation of consent of the party in accordance with 36 O.S. § 123(D)(3)(b).
- A withdrawal of consent by a party does not affect the legal effectiveness, validity or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective.
- A withdrawal of consent by a party is effective within a reasonable period of time after receipt of the withdrawal by the insurer.
- Failure by an insurer to comply with 36 O.S. § 123(D)(5) & (j) may be treated, at the election of the party, as a withdrawal of consent.

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- This section does not apply to a notice or document delivered by an insurer in an electronic form before the effective date of this act to a party who, before that date, has consented to receive notice or document in an electronic form otherwise allowed by law.
- If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before the effective date of this act, and an insurer intends to deliver additional notices or documents to such party in an electronic form, then prior to delivering such additional notices or documents electronically, the insurer shall:
 - Provide the party with a statement that describes:
 - the notices or documents that shall be delivered by electronic means that were not previously delivered electronically, and
 - the party’s right to withdraw consent to have notices or documents delivered by electronic means, without the imposition of any condition or consequence that was not disclosed at the time of initial consent; and
 - Comply with 36 O.S. § 123(D)(2).
- An insurer shall deliver a notice or document by any other delivery method permitted by law other than electronic means if:
 - The insurer attempts to deliver the notice or document by electronic means and has a reasonable basis for believing that the notice or document has not been received by the party; or
 - The insurer becomes aware that the electronic mail address provided by the party is no longer valid.
- A producer shall not be subject to civil liability for any harm or injury that occurs as a result of a party’s election to receive any notice or document by electronic means or by an insurer’s failure to deliver a notice or document by electronic means.
- This section may not be construed to modify, limit or supersede the provisions of the federal Electronic Signatures in Global and National Commerce Act, Public Law 106-229, as amended.

SB 438 - City/Town Surplus Lines Tax Exemption

Effective November 1, 2017

36 O.S. § 1115

- Policies sold to any city or town in this state, incorporated pursuant to law, shall be exempt from the surplus lines premium tax.

HB 2234 - NAIC Model Holding Company Act

Effective May 31, 2017

The 2010 revisions to the National Association of Insurance Commissioners Model Holding Company Act #440 equipped regulators with additional tools to evaluate risks to an insurance company within the insurance holding company system. The revisions provided for improvements to the insurance regulators access to books and records; required production of additional information related to the holding company; amplified corporate governance and the responsibilities of the Board of Directors and Senior Management; broadened requirements to include financial statements of all affiliates in the Insurance Holding Company System Annual Registration Statement (Form B); and requirements to identify and report enterprise risks through an enterprise risk report (Form F). Some of the many changes have already been incorporated into Oklahoma law since 2010. Instead of Oklahoma continuing a “piecemeal” legislative approach to meet the required accreditation standards, it was determined that a

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better solution would be to fully repeal the existing Holding Company Act and enact the full current version of NAIC Model Holding Company Act. **Changes from Oklahoma's previous Holding Company Act are below.**

36 O.S. § 1631 – Definitions (formerly § 1651)

- (4) Adds definition of “group-wide supervisor” – NAIC is focused on continuing to improve its group supervision framework; the group-wide supervisor is the regulator authorized to conduct and coordinate group-wide supervision activities.
- (7) Adds definition of “internationally active insurance group” (IAIG) – the NAIC’s international involvement has been increasingly focused on strengthening the supervision of insurers that operate in multiple countries, or IAIGs.

§ 1632 – Subsidiaries of Insurers (formerly § 1652)

- (B)(1) Provides additional investment authority by clarifying in detail how insurers can invest in subsidiaries.
- (C) Exemption from Investment Restrictions – other restrictions on investments in Title 36 do not affect the provisions on investments in subsidiaries.
- (D) Qualification in Investment – clarifies that investments are qualified before the investment is made.
- (E) Cessation of Control – if insurer ceases control of subsidiary, it must dispose of investment within 3 years.

§ 1633 – Acquisition of Control of or Merger with Domestic Insurer (formerly § 1653)

- (A)(2) Adds requirement that controlling person of domestic insurer seeking to divest control of insurer must file a confidential notice of the proposed divestiture with the Commissioner and the insurer at least 30 days prior to cessation of control. The information is confidential until the conclusion of the transaction unless the Commissioner determines that confidential treatment will interfere with the enforcement of this section.
- (A)(3) Adds requirement that acquiring person must also file preacquisition notification with the Commissioner.
- (B)(3) Requires fully audited financial information; removes ability to waive audit requirement.
- (B)(9) Adds requirement for description of recommendations to purchase any security referred to in subsection A to filing statement.
- (B)(11) Requires terms of a broker/dealer agreement to be included in filing statement.
- (B)(12) Requires person filing statement to provide annual report as long as control exists.
- (B)(13) Requires person filing statement to provide information to the Commissioner upon request to evaluate enterprise risk to the insurer.
- (D)(2) Increases time for Commissioner to make decision on acquisition hearing from 30 to 60 days; allows discovery pursuant to § 317.
- (D)(3) Adds provision for consolidated hearings if more than one state commissioner’s approval is required; also allows commissioners to opt out by providing 10 day notice.

§ 1634 – Acquisitions Involving Insurers Not Otherwise Covered (NEW)

- (A) Definitions: “acquisition” & “involved insurer”
- (B)(1) Applies this section to any acquisition in which there is a change in control of insurer authorized in Oklahoma.
- (B)(2) Provides exemptions:
 - A purchase of securities solely for investment purposes so long as the securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in Oklahoma,

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- The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if the proper preacquisition notification is filed with the Commissioner,
- The acquisition of already affiliated persons,
- An acquisition if, as an immediate result of the acquisition,
 - In no market would the combined market share of the involved insurers exceed 5% of the total market,
 - There would be no increase in any market share, or
 - In no market would:
 - The combined market share of the involved insurers exceed 12% of the total market, and
 - The market share increase by more than 2% of the total market.
 - “market” defined based on direct written premium for a line of business.
- An acquisition for which a preacquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business, and
- An acquisition of an insurer whose domiciliary commissioner affirmatively finds that the insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving the insurer’s condition through the acquisition exceed the public benefits that would arise from not lessening competition; and the findings are communicated by the domiciliary commissioner to the Commissioner of Oklahoma.
- (C) Pre-acquisition notification requirements:
 - (1) Shall be in a form and contain such information as prescribed by the NAIC. Commissioner may require additional material as necessary to determine whether the acquisition would violate the competitive standard set out in subsection D. May include an opinion of an economist as to the competitive impact of the acquisition.
 - (2) The waiting period required shall begin on the date of receipt of the notification and end on the earlier of the 30th days after receipt or termination of the waiting period by the Commissioner. Commissioner may require additional information relevant to the proposed acquisition, which would trigger a new waiting period.
- (D)(1) Provides for Commissioner to enter order if there is substantial evidence that acquisition may lessen competition or tend to create a monopoly.
- (D)(2) Sets out details for how Commissioner determines acquisition would violate competitive standard of paragraph 1.
- (E)(1) If an acquisition violates the competitive standards, the Commissioner may enter an order requiring an involved insurer to cease and desist from doing business in Oklahoma with respect to the line or lines of business involved in the violation or may deny the application of an acquired or acquiring insurer for a license to do business in Oklahoma. The order can only come after a hearing with proper notice, and the hearing is conducted and the order issued within 60 days after the date of the filing of the preacquisition notification. The order must contain findings of fact and conclusions of law. The order shall not apply if the acquisition is not consummated.
- (E)(2) Any person who violates a cease and desist order of the Commissioner may be subject to a fine of not more than \$10,000 for every day of violation or suspension or revocation of the person’s license.

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- (E)(3) Any insurer or other person who fails to make any filing required by this section, and who also fails to demonstrate a good-faith effort to comply with any filing requirement, shall be subject to a fine of not more than \$50,000.

§ 1635 – *Registration of Insurers (formerly § 1654)*

- (A)(3) Requires all insurers to report dividends and other distributions to shareholders within two days of declaration.
- (B)(5) If requested by Commissioner, insurer must submit financial statements of affiliates.

§ 1636 – *Standards and Management of an Insurer Within Holding Company System (formerly § 1655)*

- (A)(1)(b) Agreements for cost sharing services and management must include provisions required by Commissioner per regulation.
- (A)(2)(a)(2) Requires notice of affiliate agreements for life insurers when sales, purchases, exchanges, loans or investments are three percent (3%) of admitted assets.
- (A)(2)(c) Requires notice of reinsurance agreements in which the reinsurance premium or change in insurer's liabilities in any of the next three (3) years equals or exceeds five percent (5%) of insurer's surplus as regards policyholders.
- (B)(2) How to determine if a dividend or distribution is extraordinary for insurers other than life insurers.
- (C)(1) Management of domestic insurers subject to registration.

36 O.S. § 1637 – *Examination (formerly § 1656)*

- (B)(2) The Commissioner may order any insurer to produce info not in possession of the insurer if the insurer can gain access to such info; if the insurer cannot, Commissioner needs detailed explanation. Insurer subject to penalty.

36 O.S. § 1638 – *Supervisory Colleges (formerly § 1656.1) (No Changes)*

36 O.S. § 1639 – *Group-Wide Supervision of Internationally Active Insurance Groups (NEW)*

- (A) Authorizes Commissioner to act as group-wide supervisor for any IAIG. Commissioner may acknowledge another regulatory official as group-wide supervisor where the IAIG:
 - Does not have substantial insurance operations in the U.S.,
 - Has substantial insurance operations in the U.S., but not in Oklahoma, or
 - Has substantial insurance operations in the U.S. and in Oklahoma, but the Commissioner has determined that the other regulatory official is the appropriate group-wide supervisor. An insurance holding company system that does not otherwise qualify as an IAIG may request that the Commissioner make a determination or acknowledgement as to a group-wide supervisor.
- (B) Factors that Commissioner may consider when making this determination:
 - The place of domicile of the insurers within the IAIG that hold the largest share of the group's direct written premiums, assets, or liabilities,
 - The place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the IAIG,
 - The location of the executive officers or largest operational offices of the IAIG,
 - Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the Commissioner determines to be:
 - Substantially similar to the system of regulation provided under the laws of Oklahoma, or
 - Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials, and

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- Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the Commissioner with reasonably reciprocal recognition and cooperation.
- (C) In the event of a material change in the IAIG that results in the IAIG’s insurers domiciled in Oklahoma holding the largest share of the group’s premiums, assets or liabilities, or Oklahoma being the place of domicile of the top-tiered insurer or insurers in the holding company system of the IAIG, the Commissioner shall make a determination or acknowledgement as to the appropriate group-wide supervisor.
- (D) Commissioner is authorized to collect from any insurer all information to determine if Commissioner may act as group-wide supervisor or if Commissioner may acknowledge another regulator as the group-wide supervisor.
- (E) If Commissioner is the group-wide supervisor, he or she may:
 - Asses the enterprise risks within the IAIG to ensure that:
 - The material financial condition and liquidity risks to the members of the IAIG that are engaged in the business of insurance are identified by management, and
 - Reasonable and effective mitigation measured are in place;
 - Request from any member of an IAIG subject the Commissioner’s supervision, information necessary and appropriate to assess enterprise risk, including but not limited to, information about the members of the IAIG regarding:
 - Governance, risk assessment, and management,
 - Capital adequacy, and
 - Material intercompany transactions;
 - Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the IAIG are domiciled, compel development and implementation of reasonable measures designed to ensure that the IAIG is able to timely recognize and mitigate enterprise risks to members of such IAIG that are engaged in the business of insurance;
 - Communicate with other state, federal, and international regulatory agencies for members within the IAIG and share relevant information subject to the confidentiality provisions of § 1640, through supervisory colleges as set forth in § 1638;
 - Enter into agreements with or obtain documentation from any insurer registered under § 1635, any member of the IAIG, and any other state, federal, and international regulatory agencies for members of the IAIG, providing the basis for or otherwise clarifying the Commissioner’s role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in Oklahoma is doing business in Oklahoma or is otherwise subject to jurisdiction in Oklahoma; and
 - Other group-wide supervision activities, consistent with the authorities and purposes enumerated above, as considered necessary by the Commissioner.
- (F) If the Commissioner acknowledges another regulator from a jurisdiction not accredited by the NAIC as the group-wide supervisor, the Commissioner may reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:
 - The Commissioner’s cooperation is in compliance with the laws of Oklahoma, and

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- The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the Commissioner’s activities as a group-wide supervisor for other IAIG’s where applicable.
- (G) Commissioner authorized to enter into agreements with or obtain documentation from any insurer registered under § 1635, any affiliate of the insurer, and other state, federal, and international regulatory agencies for members of the IAIG, that provide the basis for or otherwise clarify a regulatory official’s role as group-wide supervisor.
- (H) Commissioner may promulgate rules.
- (I) A registered insurer subject to this section shall be liable for and pay the reasonable expenses of the Commissioner’s participation in the administration of this section, including the engagement of attorneys, actuaries, and any other professionals, and all reasonable travel expenses.

36 O.S. § 1640 – Confidential Treatment (formerly § 1657.1) (No Changes)

36 O.S. § 1641 – Rules, Regulations, & Orders (NEW)

- The Commissioner may issue such rules, regulations, and orders as necessary to carry out the provisions of the act after notice and opportunity for hearing.

36 O.S. § 1642 – Injunctions, Prohibitions Against Voting Securities (formerly § 1658.1) (No Changes)

36 O.S. § 1643 – Sanctions (formerly § 1658.2)

- (A) Increases amount of daily penalty for failing to register from \$200/day to \$500/day.
- (B) Increases civil forfeiture for not reporting transactions or investment from \$5,000 to \$25,000 per violation.
- (D) Increases maximum penalty for willful violation from \$50,000 to \$100,000.
- (F) If insurer violates acquisition statute, the violation may serve as an independent basis for disapproving dividends and for placing insurer in supervision.

36 O.S. § 1644 – Receivership (formerly 1659.1) (No Changes)

36 O.S. § 1645 – Recovery (formerly 1659.2) (No Changes)

36 O.S. § 1646 – Revocation (NEW)

- The Commissioner may suspend, revoke, or refuse to renew an insurer’s license or authority to do business if any person has committed a violation of this act.

36 O.S. § 1647 – Judicial Review (NEW)

- Person aggrieved by act of the Commissioner may appeal to District court of Oklahoma County. Filing of appeal shall stay the application of Commissioner’s order. Any person aggrieved by Commissioner’s failure to act may petition court for writ of mandamus.

HB 1833 – Fire Marshall Premium Tax Allocation

Effective July 1, 2017

68 O.S. § 50001

- C. All monies annually collected pursuant to the provisions of this section shall be apportioned as follows:
 - 1. For FY18, the first \$1,600,000 shall be deposited in the State Fire Marshal Revolving Fund; provided, that 10% of the first \$1,600,000 shall be paid into the General Revenue Fund of Oklahoma;
 - 2. For FY19, and for every subsequent FY thereafter, the first \$2,000,000 shall be deposited in the Fire Marshal Fund; provided, that 10% of the first \$2,000,000 shall be paid into the General Revenue Fund of Oklahoma; and

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- 3. Any remaining monies not apportioned pursuant to paragraphs 1 and 2 shall be deposited into the General Revenue Fund of Oklahoma.
 - This is an already-existing premium tax in the amount of 5/16 of 1% of the gross premiums from the following lines of insurance: fire, allied, homeowners multiperil, commercial multiperil, growing crops, ocean marine, inland marine, auto physical damage (including collision), and aircraft physical damage.
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UNINSURED MOTORISTS

SB 115 – Online Insurance Verification System Transfer

Effective November 1, 2017

47 O.S. § 7-600.2

- Transfers the Oklahoma Compulsory Insurance Verification System from the Department of Public Safety to the Oklahoma Insurance Department.
- Adds District Attorneys as authorized users of the system.
- Adds license plate number as an input for querying information from the system.
- Allows the Commissioner to initiate an administrative proceeding against any insurance company found by the Commissioner to not be in compliance with the provisions of this section or any rules promulgated pursuant to this section.

47 O.S. § 7-602

- Current law allows tag agents to obtain proof of insurance coverage in the form of the owner's current security verification if the online verification system is not online or the information is otherwise not available.
 - New law requires tag agents to allow submission of proof of insurance coverage from a licensed insurance producer or customer service representative via electronic mail at no additional cost to the person registering the vehicle.
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TITLE INSURANCE

HB 2303 – Prompt Title Insurance Schedule Delivery

Effective November 1, 2017

36 O.S. § 5001

- If the current owner or the owner's authorized agent requests, in writing, a copy of any previously issued owner's policy, the licensed title producer or the underwriting title insurance company that issued the policy shall provide the requesting party with a copy of the schedules in the previously issued policy without delay.
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SERVICE WARRANTIES

SB 427 & SB 102 – Filing Exemption, Form Filing, Misrepresentation

Effective November 1, 2017

15 O.S. §§ 141.2, 141.4, 141.6, & 141.14

- Changes “service contract” terminology to “service warranty”

§ 141.7

- Current law requires any entity claiming exemption from the definition of “service warranty” to file with the Commissioner audited financial statements to verify that the contracts are not within the definition of a service warranty.
- This new law clarifies that if the entity is claiming that the contract is either a service contract with no indemnification provisions (15 O.S. § 141.2(17)(a)), or the contracts are issued solely by the manufacturer, distributor, importer, or seller of the product whereby that entity has insurance in place covering 100% of the claims exposure (§ 141.2(17)(b)), the entity does not have to file the audited financial statements.

§ 131.13

- Changes service warranty filing requirements from “file and use” to filed for informational purposes only.
- Gives the Commissioner the authority to immediately order a service warranty association to stop using any service warranty contract if the Commissioner determines the form violates the Service Warranty Act, is misleading in any respect, or is reproduced so that any material provision is substantially illegible.
- Clarifies that for service warranties issued on and after July 1, 2017, the identity of the service warranty association and its license number may be added at the time of sale, so long as a “Jane Doe” specimen is filed with the Commissioner illustrating how the service warranty will look after printing.
- Changes “service contract” terminology to “service warranty”

§ 141.8

- Requires each service warranty association to simply maintain a registry of the name and business address of each sales representative utilized by it in Oklahoma, rather than providing such list to the Commissioner. The Commissioner may request and must receive the registry with 10 days notice, the service warranty association or insurer must provide it to the Commissioner.

§ 141.26

- Adds the following to the list of actions considered misrepresentation and false advertising of service warranties → Knowingly making, issuing, circulating, or causing to be made, issued, or circulated, and estimate, illustration, circular, statement, sales presentation, omission, or comparison which:
 - Is false, deceptive, or misleading with respect to:
 - The service warranty association’s affiliation with a motor vehicle manufacturer,
 - The service warranty association’s possession of information regarding a motor vehicle owner’s current motor vehicle manufacturer’s original equipment warranty,
 - The expiration of a motor vehicle owner’s current motor vehicle manufacturer’s original equipment warranty, or
 - A requirement that a motor vehicle owner register for a new service warranty with such provider in order to maintain coverage under the

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motor vehicle owner's current service warranty or manufacturer's original equipment warranty.

BAIL BONDSMEN

SB 525 – Insurance Department Omnibus Request

Effective November 1, 2017

59 O.S. § 1305

- A bail bondsman license applicant must submit 2 complete sets of fingerprints (previous law: 1 set). And must submit 1 photograph (previous law: 2 photographs).

§ 1308

- Bail bondsman applications are valid for 3 months after submission (previous law: 6 months).

§ 1315

- No person shall be permitted to maintain an office for the conducting of bail bond business where persons disqualified pursuant to § 1315(A)(1) are present, except as necessary for such persons to obtain a personal bail bond.
- The marriage or cohabitation of a bail bond licensee or license applicant with a person disqualified pursuant to § 1315(A)(1) does not, as a matter of fact, constitute the receipt of benefits from the execution of a bail bond. In such circumstances, the receipt of benefits from the execution of a bail bond shall be subject to a factual determination by the Commissioner.

§ 1320

- If a bail bondsman changes his or her residence or business address, he or she must notify the court clerk of the county in which the bondsman has registered his or her license in writing within 5 business days.
- Law enforcement shall post the list of bondsmen permitted to write bail in that county conspicuously near all telephones used by prisoners (previous law: must provide list to any incarcerated individual upon request).
- The list must be updated and distributed to law enforcement by the court clerk at least monthly, provided there has been a change to the list.

§ 1332

- New instances in which a bail bond will be exonerated by operation of law:
 - The warrant issued by the court has not been entered into an active warrant database available to law enforcement within 5 business days after its issued date, or
 - The defendant has been arrested on new charges in the same jurisdiction in which the bondsman or insurer has posted the appearance bond or bonds for the defendant, and the defendant has been subsequently released on his or her own personal recognizance.
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MISCELLANEOUS LEGISLATION

SB 673 - Terminology Clean Up

Effective November 1, 2017

74 O.S. § 18b

- The Attorney General of Oklahoma is authorized to represent and protect the collective interests of insurance consumers of Oklahoma in rate-related proceedings before the Insurance Commissioner (previous law listed the Property and Casualty Rate Board, which no longer exists).
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RULES

ALL RULE CHANGES ARE EFFECTIVE SEPTEMBER 15, 2017

Chapter 1 – Administrative Operations

Subchapter 9. Description of Forms and Instructions

365:1-19-18. Bail bond forms

- Updates language based on statutory changes referring to surety companies, professional bondsmen, and multicounty agent bondsmen all as “insurers.”

Chapter 10 – Life, Accident and Health

Subchapter 1. General Provisions

Part 1. General Provisions

365:10-1-17. Life, accident, and health form filings

- Clarifies that an endorsement which eliminates or restricts coverage and which is issued during the policy term shall be identified as accepted by the *policyholder*, by the signature of the *policyholder* thereon (previous rule language required acceptance and signature by the “insured”).
- Evidence of policyholder acceptance is not required if the change effected by the endorsement is mandated by applicable law.

Subchapter 5. Minimum Standards; Contract Guidelines

Part 13. Medicare Supplement Insurance Minimum Standards

365:10-5-129. Open enrollment

- Premium rates charged to disabled persons for Medicare supplement plans made available to all applicants who qualify by reason of disability may not exceed the lowest available aged premium rate for such plan.

Chapter 25 – Other Licensees

Subchapter 5. Bail Bondsmen

Part 1. Continuing Education for Bail Bondsmen

365:25-5-3. Education requirements

- A bail bondsman license applicant must pass the examination and apply within 1 year after the date of his or her prelicensing education.

365:25-5-4. Application for course approval

- Removes the temporal and dollar requirements for fees for course approval and links the requirements back to the statute (59 O.S. § 1308.1).

365:25-5-8. Extensions of time

- The Commissioner may extend by up to 12 months the amount of time during which the applicant must complete the application process (previous rule language was 6 months).

Part 5. General Provisions Pertaining to Bail Bondsmen

365:25-5-49. Property bondsman requirements

- In order to calculate the market value of property pursuant to 59 O.S. § 1324, an applicant that applies for the property line of authority shall submit to the Commissioner for approval the following documents for each property used to post bonds:
 - A certified copy of the Warranty Deed;
 - An attorney’s Title Opinion, which shall be prepared within the previous 60 days prior to application;

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- A written statement from the county assessor stating the property’s assessed value and showing the legal description of said property; and
- A written statement from any lien holder stating the current payoff amount on each lien. If there are no liens on the property, an applicant shall submit an Affidavit stating there are no liens.

Subchapter 7. Companies

Part 11. Credit for Reinsurance

Part 11 is extensively amended to bring Oklahoma’s credit for reinsurance rules in line with the most recent version of the NAIC’s Credit for Reinsurance Model Regulation #786. This follows the passage of SB 1488 in 2016, which enacted the most recent version of the NAIC’s Credit for Reinsurance Model Law #785. The information below is intended to **summarize the major changes** in the amended rules.

365:25-7-65. Credit for reinsurance – Reinsurers maintaining trust funds

- (b)(2): If an assuming insurer has permanently discontinued underwriting new business secured by a trust for at least 3 years, the commissioner with regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, subject to certain requirements.
- (f)(9)(A): In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and obligation to immediately draw down the full amount of the LOC and hold the proceeds in trust for the beneficiaries of the trust if the LOC will otherwise expire without being renewed or replaced.
- (f)(9)(B): The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the LOC in circumstances where such draw would be required shall be deemed to be negligence and/or willful misconduct.

365:25-7-70. Reinsurance contract

- (1): The agreement must contain a proper insolvency clause, which states that reinsurance is payable directly to the liquidator or successor without diminution regardless of the status of the ceding company.
- (2): The agreement must include a proper reinsurance intermediary clause, if applicable, which stipulates that the credit risk for the intermediary is carried by the assuming insurer.

365:25-7-72. Letters of credit qualified under 365:25-7-67

- (a): If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator or liquidator) (*previous rule language*: If delinquency proceedings have been filed, then the beneficiary shall be deemed to be the Commissioner as Receiver or Conservator).
- (e) & (f): The LOC shall state whether it is subject to and governed by the laws of Oklahoma or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98) (*previous rule language*: Publication 500).

365:25-7-73. Credit for reinsurance – certified reinsurers (NEW)

- (a) The Commissioner shall allow credit for reinsurance ceded to a “certified” reinsurer. The amount of security required shall correspond with the following requirements:
 - (1) Based on the rating of the assuming insurer assigned by the Commissioner:
 - (A) Secure – 1: 0% security required
 - (B) Secure – 2: 10%

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- (C) Secure - 3: 20%
 - (D) Secure - 4: 50%
 - (E) Secure - 5: 75%
 - (F) Vulnerable - 6: 100%
- (2) Affiliated reinsurance transactions may receive the same opportunity for reduced security requirements as all other reinsurance transactions.
 - (3) If a ceding insurer is placed in rehabilitation, liquidation, or conservatorship, it must post 100% security.
 - (4) A certified reinsurance shall not be required to post security for catastrophe recoverable for 1 year from the date of the first instance of a liability reserve entry by the ceding insurer as a result of a loss from a catastrophic occurrence. The deferral only applies to reinsurance recoverable related to the following lines: fire, allied lines, farmowners multiple peril, homeowners multiple peril, commercial multiple peril, inland marine, earthquake, and auto physical damage.
 - (5) This section only applies to reinsurance contracts entered into on or after the effective date of the certification of the assuming insurer. Prior contracts amended after certification or new contracts covering any risk for which collateral was provided previously, shall only be subject to this section with respect to losses incurred and reserves reported from and after the effective date of the amendment or new contract.
 - (6) Parties to a reinsurance agreement may agree to higher security requirements than those established in this section.
- (b) Procedure for certification of a reinsurer:
- (1) Commissioner shall post on the Department's website notice of receipt of an application.
 - (2) Commissioner shall submit written notice to an assuming insurer that has been approved, which shall include the insurer's assigned rating. Commissioner shall publish a list of all certified reinsurers and their ratings.
 - (3) Certified reinsurer eligibility requirements:
 - (A) Domiciled and licensed in a Qualified Jurisdiction,
 - (B) Maintain capital and surplus, or its equivalent, of no less than \$250,000,000 (may be satisfied by an association of underwriters with capital and surplus equivalents of \$250,000,000 and a central fund containing at least \$250,000,000),
 - (C) Maintain financial strength ratings from 2 or more rating agencies. Acceptable rating agencies: Standard and Poor's, Moody's, Fitch, A.M. Best, or any other nationally recognized statistical rating organization.
 - (D) Comply with any other requirements reasonably imposed by the Commissioner.
 - (4) Rated on the legal entity basis, with due consideration being given to the group rating where appropriate, except that an association of underwriters may be evaluated on the basis of its group rating. Factors to consider:
 - (A) Strength rating from an acceptable rating agency. Commissioner shall use the lowest rating received in establishing the maximum rating. Failure to obtain at least 2 ratings will result in loss of eligibility for certification. Maximum rating will correspond to the rating as follows:
 - (i) Secure - 1 rating:
 - (I) A.M. Best = A++
 - (II) Standard & Poor's = AAA
 - (III) Moody's = Aaa

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- (IV) Fitch = AAA
- (ii) Secure - 2 rating:
 - (I) A.M. Best = A+
 - (II) Standard & Poor's = AA+, AA, or AA-
 - (III) Moody's = Aa1, Aa2, or Aa3
 - (IV) Fitch = AA+, AA, or AA-
- (iii) Secure - 3 rating:
 - (I) A.M. Best = A
 - (II) Standard & Poor's = A+ or A
 - (III) Moody's = A1 or A2
 - (IV) Fitch = A+ or A
- (iv) Secure - 4 rating:
 - (I) A.M. Best = A-
 - (II) Standard & Poor's = A-
 - (III) Moody's = A3
 - (IV) Fitch = A-
- (v) Secure - 5 rating:
 - (I) A.M. Best = B++ or B+
 - (II) Standard & Poor's = BBB+, BBB, or BBB-
 - (III) Moody's = Baa1, Baa2, or Baa3
 - (IV) Fitch = BBB+, BBB, or BBB-
- (vi) Vulnerable - 6 rating:
 - (I) A.M. Best = B, B-, C++, C+, C, C-, D, E, or F
 - (II) Standard & Poor's = BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, or R
 - (III) Moody's = Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, or C
 - (IV) Fitch = BB+, BB, BB-, B+, B, B-, CCC+, CC, CCC-, or DD;
- (B) Business practices in dealing with ceding insurers, including its record of compliance with reinsurance contractual terms and obligations;
- (C) For certified reinsurers domiciled in the U.S., a review of the most recent applicable Schedule F or Schedule S;
- (D) For certified reinsurers not domiciled in the U.S., a review annually of Form CR-F (Appendix DD) or Form CR-S (Appendix EE);
- (E) The reputation of the reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurer's Schedule F reporting overdue reinsurance recoverables;
- (F) Regulatory actions against the certified reinsurer;
- (G) Report of the independent auditor on the financial statements of the insurance enterprise;
- (H) For certified reinsurers not domiciled in the U.S., audited financial statements, regulatory filings, and actuarial opinion.
- (I) The liquidation priority of obligations to a ceding insurer in the certified reinsurer's domiciliary jurisdiction in the context of an insolvency proceeding;
- (J) A certified reinsurer's participation in any solvent scheme of arrangement, or similar procedure, which involves U.S. ceding insurers. The Commissioner shall receive prior notice from a certified reinsurer that proposes participation by the certified reinsurer in a solvent scheme of arrangement; and
- (K) Any other information deemed relevant by the Commissioner.

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- (5) Commissioner may make adjustments in the security requirement for an insurer based on the reinsurer's reputation for prompt payment of claims. Shall increase security by one rating level if:
 - (A) More than 15% of the reinsurer's ceding insurance clients have overdue reinsurance recoverable on paid losses of 90 days or more which are not in dispute and which exceed \$100,000 for each cedent; or
 - (B) The aggregate amount of reinsurance recoverable on paid losses which are not in dispute that are overdue by 90 days or more exceeds \$50,000,000.
- (6) Assuming insurer must submit Form CR-1 (Appendix CC) as evidence of its submission to jurisdiction of Oklahoma, appoint Commissioner as agent for service of process, and agree to post 100% security if it resists a final U.S. judgment. Commission shall not certify an assuming insurer from a jurisdiction that does not adequately and promptly enforce final U.S. judgments or arbitration awards.
- (7) Certified reinsurer must agree to meet applicable filing requirements. All information filed which is not otherwise public information shall be exempted from disclosure under the Oklahoma open Records Act. Form filing requirements are:
 - (A) Notification within 10 days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license, or any change in rating, including a statement describing such changes and the reasons therefore;
 - (B) Annually, Form CR-F (Appendix DD) or CR-S (Appendix EE), as applicable;
 - (C) Annually, the report of the independent auditor on the financial statements of the insurance enterprise;
 - (D) Annually, audited financial statements, regulatory filings, and actuarial opinion;
 - (E) At least annually, an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers;
 - (F) A certification from the certified reinsurer's domestic regulator that the certified reinsurer is in good standing and maintains capital in excess of the jurisdiction's highest regulatory action level; and
 - (G) Any other information that the Commissioner may reasonably require.
- (8) If a certified reinsurer has a change in rating:
 - (A) If downgraded, Commissioner shall upon written notice assign a new rating.
 - (B) Commissioner may suspend, revoke, or otherwise modify a certified reinsurer's certification at any time in certain circumstances.
 - (C) If the rating of a certified reinsurer is upgraded by the Commissioner → new security requirement applicable prospectively; required to post security under previous requirement as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the Commissioner → must meet the new security requirement for all business it has assumed as a certified reinsurer.
 - (D) If certification revoked → assuming insurer required to post security in accordance with 365:25-7-67 in order for the ceding insurer to continue to take credit for reinsurance. If funds continue to be held in trust in

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accordance with 365:25-7-65, the Commissioner may allow additional credit equal to the ceding insurer's *pro rata* share of such funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer's rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer may not be denied credit for reinsurance for a period of 3 months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the Commissioner to be at high risk of uncollectibility.

- (c) Procedure for determining Qualified Jurisdictions:
- (1) Commissioner shall publish notice and evidence of recognition of a jurisdiction as qualified. May establish a procedure to withdraw recognition.
 - (2) Considerations: evaluation of the reinsurance supervisory system of the jurisdiction; consideration of the rights, benefits, and the extent of reciprocal recognition afforded by the jurisdiction to U.S reinsurers. Commissioner shall create and publish a list of jurisdictions whose reinsurers may be approved. A Qualified Jurisdiction shall agree to share information and cooperate with the Commissioner. Additional factors:
 - (A) The framework under which the assuming insurer is regulated.
 - (B) The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and financial surveillance.
 - (C) The substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction.
 - (D) The form and substance of financial reports required to be filed or made publicly available by reinsurers in the domiciliary jurisdiction and the accounting principles used.
 - (E) The domiciliary regulator's willingness to cooperate with U.S. regulators in general and the Commissioner in particular.
 - (F) The history of performance by assuming insurers in the domiciliary jurisdiction.
 - (G) Any documented evidence of substantial problems with the enforcement of final U.S. judgments in the domiciliary jurisdiction. If it does not adequately and promptly enforce final U.S. judgments or arbitration awards, the jurisdiction will not be considered.
 - (H) Any relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the IAIS or a successor organization.
 - (I) Any other matters deemed relevant by the Commissioner.
 - (3) Commissioner shall consider list of Qualified Jurisdictions published by the NAIC. If the Commissioner approves a jurisdiction not listed by the NAIC, he or she must provide thoroughly documented justification.
- (d) Commissioner may recognize a reinsurer's certification in another NAIC accredited jurisdiction according to the following:
- (1) May defer to that jurisdiction's certification, and the ratings assigned by that jurisdiction, if the insurer submits Form CR-1 (Appendix CC) and other information the Commissioner requires.
 - (2) Any change in the reinsurer's status or rating in that jurisdiction will apply automatically in Oklahoma. Notice required of any change within 10 days.
 - (3) Commissioner may withdraw recognition of other jurisdiction's assigned rating at any time.

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- (4) Commissioner may withdraw recognition of other jurisdiction's certification at any time, upon written notice. If Commissioner does not suspend or revoke the certification, reinsurer shall remain in good standing in Oklahoma for 3 months during consideration of the reinsurer's certification application.
- (e) Reinsurance contracts must include proper funding clause, which requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid a financial statement penalty on the ceding insurer.
- (f) Commissioner shall comply with all reporting and notification requirements that may be established by the NAIC.

Part 15 Company Supervision (NEW)

365:25-7-80. Purpose

- This Part specifies the confidential status and handling of certain information contained in the files of the Commissioner pursuant various provisions of Title 36.

365:25-7-81. Definitions

- "Confidential information" means all documents, materials, or other information in the possession or control of the Department pursuant to the Holding Company Act, and investigatory files, working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the Commissioner or any other person during an exam, or in the course of analysis by the Commissioner of the financial condition or market conduct of any person or company.
- "Exchange" means sending or receiving information to or from any other regulator.
- "Supervisory" means those duties of the Commissioner involving the financial condition and solvency of those engaged in the business of insurance.

365:25-7-82. Authorization

- (a) The Commissioner is authorized to enter into agreements with other regulators.
- (b) Commissioner has legal authority and power to obtain, hold, and exchange certain confidential information when:
 - (1) The Commissioner considers the information to be necessary for the supervision of insurance entities or groups, or when another regulator considers the information to be necessary, and
 - (2) Another regulator requests the Commissioner provide relevant information.
- (c) Information necessary for supervision may include:
 - (1) Information on the management and operational systems and controls operated by insurers;
 - (2) Financial data relating to an insurer and its affiliates;
 - (3) Information concerning individuals holding positions of responsibility in insurers;
 - (4) Information concerning individuals or insurers involved, or suspected of being involved, in criminal activities;
 - (5) Information arising from or developed as part of regulatory investigations and reviews, and on any restrictions imposed on the business activities of insurers;
 - (6) Information requested and gathered from a supervised entity;
 - (7) Information reported within groups to meet group supervisory requirements;
 - (8) Information on a supervised entity and affiliates including, but not limited to, branches, subsidiaries, and non-regulated holding companies; and
 - (9) Information on prospective and actual insurer transactions and prospective and actual transactions of policyholders.

365:25-7-83. Professional confidentiality

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- (a) The Commissioner and staff, or anyone acting on their behalf, are required, as a condition of employment or contract, to protect confidential information in their possession. Wrongful disclosure is grounds for termination of employment or termination of contract. Any person failing to maintain confidentiality shall be guilty of a misdemeanor pursuant to 36 O.S. § 117.
- (b) Commissioner shall deny any request for confidential information, other than when required by law or appropriately requested by another regulator.
- (c) Any exchange with another regulator shall serve no purpose other than those directly related to the fulfillment of a supervisory function.
- (d) Commissioner has a legitimate interest and a valid purpose related to the fulfillment of supervisory functions in seeking information from another regulator.
- (e) Valid purposes:
 - (1) Licensing;
 - (2) Competence, experience, and integrity criteria;
 - (3) Ongoing supervision, including enforcement action and sanctions;
 - (4) Supervisory practices;
 - (5) Winding-up, liquidation, or bankruptcy;
 - (6) Anti-money laundering or combating the financing of terrorism (“AML/CFT”).
- (f) All Department personnel and contractors are bound to a duty of professional confidentiality.
- (g) The “obligation of professional confidentiality” means that confidential information received by the Department shall not be divulged to any personal or authority whatsoever, except as provided by law.
- (h) The professional confidentiality requirements apply to any person currently or previously employed or acting on behalf of the Commissioner or Department.
- (i) Confidential information originating from another regulator must remain subject to equivalent confidentiality protections provided by this Part. Before passing on confidential information to another regulator, the Commissioner must ascertain that the person receiving the information is bound by professional confidentiality rules or laws substantially similar and equivalent to subsection 36 O.S. § 1657.1(A) [changed to § 1640 by HB 2234] and who have agreed in writing not to disclose such information.

365:25-7-84. Passing on of confidential information

- (a) Any passing on of confidential information necessitates prior explicit agreement of the regulator from whom the information originates and must be subject to agreement, in particular regarding the purpose for which the information shall be used.
- (b) Requests from other regulators for passing on of confidential information shall be decided on a case-by-case basis by the Commissioner.
- (c) The Commissioner may pass on information where is will assist:
 - (1) Other regulators in the fulfillment of their supervisory functions, and
 - (2) Governmental agencies competent in the financial services field, law enforcement agencies, and relevant courts in the performance of their duties.

365:25-7-85. Agreements for information exchange

- (a) Agreements may be used to establish a framework between regulators to facilitate the efficient execution of requests for or provision of information.
- (b) Compliance with the strict confidentiality regime, set forth in 36 O.S. § 1657.1 (now § 1640] and this Part, is a key prerequisite for the exchange of confidential information. Every agreement to exchange such information shall include a written confirmation statement in substantially the same terms as that found in the Written Confirmation Statement (Appendix BB of this Chapter), and the agreement shall be signed by an appropriate managerial representative of the regulator.

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365:25-7-86. Supervisory Colleges

- (a) Information exchange is important to supervisory colleges.
- (b) Appropriate information exchange agreements must be in place.
- (c) There shall be a formal mechanism in place with other regulators in a supervisory college to ensure the protection of confidential information.
- (d) The Commissioner shall inform other regulators in advance of taking any action that might reasonably be considered to affect group entities in that regulator's jurisdiction.
- (e) Commissioner shall proactively exchange material and relevant information with other regulators. Relevant proactively provided information:
 - (1) Any information the Commissioner considers will facilitate the effective supervision of groups or entities in the group;
 - (2) Any event or events that may have a significant bearing on the operations of group entities operating in the jurisdictions of other regulators;
 - (3) Information that may affect the financial system of another jurisdiction;
 - (4) Information that may affect the financial condition or other interests of the policyholders of a group entity in another jurisdiction; and
 - (5) Prior notification to another regulator which relies on information received from that regulator, subject to requirements applicable to criminal statutes and other similar laws.
- (f) In deciding whether and to what extent to fulfill a request by another regulator, Commissioner may take into account:
 - (1) Whether it would be contrary to the essential interest of Oklahoma;
 - (2) The existence of a requisite written agreement between the Commissioner and the requesting regulator to maintain the confidentiality of any information exchanged;
 - (3) The nature of the information to be exchanged;
 - (4) The use to which the information will be put.
- (g) Requests for information shall be made in writing.
- (h) When exchanging relevant information and in responding to requests from regulators seeking information, the Commissioner shall respond in a timely and comprehensive manner. Strict reciprocity not required. Originating regulator may attach conditions to the subsequent exchange of the information. Conditions imposed by the originating regulator should not prevent the receiving regulator from being able to use the information for its own purposes
- (i) Before exchanging confidential information, the Commissioner shall ensure that the party receiving the information is bound by confidentiality requirements.
- (j) The Commissioner shall generally permit the information that he or she exchanges with another regulator to be passed on to other relevant regulators, provided the necessary confidentiality requirements are in place.
- (k) When Commissioner receives confidential information from another regulator, the information shall only be used for the purposes specified when the info was requested. Before using such information for another purpose, including exchanging it with other parties, Commissioner shall obtain the agreement of the originating regulator.
- (l) If the Commissioner is legally compelled to disclose confidential information received from another regulator, he or she shall promptly notify the originating regulator, indicating what information he or she is being compelled to release and the circumstances surrounding the release. Where consent to passing this information on is not given, the Commissioner shall use all reasonable means to resist the demand and to protect the confidentiality of the information.

Appendix BB. Written Confirmation Statement (NEW)

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Appendix CC. Certificate of Certified Reinsurer (NEW)

Appendix DD. Annual Reinsurance Review – Property & Casualty Insurers (Form CR-F) (NEW)

Appendix EE. Annual Reinsurance Review – Life & Health Insurers (Form CR-S) (NEW)

Appendix FF. Small Employer Stop Loss Disclosure (NEW)

Chapter 40 – Health Maintenance Organizations (HMO)

Subchapter 5. Life, Accident, & Health Division and Consumer Assistance and Claims Division Rules

Part 13. Termination of Members, Providers and Continuation of Benefits

365:40-5-74. Certification of creditable coverage [REVOKED]

- This rule is revoked because the requirement to issue certification of creditable coverage is no longer necessary because of the “guaranteed issue” requirements found in federal law.