



OKLAHOMA
INSURANCE
DEPARTMENT

2019 STATUTE & RULE CHANGES



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Omnibus Request

SB 1010

Effective November 1, 2019

Timing and method of responses to the Commissioner – 36 O.S. § 1250.4(B)

- Reduces the amount of time a licensee is allowed to respond to an inquiry from the Commissioner from 30 days to 20 calendar days.
- Allows an extension of up to 7 additional days for good cause shown at the discretion of the Commissioner.
- Requires inquiries and responses to be delivered electronically.

Clarification of required addresses on a license – 36 O.S. § 1435.8(E)

- Sets out that a producer's license shall contain his or her physical residential address, physical business address, and preferred mailing address.

New grounds for administrative action against a producer – 36 O.S. § 1435.13(A)(15) and (16)

- Failing to respond to an inquiry from the Commissioner as required by § 1250.4.
- Any cause for which an original issuance of a license could have been refused.

Delivery of physical license to the Commissioner – 36 O.S. § 1435.13(J)

- Previous law required any resident producer who ceases to maintain his or her residency in Oklahoma to submit their license to the Commissioner within 10 days after terminating residency.
- This requirement is repealed – Producers no longer receive physical licenses from the Department but instead get a printable electronic copy.

When a producer appointment must be filed – 36 O.S. § 1435.15

- Clarifies that a producer appointment must be filed by an insurer within 15 days from the date the agent contract is executed.
- Previous law allowed the appointment to be filed either within 15 days after the contract's execution OR within 15 days after the first insurance application is submitted. The latter option is deleted.

Reporting of administrative or criminal actions against a licensee – 36 O.S. § 1435.18

- A producer is required to report any administrative actions taken against them in this state or any other within 30 days of final disposition (existing law). This is clarified to apply to individuals with an existing producer license or any individual applying for a producer license.
- A producer is required to report any criminal prosecution of them in any jurisdiction within 30 days of the initial pretrial hearing date (existing law). This is clarified to apply to individuals with an existing producer license or any individual applying for or seeking a renewal of a producer license.
- Failure to meet these requirements shall result in immediate suspension of a license or an application for or renewal of a license.
- These requirements apply to all surplus lines brokers, all producers, and all adjusters.

Reporting of administrative/criminal actions against a third party administrator

36 O.S. § 1450(F)

- A TPA must report any administrative or criminal action taken against them in this state or any other within 30 days of final disposition. The report shall include a copy of the order, consent to order, copy of any payment required as a result of the action, or other relevant legal documents.

Viatical settlement brokers and providers evidence of financial responsibility

36 O.S. § 4055.3(F)(4)

- Viatical settlement brokers and providers must provide evidence of financial responsibility through a surety bond executed and issued by an insurer authorized to issue surety bonds in this state, a policy of errors and omissions insurance, or a deposit of cash, certificates of deposit or securities or any combination thereof in the amount of \$50,000.
 - > Previous law allowed for evidence “up to” \$50,000.

Licensing exemption for nonresident adjusters – 36 O.S. § 6203(8)

- Previous law allowed nonresident adjusters who are licensed in another state to adjust claims in Oklahoma without a license if they did so no more than once per year on a single loss or losses arising out of an occurrence common to all such losses. The language allowing for adjusting multiple losses arising out of a single occurrence has been deleted. A nonresident adjuster without an Oklahoma license may now only adjust a single loss in Oklahoma.

Adjuster notification to the Commissioner – 36 O.S. § 6206

- Sets out that an adjuster, in addition to any change in legal name, shall notify the Commissioner within 30 days of any change to his or her preferred mailing address, physical business address, e-mail address, or physical residential address.

Cause for administrative action against an adjuster – 36 O.S. § 6220(A)(12)

- The Commissioner may censure, suspend, revoke, or refuse to issue or renew an adjuster’s license for improperly using notes or any other reference material to complete an examination for an insurance license.

Acting as an adjuster without a license – 36 O.S. § 6220(F)

- The prohibition on acting as an adjuster without a license shall apply regardless of whether the person, firm, association, company or corporation has obtained power of attorney from an insurance claimant or has entered into any other agreement with an insurance claimant to act on the behalf of the claimant.

Providing adjuster and claim-related services on a single claim – 36 O.S. § 6220.1(D)

- The prohibition on providing both adjuster services and other claim-related services on a single claim shall apply regardless of whether the person firm, association, company, or corporation has obtained power of attorney from an insurance claimant or has entered into any other agreement with an insurance claimant to act on the behalf of the claimant.

Home service contract filing – 36 O.S. § 6754(A)

- Each service contract provider shall, upon initial registration and at renewal of its registration, file a copy of each of its current contracts, issued in this state, for informational purposes. The provider shall update a filing any time a change is made to the service contract that materially affects the rights or obligations of a contract holder or upon written request by the Department.

Life & Health

HB 1157

Methods of Payment from Insurers to Providers
Effective November 1, 2019

36 O.S. § 1219.6

- Prohibits health insurers and health maintenance organizations from requiring that providers receive payments only by credit card.
- Also directs that in the case of payment by electronic funds transfer, the insurer will notify the provider of any fees associated with the payment method and advise the provider of available payment methods.
- Does not allow a contract to waive the provisions of the act.
- A health insurance plan, health insurer, or its contracted vendor or health maintenance organization that initiates or changes payments to a provider through the Automated Clearing House (ACH) Network may not charge a fee solely to transmit the payment to a provider unless the provider has consented to the fee.
- A provider agent may charge reasonable fees when transmitting an ACH Network payment related to transaction management, data management, portal services, and other value-added services in addition to the bank transmittal.

HB 2632

Pharmacy Benefits Managers
Effective November 1, 2019

36 O.S. §§ 6958-68

- Requires pharmacy benefits managers (PBMs) to comply with the following retail pharmacy network access standards, which will be reviewed and approved by the Insurance Department:
 - > At least 90% of covered individuals residing in an urban service area live within 2 miles of a retail pharmacy participating in the PBM's retail pharmacy network;
 - > At least 90% of covered individuals residing in an urban service area live within 5 miles of a retail pharmacy designated as a preferred participating pharmacy in the PBM's retail pharmacy network;
 - > At least 90% of covered individuals residing in a suburban service area live within 5 miles of a retail pharmacy participating in the PBM's retail pharmacy network;
 - > At least 90% of covered individuals residing in a suburban service area live within 7 miles of a retail pharmacy designated as a preferred participating pharmacy in the PBM's retail pharmacy network;
 - > At least 70% of covered individuals residing in a rural service area live within 15 miles of a retail pharmacy participating in the PBM's retail pharmacy network; and
 - > At least 70% of covered individuals residing in a rural service area live within 18 miles of a retail pharmacy designated as a preferred participating pharmacy in the PBM's retail pharmacy network.
- Mail-order pharmacies cannot be used to meet access standards for retail pharmacy networks.

- PBMs cannot:
 - > Require patients to use pharmacies that are directly or indirectly owned by the PBM, including all regular prescriptions, refills, or specialty drugs regardless of day supply;
 - > In any manner on any material, including but not limited to mail and ID cards, include the name of any pharmacy, hospital, or other providers unless the PBM specifically lists all pharmacies, hospitals, and providers participating in the preferred and nonpreferred pharmacy and health networks;
 - > Cause or knowingly permit the use of advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading;
 - > Charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including without limitation a fee for:
 - o the submission of a claim,
 - o enrollment or participation in a retail pharmacy network, or
 - o the development or management of claims processing services or claims payment services related to participation in a retail pharmacy network;
 - > Reimburse a pharmacy or pharmacist in the state an amount less than the amount that the PBM reimburses a pharmacy owned by or under common ownership with a PBM for providing the same covered services. The reimbursement amount paid to the pharmacy must be equal to the reimbursement amount calculated on a per-unit basis using the same generic product identifier or generic code number paid to the PBM-owned or PBM-affiliated pharmacy;
 - > Deny a pharmacy the opportunity to participate in any pharmacy network at preferred participation status if the pharmacy is willing to accept the terms and conditions that the PBM has established for other pharmacies as a condition of preferred network participation status;
 - > Deny, limit, or terminate a pharmacy's contract based on employment status of any employee who has an active license to dispense, despite probation status, with the State Board of Pharmacy;
 - > Retroactively deny or reduce reimbursement for a covered service claim after returning a paid claim response as part of the adjudication of the claim, unless:
 - o the original claim was submitted fraudulently, or
 - o to correct errors identified in an audit, so long as the audit was conducted in compliance with §§ 356.2 and 356.3 of Title 59 of the Oklahoma Statutes; or
 - > Fail to make any payment due to a pharmacy or pharmacist for covered services properly rendered in the event a PBM terminates a pharmacy or pharmacist from a PBM network.
- A PBM contract with a pharmacy or pharmacist for participation in the PBM's retail pharmacy network shall:
 - > Not restrict, directly or indirectly, any pharmacy that dispenses a prescription drug from informing, or penalize such pharmacy for informing, an individual of any differential between the individual's out-of-pocket cost or coverage with respect to acquisition of the drug and the amount an individual would pay to purchase the drug directly;
 - > Ensure that any entity that provides PBM services under a contract with any such health plan or health insurance coverage does not, with respect to such plan or coverage, restrict, directly or indirectly, a pharmacy that dispenses a prescription drug from informing, or penalize such pharmacy for informing, a covered individual of any differential between the individual's out-of-pocket cost under the plan or coverage with respect to acquisition of the drug and the amount an individual would pay for acquisition of the drug without using any health plan or health insurance coverage;
 - > Not prohibit, restrict or limit disclosure of information to the Commissioner, law enforcement or state and federal governmental officials investigating or examining a complaint or conducting a review of a PBM's compliance with the act.

- A PBM shall establish and maintain an electronic claim inquiry processing system using the National Council for Prescription Drug Programs' current standards to communicate information to pharmacies submitting claim inquiries.
- Requirements for health insurers and PBMs
 - > A health insurer shall be responsible for monitoring all activities carried out by, or on behalf of, the health insurer under the act, and for ensuring that all requirements of the act are met.
 - > An individual may be notified at the point of sale when the cash price for the purchase of a prescription drug is less than the individual's copayment or coinsurance price for the purchase of the same prescription drug.
 - > A health insurer or PBM shall not restrict an individual's choice of in-network provider for prescription drugs.
 - > An individual's choice of in-network provider may include a retail pharmacy or a mail-order pharmacy. A health insurer or PBM may not restrict such choice. The health insurer or PBM may not require or incentivize using any discounts in cost-sharing or a reduction in copay or the number of copays to individuals to receive prescription drugs from an individual's choice of in-network pharmacy.
 - > A health insurer, pharmacy, or PBM shall adhere to all Oklahoma laws when mailing, shipping, or causing to be mailed or shipped prescription drugs into Oklahoma.
- Requirements for a health insurer's pharmacy and therapeutics committee (P&T committee)
 - > The P&T committee shall establish a formulary, which shall be a list of prescription drugs, both generic and brand name, used by practitioners to identify drugs that offer the greatest overall value.
 - > A health insurer shall prohibit conflicts of interest for members of the P&T committee.
 - o A person may not serve on a P&T committee if the person is currently employed or was employed within the preceding year by a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor.
 - o A health insurer shall require any member of the P&T committee to disclose any compensation or funding from a pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor. Such P&T committee member shall be recused from voting on any product manufactured or sold by such pharmaceutical manufacturer, developer, labeler, wholesaler, or distributor.
- Powers and duties of the Insurance Commissioner
 - > The Commissioner may examine and investigate into the affairs of every PBM engaged in pharmacy benefits management in Oklahoma in order to determine compliance with the act.
 - > All PBM files and records shall be subject to examination by the Commissioner or by duly appointed designees. The Commissioner, authorized employees, and examiners shall have access to any of a PBM's files and records that may relate to a particular complaint under investigation or to an inquiry or examination by the Insurance Department.
 - > Every officer, director, employee, or agent of the PBM, upon receipt of any inquiry from the Commissioner shall, within 30 days from the date the inquiry is sent, furnish the Commissioner with an adequate response to the inquiry.
 - > When making an examination, the Commissioner may retain subject matter experts, attorneys, appraisers, independent actuaries, independent certified public accountants, or an accounting firm or individual holding a permit to practice public accounting, certified financial examiners, or other professionals and specialists as examiners, the cost of which shall be borne by the PBM which is the subject of the examination.
 - > The Commissioner shall provide for the receiving and processing of individual complaints alleging violations of the act.

- Patent's Right to Pharmacy Choice Advisory Committee
 - > The Commissioner shall establish a Patient's Right to Pharmacy Choice Advisory Committee to review complaints, hold hearings, subpoena witnesses and records, initiate prosecution, reprimand, place on probation, suspend, revoke, and/or levy fines not to exceed \$10,000 for each count for which any PBM has violated a provision of the act.
 - > The Advisory Committee may impose as part of any disciplinary action the payment of costs expended by the Department for any legal fees and costs including staff time, salary and travel expense, witness fees, and attorney fees.
 - > The Advisory Committee shall consist of 7 persons appointed for 5 year terms as follows:
 - o Two persons nominated by the Oklahoma Pharmacists Association;
 - o Two consumer members not employed or related to insurance, pharmacy or PBM nominated by the Governor;
 - o Two persons representing the PBM or insurance industry nominated by the Insurance Commissioner; and
 - o One person representing the Attorney General nominated by the Attorney General.
 - > Hearings shall be held in the Commissioner's offices or at such other place as the Commissioner may deem convenient.
 - > The Commissioner shall issue and serve upon the PBM a statement of the charges and a notice of hearing in accordance with the Administrative Procedures Act, 75 O.S. §§ 250–323.
 - > At the time and place fixed for a hearing, the PBM shall have an opportunity to be heard and to show cause why the Commissioner or his or her duly appointed hearing examiner should not revoke or suspend the PBM's license and levy administrative fines for each violation. Upon good cause shown, the Commissioner shall permit any person to intervene, appear and be heard at the hearing by counsel or in person.
 - > All hearings will be public and held in accordance with and governed by the APA.
 - > If the Insurance Commissioner determines, based on an investigation of complaints, that a PBM has engaged in violations of the act with such frequency as to indicate a general business practice and that such PBM should be subjected to closer supervision with respect to such practices, the Commissioner may require the PBM to file a report at such periodic intervals as the Commissioner deems necessary.
- Confidentiality of documents
 - > Documents, materials, reports, complaints or other information in the possession or control of the Department that are obtained by or disclosed to the Commissioner or any other person in the course of an evaluation, examination, investigation, or review made pursuant to the provisions of the act shall be confidential by law and privileged, shall not be subject to open records request, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action if obtained from the Commissioner or any employees or representatives of the Commissioner. This does not prevent the disclosure of a final order issued against a PBM by the Commissioner or his or her duly appointed hearing examiner. Such orders shall be open records.

HB 2424

Multiple Employer Welfare Arrangements (MEWAs)
Effective November 1, 2019

36 O.S. § 634

- Removes the exemption in state law for a MEWA sponsored by a press association.

36 O.S. § 635

- Expands and clarifies the types of associations which may sponsor a MEWA to include those that have a current M-1 Form filed with the U.S. Department of Labor showing Oklahoma as the state of operation and:
 - > Is formed in accordance with the applicable provisions of **29 CFR 2510**, or
 - > Was previously established or is newly formed in accordance with federal regulatory guidance effective prior to August 20, 2018.

36 O.S. § 637

- Removes the ability of the Commissioner to waive the requirements for aggregate stop-loss coverage for a MEWA.
- Requires the accountant preparing a MEWA's audited financial statement to be independent from the MEWA.

36 O.S. § 639

- Allows the chief executive officer of a governing association to verify under oath the financial report submitted by the MEWA to the Department.
- Requires the accountant preparing a MEWA's audited financial statement to be a CPA and independent from the MEWA.
- Requires the actuary preparing the actuarial certification for the MEWA to be independent from the MEWA.

36 O.S. § 640

- Removes language relating to specific actions the Commissioner may order a MEWA to take in order to correct its financial impairment and replaces it with broad language allowing the Commissioner to order the MEWA to take steps as necessary to correct its financial condition.

SB 509

Step Therapy Protocols
Effective November 1, 2019

63 O.S. § 7310 (New Law)

- Requires any health insurance plan (including the state Medicaid program and the state employee health insurance program) that utilizes a step therapy protocol to use recognized, evidence-based, and peer-reviewed clinical practice guidelines when establishing a step therapy protocol.
- When a health insurance plan restricts prescription drug coverage pursuant to a step therapy protocol, the insurer must provide to the provider and patient a clear, convenient, and readily accessible process for a step therapy exception, including making the process to request a exception available on the insurer's website.

- Requires insurers to grant an exception in cases where the justification of the prescribing provider and supporting clinical documentation, if needed, supports the statement of the provider that:
 - > The prescribed drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient;
 - > The drug is expected to be ineffective;
 - > The patient has tried the drug previously and discontinued its use due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
 - > The drug is not in the best interest of the patient, based on medical necessity; or
 - > The patient is stable on another drug selected by their provider.
- Patients may appeal any exception decision.
- Health insurers must respond to requests for exceptions or appeals within 72 hours, unless exigent circumstances exist, in which cases insurers must respond within 24 hours.
- Directs the Oklahoma Insurance Department and Oklahoma Health Care Authority to promulgate rules.

SB 704

Living Organ Donor Insurance Coverage
Effective November 1, 2019

36 O.S. § 6060.30

- Prohibits insurers from refusing to insure, refusing to continue to insure, limiting the amount, extent, or kind of coverage available for, or charging an individual a different rate for the same coverage solely because of his or her status as a living organ donor. Applies to life, disability, or long-term care insurance.
- With respect to all other conditions, persons who are living organ donors shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are persons who are not organ donors.

SB 848

Report on the Effects of Opioid Prescription Limits
Effective May 21, 2019

36 O.S. § 7402 (New Law)

- The Insurance Department shall evaluate the effect of the limits on prescriptions for opioid drugs established in the bill on the claims paid by health insurance carriers and the out-of-pocket costs including copayments, coinsurance, and deductibles paid by individual and group health insurance policyholders.
- Before January 1, 2021, the Insurance Department shall provide a report on the evaluation, along with any recommended policy and regulatory options that will ensure costs for patients are not increased as a result of the new limitations on opioid prescriptions, to the standing committees of the Legislature having jurisdiction over health and human services matters and over insurance and financial services matters.
- The Insurance Commissioner may adopt reasonable rules and regulations for the implementation and administration of these requirements.

SB 943

Association Health Plans
Effective November 1, 2019

36 O.S. § 6512

- The definition of “bona fide association” is deleted.

36 O.S. § 6513

- Existing requirements for Association Health Plans (AHPs) are deleted.

36 O.S. § 6530 (New Law)

- Sets out new requirements for AHPs in Oklahoma to align with existing U.S. Department of Labor (DOL) guidance and recently-issued federal rules.
- A “bona fide association” is defined as one that has a current M-1 Form filed with DOL showing Oklahoma as the state of operation and:
 - > Is formed under a pathway established in [29 CFR 2510](#), or
 - > Was previously formed or is newly formed under federal regulatory guidance effective prior to August 20, 2018.
- “Bona fide association health plan” means a health benefit plan that is sponsored by a bona fide association.
- Exempts health plans issued to a bona fide AHP from the provisions of the Small Employer Health Insurance Reform Act.
- All bona fide AHPs are considered a large group for purposes of the Oklahoma Insurance Code.
- A bona fide AHP must:
 - > Be delivered to a bona fide association in a form that meets the requirements of 36 O.S. § 4502;
 - > Comply with any applicable federal nondiscrimination requirements;
 - > Not exclude any small employer group, with 2 or more eligible employees, that is a member of the association;
 - > Comply with certain retention standards set out in the bill; and
 - > Make the AHP available to be marketed and sold by all licensed agents and brokers of the health carrier, at the health carrier’s standard commission and/or fee schedule.

SB 948

Dental Care Prior Authorization & Autism Coverage
Effective November 1, 2019

36 O.S. § 7303 (New Law)

- Prohibits a dental service contractor from denying a claim if it had previously issued a prior authorization for the service, unless:
 - > Benefit limitations such as annual maximums and frequency limitations not applicable at the time of the prior authorization are reached due to utilization subsequent to issuance of the prior authorization;
 - > The documentation for the claim clearly fails to support the claim as originally authorized;
 - > If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior

- authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care;
- > If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would have, at that time, required disapproval pursuant to the terms and conditions for coverage under the plan of the patient in effect at the time the prior authorization was used; or
 - > The denial of the dental service contractor was due to one of the following:
 - o Another payor is responsible for payment,
 - o The dentist has already been paid for the procedures identified on the claim,
 - o The claim was submitted fraudulently or the prior authorization was based on erroneous information provided to the dental service contractor, or
 - o The patient was not eligible to receive the procedure on the date of service and the dental service contractor did not know, and with the exercise of reasonable care could not have known, of their eligibility status.
 - Prohibits a dental service contractor from requiring the submission of any information for a prior authorization that would not be required for a claim.
 - A dental service contractor must issue a prior authorization within 30 days after the date it is submitted.

36 O.S. § 6060.21

- Expands the coverage for applied behavior analysis to include the services provided by or supervised by a board-certified behavior analyst, a board-certified assistant behavior analyst, or a licensed doctoral-level psychologist.

SB 990

Medicare Supplement Rate Filing and Policyholder Notification
Effective July 1, 2019

36 O.S. § 3611.1(D)

- Requires a premium rate filing for a Medicare supplement policy to be filed with and approved by the Commissioner and communicated to the policyholder on or after September 1 but not later than October 31 each year. The premium increase will be effective January 1 of the following year.

SB 993

Short-Term Limited-Duration Health Insurance
Effective November 1, 2019

36 O.S. § 4419 (New Law)

- Defines “short-term limited-duration insurance” or “STLDI” as individual health insurance with an expiration date less than 12 months after the original effective date and, taking into account renewals or extensions, has a duration of no longer than 36 months in total
- STLDI policies are not subject to the continuation provisions of HIPAA and not subject to the medical loss calculation requirements in place for other individual coverage.
- The benefits for an STLDI policy may be limited as follows:
 - > Not required to contain state-mandated benefits; and
 - > Must contain the definitions of individual A&H with respect to major medical benefits and standard provisions or rights of coverage.
- An applicant for an STLDI policy, in addition to any notice required by federal law or rules, must be provided a written notice that one or more benefits mandated by Oklahoma law is not included in the policy.
 - > The notice must specifically list the essential health benefits that are included in the policy.
 - > The notice must specifically list the accident and health insurance benefits otherwise required by Oklahoma law which are not covered by the policy.
 - > The insurer must retain a signed copy of this notice on file as part of the original application as evidence that the insured has acknowledged the notice.
- An STLDI policy may offer various optional combinations of coverage at additional premiums for each optional benefit offered.
- STLDI policies are subject to the filing requirements of 36 O.S. § 4402.
- An individual insured under an STLDI policy must be issued an ID card which clearly indicates that the STLDI policy is a limited duration policy not subject to Affordable Care Act requirements.

Property & Casualty

SB 886

Self-Service Storage Insurance
Effective November 1, 2019

36 O.S. § 1435.20

- Adds “self-service storage insurance” to the list of categories in which a limited lines insurance producer may receive qualification.

36 O.S. § 1435.20a (New Law)

- Provides definitions.
- Allows an owner of a self-service storage facility to sell, solicit, and offer coverage for self-service storage insurance.
- The owner must hold a limited lines producer license. The owner is not required to hold the license in order to display and make available brochures and other promotional materials created by or on behalf of an authorized insurer or surplus lines insurer. Employees may sell, solicit, and offer the coverage at any location at which the owner who holds the limited lines license conducts business.
- The owner with the limited lines license is exempt from the examination and continuing education requirements in the Insurance Code.
- The owner or supervising entity must maintain a registry of agents of the owner at each facility.
- The books and records of the owner regarding the self-service storage insurance are open to examination by the Insurance Commissioner.
- At every location where self-service storage insurance is offered, brochures or other materials must be made available to prospective purchasers which:
 - > Disclose that the insurance may duplicate existing coverage;
 - > State that the purchase of the insurance is not required in order to lease storage space; and
 - > Provide the identity of the insurer and the owner, the process for filing a claim, and that the insured may cancel the coverage at any time and receive a refund of any applicable unearned premium.
- Prospective purchasers must be provided, prior to the time of sale, a copy of the policy or certificate, as applicable.
- The insurance may be provided under an individual, master, corporate, commercial or group insurance policy.
- Rules, rates, and forms for the insurance are subject to the provisions of 36 O.S. §§ 1201–1219 (unfair and deceptive practices), 309.1–309.7 (examinations), and 1435.26 (unauthorized practices without a license).
- The insurer shall either directly supervise or appoint a supervising entity to oversee compliance. The insurer or supervising entity shall provide a training program for individuals that sell, solicit, or offer self-service storage insurance and shall include basic instruction about the insurance and required disclosures.
- No employee or authorized representative of an owner shall advertise, represent, or otherwise hold himself or herself out as a licensed insurance producer, unless so licensed.

- The premium for the coverage may be billed and collected by the owner. The premium shall be separately itemized on the bill of the occupant. All premiums received by an owner shall be considered funds held by the owner in a fiduciary capacity for the benefit of the insurer. The owner is not required to maintain the funds in a segregated account provided he or she is authorized by the insurer or supervising entity to hold the funds in an alternative manner and to remit the amounts within 60 days of receipt. Owners may receive compensation for billing and collection services.
- A sworn application for a self-service storage insurance limited lines license shall be made to and filed with the Commissioner on forms prescribed and furnished by the Commissioner.
- The application shall provide the name, residence address, principal place of business, facilities covered by the license, authorized representatives, and other information required by the Commissioner for the owner and the licensed producer that is designated by the applicant as the person supervising compliance. The information must be updated within 30 days of any change. The licensed producer that is designated by the applicant does not need to be an owner or be employed by the owner.
- Licenses last for 24 months.
- Each licensed owner must pay a fee as prescribed by the Commissioner.

Regulatory Compliance/ Insurer Operations

HB 1335

Protected Cell Companies Act
Effective November 1, 2019

Enacts the NAIC Protected Cell
Company Model Act # 290

36 O.S. § 1692 (New Law)

- Sets out the purpose of the act
 - > The Protected Cell Companies Act is adopted to provide a basis for the creation of protected cells by a domestic insurer as a means of accessing alternative sources of capital and achieving the benefits of insurance securitization or effectuating insurance business transfers in accordance with the Insurance Business Transfer Act. Investors in fully funded insurance securitization transactions provide funds that are available to pay the insurer's insurance obligations or to repay investors or both. The creation of protected cells is intended to be a means to achieve more efficiencies in conducting insurance securitizations or insurance business transfers.

36 O.S. § 1693 (New Law)

- Provides definitions, the most important of which are:
 - > "Fully funded" means that, with respect to any exposure attributed to a protected cell, the fair value of the protected cell assets, on the date on which the insurance securitization is effected, equals or exceeds the maximum possible exposure attributable to the protected cell with respect to those exposures;

- > “Indemnity trigger” means a transaction term by which relief of the issuer’s obligation to repay investors is triggered by the issuer incurring a specified level of losses under its insurance or reinsurance contracts;
- > “Protected cell” means an identified pool of assets and liabilities of a protected cell company segregated and insulated by means of this act from the remainder of the protected cell company’s assets and liabilities;
- > “Protected cell account” means a specifically identified bank or custodial account established by a protected cell company for the purpose of segregating the protected cell assets of one protected cell from the protected cell assets of other protected cells and from the assets of the protected cell company’s general account;
- > “Protected cell company” means a domestic insurer that has one or more protected cells; and
- > “Protected cell company insurance securitization” means the issuance of debt instruments, the proceeds from which support the exposures attributed to the protected cell, by a protected cell company, where repayment of principal and/or interest to investors pursuant to the transaction terms is contingent upon the occurrence or nonoccurrence of an event with respect to which the protected cell company is exposed to loss under insurance or reinsurance contracts it has issued.

36 O.S. § 1694 (New Law)

- Allows a protected cell company (PCC) to establish one or more protected cells (cells) with the prior written approval of the Commissioner of a plan of operation for each cell.
- Unless otherwise approved by the Commissioner, a PCC may not make an attribution of assets and/or liabilities between the PCC’s general account and one or more of its cells.
- Any attribution of assets and liabilities to a cell, either from the PCC’s general account or from investors in the form of principal on a debt instrument issued by the PCC in connection with a PCC securitization, shall be in cash or readily marketable securities with established market values.
- The creation of a cell does not create a legal person separate from the PCC. Amounts attributed to a cell are owned by the PCC. The PCC may allow for a security interest to attach cell assets or a cell account when in favor of a creditor of the cell.
- PCC’s may engage the services of an investment advisor, commodity trading advisor, or other third party to manage a cell’s assets, provided that payment to the third party is from the cell’s assets and not from the assets of other cells or from the PCC’s general account.
- A PCC shall establish administrative and accounting procedures necessary to properly identify its cells and the assets and liabilities attributed to the cells. PCC directors shall have a duty to:
 - > Keep cell assets and liabilities separate and separately identifiable from the assets and liabilities of the PCC’s general account, and
 - > Keep cell assets and liabilities attributable to one cell separated and separately identifiable from the assets and liabilities attributed to other cells.
- Unless otherwise approved by the Commissioner, a PCC shall, when establishing a cell, attribute to the cell assets at least equal to the reserves and other insurance liabilities attributed to that cell.

36 O.S. § 1695 (New Law)

- Cell assets shall not be charged with liabilities arising out of any other business of the PCC.
- Unless otherwise approved by the Commissioner, cell assets shall be valued at their fair value on the date of valuation.
- Income, gains, and losses from cell assets and liabilities shall be credited to or charged against the cell without regard to other income, gains, or losses of the PCC, including income, gains, or losses of other cells.
- Amounts attributed to a cell and any accumulations are not subject to the investment restrictions otherwise applicable to domestic insurers and may not be taken into account in applying the investment limitations otherwise applicable to the investments of the PCC.
- A PCC may engage in fully funded indemnity triggered insurance securitization to support in full the exposures attributable to a cell. An insurance securitization for a cell which is nonindemnity triggered may only qualify if the Commissioner adopts regulations addressing the methods of funding of the portion of the risk that is no indemnity-based, accounting, disclosure, risk-based capital treatment, and assessing risks associated with those securitizations. A PCC insurance securitization that is not fully funded, whether indemnity triggered or nonindemnity triggered, is prohibited.
- A PCC may only attribute to a cell account the insurance obligations relating to the PCC's general account. A cell may not issue insurance or reinsurance contracts directly to policyholders or reinsureds or have any obligation to the policyholders or reinsureds of the PCC's general account.

36 O.S. § 1696 (New Law)

- Cell assets are only available to the creditors of the PCC that are creditors of the cell and are protected from the creditors of the PCC that are not creditors of the cell. Creditors of a cell are not entitled to have recourse against assets attributed to other cells or assets of the PCC's general account.
- Cell assets are only available to creditors of a PCC after all cell liabilities have been extinguished or provided for under the plan of operation of the cell.
- When an obligation of a PCC to a person arises from a transaction, or is imposed, with respect to a cell:
 - > That obligation of the PCC extends only to, and the person has recourse only to, the assets attributable to that cell; and
 - > That obligation of the PCC does not extend to, and that person is not entitled to have recourse to, the assets attributable to other cells or the assets of the PCC's general account.
- When an obligation of a PCC relates solely to the PCC's general account, the obligation of the PCC shall extend only to, and that creditor shall, with respect to that obligation, be entitled to have recourse only to, the assets of the PCC's general account.
- The activities, assets, and obligations relating to a cell are not subject to the provisions of the Oklahoma Property and Casualty Insurance Guaranty Association Act or the Oklahoma Life and Health Insurance Guaranty Association Act. Neither a cell nor a PCC can be assessed by or be required to contribute to any guaranty fund or guaranty association in Oklahoma with respect to the activities, assets, or obligations of a cell. This does not affect the activities or obligations of the PCC's general account.
- The establishment of one or more cells alone does not constitute and cannot be deemed to be a fraudulent conveyance, an intent by the PCC to defraud creditors, or the carrying out of business by the PCC for any other fraudulent purpose.

36 O.S. § 1697 (New Law)

- If a PCC is placed into supervision, conservation, rehabilitation, or liquidation, the receiver is bound to deal with the PCC's assets and liabilities, including cell assets and liabilities, in accordance with this act.
- Amounts recoverable by the receiver under a PCC insurance securitization shall not be reduced or diminished as the result of the placement of the PCC under supervision, conservation, rehabilitation, or liquidation.

36 O.S. § 1698 (New Law)

- A PCC insurance securitization is not an insurance or reinsurance contract. An investor in a PCC insurance securitization is not, by sole means of the investment, transacting an insurance business. The underwriters or selling agents and their partners, directors, officers, members, managers, employees, agents, representatives, and advisors involved in a PCC insurance securitization are not conducting an insurance or reinsurance agency, brokerage, intermediary, advisory, or consulting business by virtue of their activities in connection with those businesses.

36 O.S. § 1699 (New Law)

- The Commissioner may promulgate rules to implement the act.

HB 1060

Life & Health Guaranty Association Act
Effective November 1, 2019

Enacts updates to the NAIC Life and Health
Guaranty Association Model Act #520

36 O.S. §§ 2022-2028, 2030, 2032, 2036, 2038, & 2043

- Future Class B assessments for long-term care insurance written by an impaired or insolvent insurer will be allocated as follows:
 - > 50% of the assessment to accident and health member insurers, and
 - > 50% to life and annuity member insurers.
- Makes Health Maintenance Organizations (HMOs) members of the guaranty association.

36 O.S. § 6913

- Provisions related to the procedure for handling HMO insolvency are deleted.

36 O.S. §§ 6914, 6921, & 6932 (Repealed)

- Sections related to the procedure for handling HMO insolvency are repealed.

36 O.S. §§ 311A.1-311A.3, 311A.9, 311A.11-311A.12, 311A.14, & 311A.16-311A.18

- Makes the audit committee of a large insurer responsible for overseeing the insurer's internal audit function and granting the person(s) performing the function suitable authority and resources to fulfill their responsibilities.
- Provides a definition of "internal audit function"
 - > A person or persons that provide independent, objective and reasonable assurance designed to add value and improve an organization's operations and accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes

36 O.S. § 311A.14.1 (New Law)

- Exempts an insurer from the requirements of the section if:
 - > The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program less than Five Hundred Million Dollars; or
 - > If the insurer is a member of a group of insurers that has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than One Billion Dollars.
- Requires each insurer or group of insurers to establish an internal audit function to analyze the insurer's governance, risk management, and internal controls. The purpose is to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations.
- The internal audit function must be organizationally independent, meaning, it will not defer ultimate judgment on audit matters to others; and an individual must be appointed to head the internal audit function who will have direct and unrestricted access to the board of directors.
- The head of the internal audit function must report to the audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the internal audit function's independence or effectiveness, material findings from completed audits, and the appropriateness of corrective actions implemented by management as a result of audit findings.
- If an insurer is a member of an insurance holding company system or included in a group of insurers, the insurer may satisfy the internal audit function requirements at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level.
- Upon written request and with good cause shown, the Commissioner may grant an exemption from the internal audit function.

HB 2191

Corporate Governance Annual Disclosure
Effective November 1, 2019

Enacts the NAIC Corporate Governance
Annual Disclosure Model Act #305

36 O.S. § 1534 (New Law)

- The purpose of the act is to:
 - > Provide the Commissioner a summary of an insurer or insurance group's corporate governance structure, policies, and practices to permit the Commissioner to gain and maintain an understanding of the insurer's corporate governance framework;
 - > Outline the requirements for completing a Corporate Governance Annual Disclosure (CGAD) with the Commissioner;
 - > Provide for the confidential treatment of the CGAD and related information that will contain confidential and sensitive information related to an insurer or insurance group's internal operations and proprietary and trade secret information which, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.
- The act does not impose new corporate governance standards or internal procedures beyond those which are required under applicable state corporate law. However, the Commissioner retains examination authority under 36 O.S. §§ 309.1-309.7.
- The act applies to all insurers domiciled in Oklahoma.

36 O.S. § 1535 (New Law)

- Provides definitions, the most important of which is:
 - > "Corporate Governance Annual Disclosure (CGAD)" means a confidential report filed by the insurer or insurance group made in accordance with the requirements of this act.

36 O.S. § 1536 (New Law)

- Each insurer or insurer group must submit the CGAD by June 1 of each year. If submitting as a group, the CGAD must be submitted to the commissioner of the lead state for the group.
- As insurer not required to submit a CGAD must do so if the Commissioner requests it.
- For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level, and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance.
- If an insurer provides information substantially similar to the information required in a CGAD in other documents provided to the Commissioner, it is not be required to duplicate that information in the CGAD but only has to cross-reference the other document.

36 O.S. § 1537 (New Law)

- The insurer or insurance group has discretion over its responses to CGAD inquiries, as long as the CGAD contains the material information necessary to permit the Commissioner to gain an understanding of the insurer's or group's corporate governance structure, policies, and practices. The Commissioner may request additional information deemed material and necessary to provide a clear understanding of the corporate governance policies, the reporting or information system, or controls implementing those policies.
- The CGAD must be prepared consistent with any rules promulgated by the Commissioner. Documentation and supporting information must be maintained and made available upon examination or upon request of the Commissioner.

36 O.S. § 1538 (New Law)

- Documents or information in the possession of the Commissioner or Department pursuant to this act are proprietary and contain trade secrets. All such documents and information are confidential, not subject to the Open Records Act, subpoena, or discovery, and are not admissible in evidence in any private civil action. The Commissioner may use them in furtherance of any regulatory or legal action brought as part of his or her official duties but may not otherwise make them public without the consent of the insurer.
- Neither the Commissioner nor anyone working on his or her behalf may be permitted or required to testify in any private civil action concerning any confidential documents or information subject to this confidentiality.
- The Commissioner may:
 - > Upon request, share such confidential documents or information with other state, federal and international financial regulatory agencies, provided that the recipient agrees in writing to maintain the confidentiality and privileged status and has verified in writing the legal authority to maintain confidentiality; and
 - > Receive such confidential documents, materials, and information from officials of other state, federal and international financial regulatory agencies and shall maintain them as confidential or privileged if received with notice or the understanding that they are confidential or privileged under the laws of their source jurisdiction.
- The sharing of information and documents by the Commissioner shall not constitute a delegation of regulatory authority or rulemaking; and the Commissioner is solely responsible for the administration, execution, and enforcement of the provisions of this act.
- No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade secret materials, or other CGAD-related information shall occur as a result of disclosure or sharing of such CGAD-related information or documents.

36 O.S. § 1539 (New Law)

- The Commissioner may retain, at the insurer's expense, third-party consultants as may be reasonably necessary to assist the Commissioner in reviewing the CGAD and related information or the insurer's compliance with this act.
- Any such persons retained shall be under the direction and control of the Commissioner and act in a purely advisory capacity.
- The NAIC and third-party consultants are subject to the same confidentiality standards and requirements as the Commissioner.
- As part of the retention process, any third-party consultant must verify to the Commissioner, with notice to the insurer, that it is free of a conflict of interest and that it has internal procedures in place to monitor compliance with a conflict and to comply with the confidentiality standards and requirements of this act.
- A written agreement with the NAIC and/or a third-party consultant governing sharing and use of information provided pursuant to this act shall contain the following provisions and expressly require the written consent of the insurer prior to making public information provided under this act:
 - > Specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information;
 - > Procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;
 - > A provision specifying that ownership of the CGAD-related information remains with the Department and the NAIC's or third-party consultant's use of the information is subject to the direction of the Commissioner;

- > A provision that prohibits the NAIC or a third-party consultant from storing the information in a permanent database after the underlying analysis is completed;
- > A provision requiring the NAIC or third-party consultant to provide prompt notice to the Commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information; and
- > A requirement that the NAIC or a third-party consultant consents to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this act.

36 O.S. § 1540 (New Law)

- Any insurer failing, without just cause, to timely file the CGAD shall be required, after notice and hearing, to pay a penalty of \$100 for each day delayed. The maximum penalty is \$10,000.

36 O.S. § 1541 (New Law)

- The Commissioner may promulgate rules to implement the act.

SB 885

IBT Act Clean Up
Effective November 1, 2019

36 O.S. § 1682

- Expands the purpose of the act:
 - > "... to provide options to address the significant limitations in the current methods available to insurers to transfer or assume blocks of insurance business in an efficient and cost-effective manner that provides needed legal finality for such transfers in order to provide for improved operational and capital efficiency for insurance companies, stimulates the economy by attracting segments of the insurance industry to the state, makes Oklahoma an attractive home jurisdiction for insurance companies, encourages economic growth and increased investment in the financial services sector and increases the availability of quality insurance industry jobs in Oklahoma."

36 O.S. § 1683

- Removes the option for Independent Expert (IE) compensation to be on a fixed basis, making an hourly basis the only option.
- Adds "annuity" to the definition of "policy."

36 O.S. § 1686

- Allows the IE report to contain a "listing and summaries of" documents, reports, and other material information the IE considered in preparing the report rather than requiring all such documents, reports, and information to be included in the report.
- Clarifies language related to the assuming insurer being treated as if it were the original insurer of the policies.
- Sets out confidentiality:
 - > "The review of an application for an Insurance Business Transfer, including any documents, materials, communications or other information submitted to the Commissioner in contemplation of such application, or developed by the Commissioner in connection with such application, shall be treated for purposes of confidentiality as an examination of the financial condition and/or market conduct of the transacting companies under Sections 309.1 through 309.7 of this title."

36 O.S. § 1688

- Clarifies that the assuming and transferring insurers are jointly liable for paying the IE and any consultants which are retained by the IE and approved by the Department. Also states that the act does not create any duty for the IE other than to the Department or the Court.

Bail Bondsmen

HB 1107

Travel Expenses & Bond Exonerations
Effective November 1, 2019

59 O.S. § 1327

- Reasonable expenses, for the purposes of how much a bondsman owes for the return of a defendant to custody from another jurisdiction, means “the actual miles traveled in transporting the defendant at a rate equal to the current Internal Revenue Service standard mileage rate.” This does not apply when the defendant is returned via a contracted transport company.
- A bond shall be exonerated by operation of law in any case in which:
 - > The defendant has been arrested on new charges in the same jurisdiction and the defendant has been subsequently released on his or her own personal recognizance, or
 - > The defendant has been arrested and there is an added charge to the case, or an amendment to the charge, that would result in a higher fine or a longer term of sentence if convicted. However, if any premium paid previously to the bondsman or insurer for the original charge must be at the same rate and be credited to the defendant if the same bondsman or insurer posts the bond(s) on the added or amended charge.

HB 1373

Licensing Reform & Previous Convictions
Effective November 1, 2019

59 O.S. § 1305

- An applicant for a bail bondsman license no longer has to show that he or she:
 - > Is “competent, trustworthy, financially responsible, and is of good personal and business reputation and character;” or
 - > Has not been convicted of, or pled guilty or nolo contendere to “a misdemeanor involving moral turpitude or dishonesty.”
- Clarifies that the probation on having a previous felony conviction does not apply to any felony conviction but only one “that substantially relates to the occupation of a bail bondsman and poses a reasonable threat to public safety.”
- Provides definitions:
 - > “Substantially relates” means the nature of criminal conduct for which the person was convicted has a direct bearing on the fitness or ability to perform one or more of the duties or responsibilities necessarily related to the occupation.

- > “Poses a reasonable threat” means the nature of criminal conduct for which the person was convicted involved an act or threat of harm against another and has a bearing on the fitness or ability to serve the public or work with others in the occupation.

59 O.S. § 1310

- A bail bondsman is no longer subject to administrative action for being convicted of, or having entered a plea of guilty or nolo contendere to “a misdemeanor involving moral turpitude or dishonesty.”
- A bail bondsman remains subject to action against his or her license for a felony conviction but only one “that substantially relates to the occupation of a bail bondsman and poses a reasonable threat to public safety;”
- Provides the same definitions as above.

59 O.S. § 4000.1 (New Law)

- At any time, including before obtaining the necessary education or training, a person with a criminal history may request an initial determination regarding whether that history would potentially disqualify them from obtaining a bail bondsman license. The request has to be in writing and include either a copy of the criminal history record with an explanation of each conviction or a statement describing each conviction including the date of each conviction, the court of jurisdiction, and the sentence imposed. The person may include a statement with his or her request describing additional information for consideration including, but not limited to, information about his or her current circumstances, the length of time since conviction, what has changed since the conviction, evidence of rehabilitation, testimonials or personal reference statements, and his or her employment aspirations.
- The Department is required to list with specificity any criminal offense that is a disqualifying offense for a bail bondsman license. Disqualifying offenses must be provided to applicants and others upon request.
- Upon receipt of a written request for consideration of a criminal history record the Department must evaluate the request and make an initial determination based upon the information provided in such request whether the stated conviction is a disqualifying offense. A notice of initial determination must be issued to the petitioner within 60 days from the date the request was received.
- The notice of initial determination must be in writing and mailed to the requestor at the address provided in his or her request and shall contain the following statements:
 - > Whether the person appears eligible for the license at the current time based upon the information submitted by the requestor;
 - > Whether there is a disqualifying offense prohibiting licensure at any time and a statement identifying such offense in the criminal history record or information submitted for consideration;
 - > Any actions the person may take to remedy what appears to be a temporary disqualification, if any;
 - > The earliest date the person may submit another request for consideration, if any; and
 - > A statement that the notice of initial determination is only an initial determination for eligibility for licensure based upon the information provided by the requestor.
- The Department may promulgate forms for requests for initial determinations and may charge a fee not to exceed \$95 for each initial determination.

SB 721

Education for Bail Bondsmen
Effective November 1, 2019

59 O.S. § 1308.1

- Allows entities or persons other than the Oklahoma Bondsman Association to provide pre-licensing education and continuing education for bail bondsmen.

State Government/ OID Operations

HB 2368

Oklahoma Commission on Opioid Abuse
Effective July 1, 2019

74 O.S. §§ 30.1-30.2 (New Law)

- Creates the Oklahoma Commission on Opioid Abuse, on which the Insurance Commissioner, or a designee, will serve as an ex officio member.

HB 2771

State Employee Pay Raises
Effective July 1, 2019

New Law not Codified

- Provides an annualized pay raise for state employees:
 - \$1,500 for individuals with a salary of \$40,000 or less.
 - \$1,250 for individuals with a salary of \$40,001 - \$49,999.
 - \$800 for individuals with a salary of \$50,000 - \$59,999.
 - \$600 for individuals with a salary of \$60,000 or greater.

SB 198

State Employee Social Networking and Social Media Policies
Effective November 1, 2019

74 O.S. § 840-8.1 (New Law)

- Requires all state agencies to adopt a social networking and social media policy that applies to the use of social media by state employees “to discourage abusive or offensive online behavior.”
- Provides definitions.
- On May 3, 2019, Governor Stitt issued [Executive Order 2019-20](#), stating that SB 198 “contains

ambiguities regarding the employees to which it applies and when and where the policy would apply” and ordering all state agencies to make their policy “. . . apply to all state agency employees and limit it only to employee conduct while in their capacity as a state employee, on state time, using state resources.”

SB 240

State Employee Air Travel
Effective November 1, 2019

74 O.S. § 85.45k

- Removes the requirement that state agencies make air travel arrangements through the State Travel Office. Utilization of the State Travel Office for air travel arrangements is now optional.

SB 271

State Agencies and Federal Funds
Effective November 1, 2019

62 O.S. § 34.42.1

- Requires every state agency to make an annual disclosure in a written report on its website of all federal funds under the control of the entity and the programs for which the federal funds are used by distinct expenditure categories.
- Requires the agency to identify the priority or rank of the federal funds in descending order with the funding source the agency relies on to the greatest extent listed first and the funding source the agency relies on to the least extent listed last.
- The information shall include, but not be limited to, a description of:
 - > Any action required to be taken by the agency as a condition for the receipt or continued receipt of federal funds;
 - > Any action prohibited to be taken by the agency as a condition for the receipt or continued receipt of federal funds;
 - > Any action required to be taken by any individual or lawfully recognized business entity or other entity as a condition for the benefits purported to be conferred on the individual or other legal entity as a result of the use of the federal funds; and
 - > Any action prohibited to be taken by any individual or lawfully recognized business entity or other entity as a condition for the benefits purported to be conferred on the individual or other legal entity as a result of the use of the federal funds.
- Requires agencies to make a disclosure, either via a written report, on its website, or both, of the federal funds for which the agency must incur costs to implement and provide such information in descending order with the most costly federal funds listed first and the least costly federal funds listed last.

SB 316

Government Transparency Act of 2019
Effective November 1, 2019

74 O.S. § 3122

- A state agency entering into a Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA) with any agency, department, or any organization receiving appropriated money, grants, contracts from the State of Oklahoma, or any other state or funds from the U.S. government shall publish a report on its website and the documents.ok.gov website of all MOUs or MOAs within 15 business days of the Memorandum's effective date.
- The report shall contain a detailed accounting of each MOU or MOA which shall include:
 - > The effective date of the Memorandum;
 - > The duration of the Memorandum;
 - > The entities subject to the Memorandum;
 - > The purpose of the Memorandum; and
 - > The constitutional or statutory provisions allowing for the subject addressed in the Memorandum.
- When an agency enters into a Memorandum, and when the state Legislature is in session, the agency shall provide the chair of the appropriate legislative committee, based on the subject matter or agency executing the document, with a copy of the Memorandum.
- The agency may not publish any such report on a Memorandum that is privileged under law pursuant to the Open Records Act. However, a report shall still be published to indicate what entities are subject to the privileged Memorandum and its duration.
- Memorandums solely between departments or agencies of this state shall cite the state constitutional or statutory authority granted for the subject addressed in the Memorandum. Memorandums between any agencies, departments and any organizations receiving appropriated money, grants, contracts from the State of Oklahoma, or any other state, or funds from the U.S. government shall cite the authority granted by federal or state statute and/or in the U.S. Constitution as well as the Oklahoma Constitution for the subject addressed in the Memorandum.

SB 583

State Agency Desktop Computer Support
Effective November 1, 2019

62 O.S. § 34.203

- Requires the Director of the Office of Management and Enterprise Services (OMES) to initiate a request for proposal (RFP) for the ongoing maintenance of desktop support and management systems for all state agencies. Authorizes OMES to enter into a contract for such services.
- Sets out requirements for the RFP and for awarding of the contract.

SB 585

OMES Policy Changes
Effective November 1, 2019

62 O.S. § 34.202

- If OMES changes a policy affecting a state agency, it shall provide the affected agency notice at least 30 days in advance of the policy's implementation and must permit the affected agency to respond and request to be exempted from the policy change or request modifications to the policy.

SB 670

Military Personnel Occupational Licensing
Effective November 1, 2019

59 O.S. § 4100.8 (New Law)

- Every active duty military personnel and his or her spouse who is licensed or certified in any occupation or profession in another state, upon receiving notice or orders for transfer or honorable discharge to Oklahoma, may in advance of the transfer or discharge submit a completed application to the appropriate licensing or credentialing agency in Oklahoma to request an expedited temporary, reciprocal, or comity license or certification for their currently held valid license or certification.
- Every state agency director shall, upon receipt of an active duty military application and presentation of satisfactory evidence of equivalent education, training, and experience on such valid license or certification from another state, accept the valid license or certification and apply all its education, training, and experience in the manner most favorable toward satisfying the qualifications for issuance of the requested license or certification in this state and shall issue the requested Oklahoma license or certification within thirty (30) days provided the license or certification from the other state is found to be in good standing and reasonably equivalent to the requirements of this state.
- The application fee and the first period license fee are waived.

Rules

ALL RULE CHANGES ARE EFFECTIVE SEPTEMBER 15, 2019

CHAPTER 1

Administrative Operations
Subchapter 1. General Provisions

365:1-1-4.1. Fees

- Implements the provisions of HB 2933 (2018) requiring a one-time, one-year fee waiver of licensing fees for low-income individuals.

CHAPTER 10

Life, Accident and Health
Subchapter 5. Minimum Standards; Contract Guidelines
Part 13. Medicare Supplement Insurance Minimum Standards

365:10-5-123, 127.1, 128.2, 128.4, & 132

- Updates the regulation to conform to the most recent National Association of Insurance Commissioners' model regulation and implements federal requirements set out in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

CHAPTER 15

Property and Casualty

Appendix C. Excess Consent Rate Application

- Deletes the requirement to submit the form in duplicate with a stamped, self-addressed envelope because it is now submitted electronically.

CHAPTER 25

Other Licensees
Subchapter 7. Companies
Part 5. Oklahoma Insurance Holding Company System Regulatory Act

365:25-7-28. Acquisition of control; statement filing (Form A)

- Sets out that a Form A is considered filed with the Commissioner once the Commissioner has provided notification to the applicant the statement required by 36 O.S. § 1633(A) is complete.

Subchapter 9. Prepaid Funeral Benefits

365:25-9-8. Conversion from trust to insurance funded contracts

- Removes the requirement that a conversion application include a copy of the proposed negative response notification letter to the prepaid funeral contract purchasers because such a notification has not been required by law since 2009.

Subchapter 15. Captive Insurance Companies Regulation

365:25-15-1.1. Definitions

- Defines “feasibility study” to mean an analysis of the owner/insured’s risk profile and financial condition and must include and consider the following:
 - > A detailed analysis as to how the captive will effect risk management and loss control;
 - > Risks to be insured;
 - > Recommendations and projections by a qualified independent actuary recommended premiums, losses, expenses, and retentions;
 - > Tax projections;
 - > Domicile options that address the impact on operating costs and tax issues;
 - > Comparison of a captive program with other viable risk financing alternatives;
 - > Five-year pro forma financial statements and projections and analysis of the financial impact of establishing a captive, of any form; and
 - > Identification of management procedures, underwriting procedures, managerial oversight methods, investment policies, and reinsurance agreements.
- Defines “business plan” to mean the business activity of the company designed to accomplish its stated purpose. At a minimum, it must include the following:
 - > Identity of the ownership and management;
 - > The type and expected volume of business to be written;
 - > Details of any reinsurance agreements to be entered into;
 - > Details of any management services or tax allocation agreements; and
 - > Financial projections as required in the definition of “feasibility study.”

Subchapter 21. Regulation on the Use of Senior-Specific Certifications and Professional Designations in the Sale of Life Insurance and Annuities.

365:25-21-1, 2, & 5

- Adds Medicare Supplement plans, Medicare Advantage plans, and Medicare Part D Prescriptions plans to the list of products sold in which senior-specific certifications and professional designations cannot be used in the sale, purchase, or advice made.

Subchapter 25. Oklahoma Employee Injury Benefit Act

- The entirety of Subchapter 25 is revoked because the provisions of 85A O.S. §§ 200–213 were declared unconstitutional by the Oklahoma Supreme Court.

Subchapter 30. Professional Employer Organizations

365:25-30-1, 2, 3, & 4

- These are new rules addressing the regulation of Professional Employer Organizations (PEOs) and applying to all PEOs which must be registered with the Insurance Department pursuant to 40 O.S. § 600.4.
- Allows the Commissioner to refuse to register any person or suspend or revoke the registration of any PEO in accordance with 40 O.S. § 600.9. Sets out fines of \$100–\$1,000 for each violation of the Oklahoma Professional Employer Organization Recognition and Registration Act.

CHAPTER 40

Health Maintenance Organizations (HMO)

Subchapter 1. General Provisions

365:40-1-3. Medicaid HMOs

- Deletes the exemption from 365:40-3-2 in order to comply with 36 O.S. § 6903.1, which now requires HMOs to comply with 36 O.S. § 6913.