



OKLAHOMA
INSURANCE
DEPARTMENT

2020 STATUTE & RULE CHANGES



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Life & Health

HB 3242

Premium Rate Filing Exemption

Effective November 1, 2020

36 O.S. § 6311.1

- Exempts insurers with 5,000 or fewer policyholders from the September 1st premium rate filing deadline for a Medicare supplement policy.

SB 1718

Mental Health Parity

Effective November 1, 2020

36 O.S. § 6060.10, 6060.11, 6060.12, 6060.13

- Removes definition for “health benefit plan,” “severe mental illness,” and “small employer.”
- Defines “insurer,” “mental health and substance use disorder,” and “mental health and substance use disorder benefits.”
- Removes permitted offering of benefits for mental health and substance abuse disorder benefits.
- Removes exclusion of application of this section on coverage provided by a health benefit plan for a small employer.
- A health benefit plan shall not impose a nonquantitative treatment limitation with respect to mental health and substance use disorders (MH/SUD) unless, under the terms of the plan, any processes, strategies, evidentiary standards or other factors used in applying the same limitations are comparable to and applied no more stringently than to medical and surgical (M/S) benefits in the same classification
- Requires all health benefit plans meet the requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and federal guidance or regulations issued under these acts including 45 CFR 146.136, 45 CFR 147.160 and 45 CFR 156.115(a)(3) (Federal Act).
- Beginning November 1, 2020, each insurer offering, issuing, or renewing any plan providing MH/SUD benefits shall submit an annual report to the Insurance Commissioner by April 1 of each year containing:
 - > A description of the process used to develop or select the medical necessity criteria for MH/SUD benefits and the process used to develop or select the medical necessity criteria for M/S benefits;
 - > Identification of all nonquantitative treatment limitations applied to both MH/SUD benefits and M/S benefits within each classification of benefits; and
 - > The results of an analysis that demonstrates that for the medical necessity criteria and for each nonquantitative treatment limitation identified, as written and in operation, the

processes, strategies, evidentiary standards or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to MH/SUD benefits within each classification of benefits are comparable to and are applied no more stringently than to M/S in the same classification of benefits. At a minimum, the results of the analysis shall:

- Identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit including factors that were considered but rejected;
 - Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation;
 - Provide the comparative analyses including the results of the analyses performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as written processes and strategies used to apply the nonquantitative treatment limitation to MH/SUD benefits are comparable to and applied no more stringently than the processes and strategies used to design each nonquantitative treatment limitation to M/S benefits.
 - Provide the comparative analyses including the results of the analyses performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for MH/SUD benefits are comparable to and applied no more stringently than the processes or strategies used to apply each nonquantitative treatment limitation for M/S benefits in the same classification of benefits; and
 - Disclose the specific findings and conclusions reached by the insurer that the results of the analyses required by this subsection indicate that the insurer is in compliance with this section and the Federal Act.
- Requires the Insurance Commissioner to implement and enforce applicable provisions of the Federal Act.
 - Requires the Insurance Commissioner to make available to the public the reports submitted during the most recent annual cycle no later than June 1 of each year and starting no later than June 1, 2021. Confidential or trade secret information shall be redacted.
 - Requires the Insurance Commissioner to identify insurers that have failed in whole or in part to report and make a reasonable attempt to obtain the missing report or information by June 1 of the following year.
 - Requires the Insurance Commissioner to make available to the public on the Internet website of the Insurance Department the reports submitted and identification of noncompliant insurers.
 - Requires the Insurance Commissioner to promulgate rules pursuant to this section and the Federal Law that relate to the business of insurance.
 - Requires the Insurance Commissioner to make available to the public on the Internet website of the Insurance Department the reports submitted and identification of noncompliant insurers.

Regulatory Compliance/ Insurer Operations

HB 3864

Captive Premium Tax Reallocation

Effective July 1, 2020

36 O.S. § 6470.19

- Changes allocation of captive insurance premium tax starting July 1, 2020.
- Captive insurer premium taxes collected up to \$500,000 will be distributed exactly as they are today:
 - > 36% to the Oklahoma Firefighters Pension and Retirement Fund,
 - > 14% to the Oklahoma Police Pension and Retirement System,
 - > 5% to the Law Enforcement Retirement Fund, and
 - > 45% to the General Revenue Fund.
- Collections between \$500,001 and \$750,000 will be retained by the Insurance Department for the purpose of implementation of the Oklahoma Captive Insurance Company Act.
- Any collections above \$750,000 are then split as follows:
 - > 36% to the Oklahoma Firefighters Pension and Retirement Fund,
 - > 14% to the Oklahoma Police Pension and Retirement System,
 - > 5% to the Law Enforcement Retirement Fund,
 - > 15% to the General Revenue Fund, and
 - > 30% to the Insurance Department.

SB 1642

Appointment of Producers

Effective July 1, 2020

36 O.S. § 1435.15(B)

- Permits filing a notice of appointment for a producer within 15 days from the first insurance application submitted.

State Government/ OID Operations

HB 3613

Personal Privacy Protection Act

Effective November 1, 2020

51 O.S. § 50 (New Law)

- Defines “personal affiliation information” as any list, record, register, registry, roll, roster or other compilation of data of any kind that directly or indirectly identifies a person as a member, supporter, or volunteer of, or donor of financial or nonfinancial support to, any entity organized pursuant to Section 501(c) of the Internal Revenue Code (IRC).
- Prohibits a public agency from any of the following:
 - > Requiring any individual to provide the public agency with personal affiliation information or otherwise compel the release of personal affiliation information,
 - > Requiring any entity organized pursuant to Section 501(c) of the IRC to provide the state agency or political subdivision with personal affiliation information or otherwise compel the release of personal affiliation information,
 - > Releasing, publicizing or otherwise publicly disclosing any personal affiliation information in the possession of the public agency, or
 - > Requesting or requiring a current or prospective contractor or grantee with the public agency to provide the public agency with a list of entities organized pursuant to Section 501(c) of the IRC to which it has provided financial or nonfinancial support.
- Exempts personal affiliation information from the Oklahoma Open Records Act.
- This Act shall not preclude any of the following:
 - > Any report or disclosure required by the Oklahoma Ethics Commissioner prior to the effective date of this act,
 - > Any lawful warrant for personal affiliation information issued by a court of competent jurisdiction,
 - > Any lawful request for discovery of personal affiliation information in litigation if both of the following conditions are met:
 - The requestor demonstrates a compelling need for the personal affiliation information requested by clear and convincing evidence, and
 - The requestor obtains a protective order barring disclosure of personal affiliation information to any person not directly involved in the litigation; or
 - > Admission of personal affiliation information as relevant evidence before a court of competent jurisdiction. However, no court shall publicly reveal personal affiliation information absent a specific finding of good cause.
- Any person alleging a violation of this act may bring a civil action for injunctive relief, damages, or both. Damages may include one of the following:
 - > \$2,500 to compensate for injury or loss caused by each violation of this act, or
 - > For an intentional violation, a sum of money not to exceed three times the sum above.
- A court may award all or a portion of the costs of litigation, including reasonable attorney fees and witness fees.
- A person who knowingly violates this act shall be guilty of a misdemeanor, a fine of not more than \$1,000, or both.

HB 4025

State Agencies Report Information to Office of Fiscal Transparency

Effective July 1, 2020

62 O.S. § 8014

- Requires all state agencies to regularly transmit to the Legislative Office of Fiscal Transparency (LOFT) raw datasets as requested by LOFT.
- LOFT shall adopt policies and procedures including the format in which data is to be transmitted and how the data is organized.

SB 285

State Employee Break Time for Breast-Feeding

Effective November 1, 2020

40 O.S. § 435

- Requires all state agencies to allow an employee who is lactating reasonable paid break time each day to use the designated lactation room for the purpose of maintaining milk supply and comfort.

SB 1422

Central Purchasing Act Reform

Effective November 1, 2020

74 O.S. §§ 85.1–85.5, 85.5a– 85.7a, 85.7e, 85.7g, 85.8, 85.9B, 85.9D, 85.9G–85.12, 85.15, 85.17A, 85.19, 85.22, 85.33–85.33B, 85.39, 85.41–85.44D, 85.45j, 85.45j.1, 85.45q, 85.45q, 85.58A, 85.26,

- Modernization of the Central Purchasing Act that includes modernization in updated language reflecting a modern approach to procurement and reconfiguration of sections to align content with titles to make the Act more user friendly; increased speed through increased solicitation threshold to \$25,000; and increase in efficiency by offering the opportunity to expand agency purchasing thresholds up to \$250,000.

SB 1877

Lactation Room in Public Buildings

Effective November 1, 2020

61 O.S. § 334 (New Law)

- Defines “lactation room” as a hygienic place, other than a bathroom, that:
 - > Is shielded from view,
 - > Is free from intrusion, and
 - > Contains a chair, a work surface and an electrical outlet.
- Requires that a public building contain a lactation room that is made available for use by state employees to breast feed or express breast milk.

BUDGET

HB 2742

Insurance Premium Tax Reallocation

Effective September 1, 2020

- The Oklahoma Legislature temporarily changed premium tax allocation for the Oklahoma Firefighters Pension and Retirement Fund, the Oklahoma Police Pension and Retirement System, and the Law Enforcement Retirement Fund to provide additional funding to the Education Reform Revolving Fund of the State Department of Education

SB 1922

Revolving Fund

Effective July 1, 2020

- This bill pulled \$6.5 million from the Department's revolving fund to help with appropriations for FY 2021.

RULES

ALL RULE CHANGES ARE EFFECTIVE SEPTEMBER 15, 2020

CHAPTER 10

Life, Accident and Health

*Subchapter 5. Minimum Standards; Contract Guidelines
Part 13. Medicare Supplement Insurance Minimum Standards*

365:10-5-129.1(e)(1), (2) & (4)

- Clarifies that Medicare supplement insurance due to disability falls within guaranteed issue. Additionally, Medicare supplement C and F are replaced with D and G Plans.
- Limits certain individuals to the standardized Medicare supplement plan identified by the issuer. The premium rate charged for such disabled person may not exceed the lowest available aged premium rate for such plan.

365:10-5-132. Filing and approval of policies and certificates and premium rates

- Adds that an issuer will not present a Medicare supplement policy rate structure for filing or approval based on attained age rating greater than one year after age 67. After the age of 90, a rate structure with groupings of attained ages greater than one year is allowed.

Appendix C, F, H, J, K, M, N, O, QQ, RR, SS and TT

- Updates appendices to reflect the Department's new address, the correct date, or both.

CHAPTER 15

Property and Casualty

Appendix C. Excess Consent Rate Application

- Updates the Department's address.

CHAPTER 25

Other Licensees

Subchapter 7. Companies

365:25-7-90-95

- These are new rules addressing the regulation of the Corporate Governance Annual Disclosure including filing procedures and contents of the filing. 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.

365:25-7-100-119

- There are new rules addressing the regulation of the Oklahoma Annual Financial Report Act which is to improve the surveillance of the Insurance Commissioner over the financial condition of insurers.

365:25-29-1, 3 and 6.

- Updates to include 36 O.S. §§ 6858–6868 under the purpose and authority of this subchapter. Also updates the surety bond to be also for the benefit of protection by the provisions of 36 O.S. §§ 6958–6968.

365:25-29-2. Scope

- Clarifies applicability of the subchapter to include all health insurers subject to compliance with 36 O.S. § 6958 et seq.

365:25-29-4. Definitions

- Defines “preferred participating pharmacy” to mean a pharmacy that is designated as a preferred participating pharmacy in a PBM’s retail pharmacy network.
- Defines “provider” to mean an Oklahoma licensed retail pharmacy.

365:25-29-5. Forms and contents of application for PBM license

- Updates for clarification and a word correction from “without” to “outside.”

365:25-29-7.1. Retail pharmacy network access -audit

- Adds the standards required by the act for the retail pharmacy network access. Specifically, health insurers are required to audit their contracting PBMs to confirm compliance with the act and provide those audits along with verification of the audit to the Department to confirm compliance. The insurers are required to report situations of inadequate access to the Department. This section addresses the use of mail-order pharmacies for adequacy standards, clarification of the act applying to specialty drugs, and use of pharmacy, hospital or other providers on mail and ID cards.
- Audits must be completed within 90 days of the effective date of 36 O.S. § 6958–6968 and annually each year thereafter. The results of the audits shall be reported to the Insurance Commissioner within 30 days of the completion of the audit.

365:25-29-9. Contractual requirements – maximum allowable cost

- Clarifies formatting and adds instructive language regarding the insurer’s responsibility to confirm the PBM contracts are in compliance with the act. It requires insurers to conduct an audit of its contracting PBMs to confirm the requirements of 36 O.S. § 6962 are being met and provide that information to the Department.
- The PBM acts on behalf of the payor to facilitate the delivery of prescription medication benefits provided by such payor. Requirements and limitations within the act must be understood within this contractor relationship.
- PBMs shall be responsible as follows:
 - > For approving all contractual documents utilized by its contracted PBMs and its retail pharmacy network to ensure compliance with the act;
 - > For conducting an annual audit of transactions and practices utilized by its contracted PBMs and members of its retail pharmacy network to ensure compliance with the act; and
 - > Any exceptions found shall be reported to the Department pursuant to the Commissioner’s examination authority.

365:25-29-10. Penalty for noncompliance

- Updates to include 36 O.S. §§ 6858–6968 and to include penalty language for insurers for failing to comply with the act.
- Removes requirement for every PBM to respond within 30 days to an inquiry from the Department.
- Allows the Commissioner to suspend or revoke a PBM’s license and/or levy fines not to exceed \$10,000 for each count for which a PBM has violated 36 O.S. §§ 6958-6968 after notice and opportunity for a hearing.
- Allows the Commissioner to suspend or revoke a health insurer’s certificate of authority and/or access a civil penalty of not less than \$500 nor more than \$5,000 for each instance of violation of 36 O.S. §§ 6958-6968 after notice and opportunity for a hearing.
- Adds requirement that every health insurer upon receipt of an inquiry from the Insurance Commissioner must respond within 30 days.

365:25-29-12. Commissioner’s authority – advisory committee

- Clarifies the authority of the Insurance Commissioner and the role of the advisory committee. The advisory committee will function in an advisory capacity. The committee members will be privy to confidential material and will therefore need to submit to a background check.
- Any investigation or enforcement action shall be the sole discretion of the Insurance Commissioner.
- Because committee members will be dealing with confidential, proprietary, or competitively sensitive information the Insurance Commissioner shall implement the following protections to prevent such information from being viewed or used inappropriately:
 - > Advisory committee members shall void conflict of interest and recuse themselves from being involved in any proceedings where they may have insight into a competitor’s pricing or proprietary information. The committee members must also avoid any conduct which could be viewed as a conspiracy to fix prices or otherwise restrict competition.
 - > Committee members shall be required to sign conflict of interest forms that disclose potential conflicts before serving on the committee, and affirmatively recuse themselves when a potential conflict arises. A conflict arises when a committee member has a financial stake in the outcome of a complaint or issue before the committee, or has an existing contract with a PBM, pharmacy, or insurer that is the subject of the committee’s review. In addition, committee members shall be required to sign confidentiality commitments that acknowledge the statutory prohibition of any disclosure of confidential information that is available to the committee.
 - > All committee nominations must be supported by a NAIC biographical affidavit and background check.
- The committee meetings shall be convened by the Insurance Commissioner upon 10 days written notice.

365:25-29-13. Claims payment

- Clarifies that claims payments are the obligation of the insurer that issues the policy.

365:25-29-14. Inquiry/complaint handling process

- Creates the process for complaints including requirement that the complaint be in writing to the Insurance Commission on the PBM Complaint Form and supported by evidentiary materials.
- Health insurer audits of PBMs shall include a review of complaints.

- Requires PBMs provide the complainant written notice as to the final disposition of a complaint.
- As part of its response to the Department, the PBM must provide a statement to the Department that the complaint was carefully reviewed and could not be resolved under the terms and conditions of the contract.

365:25-29-15. Examinations of PBMs and health insurers

- Addresses the examination of PBMs and insurers by the Department for compliance with the act.
- Excludes PBMs from the time constraints under 36 O.S. §§ 309.1-309.7.

Appendix B, D, E, F, G, H, N, O and Q.

- Updates appendices to reflect the correct date.

Appendix R. Conversion from Pre-Paid Funeral Trust to Insurance Funded Contracts

- Removes the former requirement of 36 O.S. § 6136(C)(2), superseded November 1, 2009.