OKLAHOMA INSURANCE DEPARTMENT

2025 STATUTE & RULE CHANGES

CONTENTS

LEGISLATIVE AGENDA

RULES

LEGISLATION OF INTEREST

Legislative Agenda

HB 1497
Liquidity Stress Test Framework
Effective November 1, 2025

36 O.S. §§ 1630-1640

- The measure requires the controlling person of an insurer to file an annual group capital calculation with their registration unless the insurer meets specific exemption criteria. Insurers subject to registration and scoped into the National Association of Insurance Commissioners (NAIC) Liquidity Stress Test Framework must also report the results of the stress test. The criteria for determining which insurers must complete the test are set by the NAIC's framework. The reports must be submitted to the lead state insurance commissioner, as determined by the NAIC's Financial Analysis Handbook procedures. This data will remain confidential, exempt from open records laws, and cannot be used in private civil actions

HB 1498
2025 Omnibus Bill
Effective November 1, 2025

36 O.S. §§ 673, 1106.1, 2208, 6124, 6124.1, 6124.2, 6125.2, 6128, 6129, 6130, 6813, 6814, 6815, 7125, 7127, 7128, 7131, and 7133

- The measure corrects a component of the Insurance Data Security Act passed last year, to ensure the Board of Insurers is the entity that receives the report. It also requires prepaid funeral benefit and cemetery merchandise permit holders to respond to an inquiry from the commissioner within 20 days and notify the Insurance Commissioner of any changes in business name, address, or contact information within 30 days. Permit holders may apply to renew an expired permit within 90 days of expiration with an additional fee. Additionally, the measure allows a fixed annuity to cover prepaid funeral benefits and reduces the notification period for organizations to inform the commissioner about the termination of a cemetery merchandise surety bond from 90 days to 30 days prior to the bond's termination. The measure also removes the requirement for the Insurance Commissioner to submit a report analyzing the administrative costs of medical professional liability trusts and insurers providing medical liability coverage. Finally, the measure repeals the sections of law requiring composite data reports on closed medical liability claims to be compiled, stored in a database, and submitted to the Governor and Legislature. The section exempting surplus lines insurers from due diligence searches is also repealed.

HB 1512
State-Based Marketplace
Effective July 1, 2025

36 O.S. §§ 4606 and 4606.1.

- HB 1512 authorizes the Insurance Commissioner to establish and operate a state-based health insurance marketplace.

Permanent Rules

CHAPTER 10
Life, Accident and Health
Effective July 11, 2025

Subchapter 29

- Removes an outdated external review request form and updates the rule with where the new form can be obtained. It also updates the Department's physical address.

CHAPTER 25
Other Licensees
Effective July 11, 2025

Subchapters 7

- Updates rules to adopt newer model law provision Group Capital Calculations, which is a requirement for Accreditation with the National Association of Insurance Commissioners (NAIC).

Legislation of Interest

- HB1804, prohibits the solicitation or acceptance of assignment agreements for post-loss insurance benefits for property damage under auto, residential, or commercial property insurance policies. The measure does not apply to assignments, transfers, pledges, or conveyances granted to federally insured financial institutions, mortgagees, or subsequent purchasers of the property as well as liability coverage under the specified insurance policies.

- HB 1389 relates to mammography screening and diagnostic examination, amending language found at 36 O.S. § 6060. The bill amends 36 O.S. § 6060(A)(3) by adding "contrast-enhanced mammogram" and "molecular breast imaging" to what may be included under the definition of "diagnostic examination for breast cancer".

- HB 1501, caps the commission payable to a public insurance adjuster at ten (10) percent of the settlement when adjusting for an entity subject to the Governmental Tort Claims Act.

- HB 1516, raises the minimum age a minor can contract for a life, accident, or health insurance policy from 15 to 16 years of age. The measure also requires parental or guardian consent for a minor to hold any type of insurance policy.

- HB 1808 creates the Ensuring Transparency in Prescription Drugs Prior Authorization Act, which outlines the requirements of utilization review entities and health benefit plans during the prior authorization process.

- HB 1811, reduces the timeframe for a health care provider to submit a timely prior authorization request for continued inpatient care for a chronic condition from 72 hours to 24 hours before the previously approved care ends.

- SB 109 requires any health benefit plan offered, issued, or renewed in this state on or after the act's effective date to provide coverage for clinical genetic testing for an inherited gene mutation in individuals with a person or family history of cancer and evidence-based cancer imaging for individuals with an increased risk of cancer. Coverage under this will not be subject to any annual deductibles, copayments, or coinsurance limits as established for all covered benefits under the health benefit plan. If application of this would result in health savings account ineligibility, the provisions will only apply to a high deductible plan after the enrollee has satisfied the minimum deductible.

- SB 176 relates to conceptive drugs, creating new law and definitions to be found at 36 O.S. § 6060.3b. The bill requires any health benefit plan that offers coverage for contraceptive drugs to provide coverage for a three-month supply at once the first time the enrollee obtains the drug and a six-month supply each subsequent time, regardless if the enrollee was in the health benefit plan the first time they obtained the drug. An enrollee may obtain only one six-month supply during each six-month period. Nothing will prohibit an enrollee from requesting a smaller supply of a contractive drug and nothing will be construed to require coverage for any medications that could be used to terminate a pregnancy.

- SB 515 provides relevant definitions in the measure and also specifies that the term health care service will also include mental health and substance use disorder services and durable medical equipment, but will not include the administration or prescription of pharmaceutical products or services. The measure provides that an enrollee may choose to pay out of pocket for a health care service from a health care provider. If an enrollee obtains a medically necessary service covered by their health benefit plan and negotiates a price lower than the average amount established by the benefit plan and provided to the enrollee upon request and pay out of pocket, the enrollee may electronically send documentation that lists the information in the measure to the carrier. The health care provider must accept the payment from the enrollee as payment in full and must not bill the enrollee or the benefit plan for any balance between the amount collected from the enrollee and the billed charge for the service by the provider. A carrier that receives the necessary documentation will found the full amount paid of pocket toward the deductible and annual maximum out-of-pocket expense if the service is covered under the plan and the enrollee negotiated for a lower cost. The amount of out-of-pocket cost will be attributed to the in-network deductible and annual maximum out-of-pocket if the provider was in-network and it will be attributed to the out-of-network deductible and annual maximum out-of-pocket if the provider was out-of-network. The amount counted towards an application out-of-pocket deductible and expense will not exceed the total amount an enrollee is required to pay out of pocket during a contractually agreed upon time for health services included under their benefit plan and will not carry over when a new plan contract or agreement plan begins.

- SB 641 creates the Oklahoma Motor Vehicle Consumer Protection Act. The measure establishes the hourly rate for labor for administrative charges as the rate relates to total loss vehicles, is to be determined in accordance with the Unfair Claims Settlement Practices Act. The measure authorizes the Insurance Commissioner to adjust the rate for labor to account for inflation annually beginning on January 1, 2027.

- SB 1019 relates to anesthesia coverage, creating new law and definitions to be found at 36 O.S. 7500. The bill prohibits an insurer from establishing, implementing, or enforcing any policy, practice, or procedure which imposes a time limit on the amount of covered anesthesia services provided during a medial or surgical procedure, or restricts or excludes coverage or payment of anesthesia time.

- SB 1050 relates to the Unfair Claims Settlement Practices Act, amending language found at 36 O.S. 1250.5(15). The bill reduces the amount of time claimants and health providers have to request a refund on paid claims. The time limit for claimants has been reduced from twelve (12) months to six (6) months and for health care providers from eighteen (18) months to twelve (12) months.

- SB 1067 authorizes a local government entity or ambulance service provider acting on its behalf to annually submit ambulance service rates set by the local government to the Insurance Department. The Department must establish and maintain a public database with all the submitted rates by January 1, 2026. The minimum allowable rate must be the least of the submitted rates, 325% of the current published rate as established by the Centers for Medicare and Medicaid Services, or the ambulance service provider's billed charge. The Department must submit a report using a review of the data and the rates will cease to remain in effect unless modified by the Legislature by December 31, 2027.