

An Act

ENROLLED HOUSE
BILL NO. 1060

By: McEntire of the House

and

Quinn of the Senate

An Act relating to insurance; amending 36 O.S. 2011, Sections 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2030, 2032, 2036, 2038 and 2043, which relate to the Oklahoma Life and Health Insurance Guaranty Association Act; providing for broader applicability; defining terms; providing coverages and liabilities; modifying board of directors membership; modifying travel reimbursement; providing procedural rules and amendments; modifying for impaired or insolvent insurers; providing for assessments of member insurers; modifying circumstances for certain assessments; modifying powers and duties of the Insurance Commissioner; modifying applicability of procedures for detection and prevention of insolvencies; modifying assets of impaired or insolvent insurers; modifying ownership rights; providing for the recovery of distributions; modifying prohibitions on advertising; amending 36 O.S. 2011, Section 6913, as amended by Section 19, Chapter 275, O.S.L. 2014 (36 O.S. Supp. 2018, Section 6913), which relates to deposit with Insurance Commissioner; modifying deposit use; repealing 36 O.S. 2011, Sections 6914, 6921 and 6932, which relate to health maintenance organization insolvency; and providing an effective date.

SUBJECT: Insurance

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

SECTION 1. AMENDATORY 36 O.S. 2011, Section 2022, is amended to read as follows:

Section 2022. A. The purpose of ~~this act~~ the Oklahoma Life and Health Insurance Guaranty Association Act is to protect, subject to certain limitations, the persons specified in subsection A of Section 2025 of ~~the Insurance Code~~ this title, against failure in the performance of contractual obligations, under life ~~and~~ health insurance policies, and annuity policies, plans or contracts specified in subsection B of Section 2025 of ~~the Insurance Code~~ this title, because of the impairment or insolvency of the member insurer that issued the policies, plans or contracts.

B. To provide this protection, an association of member insurers has been created and exists to pay benefits and to continue coverages as limited in this act, and members of the Association are subject to assessment to provide funds to carry out the purposes of this act.

SECTION 2. AMENDATORY 36 O.S. 2011, Section 2023, is amended to read as follows:

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

B. The Association shall perform its functions under a plan of operation established and approved in accordance with this act and shall exercise its powers through the Board of Directors established in this act. For purposes of administration and assessment, the Association shall maintain three ~~(3)~~ accounts:

1. The health ~~insurance~~ account;
2. The life insurance account; and
3. The annuity account.

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

SECTION 3. AMENDATORY 36 O.S. 2011, Section 2024, is amended to read as follows:

Section 2024. As used in ~~Sections 2021 through 2043 of this title~~ the Oklahoma Life and Health Insurance Guaranty Association Act:

1. "Account" means ~~either one~~ one of the ~~two~~ three accounts created under Section 2023 of this title;

2. "Association" means the Oklahoma Life and Health Insurance Guaranty Association created in Section 2023 of this title;

3. "Commissioner" means the Oklahoma Insurance Commissioner;

4. "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under Section 2025 of this title;

5. "Covered contract" or "covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under Section 2025 of this title;

6. "Extra-contractual claims" includes, but is not limited to, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorneys fees and costs;

7. "Health benefit plan" means any hospital or medical expense policy or certificate or health maintenance organization subscriber contract or any other similar health contract. Health benefit plan does not include:

a. accident-only insurance,

b. credit insurance,

c. dental-only insurance,

d. vision-only insurance,

e. Medicare supplemental insurance,

f. benefits for long-term care, home health care, community-based care, or any combination thereof,

- g. disability income insurance,
- h. coverage for on-site medical clinics, or
- i. specified disease, hospital confinement indemnity or limited health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates;

8. "Impaired insurer" means a member insurer which, after the effective date of this act, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

~~8.~~ 9. "Insolvent insurer" means a member insurer which, after the effective date of this act, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

~~9.~~ 10. "Member insurer" means any nonprofit hospital service and medical indemnity corporation and any insurer or health maintenance organization licensed or that holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided under Section 2025 of this title, and includes any insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

- ~~a.~~ ~~a health maintenance organization,~~
- ~~b.~~ a. a fraternal benefit society,
- ~~c.~~ b. a mandatory state-pooling plan,
- ~~d.~~ c. a mutual assessment company or other person that operates on an assessment basis,
- ~~e.~~ d. an insurance exchange,
- ~~f.~~ e. an organization that has a certificate or license limited to the issuance of charitable gift annuities under Sections 4071 through 4082 of this title, or

~~g.~~ f. any entity similar to any of the above;

~~10.~~ 11. "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto;

~~11.~~ 12. "Owner", "policyholder", "policy owner" or "contract owner" means the person who is identified as the legal owner of a policy or contract under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. Owner, policyholder, policy owner or contract owner does not include persons with a mere beneficial interest in a policy or contract;

~~12.~~ 13. "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization;

~~13.~~ 14. "Premiums" means amounts or considerations by whatever name called, received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits. "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of any policies or contracts for which coverage is not provided under subsection B of Section 2025 of this title except that assessable premium shall not be reduced on account of subparagraph ~~(e)~~ c of paragraph 2 of subsection B of Section 2025 of this title relating to interest limitations and paragraph 2 of subsection C of Section 2025 of this title relating to limitations with respect to one individual, one participant and one policy or contract owner. Premiums does not include:

- a. premiums on an unallocated annuity contract, or
- b. premiums in excess of Five Million Dollars (\$5,000,000.00) on multiple non-group policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees or other persons, regardless of the number of policies or contracts held by the owner;

~~14.~~ 15. "Principal place of business" of a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the Association in its reasonable judgment by considering the following factors:

- a. the state in which the primary executive and administrative headquarters of the entity are located,
- b. the state in which the principal office of the chief executive officer of the entity is located,
- c. the state in which the board of directors or similar governing person or persons of the entity conducts the majority of its meetings,
- d. the state in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings,
- e. the state from which the management of the overall operations of the entity is directed, and
- f. in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors listed in subparagraphs a through e of this paragraph;

~~15.~~ 16. "Receivership court" means the court in the insolvent or impaired state of the insurer having jurisdiction over the conservation, rehabilitation or liquidation of the member insurer;

~~16.~~ 17. "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either residents of foreign countries or residents of the United States possessions, territories or protectorates that

do not have an association similar to the Association created by the Oklahoma Life and Health Insurance Guaranty Association Act, shall be deemed residents of the state of domicile of the insurer that issued the policy or contract;

~~17.~~ 18. "State" means a state of the United States, the District of Columbia, Puerto Rico, or a United States possession, territory or protectorate;

~~18.~~ 19. "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by a plaintiff or other claimant;

~~19.~~ 20. "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract; and

~~20.~~ 21. "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

SECTION 4. AMENDATORY 36 O.S. 2011, Section 2025, is amended to read as follows:

Section 2025. A. For the policies and contracts specified in subsection B of this section, the Oklahoma Life and Health Insurance Guaranty Association Act shall provide coverage:

1. a. To persons, who regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under subparagraph b of this paragraph,
- b. To persons who are owners of or certificate holders or enrollees under the policies or contracts, other than structured settlement annuities, and in each case who:
 - (1) are residents, or

(2) are not residents, but only under all of the following conditions:

(a) the member insurer that issued the policies or contracts are domiciled in this state,

(b) the states in which the persons reside have associations similar to the Oklahoma Life and Health Insurance Guaranty Association created by this act, and the persons are not eligible for coverage by an association in any other state due to the fact that the insurer or health maintenance organization was not licensed in the state at the time specified in the guaranty association law of the state;

2. Subparagraphs a and b of paragraph 1 of this subsection shall not apply to structured settlement annuities specified in subsection B of this section and in the Oklahoma Life and Health Insurance Guaranty Association Act shall, except as provided in paragraphs 3 and 4 of this subsection, provide coverage to a person who is a payee under a structured settlement annuity or a beneficiary of a payee if the payee is deceased, if the payee:

a. is a resident, regardless of where the contract owner resides, or

b. is not a resident, but only under both of the following conditions:

(1) (a) the contract owner of the structured settlement annuity is a resident, or

(b) the contract owner of the structured settlement annuity is not a resident but:

i. the insurer that issued the structured settlement annuity is domiciled in this state, and

ii. the state in which the contract owner resides has an association similar to the association created by the Oklahoma

Life and Health Insurance Guaranty
Association Act, and

- (2) neither the payee nor beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides;

3. The Oklahoma Life and Health Insurance Guaranty Association Act shall not provide coverage to a person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded coverage by the association of another state; and

4. The Oklahoma Life and Health Insurance Guaranty Association Act is intended to provide coverage to a person who is a resident of this state and in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under the Oklahoma Life and Health Insurance Guaranty Association Act is provided coverage under the laws of any other state, the person shall not be provided coverage under the Oklahoma Life and Health Insurance Guaranty Association Act. In determining the application of the provisions of this paragraph to situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary or assignee, the Oklahoma Life and Health Insurance Association Act shall be construed in conjunction with the laws of other states to result in coverage by only one association.

B. 1. The Oklahoma Life and Health Insurance Guaranty Association Act shall provide coverage to the persons specified in subsection A of this section for policies or contracts of direct, non-group life insurance, health, annuity insurance, which for the purposes of this act includes health maintenance organization subscriber contracts and certificates, or annuities and supplemental policies or contracts to any of these, and for certificates under direct group policies and contracts, except as limited by the Oklahoma Life and Health Insurance Guaranty Association Act. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities and any immediate or deferred annuity contracts.

2. ~~This act~~ Except as provided in paragraph 3 of this subsection, the Oklahoma Life and Health Insurance Guaranty Association Act shall not provide coverage for:

- a. a portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner,
- b. a policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract,
- c. a portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:
 - (1) averaged over the period of four (4) years prior to the date on which the Association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four (4) years before the Association became obligated, and
 - (2) on and after the date on which the Association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available,
- d. a portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others, to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association or other person under:
 - (1) a Multiple Employer Welfare Arrangement as defined in 29 U.S.C. Section 1144,

- (2) a minimum premium group insurance plan,
 - (3) a stop-loss group insurance plan, or
 - (4) an administrative services only contract~~+~~l
- e. a portion of a policy or contract to the extent that it provides for:
- (1) dividends or experience rating credits,
 - (2) voting rights, or
 - (3) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract,
- f. a policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state,
- g. a portion of a policy or contract to the extent that the assessments required by Section 2030 of this title with respect to the policy or contract are preempted by federal or state law,
- h. an obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder or contract or policy owner, including without limitation:
- (1) claims based on marketing materials,
 - (2) claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements,
 - (3) misrepresentations of or regarding policy or contract benefits,
 - (4) extra-contractual claims, or

- (5) a claim for penalties or consequential or incidental damages,
- i. a contractual agreement that establishes the obligations of the member insurer to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer,
- j. an unallocated annuity contract,
- k. a portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under the Oklahoma Life and Health Insurance Guaranty Association Act, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture, or
- l. a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code, commonly known as Medicare Part C or Part D, or Subchapter XIX, Chapter 7 of Title 42 of the United States Code or any regulations issued pursuant thereto.

3. The exclusion from coverage in this section shall not apply to any portion of a policy or contract, including a rider that provides long-term care or any other health insurance benefits.

C. The benefits that the Association may become obligated to cover shall in no event exceed the lesser of:

1. The contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

2. a. with respect to any one life, regardless of the number of policies or contracts:

(1) Three Hundred Thousand Dollars (\$300,000.00) in life insurance death benefits, but not more than One Hundred Thousand Dollars (\$100,000.00) in net cash surrender and net cash withdrawal values for life insurance,

(2) ~~in~~ for health insurance benefits:

(a) One Hundred Thousand Dollars (\$100,000.00) for coverages not defined as disability income insurance or ~~basic hospital, medical and surgical insurance or major medical insurance~~ health benefit plans or long-term care insurance as defined in Section 4424 of this title, including any net cash surrender and net cash withdrawal values,

(b) Three Hundred Thousand Dollars (\$300,000.00) for insurance providing income payments to an insured wage earner when income is interrupted or terminated because of illness, sickness or accident, commonly known as disability income insurance and Three Hundred Thousand Dollars (\$300,000.00) for long-term care insurance as defined in Section 4424 of this title, and

(c) Five Hundred Thousand Dollars (\$500,000.00) for ~~basic hospital, medical and surgical insurance or insurance providing coverage in excess of that provided by a basic hospital,~~

~~medical and surgical insurance, commonly known as major medical insurance~~ health benefit plans, or

- (3) Three Hundred Thousand Dollars (\$300,000.00) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, or
- b. with respect to each payee of a structured settlement annuity or beneficiary or beneficiaries of the payee if the payee is deceased, Three Hundred Thousand Dollars (\$300,000.00) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values,
 - c. however, in no event shall the Association be obligated to cover more than:
 - (1) an aggregate of Three Hundred Thousand Dollars (\$300,000.00) in benefits with respect to any one life under this subparagraph and subparagraphs a and b of this paragraph except with respect to ~~benefits for basic hospital, medical and surgical insurance and major medical insurance~~ health benefit plans under division (2) of subparagraph a of this paragraph, in which case the aggregate liability of the Association shall not exceed Five Hundred Thousand Dollars (\$500,000.00) with respect to any one individual, or
 - (2) with respect to one owner of multiple non-group policies of life insurance, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than Five Million Dollars (\$5,000,000.00) in benefits, regardless of the number of policies and contracts held by the owner,
 - d. the limitations set forth in this subsection are limitations on benefits for which the Association is obligated before taking into account either its subrogation and assignment rights or the extent to

which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the obligations of the Association under the Oklahoma Life and Health Insurance Guaranty Association Act may be met by the use of assets attributable to covered policies or reimbursed to the Association pursuant to its subrogation and assignment rights,

e. for purposes of the Oklahoma Life and Health Insurance Guaranty Association Act, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

D. In performing its obligations to provide coverage under Section 2028 of this title, the Association shall not be required to guarantee, assume, reinsure, reissue or perform, or cause to be guaranteed, assumed, reinsured, reissued or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

SECTION 5. AMENDATORY 36 O.S. 2011, Section 2026, is amended to read as follows:

Section 2026. A. The Board of Directors of the Oklahoma Life and Health Insurance Guaranty Association shall consist of not less than ~~five (5)~~ seven (7) nor more than ~~nine (9)~~ eleven (11) member insurers serving terms as established in the procedural rules of the Association. A majority of the Board shall be selected from the fifty (50) member insurers which write the largest volume of life and accident and health premiums and annuity considerations for the previous year. The members of the Board shall be selected by member insurers subject to the approval of the Insurance Commissioner. Vacancies on the Board shall be filled for the remaining period of the term by a majority vote of the remaining Board members, subject to the approval of the Commissioner.

B. In calculating total premium for Board qualification purposes, premiums collected by different members of the same multi-insurer group may be attributable to each member of the group;

provided, no two members of the same group shall serve on the Board at the same time.

C. In approving selections, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

D. Members of the Board may be reimbursed ~~according to the provisions of the State Travel Reimbursement Act~~ by the Association for expenses incurred by them as members of the Board, but members of the Board shall not otherwise be compensated by the Association for their services.

SECTION 6. AMENDATORY 36 O.S. 2011, Section 2027, is amended to read as follows:

Section 2027. A. 1. The Oklahoma Life and Health Insurance Guaranty Association shall submit to the Insurance Commissioner procedural rules and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the Association. The procedural rules and any amendments thereto shall become effective upon approval in writing by the Commissioner.

2. If the Association fails to submit suitable procedural rules within one hundred eighty (180) days following the effective date of this act or if at any time thereafter the Association fails to submit suitable amendments to the rules, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary to effectuate the provisions of ~~this act~~ the Oklahoma Life and Health Insurance Guaranty Association Act. Such rules shall continue in force until modified by the Commissioner or superseded by rules submitted by the Association and approved by the Commissioner. All member insurers shall comply with the procedural rules.

B. The procedural rules shall, in addition to requirements enumerated elsewhere in ~~this act~~ the Oklahoma Life and Health Insurance Guaranty Association Act:

1. Establish procedures for handling the assets of the Association;

2. Establish regular places and times for meeting of the Board of Directors;

3. Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the Board of Directors;

4. Establish the procedures whereby selections for the Board of Directors will be made and submitted to the Commissioner;

5. Establish any additional procedures for assessments under ~~Section 10 of this act~~ 2030 of this title; and

6. Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

C. The procedural rules may provide that any or all powers and duties of the Association, except those under ~~paragraph 3 of Section 9 and those under Section 10 of this act~~ 2030 of this title, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this Association, or its equivalent, in two or more states if there is a reciprocal agreement with such states to provide similar services. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the Association and shall be paid for the performance of any function of the Association. A delegation of powers or duties under this subsection shall take effect only with the approval of both the Board and the Commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this act.

SECTION 7. AMENDATORY 36 O.S. 2011, Section 2028, is amended to read as follows:

Section 2028. A. If a member insurer is an impaired insurer, the Oklahoma Life and Health Insurance Guaranty Association may, in its discretion, and subject to any conditions imposed by the Association that do not impair the contractual obligations of the impaired insurer and that are approved by the Insurance Commissioner:

1. Guarantee, assume, reissue or reinsure, or cause to be guaranteed, assumed, reissued or reinsured, any or all of the policies or contracts of the impaired insurer; or

2. Provide monies, pledges, notes, guarantees or other means as are proper to effectuate paragraph 1 of this subsection, and assure

payment of the contractual obligations of the impaired insurer pending action under paragraph 1 of this subsection.

B. If a member insurer is an insolvent insurer, the Association shall, in its discretion, either:

1. a. (1) guarantee, assume, reissue or reinsure, or cause to be guaranteed, assumed, reissued or reinsured, the policies or contracts of the insolvent insurer, or
(2) assure payment of the contractual obligations of the insolvent insurer, and
- b. provide monies, pledges, loans, notes, guarantees or other means as are reasonably necessary to discharge the duties of the Association; or

2. Provide benefits and coverages in accordance with the following provisions:

- a. with respect to ~~life and health insurance policies and annuities~~ policies and contracts, assure payment of benefits ~~for premiums identical to the premiums and benefits, except for terms of conversion and renewability,~~ that would have been payable under the policies or contracts of the insolvent insurer for claims incurred:
 - (1) with respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the date on which the Association becomes obligated with respect to the policies and contracts, or
 - (2) with respect to non-group policies, contracts, and annuities not later than the earlier of the next renewal date, if any, under the policies or contracts for one (1) year, but in no event less than thirty (30) days, from the date on which the Association becomes obligated with respect to the policies or contracts,

- b. make diligent efforts to provide all known insureds, enrollees or annuitants for non-group policies and contracts, or group policy or contract owners with respect to group policies and contracts, thirty (30) days' notice of the termination of the benefits provided pursuant to subparagraph a of this paragraph,
- c. with respect to non-group ~~life and health insurance policies and annuities~~ policies and contracts covered by the Association, make available to each known insured, enrollee or annuitant, or owner if other than the insured, enrollee or annuitant, and with respect to an individual formerly an insured, enrollee or ~~formerly an~~ annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph d of this paragraph, if the insureds, enrollees or annuitants had a right under law or the terminated policy, contract or annuity to convert coverage to individual coverage or to continue an individual policy, contract or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract or annuity or had a right only to make changes in premium by class,
- d. (1) in providing the substitute coverage required under subparagraph c of this paragraph, the Association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the Insurance Commissioner,
- (2) alternative or reissued policies or contracts shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract, and
- (3) the Association may reinsure any alternative or reissued policy or contract,

- e. (1) alternative policies or contracts adopted by the Association shall be subject to the approval of the ~~domiciliary insurance commissioner and the receivership court~~ Insurance Commissioner. The Association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency,
- (2) alternative policies or contracts shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy or contract was last underwritten,
- (3) any alternative policy or contract issued by the Association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the Association,
- f. if the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the Association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the ~~domiciliary insurance commissioner and the receivership court~~ Insurance Commissioner,
- g. the obligations of the Association with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date the coverage or policy or contract is replaced by another similar policy or contract by the policy or

contract owner, the insured, enrollee or the Association,

- h. when proceeding under paragraph 2 of subsection B of this section with respect to a policy or ~~contact~~ contract carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with subparagraph c of paragraph 2 of subsection B of Section 2025 of this title.

C. Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the Association's obligations under the policy, contract or coverage under the Oklahoma Life and Health Insurance Guaranty Association Act with respect to the policy, contract or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of ~~this act~~ the Oklahoma Life and Health Insurance Guaranty Association Act.

D. Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the Association. If the liquidator of an insolvent insurer requests, the Association shall provide a report to the liquidator regarding the premium collected by the Association. The Association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

E. The protection provided by the Oklahoma Life and Health Insurance Guaranty Association Act shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

F. In carrying out its duties under subsection B of this section the Association may, subject to approval by a court in this state:

- 1. Impose permanent policy or contract liens in connection with a guarantee, assumption or reinsurance agreement, if the Association finds that the amounts which can be assessed under this act are less than the amounts needed to assure full and prompt performance of the

duties of the Association under the Oklahoma Life and Health ~~Guaranty~~ Insurance Guaranty Association Act, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of permanent policy or contract liens, to be in the public interest; and

2. Impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the Association may defer the payment of cash values, policy loans or other rights by the Association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the Association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

G. A deposit in this state, held pursuant to law or required by the Commissioner for the benefit of creditors, including but not limited to policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of ~~an~~ a member insurer domiciled in this state or in a reciprocal state, shall be promptly paid by the Association. The Association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners claims related to that insolvency for which the Association has provided statutory benefits by the aggregate amount of all claims by the policy or contract owners in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the Association less the amount retained pursuant to this subsection. Any amount so paid to the Association and retained by it shall be treated as a distribution of estate assets pursuant to applicable state receivership laws dealing with early access disbursements.

H. If the Association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection B of this section, the Commissioner shall have the powers and duties of the Association under the Oklahoma Life and Health

Insurance Guaranty Association Act with respect to the insolvent insurer~~r~~.

I. The Association may render assistance and advice to the Commissioner, upon the request of the Commissioner, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer~~r~~.

J. The Association shall have standing to appear or intervene before a court or agency in this state which has jurisdiction over an impaired or insolvent insurer concerning which the Association is or may become obligated under the Oklahoma Life and Health ~~Guaranty~~ Insurance Guaranty Association Act or with jurisdiction over any person or property against which the Association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the Association including, but not limited to, proposals for reinsuring, reissuing, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The Association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the Association is or may become obligated or with jurisdiction over any person or property against whom the Association may have rights through subrogation or otherwise.

K. 1. Any person receiving benefits under the Oklahoma Life and ~~Insurance~~ Health Insurance Guaranty Association Act shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the Association to the extent of the benefits received because of this act, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative policies, contracts or coverages. The Association may require an assignment to it of the rights and cause of action by any enrollee, payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this act upon the person.

2. The subrogation rights of the Association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person

entitled to receive benefits under the Oklahoma Life and Health Insurance Guaranty Association Act.

3. In addition to paragraphs 1 and 2 of this subsection, the Association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee or payee of a policy or contract with respect to the policy or contracts, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to the Oklahoma Life and Health Insurance Guaranty Association Act, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment ~~therefore~~ therefor, excepting any person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code Section 130.

4. If paragraphs 1 through 3 of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the Association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts, or portion thereof, covered by the Association.

5. If the Association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the Association has rights as described in paragraphs 1 through 4 of this subsection, the person shall pay to the Association the portion of the recovery attributable to the policies or contracts, or portion thereof, covered by the Association.

L. In addition to the rights and powers specified in the Oklahoma Life and Health Insurance Guaranty Association Act, the Association may:

1. Enter into contracts as are necessary or proper to carry out the provisions and purposes of the Oklahoma Life and Health Insurance Guaranty Association Act;

2. Sue or be sued, including, but not limited to, taking any legal actions necessary or proper to recover any unpaid assessments under Section 2030 of this title and to settle claims or potential claims against it;

3. Borrow money to effect the purposes of the Oklahoma Life and Health Insurance Guaranty Association Act. Any notes or other evidence of indebtedness of the Association not in default shall be legal investments for domestic member insurers and may be carried as admitted assets;

4. Employ or retain persons as are necessary or appropriate to handle the financial transactions of the Association, and to perform other functions as become necessary or proper under the Oklahoma Life and Health Insurance Guaranty Association Act;

5. Take any legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

6. Exercise, for the purposes of the Oklahoma Life and Health Insurance Guaranty Association Act and to the extent approved by the Commissioner, the powers of a domestic life ~~or~~ insurer, health insurer or health maintenance organization, but in no case may the Association issue ~~insurance~~ policies or ~~annuity~~ contracts other than those issued to perform its obligations under the Oklahoma Life and Health Insurance Guaranty Association Act;

7. Organize itself as a corporation or in other legal form permitted by the laws of the state;

8. Request information from a person seeking coverage from the Association in order to aid the Association in determining its obligations under the Oklahoma Life and Health Insurance Guaranty Association Act with respect to the person, and the person shall promptly comply with the request; ~~and~~

9. Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under the Oklahoma Life and Health Insurance Guaranty Association Act; and

10. Take other necessary or appropriate action to discharge its duties and obligations under the Oklahoma Life and Health Insurance Guaranty Association Act or to exercise its powers under the Oklahoma Life and Health Insurance Guaranty Association Act.

M. The Association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the Association.

N. 1. a. At any time within one hundred eighty (180) days of the date of the order of liquidation, the Association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts or annuities covered, in whole or in part, by the Association, in each case under any one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the Association. Any assumption shall be effective as of the date of the order of liquidation. The election shall be effected by the Association or the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) on its behalf sending written notice, return receipt requested, to the affected reinsurers.

b. To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the Association or to NOLHGA on its behalf as soon as possible after commencement of formal delinquency proceedings, copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether the contracts should be assumed, and notices of any defaults under the reinsurance contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.

c. The requirements provided in this subparagraph shall apply to reinsurance contracts assumed by the Association:

(1) the Association shall be responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation, and shall be responsible for the performance of all other obligations to be performed after the date of the

order of liquidation, in each case which relate to policies, contracts or annuities covered, in whole or in part, by the Association. The Association may charge policies, contracts or annuities covered in part by the Association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the Association and shall provide notice and an accounting of these charges to the liquidator,

- (2) the Association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts or annuities covered, in whole or in part, by the Association, provided that, upon receipt of any of these amounts, the Association shall be obliged to pay to the beneficiary under the policy, contract or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:
 - (a) the amount received by the Association, or
 - (b) the excess of the amount received by the Association over the amount equal to the benefits paid by the Association on account of the policy, contract or annuity less the retention of the insurer applicable to the loss or event,
- (3) within thirty (30) days following the election date of the Association, the Association and each reinsurer under contracts assumed by the Association shall calculate the net balance due to or from the Association under each reinsurance contract as of the election date with respect to policies, contracts or annuities covered, in whole or in part, by the Association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the

order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the Association or reinsurer shall pay any remaining balance due the other, in each case within five (5) days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the Association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the Association pursuant to division (2) of this subparagraph, the receiver shall remit the same to the Association as promptly as practicable, and

- (4) if the Association or receiver, on the behalf of the Association, within sixty (60) days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies, contracts or annuities covered, in whole or in part, by the Association, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay the premium insofar as the reinsurance contracts relate to policies, contracts or annuities covered, in whole or in part, by the Association, and shall not be entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the Association, against amounts due the Association.

2. During the period from the date of the order of liquidation until the election date, or if the election date does not occur, until one hundred eighty (180) days after the date of the order of liquidation:

- a. (1) neither the Association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the Association has the right to assume under paragraph 1 of this subsection, whether for periods prior to or after the date of the order of liquidation, and

(2) the reinsurer, the receiver and the Association shall, to the extent practicable, provide each other data and records reasonably requested.

- b. Provided that once the Association has elected to assume a reinsurance contract, the rights and obligations of the parties shall be governed by paragraph 1 of this subsection.

3. If the Association does not elect to assume a reinsurance contract by the election date pursuant to paragraph 1 of this subsection, the Association shall have no rights or obligations, in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.

4. When policies, contracts or annuities, or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies, contracts or annuities may also be transferred by the Association, in the case of contracts assumed under paragraph 1 of this subsection, subject to the following:

- a. unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any new policies, contracts of insurance or annuities in addition to those transferred,
- b. the obligations described in paragraph 1 of this subsection shall no longer apply with respect to matters arising after the effective date of the transfer, and
- c. notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than thirty (30) days prior to the effective date of the transfer.

5. The provisions of this subsection shall govern any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the insolvent insurer or any other person. The receiver shall remain entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in

periods prior to the date of the order of liquidation, subject to applicable setoff provisions.

6. Except as otherwise provided in this section, nothing in this subsection shall alter or modify the terms and conditions of any reinsurance contract. Nothing in this section shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this section shall give a policyholder, contract owner, enrollee, certificate holder or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract. Nothing in this section shall limit or affect the rights of the Association as a creditor of the estate against the assets of the state. Nothing in this section shall apply to reinsurance agreements covering property or casualty risks.

O. The Board of Directors of the Association shall have discretion and may exercise reasonable business judgment to determine the means by which the Association is to provide the benefits of the Oklahoma Life and Health Insurance Guaranty Association Act in an economical and efficient manner.

P. Where the Association has arranged or offered to provide the benefits of the Oklahoma Life and Health Insurance Guaranty Association Act to a covered person under a plan or arrangement that fulfills the obligations of the Association under the Oklahoma Life and Health Insurance Guaranty Association Act, the person shall not be entitled to benefits from the Association in addition to or other than those provided under the plan or arrangement.

Q. Venue in a suit against the Association arising under the Oklahoma Life and Health Insurance Guaranty Association Act shall be in Oklahoma County. The Association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under the Oklahoma Life and Health Insurance Guaranty Association Act.

R. In carrying out its duties in connection with guaranteeing, assuming or reinsuring policies or contracts under subsection A or B of this section, the Association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or

changes in value by issuing an alternative policy or contract in accordance with the following provisions:

1. In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for:

- a. a fixed interest rate,
- b. payment of dividends with minimum guarantees, or
- c. a different method for calculating interest or changes in value;

2. There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and

3. The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

SECTION 8. AMENDATORY 36 O.S. 2011, Section 2030, is amended to read as follows:

Section 2030. A. For the purpose of providing the funds necessary to carry out the powers and duties of the Oklahoma Life and Health Insurance Guaranty Association, the Board of Directors of the Oklahoma Life and Health Insurance Guaranty Association shall assess the member insurers, separately for each account, at such time and for such amounts as the Board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at six percent (6%) per annum on and after the due date.

B. There shall be two classes of assessments, as follows:

1. Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses and examinations ~~conducted under the authority of subsection D of Section 2033 of the Insurance Code~~. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer;

2. Class B assessments shall be made to the extent necessary to carry out the powers and duties of the Association under Section

2028 of ~~the Insurance Code~~ this title with regard to an impaired or an insolvent foreign or domestic insurer.

C. 1. The amount of any Class A assessment shall be determined by the Board and may be made on a pro rata or non-pro rata basis. If pro rata, the Board may provide that it be credited against future Class B assessments. A non-pro rata assessment shall be credited against future insolvency ~~assessments and shall not exceed One Hundred Fifty Dollars (\$150.00) per member insurer in any one calendar year.~~

The amount of any Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes among the accounts and among the subaccounts of the life insurance and annuity account, pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the Board in its sole discretion as being fair and reasonable under the circumstances.

The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the Commissioner. The methodology shall provide for fifty percent (50%) of the assessment to be allocated to accident and health member insurers and fifty percent (50%) to be allocated to life and annuity member insurers.

2. Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the member insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

3. Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this act. Classification of assessments under subsection B of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

D. The Association may abate, or defer in whole or in part, the assessment of a member insurer if, in the opinion of the Board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

E. The total of all assessments upon a member insurer for each account in any one (1) calendar year shall not exceed two percent (2%) of such average premiums of the insurer received in this state during the three (3) calendar years preceding the assessment on the policies and contracts covered by the account and in which the member insurer became an impaired or insolvent insurer. If the maximum assessment together with the other assets of the Association in any account does not provide in any one (1) year in either account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by ~~this act~~ the Oklahoma Life and Health Insurance Guaranty Association Act. The Board may provide in the plan of operation, a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

F. The Board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contributions of each insurer to that account, the amount by which the assets of the account exceed the amount the Board finds is necessary to carry out the obligations of the Association during the coming year with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future losses.

G. It shall be proper for any member insurer to consider the amount reasonably necessary to meet its obligations under this act in determining its premium rates and ~~policyowner~~ policy owner dividends as to any kind of insurance or health maintenance organization business within the scope of ~~this act~~ the Oklahoma Life and Health Insurance Guaranty Association Act.

H. The Association shall issue to each member insurer paying an assessment under ~~this act~~ the Oklahoma Life and Health Insurance Guaranty Association Act, other than a Class A assessment, a certificate of contribution, in a form prescribed by the Commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the Commissioner may approve.

I. A member insurer may offset against its premium, franchise or income tax liability to this state, an assessment described in subsection H of this section to the extent of twenty percent (20%) of the amount of such assessment for each of the five (5) calendar years following the year in which such assessment was paid. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its premium, franchise or income tax liability for the year it ceases doing business.

J. Any sums acquired by refund, pursuant to subsection F of this section, from the Association which have theretofore been written off by contributing insurers and offset against premium, franchise or income taxes as provided in subsection I of this section, and are not then needed for purposes of ~~this act~~ the Oklahoma Life and Health Insurance Guaranty Association Act, shall be paid by the Association to the Insurance Commissioner who shall dispense such funds in accordance with the statutes regarding disbursement of such taxes.

SECTION 9. AMENDATORY 36 O.S. 2011, Section 2032, is amended to read as follows:

Section 2032. A. To aid in the detection and prevention of member insurer insolvencies, it shall be the duty of the Insurance Commissioner:

1. To notify the commissioners of all of the other states, territories of the United States and the District of Columbia within thirty (30) days following the action taken or the date the action occurs, when the Commissioner takes any of the following actions against a member insurer:

a. revocation of license,

- b. suspension of license, or
- c. makes a formal order that the ~~company~~ member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus or any other account for the security of policy owners, contract owners, certificate owners or creditors;

2. To report to the board of directors when the Commissioner has taken any of the actions set forth in paragraph 1 of this subsection or has received a report from any other commissioner of other states indicating that any action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from a commissioner from another state;

3. To report to the board when the Commissioner has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer;

4. To furnish to the board of directors the National Association of Insurance Commissioners (NAIC) Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the NAIC, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until a time as made public by the Commissioner or other lawful authority.

B. The Commissioner may seek the advice and recommendations of the board of directors of the Oklahoma Life and Health Insurance Guaranty Association concerning any matter affecting the duties and responsibilities of the Commissioner regarding the financial condition of member insurers and ~~companies~~ health maintenance organizations seeking admission to transact ~~insurance~~ business in this state.

C. The board of directors may, upon majority vote, make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any ~~company~~ member

insurer or health maintenance organization seeking to do an insurance business in this state. The reports and recommendations shall not be considered public documents.

D. The board of directors may, upon majority vote, notify the Commissioner of any information indicating a member insurer may be an impaired or insolvent insurer.

E. The board of directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of member insurer insolvencies.

SECTION 10. AMENDATORY 36 O.S. 2011, Section 2036, is amended to read as follows:

Section 2036. A. For the purpose of carrying out its obligations under the Oklahoma Life and Health Insurance Guaranty Association Act, the Oklahoma Life and Health Insurance Guaranty Association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee pursuant to subsection K of Section 2028 of this title. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by the Oklahoma Life and Health Insurance Guaranty Association Act. Assets attributable to covered policies or contracts, as used in this subsection, are that proportion of the assets that the reserves which should have been established for such policies, or contracts bear to the reserves which should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

B. As a creditor of the impaired or insolvent insurer as established in subsection A of this section and consistent with Section 1927.1 of this title, the Association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this act. If the liquidator has not, within one hundred twenty (120) days of a final determination of insolvency of ~~an~~ a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the Association shall be entitled to

make application to the receivership court for approval of its own proposal to disburse these assets.

SECTION 11. AMENDATORY 36 O.S. 2011, Section 2038, is amended to read as follows:

Section 2038. A. If an order for liquidation or rehabilitation of ~~an~~ a member insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of subsections B through D of this section.

B. No such dividend shall be recoverable if the member insurer shows that when paid the distribution was lawful and reasonable, and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

C. Any person who was an affiliate that controlled the member insurer at the time the distributions were paid shall be liable up to the amount of distributions he received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared, shall be liable up to the amount of distributions he would have received if they have been paid immediately. If two ~~(2)~~ persons are liable with respect to the same distributions, they shall be jointly and severally liable.

D. The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

E. If any person liable under subsection C of this section is insolvent, all its affiliates that controlled it at the time the dividend was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

SECTION 12. AMENDATORY 36 O.S. 2011, Section 2043, is amended to read as follows:

Section 2043. A. No person, including ~~an~~ a member insurer, agent or affiliate of ~~an~~ a member insurer, shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement which uses the existence of the Oklahoma Life and Health Insurance Guaranty Association of this state for the purpose of sales, solicitation or inducement to purchase any form of insurance or other coverage covered by the Oklahoma Life and Health Insurance Guaranty Association Act. Provided, however, that this section shall not apply to the Oklahoma Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance or coverage by a health maintenance organization.

B. ~~Prior to May 1, 1988, the~~ The Association shall ~~prepare~~ have a summary document describing the general purposes and current limitations of the Association and complying with subsection C of this section. This document shall ~~be~~ have been submitted to, and approved by, the Insurance Commissioner ~~by May 1, 1988, for approval.~~ Sixty (60) days after receiving such approval, no member insurer shall deliver a policy or contract described in paragraph 1 of subsection B of Section 2025 of this title to a policy ~~or~~ owner, contract owner, certificate holder or enrollee unless the document is delivered to the policy or contract holder prior to or at the time of delivery of the policy or contract, except if subsection D of this section applies. The document should also be available upon request by a ~~policyholder~~ policy owner, contract owner, certificate holder or enrollee. The distribution, delivery or contents or interpretation of this document shall not mean that either the policy or the contract or the holder thereof would be covered in the event of impairment or insolvency of a member insurer. The description document shall be revised by the Association as amendments to the act may require. Failure to receive this document does not give the policyholder, contract holder, certificate holder, enrollee or insured any greater rights than those stated in this act.

C. The document prepared under subsection B of this section shall contain a clear and conspicuous disclaimer on its face. The Commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

1. State the name and address of the life and health insurance guaranty association and insurance department;

2. Prominently warn the policy ~~or~~ owner, contract owner, certificate holder or enrollee that the Life and Health Insurance Guaranty Association may not cover the policy or contract or, if coverage is available, it will be subject to substantial limitations, exclusions and conditioned on continued residence in the state;

3. State that the member insurer and its agents are prohibited by law from using the existence of the Oklahoma Life and Health Insurance Guaranty Association for the purpose of sales, solicitation or inducement to purchase any form of insurance or health maintenance organization coverage;

4. Emphasize that the policy or contract holder should not rely on coverage under the Oklahoma Life and Health Insurance Guaranty Association when selecting an insurer;

5. Provide other information as directed by the Commissioner.

D. No insurer or agent may deliver a policy or contract described in paragraph 1 of subsection B of Section 2025 of this title, but excluded under subparagraph a of paragraph 2 of subsection B of Section 2025 of this title from coverage under ~~this act~~ the Oklahoma Life and Health Insurance Guaranty Association Act, unless the insurer or agent, prior to or at the time of delivery, gives the policy ~~or~~ owner, contract owner, certificate holder or enrollee a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the Life and Health Insurance Guaranty Association. The Commissioner shall by rule specify the form and content of the notice.

SECTION 13. AMENDATORY 36 O.S. 2011, Section 6913, as amended by Section 19, Chapter 275, O.S.L. 2014 (36 O.S. Supp. 2018, Section 6913), is amended to read as follows:

Section 6913. A. 1. Before issuing any certificate of authority, the Insurance Commissioner shall require that the health maintenance organization have an initial net worth of One Million Five Hundred Thousand Dollars (\$1,500,000.00) and that the HMO shall thereafter maintain the minimum net worth required under paragraph 2 of this subsection.

2. Except as provided in paragraphs 3 and 4 of this subsection, every health maintenance organization shall maintain a minimum net worth equal to the greater of:

- a. One Million Five Hundred Thousand Dollars (\$1,500,000.00),
- b. two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the Commissioner on the first One Hundred Fifty Million Dollars (\$150,000,000.00) of premium and one percent (1%) of annual premium on the premium in excess of One Hundred Fifty Million Dollars (\$150,000,000.00),
- c. an amount equal to the sum of three (3) months of uncovered health care expenditures as reported on the most recent financial statement filed with the Commissioner, or
- d. an amount equal to the sum of:
 - (1) eight percent (8%) of annual health care expenditures, except those paid on a capitated basis or managed hospital payment basis, as reported on the most recent financial statement filed with the Commissioner, and
 - (2) four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis, as reported on the most recent financial statement filed with the Commissioner.

3. Every health maintenance organization licensed before November 1, 2003, shall maintain a minimum net worth of the greater of Seven Hundred Fifty Thousand Dollars (\$750,000.00) or:

- a. twenty-five percent (25%) of the amount required by paragraph 2 of this subsection by December 31, 2003,
- b. fifty percent (50%) of the amount required by paragraph 2 of this subsection by December 31, 2004,

- c. seventy-five percent (75%) of the amount required by paragraph 2 of this subsection by December 31, 2005, and
 - d. one hundred percent (100%) of the amount required by paragraph 2 of this subsection by December 31, 2006.
4. a. In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the Commissioner. An interest obligation relating to the repayment of any subordinated debt shall be similarly subordinated.
- b. The interest expenses relating to the repayment of a fully subordinated debt shall be considered covered expenses.
- c. A debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the Insurance Commissioner, shall not be considered a liability and shall be recorded as equity.

B. 1. Unless otherwise provided below, each health maintenance organization shall deposit with the Commissioner or, at the discretion of the Commissioner, with any organization or trustee acceptable to the Commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the Commissioner, which at all times shall have a value of not less than Five Hundred Thousand Dollars (\$500,000.00).

2. The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

3. All income from deposits shall be an asset of the organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the Commissioner before being deposited or substituted.

4. The deposit shall be used to protect the interests of the health maintenance organization's enrollees and to ensure continuation of health care services to enrollees ~~of a health~~

~~maintenance organization that is in rehabilitation or conservation. The Commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation.~~ If a health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the Uniform Insurers Liquidation Act.

5. The Insurance Commissioner may reduce or eliminate the deposit requirement if a health maintenance organization deposits with the Commissioner or other official body of the state or jurisdiction of domicile for the protection of all subscribers and enrollees of the health maintenance organization, wherever located, cash, acceptable securities or surety, and delivers to the Commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

C. 1. Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for:

- a. any unearned premium,
- b. the payment of all claims for incurred health care expenditures, whether reported or unreported, that are unpaid and for which the organization is or may be liable, and
- c. the expense of adjustment or settlement of those claims.

2. The liabilities shall be computed in accordance with rules promulgated by the Commissioner upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

D. 1. Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall provide that, in the event the health maintenance organization fails to pay for health care services as set forth in the contract, a subscriber or an enrollee shall not be liable to the provider for any sums owed by the health maintenance organization.

2. In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the required prohibition, the

participating provider shall not collect or attempt to collect from a subscriber or an enrollee sums owed by the health maintenance organization.

3. No participating provider or the provider's agent, trustee or assignee may maintain an action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

E. The Commissioner shall require that each health maintenance organization have a plan for handling insolvency that allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to subscribers or enrollees who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the Commissioner may require:

1. Insurance to cover the expenses to be paid for continued benefits after an insolvency;

2. Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

3. Insolvency reserves;

4. Acceptable letters of credit; or

5. Any other arrangements to ensure continuation of benefits as specified above.

F. An agreement to provide health care services between a provider and a health maintenance organization shall require that if the provider terminates the agreement, the provider shall give the organization at least ninety (90) days' advance notice of such termination.

SECTION 14. REPEALER 36 O.S. 2011, Sections 6914, 6921, and 6932, are hereby repealed.

SECTION 15. This act shall become effective November 1, 2019.

Passed the House of Representatives the 8th day of May, 2019.

Presiding Officer of the House
of Representatives

Passed the Senate the 22nd day of April, 2019.

Presiding Officer of the Senate

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this _____
day of _____, 20_____, at _____ o'clock _____ M.
By: _____

Approved by the Governor of the State of Oklahoma this _____
day of _____, 20_____, at _____ o'clock _____ M.

Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _____
day of _____, 20_____, at _____ o'clock _____ M.
By: _____