An Act

ENROLLED HOUSE BILL NO. 1979

By: Hilbert, Fetgatter, Lawson, Johns, Bashore, and West (Josh) of the House and Haste, Weaver, and Stanley of the Senate

An Act relating to vision care; defining terms; establishing requirements for agreements between certain vision care insurers and providers; setting reimbursement standards; prohibiting vision care plans from offering certain provisions to insureds; providing standards for contract negotiation; establishing requirements for changes to certain agreements between insurers and providers; prohibiting vision care plans from limiting services or materials offered by vision care providers; requiring vision care plans to register for and maintain certificate of authority with Insurance Department; establishing application requirements; establishing financial surety provisions; requiring vision care plans to issue coverage policies to insureds; establishing reporting requirements; prescribing revocation and suspension processes for certificates of authority; requiring filing of certain advertising materials with the Department; establishing authority of Department with regard to vision care plans; directing rule promulgation; amending 36 O.S. 2021, Sections 1202 and 1204, which relate to unfair practices and frauds; modifying definition; modifying provisions to be considered an unfair practice by a vision care plan; and declaring an emergency.

SUBJECT: Vision care

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

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6972 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. “Contractual discount” means a reduction from a provider’s usual and customary rate for covered services and materials required under a prepaid vision plan agreement with a provider;

2. “Covered materials” means materials for which reimbursement from the insurer, vision plan, or vision care discount plan is provided to a vision care provider by an enrollee’s plan contract, or for which a reimbursement would be available but for the application of the enrollee’s contractual limitations of deductibles, copayments, or coinsurance;

3. “Covered services” means services eligible for reimbursement from the insurer or vision plan to a provider, or services that would be eligible for reimbursement but for the application of the enrollee’s contractual plan limitations of deductibles, copayments, or coinsurance, regardless of how the benefits are listed in the explanation of benefits provided in the vision plan of the enrollee;

4. “Enrollee” means any individual enrolled in a health care plan, vision plan, or vision care discount plan provided by a group, employer, or other entity that purchases or supplies coverage for a vision plan;

5. “Extrapolation” means a mathematical process or technique used by a vision plan in the process of auditing a vision care provider to estimate audit results for a larger batch of group claims not reviewed in the audit by the plan;

6. “Health benefit plan” means a health benefit plan as defined pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes;

7. “Materials” means ophthalmic devices including but not limited to lenses, devices containing lenses, artificial intraocular lenses, ophthalmic frames and other lens mounting apparatus, prisms, lens treatments and coatings, contact lenses, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa, or any material allowed to be utilized by the Board of Examiners in Optometry and optometry’s scope of practice as provided by law;

8. “Net equity” means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the Insurance Commissioner;

9. “Prepaid vision plan” means any contractual agreement whereby any prepaid vision plan organization undertakes to provide full payment or a discount of vision services directly, to arrange for prepaid vision services, or to pay or make reimbursement for any vision service not provided for by other insurance;

10. “Prepaid vision plan organization” means any person who, or organization or entity that, undertakes to conduct one or more prepaid vision plans providing only vision services;

11. “Services” means the professional work performed by a vision care provider;

12. “Subcontractor” means any company, group, or third-party entity including agents, servants, partially or wholly owned subsidiaries, and controlled organizations contracted by the insurer, vision plan, or vision care discount plan to supply services or materials for a vision care provider or enrollee to fulfill the benefit plan of an insurer, vision plan, or vision care discount plan;

13. “Tangible net equity” means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill, going concern value, organizational expenses, start-up costs, long-term prepayments of deferred charges, nonreturnable deposits, and obligations of officers, directors, owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same term as equivalent transactions with nonaffiliates and that are not past due;

14. “Uncovered expense” means the cost of health care services that are the obligation of a prepaid vision plan organization for which:

a. an enrollee may be liable in the event of the insolvency of the organization, and

b. alternative arrangements acceptable to the Commissioner have not been made to cover the costs; and

15. “Vision care provider” or “provider” means a licensed doctor of optometry or a licensed medical or osteopathic doctor practicing under the authority of the applicable provisions of Title 59 of the Oklahoma Statutes.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6973 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. No agreement between an insurer or prepaid vision plan and a vision care provider may require that a provider provide services or materials at a fee limited or set by the insurer or prepaid vision plan, unless the services or materials are reimbursed as covered services or covered materials under the contract.

B. A provider shall not charge more for services and materials that are not covered services or materials to an enrollee of a prepaid vision plan or insurer than his or her usual and customary rate for those services and materials.

C. Reimbursements paid by an insurer or prepaid vision plan for covered services and covered materials, regardless of the supplier or optical lab used to obtain materials, shall be at the usual, customary, and reasonable rate and made available to the vision care provider prior to the provider accepting a contract from the insurer or prepaid vision plan. An insurer or prepaid vision plan shall not provide nominal reimbursement or advertise services and materials to be covered with additional copay or coinsurance in order to claim that services and materials are covered services and materials if the health benefit plan or prepaid vision plan does not reimburse for the services or materials.

D. Prepaid vision plans shall not in any manner impact the pricing of noncovered services or materials.

E. Prepaid vision plans shall provide standard reimbursements for all lenses with the same design, quality, and composition. The period of time prescribed by a contract between any prepaid vision plan and a provider for the plan to recover any reimbursement amount from a provider shall be the same period of time allowed or required for any provider to recover any reimbursement amount from a prepaid vision plan.

F. A prepaid vision plan shall not use extrapolation to complete an audit of a vision care provider. Any additional payment due to a provider or any refund to a prepaid vision plan shall be based on actual overpayment or underpayment and shall not be based on extrapolation.

G. A prepaid vision plan shall not incentivize patients to receive vision care services at an entity owned wholly or in part by the plan or subsidiaries of the plan. Any entity providing vision care services shall provide notice to patients that an entity is owned wholly or in part by the plan or subsidiaries of the plan.

H. No person or entity shall sell, solicit, or negotiate any prepaid vision plan to an enrollee in this state without an approved certificate of authority under Section 7 of this act.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6974 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. No agreement between an insurer or a prepaid vision plan and a vision care provider shall require that a provider participate with or be credentialed by any specific prepaid vision plan as a condition for participation in the health care network of the insurer to provide covered services to its enrollees.

2. In the event that a vision care provider is credentialed by an insurer or vision care plan organization, no insurer or vision care plan organization shall construe re-credentialing as re-contracting with a vision care provider. All contracts shall be distinct and separate documents from any credentialing materials.

B. Any insurer issuing or renewing a health benefit plan or prepaid vision plan which provides coverage for services rendered by a duly licensed physician or osteopath that are within the scope of practice of a duly licensed optometrist shall provide the same reimbursement for services to optometrists as allowed for those services rendered by physicians or osteopaths.

C. No insurer or prepaid vision plan organization shall require an optometrist to meet terms and conditions that are not required of a physician or osteopath as a condition for participation in its provider network for the provision of services that are within the scope of practice of an optometrist.

D. If a vision care provider enters into any subcontract agreement with another provider to provide his or her licensed health care services to the enrollee, dependent of the enrollee, or an enrollee of a managed care plan where the subcontracted provider will bill the managed care plan or enrollee directly for the subcontracted services, the subcontract agreement shall meet all requirements of this act.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6975 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An insurer or prepaid vision plan organization shall not change or alter an agreement entered into with a vision care provider unless the insurer or organization:

1. Provides notice of any proposed change to the provider through a certified letter or an electronic communication requiring an electronic signature proving receipt detailing proposed changes to the vision care provider. A face-to-face or virtual meeting shall be conducted if requested by the provider. If the changes in the contract are not agreed to by the vision care provider within ninety (90) days of the date of the provided notice, the agreement shall terminate; and

2. Supplies the vision care provider with an explanation of benefits and an explanation of payment for services and materials rendered by the provider upon request, regardless of the provider's network status with the vision plan.

B. 1. A new agreement is required to be established and agreed upon after three or more material changes are made to an existing agreement from an insurer, vision plan, or vision care discount plan.

2. Any amendment to a proposed contract that is being reviewed by a provider prior to its execution and any amendment to an existing contract with a service provider shall be underlined to clearly indicate the contract modification.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6976 of Title 36, unless there is created a duplication in numbering, reads as follows:

No agreement between an insurer or prepaid vision plan and a vision care provider shall restrict or limit, either directly or indirectly, the provider's choice of sources and suppliers of services or materials or use of optical labs provided by the vision care provider to an enrollee. Vision care providers shall not receive reduced reimbursement for using labs and suppliers that the provider chooses to best serve patient outcomes.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6977 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. No person, organization, or entity, unless authorized pursuant to an approved certificate of authority under Section 7 of this act, shall establish or operate a prepaid vision plan organization in this state or sell, offer to sell, solicit offers to purchase, or receive advance or periodic consideration in conjunction with a prepaid vision plan without obtaining and maintaining a certificate of authority.
B. On or before February 1, 2025, every prepaid vision plan organization operating in this state shall submit an application for a certificate of authority to the Insurance Commissioner. Each applicant may continue to operate as an organization until the Commissioner acts upon the application.

C. An application for a certificate of authority to operate as a prepaid vision plan organization shall be electronically filed with the Insurance Commissioner in the form and manner prescribed by the Commissioner, along with any transaction or other applicable fees. The application shall be verified by an officer or authorized representative of the applicant and shall set forth or be accompanied by:

1. A copy of any documents of organization of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, with all amendments to the documents;

2. A copy of any bylaws, rules, regulations, or similar documents regulating the conduct of the internal affairs of the applicant;

3. A list of the names, addresses, and official positions of the persons who are responsible for the conduct of the business affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, and the principal officers, in the case of a corporation, or the partners or members in the case of a partnership or association;

4. A copy of the form of any contract made or to be made between any providers of vision services or persons listed in paragraph 3 of this subsection and the applicant;

5. A statement generally describing the prepaid vision plan organization, the facilities, personnel of the organization, and prepaid vision plans offered by the organization;

6. A copy of the form of individual or group coverage or a copy of any form of evidence of coverage to be issued to enrollees;

7. Financial statements showing assets, liabilities, and sources of financial support of the applicant. If the financial affairs of the applicant are audited by independent certified public accountants, a copy of the most recent regular certified financial statement for the applicant shall satisfy the requirement of this paragraph, unless the Commissioner determines that additional or more recent financial information is required;

8. A description of the proposed method of marketing the prepaid vision plan, a financial prospectus which includes a three-year projection of the initial operating results anticipated, and a statement as to the sources of working capital available for the operation of the prepaid vision plan and any other source of funding;

9. A power of attorney, duly executed by the applicant if not domiciled in this state, appointing the Commissioner as the true and lawful representative for service of process for the applicant in this state upon whom all lawful process in any legal action or proceeding against the prepaid vision plan organization on a cause of action arising in this state may be served;

10. A fee of One Hundred Dollars ($100.00) for issuance of a certificate of authority; and

11. Any other information as the Commissioner may require.

D. Within ten (10) days following any modification of information previously furnished as required by subsection C of this section, a prepaid vision plan organization shall file a notice of the modification with the Commissioner, in the form and manner prescribed by the Commissioner, along with any applicable fees.

E. Any service of legal process against a prepaid vision plan organization served upon the Commissioner shall comply with all requirements set forth pursuant to Section 622 of Title 36 of the Oklahoma Statutes for legal processes against a foreign or alien insurer.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6978 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Issuance of a certificate of authority for a prepaid vision plan organization shall be granted by the Insurance Commissioner if the Commissioner is satisfied that the following conditions are met:

1. The requirements of Section 6 of this act have been fulfilled;

2. The persons, organization, or entity responsible for conducting the business affairs of the prepaid vision plan organization are competent, trustworthy, and professionally capable of providing or arranging for the provision of services offered;

3. The prepaid vision plan organization constitutes an appropriate mechanism to achieve an effective prepaid vision plan;

4. The prepaid vision plan organization has filed with the Commissioner a fidelity bond that is in its own name on its officers and employees in an amount not less than Fifty Thousand Dollars ($50,000.00) and is subject to the approval of the Commissioner;

5. The financial structure of the prepaid vision plan organization may reasonably be expected to meet obligations for payment of services for enrollees and prospective enrollees. In making this determination, the Commissioner may consider:

a. the financial soundness of the arrangements made pursuant to the provisions of the prepaid vision plan for services and the schedule of charges used,

b. any agreement with an insurer, hospital, medical service corporation, or any other organization for ensuring the payment of prepaid vision services,

c. provisions in the plan for automatic coverage of vision services if the prepaid plan is discontinued, and

d. the sufficiency of the agreement for prepaid vision services with providers of vision services; and

6. The Commissioner has not made a determination that the prepaid vision plan organization is incompetent, untrustworthy, or financially irresponsible, and the organization has not had any insurance license denied for cause by any state.

B. A certificate of authority shall expire at midnight on June 30 following the date of issuance or the most recent renewal date, and annually on June 30 thereafter. If the prepaid vision plan organization remains in compliance with the provisions of this act and pays a renewal fee of One Hundred Dollars ($100.00), the certificate of authority may be renewed.

C. Every prepaid vision plan organization, upon receipt of any inquiry from the Insurance Commissioner, shall furnish the Commissioner with an adequate response to the inquiry within twenty (20) days from the receipt of inquiry.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6979 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. Except as approved in accordance with subsection B of this section, each prepaid vision plan organization shall at all times have and maintain tangible net equity equal to the greater of:

a. Fifty Thousand Dollars ($50,000.00), or

b. two percent (2%) of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

2. A prepaid vision plan organization that has uncovered expenses in excess of Fifty Thousand Dollars ($50,000.00), as reported on the most recent annual financial statement filed with the Insurance Commissioner, shall maintain tangible net equity equal to twenty-five percent (25%) of the uncovered expenses in excess of Fifty Thousand Dollars ($50,000.00) in addition to the tangible net equity required by paragraph 1 of this subsection.

B. 1. Each prepaid vision plan organization shall deposit in trust with the Commissioner cash, securities eligible for the investment of capital funds under the Oklahoma Insurance Code, other measures deemed acceptable by the Commissioner, or any combination thereof in an amount equal to Twenty-five Thousand Dollars ($25,000.00) plus twenty-five percent (25%) of the tangible net equity required in subsection A of this section; provided, however, that the deposit shall not be required to exceed One Hundred Thousand Dollars ($100,000.00). Any securities deposited under this subsection shall be issued to the Commissioner and the prepaid vision plan organization and shall not be released by any company holding such security without the signatures of the Commissioner and the authorized prepaid vision plan organization's personnel.

2. The deposit shall be an admitted asset of the prepaid vision plan organization in the determination of tangible net equity.

3. All income from deposits shall be an asset of the prepaid vision plan organization. A prepaid vision plan organization may withdraw a deposit or any part thereof after making a substitute deposit of an equal amount and value. Any securities shall be approved by the Commissioner before being substituted.

4. The deposit shall be used to protect the interests of the members of the prepaid vision plan organization and to assure continuation of vision plan services to members of a prepaid vision plan organization that is in rehabilitation or conservation. If a prepaid vision plan organization is placed in receivership or liquidation, the deposit shall be an

asset subject to the provisions of Article 19 of the Oklahoma Insurance Code pursuant to Section 1901 et seq. of Title 36 of the Oklahoma Statutes, provided the deposit shall not be subject to attachment by any creditors of the prepaid vision plan organization.

5. The deposit shall not apply to a prepaid vision plan organization that is funded by the United States government, this state, or a political subdivision thereof.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6980 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Insurance Commissioner may increase the amounts required under this act for tangible net equity, capital maintained, fidelity bond, and deposit to any amount the Commissioner determines to be appropriate if the Commissioner determines that such an increase is necessary to:

1. Assist the Commissioner in the performance of his or her regulatory duties;

2. Ensure the prepaid vision plan organization complies with the requirements of this act; or

3. Ensure the solvency of the prepaid vision plan organization.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6981 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Every enrollee of a prepaid vision plan shall be issued a coverage policy by the prepaid vision plan organization. No policy for coverage or amendment to the policy shall be issued or delivered to any person in this state until a copy of the policy for coverage or amendment to the policy has been filed with and approved by the Insurance Commissioner.

B. A policy for coverage shall contain a statement of:

1. The prepaid vision services or other benefits to which the enrollee is entitled under the prepaid vision plan;

2. Any limitations of the services or benefits to which the enrollee is entitled under the prepaid vision plan;

3. Information as to how services may be obtained; and

4. The obligation of the enrollee for charges for the prepaid vision plan.

C. The Commissioner shall approve any policy of coverage if the requirements of this section are complied with and the prepaid vision plan, in the judgment of the Commissioner, is able to meet its financial obligations for the membership coverage. It shall be unlawful for a prepaid vision plan organization to issue a policy until it is approved by the Commissioner.

D. 1. If the Commissioner does not disapprove any policy within thirty (30) days after filing, the policy shall be deemed approved.

2. If the Commissioner disapproves a policy of membership coverage, the Commissioner shall notify the prepaid vision plan organization, specifying the reasons for disapproval. The Commissioner shall grant a hearing on any disapproval within thirty (30) days after a request in writing for a hearing is received by the Commissioner from the prepaid vision plan organization.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6982 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. On or before March 1 of each calendar year, every prepaid vision plan organization offering coverage in this state shall file with the Insurance Commissioner a report of the business activities of the organization for the preceding calendar year. The report shall contain a notarized signature of at least two principal officers of the corporation or members of the entity.

B. A report submitted under this section shall be in the form and manner prescribed by the Commissioner and shall include:

1. A financial statement of the organization, including a copy of the balance sheet, receipts, and disbursements of the organization for the subject year certified by an independent certified public accountant. The Commissioner may accept a full report of the most recent examination of a foreign prepaid vision plan, certified to by the appropriate examining official of another state;

2. Any material changes in the information required to be provided pursuant to Section 6 of this act;

3. The number of persons who have enrolled in plans offered by the organization during the preceding year, the total number of enrollees of each plan as of the end of the year, and the number of enrollments terminated during the year;

4. The costs of all care provided and the number of enrollees who received care pursuant to the provisions of the prepaid vision plan; and 5. Any other information relating to the performance of the prepaid vision plan organization deemed necessary by the Commissioner.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6983 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner may suspend or revoke any certificate of authority issued pursuant to this act if the Commissioner finds that the prepaid vision plan organization:

1. Is operating contrary to the basic organizational documents of the organization or in a manner contrary to that described in or reasonably inferred from any information submitted pursuant to Section 6 of this act;

2. Issues a coverage policy which does not comply with the requirements of Section 10 of this act;

3. Does not provide or arrange for basic vision services appropriate to a prepaid vision plan;

4. Can no longer be expected to meet the obligations to enrollees or prospective enrollees of the prepaid vision plan;

5. Uses fraudulent, coercive, or dishonest practices, or demonstrates incompetence, untrustworthiness, or financial irresponsibility in the conduct of business;

6. Fails to deal equitably with any providers or other persons or facilities which offer services covered within a contract or policy issued pursuant to this act; or

7. Fails to substantially comply with the insurance laws of this state or violates any regulation, rule, subpoena, or order of the Commissioner.

B. When the certificate of authority of a prepaid vision plan organization is suspended, the organization shall not accept, during the period of such suspension, any additional enrollments for coverage except newly acquired dependents of existing enrollees and shall not engage in any advertising or solicitation.

C. When the certificate of authority of a prepaid vision plan organization is revoked, the organization shall terminate operation of the organization in this state immediately and shall conduct no further business except as may be essential to the orderly conclusion of the business affairs of the organization. The Commissioner, by written order, may permit further operation of the organization as the Commissioner finds to be in the best interest of members of the organization.

D. In addition to or in lieu of any applicable suspension or revocation of a certificate of authority, the Commissioner may invoke a fine not to exceed One Thousand Dollars ($1,000.00) for each violation. The payment of the fine may be enforced in the same manner as civil judgments may be enforced.

E. A prepaid vision plan organization which has had its certificate of authority denied, suspended, or revoked, or has suffered an adverse determination by the Commissioner shall be entitled to a hearing pursuant to the provisions of the Administrative Procedures Act under Section 250 et seq. of Title 75 of the Oklahoma Statutes.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6984 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. No advertising or sales material relating to a prepaid vision plan organization shall be issued or delivered to any person in this state until a copy of the material has been filed with and approved by the Insurance Commissioner.
2. Within thirty (30) days after the submission of advertising or material under this subsection, the Commissioner shall issue a determination approving or disapproving of the material.

3. Disapproval of the advertising or material shall be on the basis that, in whole or in part, the material is false, deceptive, or misleading. Written notification shall be issued to an organization that has materials disapproved pursuant to this subsection. Thereafter, the disapproved advertising material shall not be used.

4. Violation of the provisions of this subsection shall entitle the Commissioner in his or her discretion and without additional cause to withdraw approval of any coverage policy with respect to which the advertising or sales material is used.

B. Advertisement and publication of material by a prepaid vision plan organization or anyone acting on behalf of the organization to inform enrollees or prospective enrollees of the plan as to the coverage offered by the plan and the operation of the organization shall not be a violation of any provisions of law relating to solicitation of customers or advertising by prepaid vision plan providers if the advertising or sales material:

1. Is approved prior to use by the Commissioner upon determination by the Commissioner that the material is not inaccurate, false, deceptive, or misleading;

2. Does not identify the providers of vision services nor describe their professional qualifications, except upon request of the enrollee or prospective enrollee;

3. Does not describe the professional experience or attainments of providers individually or as a group, or contain language that states, evaluates, or lauds the professional competence, skills, or reputations of the providers; and

4. Shall not cause any providers to violate any professional ethics or laws that prohibit the solicitation of patients.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6985 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner may conduct an examination of the business affairs of any prepaid vision plan organization as often as the Commissioner deems necessary for the protection of the interests of the people of this state.

B. Any receivership, rehabilitation, liquidation, or conservation of a prepaid vision plan organization shall be conducted pursuant to the provisions for the receivership, rehabilitation, liquidation, or conservation of an insurer provided for by Articles 18 and 19 of Title 36 of the Oklahoma Statutes.

C. The Commissioner shall promulgate any rules necessary to effectuate the provisions of this act.

SECTION 15. AMENDATORY 36 O.S. 2021, Section 1202, is amended to read as follows:
Section 1202. When used in this article:

1. “Person” shall mean any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd’s insurer, Lloyd’s Name, Lloyd’s Syndicate Name, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers ~~and~~, adjusters, and prepaid vision plan organizations and insurers;

2. “Commissioner” shall mean the Insurance Commissioner of this state; and

3. “Name” shall mean any individual or corporate entity underwriting insurance for their own account through the Lloyd’s of London market and any agents or employees of any such individual or corporate entity.

SECTION 16. AMENDATORY 36 O.S. 2021, Section 1204, is amended to read as follows:

Section 1204. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

1. Misrepresentations and false advertising of policy contracts. Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his or her insurance.;

2. False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his or her insurance business which is untrue, deceptive or misleading. No insurance company shall issue, or cause to be issued, any policy of insurance of any type or description upon life, or property, real or personal, whenever such policy of insurance is to be furnished or delivered to the purchaser or bailee of any property, real or personal, as an inducement to purchase or bail said such property, real or personal, and no other person shall advertise, offer or give free insurance, insurance without cost or for less than the approved or

customary rate, in connection with the sale or bailment of real or personal property, except as provided in Section 4101 of this title. No person that is not an insurer shall assume or use any name which deceptively infers or suggests that it is an insurer.;

3. Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.;

4. Boycott, coercion and intimidation. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.;

5. False financial statements. Filing with any supervisory or other public official, or making, publishing, disseminating, circulating or delivering to any person, or placing before the public or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person or placed before the public, any false statement of financial condition of an insurer with intent to deceive.

Making any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.;

6. Stock operations and advisory board contracts. Issuing or delivering or permitting agents, officers, or employees to issue or deliver agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.;

7. Unfair discrimination.

(a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(c) As to kinds of insurance other than life and accident and health, no person shall make or permit any unfair discrimination in favor of particular persons, or between insureds or subjects of insurance having substantially like insuring, risk, and exposure factors, or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charged therefor. This subsection paragraph shall not apply as to any premium rate in effect pursuant to Article 9 of the Oklahoma Insurance Code.;

8. Rebates.

(a) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of insurance or agreement as to such contract other than as plainly expressed in the contract issued thereon; or paying or allowing, or giving or offering to pay, allow or give, directly or indirectly, as inducement to any contract of insurance, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; except in accordance with an applicable rate filing, rating plan or rating system filed with and approved by the Insurance Commissioner; or giving or selling or purchasing or offering to give, sell, or purchase as inducement to such insurance, or in connection therewith, any stocks, bonds or other securities of any company, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract or receiving or accepting as inducement to contracts of insurance, any rebate of premium payable on the contract, or any special favor or advantage in the dividends or other benefit to accrue thereon, or any valuable consideration or inducement not specified in the contract.

(b) Nothing in subsection paragraph 7 or paragraph subparagraph (a) of this subsection paragraph shall be construed as including within the definition of discrimination or rebates any of the following practices:

(1) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided, that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interest of the company and its policyholders;

(2) In the case of life or accident and health insurance policies issued on the industrial debit or weekly premium plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense;

(3) Making a readjustment of the rate of premium for a policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;

(4) In the case of life insurance companies, allowing its bona fide employees to receive a commission on the premiums paid by them on policies on their own lives;

(5) Issuing life or accident and health policies on a salary saving or payroll deduction plan at a reduced rate commensurate with the savings made by the use of such plan;, and

(6) Paying commissions or other compensation to duly licensed agents or brokers, or allowing or returning to participating policyholders, members or subscribers, dividends, savings or unabsorbed premium deposits.

(c) As used in this section, the word "insurance" includes suretyship and the word "policy" includes bond.;

9. Coercion prohibited. Requiring as a condition precedent to the purchase of, or the lending of money upon the security of, real or personal property, that any insurance covering such property, or liability arising from the ownership, maintenance or use thereof, be procured by or on behalf of the vendee or by the borrower in connection with such purchase or loan through any particular person or agent or in any particular insurer, or requiring the payment of a reasonable fee as a condition precedent to the replacement of insurance coverage on mortgaged property at the anniversary date of the policy; provided, however, that this provision shall not prevent the exercise by any such vendor or lender of the right to approve or disapprove any insurer selected to underwrite the insurance;, but any disapproval of any insurer shall be on reasonable grounds.;

10. Inducements. No insurer, agent, broker, solicitor, or other person shall, as an inducement to insurance or in connection with any insurance transaction, provide in any policy for or offer, sell, buy, or offer or promise to buy, sell, give, promise, or allow to the insured or prospective insured or to any other person in his or her behalf in any manner whatsoever:

(a) any employment.,

(b) any shares of stock or other securities issued or at any time to be issued or any interest therein or rights thereto.,

(c) any advisory board contract, or any similar contract, agreement or understanding, offering, providing for, or promising any special profits.,

(d) any prizes, goods, wares, merchandise, or tangible property of an aggregate value in excess of One Hundred Dollars ($100.00)., or

(e) any special favor, advantage or other benefit in the payment, method of payment or credit for payment of the premium through the use of credit cards, credit card facilities, credit card lists, or wholesale or retail credit accounts of another person. The provisions of this paragraph shall not apply to individual policies insuring against loss resulting from bodily injury or death by accident as defined by Article 44 of the Oklahoma Insurance Code.;

11. Premature disposal of premium notes prohibited. No insurer or agent thereof shall hypothecate, sell, or dispose of a promissory note received in payment of any part of a premium on a policy of insurance applied for prior to the delivery of the policy.;

12. Fraudulent statement in application; penalty. Any insurance agent, examining physician, or other person who knowingly or willfully makes a false or fraudulent statement or representation in or relative to an application for insurance, or who makes any such statement to obtain a fee, commission, money, or benefit, shall be guilty of a misdemeanor.;

13. Deceptive use of financial institution's name in notification or solicitation. Verbally or by any other means notifying or soliciting any person in a manner that:

(a) mentions the name of an unrelated and unaffiliated financial institution,

(b) mentions an insurance product or the possible lack of insurance coverage,

(c) does not mention the actual or trade name of the insurance agency or company on whose behalf the notification or solicitation is provided, and

(d) thereby creates an impression or implication, including by omission, that the financial institution or a financial-institution-authorized entity is or may be the one making the notification or solicitation. Nothing in this paragraph shall be interpreted to prohibit the reference to or use of the name of a financial institution made pursuant to a contractual agreement between the insurer and the financial institution.; and

<u>14. No insurer or prepaid vision plan organization as defined in Section 1 of this act which offers multiple prepaid vision plans may require as a condition of participation in any one prepaid vision plan that a vision care provider participate in any of the other prepaid vision plans offered by the insurer or prepaid vision plan organization.</u>

SECTION 17. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.