SHORT TITLE: Insurance; creating the Oklahoma Health Maintenance Organization Act. Effective date.

STATE OF OKLAHOMA

2nd Session of the 46th Legislature (1998)

SENATE BILL NO. 1301 By: Williamson

AS INTRODUCED

An Act relating to health care; creating the Oklahoma Health Maintenance Organization Act; stating short title; providing definitions; providing for application for certificate of authority; requiring certificate; allowing compliance for foreign corporations; requiring present health maintenance organizations to submit application; allowing continuance of operation during certain time period; stating that denial of application serves as revocation; stating contents of application; requiring certain verification and form; authorizing promulgation of certain rules; deeming approval of modifications or amendments; allowing Commission to postpone certain action; requiring copies of application to State Commissioner of Health; requiring certain determination by the State Commissioner of Health; stating grounds which the Commissioner of Health shall consider in determining certification; prohibiting denial of certificate until certain requirements are met; stating powers; requiring the filing of certain notice; limiting disapproval of exercise of power; deeming approval of contents of notice; allowing promulgation of certain rules; providing for fiduciary relationship; requiring bond; requiring the establishment of certain procedures; requiring

internal quality assurance program and stating contents; requiring recording of certain proceedings and maintenance of confidentiality; allowing State Commissioner of Health access to certain minutes; requiring adequate patient record system; making enrollees' clinical records available to State Commissioner of Health; requiring establishment of certain mechanism; stating provisions relating to contracts; requiring contract allow for examination period, premium refund and payment for services if refund received; providing for evidence of coverage and contract procedures related thereto; allowing the adoption of certain rules; providing for approval or disapproval of form and procedures related thereto; exempting submission of certain evidence of coverage from submission to the Commissioner; requiring filing of certain report and stating contents; requiring provision of list of providers and certain other information, notice of change in operation and termination of primary care provider; requiring health maintenance to provide assistance to certain enrollees; requiring grievance procedures; requiring certain minimum net worth and stating procedures thereto; requiring that deposit be asset; stating use of deposit; allowing for reduction or elimination of deposit requirement; providing procedures for computing liabilities; stating requirements for contracts and stating consequences; prohibiting certain action at law; requiring plan for handling insolvency and stating requirements; requiring notice of termination;

stating conditions for insolvency deposit, stating amount and requiring report; providing procedures for use and withdrawal of deposit; allowing promulgation of certain rules; allowing transfer of group enrollees upon insolvency of health maintenance organization; requiring equality in coverage and rates; requiring equitable allocation of insolvent health maintenance organizations' group contracts and nongroup enrollees; allowing aggregation of allocated nongroup enrollees; defining term; prohibiting pre-existing conditions in succeeding carrier's contract; requiring certain filing and approval prior to use of premium rates; stating criteria for establishment of premium rates and requiring approval or disapproval; allowing hearing upon disapproval of filing; deeming approval of rate schedule or methodology; allowing promulgation of rules and stating grounds for rules; exempting certain persons from being licensed as a health maintenance organization producer; allowing Insurance Commissioner to exempt by rule certain classes of persons from licensure; allowing organization and operation of health maintenance organizations by subsidiaries, affiliates or jointly; allowing contracts between certain entities and health maintenance organizations and stating procedures; allowing the Insurance Commissioner to examine the affairs and quality assurance of a health maintenance organization and providers and providing procedures thereto; charging the health maintenance organization for the examination; allowing report

in lieu of examination; allowing for suspension, revocation or denial of certificate of authority under certain conditions; stating penalties; stating conditions for determining insufficient net worth and procedures related thereto; deeming a deficiency an impairment and stating consequences; prohibiting certain actions by a health maintenance organization when impaired and stating exceptions; stating conditions precedent to suspension, revocation or denial of a certificate of authority or imposition of an administrative penalty; providing for hearing and review; prohibiting additional enrollment and solicitation by a suspended health maintenance organization; requiring wind up of affairs of a health maintenance organization upon revocation of certificate of authority and providing exception; requiring rehabilitation, liquidation or conservation be conducted under supervision of Insurance Commissioner and providing procedures; allowing enrollees and providers certain priority; requiring certain actions by a health maintenance organization under specified conditions; deeming violations of state law to be in violation of this act; requiring Insurance Commissioner to promulgate certain rules; stating that certain remedies and measures are not in lieu of certain other remedies and measures; allowing and requiring promulgation of certain rules; allowing levying of administrative penalty and stating amount of penalty; allowing informal conference to ascertain facts related to suspected violation; allowing for

cease and desist order or proceeding to obtain injunctive or other relief; allowing hearing on cease and desist order; allowing Commissioner to take appropriate action under certain circumstances; exempting certain entities from provision of law and stating exceptions; construing act; exempting health maintenance organization from provision of law relating to practice of medicine; treating certain documents as public documents, with exception; providing for confidentiality of certain documents with exceptions for disclosure; prohibiting liability for civil damages or legal action under certain circumstances; construing section of law; providing for confidentiality and prohibiting subpoenas under certain circumstances; allowing contracting by State Commissioner of Health with certain entities; prohibiting exchange or acquisition of securities unless certain conditions are met; requiring certain employers to allow employees option of enrolling in a health maintenance organization; limiting amount employer must pay for health benefits; prohibiting financial discrimination against health maintenance organization enrollee; allowing adoption of coordination of benefits provisions and providing procedures; requiring health maintenance organizations to make payments for certain services; allowing assessments on health maintenance organizations in state to pay for insolvency and providing limits; allowing Insurance Commissioner to use certain funds; allowing Insurance Commissioner to promulgate certain rules;

allowing certain claims assignments and subrogation; allowing subrogation rights to have certain priority; requiring pro rata distribution of certain funds; limiting aggregate coverage of uncovered expenditures; limiting continuation of coverage with exception; allowing waiver of assessments; stating penalty; allowing appeal; providing for codification; and providing an effective date.

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 2699.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Oklahoma Health Maintenance Organization Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. "Basic health care services" means the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment;

2. "Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the

type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities;

3. "Carrier" means a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, or other entity responsible for the payment of benefits or provision of services under a group contract;

4. "Commissioner" means the Insurance Commissioner;

5. "Copayment" means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid;

6. "Deductible" means the amount an enrollee is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment;

7. "Enrollee" means an individual who is covered by a health maintenance organization;

8. "Evidence of coverage" means a statement of the essential features and services of the health maintenance organization coverage which is given to the subscriber by the health maintenance organization or by the group contract holder;

9. "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee who is totally disabled on the date of termination;

10. "Grievance" means a written complaint submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee;

11. "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents;

12. "Group contract holder" means the entity to which a group contract has been issued;

13. "Health maintenance organization" means an organization, organized pursuant to the laws of this state and subject to the provisions of this act, that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both;

14. "Health maintenance organization producer" means a person who solicits, negotiates, effects, procures, delivers, renews or continues a policy or contract for HMO membership, or who takes or transmits a membership fee or premium for such a policy or contract, other than for himself or herself, or a person who advertises or otherwise holds himself or herself out to the public as a producer;

15. "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber;

16. "Insolvent" or "insolvency" means that an organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction;

17. "Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services;

18. "Net worth" means the excess of total admitted assets over total liabilities; provided, however, the liabilities shall not include fully subordinated debt;

19. "Participating provider" means a provider as defined in paragraph 20 of this section who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment,

other than copayment or deductible, directly or indirectly from the health maintenance organization;

20. "Provider" means a physician, hospital or other person licensed or otherwise authorized to furnish health care services;

21. "Replacement coverage" means the benefits provided by a succeeding carrier;

22. "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in a health maintenance organization or, in the case of an individual contract, the person in whose name the contract is issued; and

23. "Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization for which an enrollee may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the Commissioner.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Notwithstanding any law of this state to the contrary, any person may apply to the Insurance Commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this act. No person shall establish or operate a health maintenance organization in this state, without obtaining a certificate of authority under this act. A foreign corporation may qualify under this act, subject to its registration to do business in this state as a foreign corporation and compliance with all provisions of this act and other applicable state laws.

B. Any health maintenance organization that has not previously received a certificate of authority to operate as a health maintenance organization as of the effective date of this act shall

submit an application for a certificate of authority under subsection C of this section within sixty (60) days of the effective date of this act. Each applicant may continue to operate until the Commissioner acts upon the application. In the event that an application is denied under Section 4 of this act, the applicant shall thereafter be treated as a health maintenance organization whose certificate of authority has been revoked.

C. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commissioner, and shall set forth or be accompanied by the following:

1. A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

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

3. A list of the names, addresses and official positions and biographical information on forms acceptable to the Commissioner of the persons who are to be responsible for the conduct of the affairs and day-to-day operations 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 any contract form made or to be between any class of providers and the health maintenance organization and a copy of any contract made or to be made between third-party administrators, marketing consultants or persons listed in paragraph 3 of this subsection, and the health maintenance organization;

5. A copy of evidence of coverage to be issued to the enrollees;

6. A copy of the form of group contract, if any, which is to be issued to employers, unions, trustees or other organizations;

7. Financial statements showing the applicant's assets, liabilities and sources of financial support including, but not limited to, both a copy of the applicant's most recent certified financial statement and an unaudited current financial statement;

8. A financial feasibility plan which includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve (12) months of operations certified by an actuary or other qualified person, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one (1) year, and a statement as to the sources of working capital as well as any other sources of funding;

9. A power of attorney duly executed by the applicant, if not domiciled in this state, appointing the Commissioner and his or her successors in office, and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

10. A statement or map reasonably describing the geographic area or areas to be served;

11. A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances;

12. A description of the proposed quality assurance program, including, but not limited to, the formal organizational structure,

methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

13. A description of the procedures to be implemented to meet the protection against insolvency requirements provided in Section 13 of this act;

14. A list of the names, addresses, and license numbers of all providers with which the health maintenance organization has agreements; and

15. Other information the Commissioner may require to make the determinations required in Section 4 of this act.

D. 1. The Commissioner may promulgate rules the Commissioner deems necessary to the proper administration of this act to require a health maintenance organization, subsequent to receiving its certificate of authority, to submit the information, modifications or amendments to the items described in subsection C of this section to the Commissioner, either for approval or for information only, prior to the effectuation of the modification or amendment, or to require the health maintenance organization to indicate the modifications to both the State Commissioner of Health and the Insurance Commissioner at the time of the next succeeding site visit or examination.

2. Any modification or amendment for which the Insurance Commissioner's approval is required shall be deemed approved unless disapproved within thirty (30) days, provided, the Insurance Commissioner may postpone the action for such further time, not exceeding an additional thirty (30) days, as necessary for proper consideration.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. Upon receipt of an application for issuance of a certificate of authority, the Insurance Commissioner shall forthwith transmit copies of such application and accompanying documents to the State Commissioner of Health.

2. The State Commissioner of Health shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished, has complied with the provisions of Section 7 of this act.

3. Within forty-five (45) days of receipt of the application for issuance of a certificate of authority, the State Commissioner of Health shall certify to the Commissioner that the proposed health maintenance organization meets the requirements of Section 7 of this act or shall notify the Commissioner that the health maintenance organization does not meet such requirements, and specify in what respects it is deficient.

B. The Commissioner shall within forty-five (45) days of receipt of certification or notice of deficiencies from the State Commissioner of Health, issue a certificate of authority to a person filing a completed application upon receiving the prescribed fees and upon the Commissioner being satisfied that:

1. The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;

2. Any deficiencies identified by the State Commissioner of Health have been corrected and the State Commissioner of Health has certified to the Commissioner that the health maintenance organization's proposed plan of operation meets the requirements of Section 7 of this act;

3. The health maintenance organization shall effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments or deductibles, or both; and

4. The health maintenance organization is in compliance with Sections 13 and 15 of this act.

C. A certificate of authority shall be denied only after the Commissioner complies with the requirements of Section 20 of this act.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The powers of a health maintenance organization include, but are not limited to, the following:

1. The purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and property reasonably required for its principal office or for purposes necessary to the transaction of the business of the organization;

2. Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts between affiliates or between the health maintenance organization and its parent company;

3. The furnishing of health care services through providers, provider associations or agents for providers which are under contract with or employed by the health maintenance organization;

4. The contracting with a person for the performance on its behalf of certain functions such as marketing, enrollment and administration;

5. The contracting with an insurance company licensed in this state, or with a hospital or medical service corporation authorized

to do business in this state, for the provision of insurance, indemnity or reimbursement against the cost of health care services provided by the health maintenance organization;

6. The offering of other health care services, in addition to basic health care services. Nonbasic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual; and

7. The joint marketing of products with an insurance company licensed in this state or with a hospital or medical service corporation authorized to do business in this state as long as the company that is offering each product is clearly identified.

B. 1. A health maintenance organization shall file notice, with adequate supporting information, with the Insurance Commissioner prior to the exercise of any power granted in paragraph 1, 2 or 4 of subsection A of this section which may affect the financial soundness of the health maintenance organization. The Commissioner shall disapprove the exercise of power only if, in the Commissioner's opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization, and endanger its ability to meet its obligations. If the Commissioner does not disapprove within thirty (30) days of the filing, it shall be deemed approved.

2. The Commissioner may promulgate rules exempting from the filing requirement of paragraph 1 of this subsection those activities having a de minimis effect.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A director, officer, employee or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of the organization

shall be responsible for the funds in a fiduciary relationship to the organization.

B. A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on such employees and officers, directors and partners in an amount not less than Two Hundred Fifty Thousand Dollars ($250,000.00) for each health maintenance organization; or a maximum of Five Million Dollars ($5,000,000.00) in aggregated maintained on behalf of health maintenance organizations owned by a common parent corporation; or an amount prescribed by the Insurance Commissioner.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The health maintenance organization shall establish procedures to ensure that the health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. The procedures shall include mechanisms to assure availability, accessibility and continuity of care.

B. The health maintenance organization shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and noninstitutional settings. The program shall include, at a minimum, the following:

1. A written statement of goals and objectives that emphasizes improved health status in evaluating the quality of care rendered to enrollees;

2. A written quality assurance plan that describes the following:

a. the health maintenance organization's scope and purpose in quality assurance,

b. the organizational structure responsible for quality assurance activities,

c. contractual arrangements, where appropriate, for delegation of quality assurance activities,

d. confidentiality policies and procedures,

e. a system of ongoing evaluation activities,

f. a system of focused evaluation activities,

g. a system for credentialing providers and performing peer review activities, and

h. duties and responsibilities of the designated physician responsible for the quality assurance activities;

3. A written statement describing the system of ongoing quality assurance activities including:

a. problem assessment, identification, selection and study,

b. corrective action, monitoring, evaluation and reassessment, and

c. interpretation and analysis of patterns of care rendered to individual patients by individual providers;

4. A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population which identifies method of topic selection, study, data collection, analysis, interpretation and report format; and

5. Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

C. The organization shall record proceedings of formal quality assurance program activities and maintain documentation in a

confidential manner. Quality assurance program minutes shall be available to the State Commissioner of Health.

D. The organization shall ensure the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

E. Enrollee clinical records shall be available to the State Commissioner of Health or a designee for examination and review to ascertain compliance with this section, or as deemed necessary by the State Commissioner of Health.

F. The organization shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.8 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. Every group and individual contract holder shall be entitled to a group or individual contract.

2. The contract shall not contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation.

3. The contract shall contain a clear statement of the following:

a. the name and address of the health maintenance organization,

b. eligibility requirements,

c. benefits and services within the service area,

d. emergency care benefits and services,

e. out-of-area benefits and services, if any,

f. copayments, deductibles or other out-of-pocket expenses,

g. limitations and exclusions,

h. enrollee termination,

i. enrollee reinstatement, if any,

j. claims procedures,

k. enrollee grievance procedures,

l. continuation of coverage,

m. conversion,

n. extension of benefits, if any,

o. coordination of benefits, if applicable,

p. subrogation, if any,

q. description of the service area,

r. entire contract provision,

s. term of coverage,

t. cancellation of group or individual contract holder,

u. renewal,

v. reinstatement of group or individual contract holder, if any,

w. grace period, and

x. conformity with state law.

An evidence of coverage may be filed as part of the group contract to describe the provisions required in this paragraph.

B. In addition to the provisions of paragraph 3 of subsection A of this section, an individual contract shall provide for a ten-day period to examine and return the contract and have the premium refunded. If services were received during the ten-day period, and the person returns the contract to receive a refund of the premium paid, he or she shall pay for those services.

C. 1. Every subscriber shall receive an evidence of coverage from the group contract holder or the health maintenance organization.

2. The evidence of coverage shall not contain provisions or statements that are unfair, unjust, inequitable, misleading, deceptive, or which encourage misrepresentation.

3. The evidence of coverage shall contain a clear statement of the provisions required in paragraph 3 subsection A of this section.

D. The Insurance Commissioner may adopt rules establishing readability standards for individual contract, group contract, and evidence of coverage forms.

E. No group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form has been filed with and approved by the Commissioner, subject to the provisions of subsection F and G of this section.

F. If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage need not be submitted to the Commissioner of this state for approval.

G. 1. Every form required by this section shall be filed with the Commissioner not less than thirty (30) days prior to delivery or issue for delivery in this state. At any time during the initial thirty-day period, the Commissioner may extend the period for review an additional thirty (30) days. Notice of an extension shall be in writing. At the end of the review period, the form shall be deemed approved if the Commissioner has taken no action. The filer shall notify the Commissioner in writing prior to using a form that is deemed approved.

2. At any time, after thirty (30) days' notice and for cause shown, the Commissioner may withdraw approval of a form, effective at the end of the thirty-day period.

3. When a filing is disapproved or approval of a form is withdrawn, the Commissioner shall give the health maintenance organization written notice of the reasons for disapproval and in the notice shall inform the health maintenance organization that within thirty (30) days of receipt of the notice the health maintenance organization may request a hearing. A hearing shall be conducted within thirty (30) days after the Commissioner has received the request for hearing.

H. The Commissioner may require the submission of whatever relevant information he or she deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.9 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Every health maintenance organization shall annually, on or before the first day of March, file a report verified by at least two principal officers with the Insurance Commissioner, with a copy to the State Commissioner of Health covering the preceding calendar year. The report shall be on forms prescribed by the Commissioner. In addition, the health maintenance organization shall file by the first day of March, unless otherwise stated:

1. Audited financial statements on or before June 1;

2. A list of the providers who have executed a contract that complies with the provisions of this act; and

3. a. a description of the grievance procedures, and

b. the total number of grievances handled through these procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.

B. The Commissioner may require additional reports deemed necessary and appropriate to enable the Commissioner to carry out his or her duties under this act.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.10 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The health maintenance organization shall provide to its subscribers a list of providers upon enrollment and reenrollment.

B. Every health maintenance organization shall provide within thirty (30) days to its subscribers notice of any material change in the operation of the organization that will affect them directly.

C. An enrollee shall be notified in writing by the health maintenance organization of the termination of the primary care provider who provided health care services to that enrollee. The health maintenance organization shall provide assistance to the enrollee in transferring to another participating primary care provider.

D. The health maintenance organization shall provide to subscribers information on how services may be obtained, where additional information on access to services can be obtained and a number where the enrollee can contact the HMO, at no cost to the enrollee.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.11 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Every health maintenance organization shall establish and maintain a grievance procedure which has been approved by the Insurance Commissioner, after consultation with the State Commissioner of Health, to provide procedures for the resolution of grievances initiated by enrollees. The health maintenance organization shall maintain records regarding grievances received since the date of its last examination of grievances.

B. The Commissioner or the State Commissioner of Health may examine the grievance procedures.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.12 of Title 36, unless there is created a duplication in numbering, reads as follows:

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 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 Dollars ($1,000,000.00),

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' 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. A health maintenance organization licensed before the effective date of this act shall maintain a minimum net worth of:

a. twenty-five percent (25%) of the amount required by paragraph 2 of subsection A of this section by December 31, 1998,

b. fifty percent (50%) of such amount by December 31, 1999,

c. seventy-five percent (75%) of such amount by December 31, 2000, and

d. one hundred percent (100%) of such amount by December 31, 2001.

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 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 Three Hundred Thousand Dollars ($300,000.00).

2. A health maintenance organization that is in operation on the effective date of this section shall make a deposit equal to One Hundred Fifty Thousand Dollars ($150,000.00). In the second year, the amount of the additional deposit for a health maintenance organization that is in operation on the effective date of this section shall be equal to One Hundred Fifty Thousand Dollars ($150,000.00) for a total of Three Hundred Thousand Dollars ($300,000.00).

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

4. 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.

5. The deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure 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 the health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the liquidation act.

6. The Commissioner may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, Commissioner, or other official body of the state

or jurisdiction of domicile for the protection of all subscribers and enrollees, wherever located, of the health maintenance organization, 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 any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid and for which the organization is or may be liable, and to provide for 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 set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or 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 the subscriber or 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 which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members 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 enrollee's discharge from inpatient facilities;

3. Insolvency reserves;

4. Acceptable letters of credit; or

5. Any other arrangements to assure the benefits are continued 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 sixty (60) days' advance notice of termination.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.13 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the Insurance Commissioner, with an organization or trustee acceptable to the Commissioner through which a custodial or controlled account is maintained, cash or securities that are

acceptable to the Commissioner. The deposit shall at all times have a fair market value in an amount of one hundred twenty percent (120%) of the HMO's outstanding liability for uncovered expenditures for enrollees in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

B. The deposit required under this section is in addition to the deposit required under Section 12 of this act and is an admitted asset of the health maintenance organization in the determination of net worth. All income from deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the Commissioner.

C. A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:

1. A substitute deposit of cash or securities of equal amount and value is made;

2. The fair market value exceeds the amount of the required deposit; or

3. The required deposit under subsection A of this section is reduced or eliminated. Deposits, substitutions or withdrawals may be made only with the prior written approval of the Commissioner.

D. The deposit required under this section is in trust and may be used only as provided under this section. The Commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of enrollees of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall

be paid on a pro rata basis based on assets available to pay the ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.

E. The Commissioner may, by rule, prescribe the time, manner and form for filing claims under subsection D of this section.

F. The Commissioner may, by rule or order, require health maintenance organizations to file annual, quarterly or more frequent reports deemed necessary to demonstrate compliance with this section. The Commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.14 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. In the event of an insolvency of a health maintenance organization, upon order of the Insurance Commissioner, all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer the group's enrollees of the insolvent health maintenance organization a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer the enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

2. If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the Commissioner determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, then the Commissioner shall allocate equitably the insolvent health

maintenance organization's group contracts for these groups among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer the group or groups the health maintenance organization's existing coverage that is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

3. The Commissioner shall also allocate equitably the insolvent health maintenance organization's nongroup enrollees that are unable to obtain other coverage among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer the nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by the enrollee's type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

B. 1. As used in this section, "discontinuance" means the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health maintenance organization, and does not refer to the termination of

any agreement between any individual enrollee and the health maintenance organization.

2. Any carrier providing replacement coverage with respect to group hospital, medical or surgical expense or service benefits within a period of sixty (60) days from the date of discontinuance of a prior health maintenance organization contract or policy providing hospital, medical or surgical expense or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy as of the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

3. Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.15 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. No premium rate may be used until either a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the Insurance Commissioner.

B. Either a specific schedule of premium rates, or a methodology for determining premium rates, shall be established in accordance with actuarial principles for various categories of enrollees, provided that the premium applicable to an enrollee shall

not be individually determined based on the status of the enrollee's health. However, the premium rates shall not be excessive, inadequate or unfairly discriminatory. A certification by a qualified actuary or other qualified person acceptable to the Commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

C. The Commissioner shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of subsection B of this section are met. If the Commissioner disapproves the filing, the Commissioner shall notify the health maintenance organization. In the notice, the Commissioner shall specify the reasons for disapproval. A hearing shall be conducted within thirty (30) days after a request in writing by the person filing. If the Commissioner does not take action on the schedule or methodology within thirty (30) days of the filing of the schedule or methodology, it shall be deemed approved.

SECTION 16. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.16 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner may, after notice and hearing, promulgate rules necessary to provide for the licensing of health maintenance organization producers. Such rules shall establish:

1. The requirements for licensure of resident health maintenance organization producers;

2. The conditions for entering into reciprocal agreements with other jurisdictions for the licensure of nonresident health maintenance organization producers;

3. Any examination, prelicensing or continuing education requirements;

4. The requirements for registering and terminating the appointment of health maintenance organization producers;

5. Any requirements for registering any assumed names or the office locations in which a health maintenance organization producer does business;

6. The conditions for health maintenance organization producer license renewal;

7. The grounds for denial, refusal, suspension or revocation of a health maintenance organization producer's license;

8. Any required fees for the licensing activities of health maintenance organization producers; and

9. Any other requirement or procedure and any form as may be reasonably necessary to provide for the effective administration of the licensing of health maintenance organization producers under this section.

B. The following shall not be required to be licensed as a health maintenance organization producer:

1. A regular salaried officer or employee of a health maintenance organization who devotes substantially all of his or her time to activities other than the taking or transmitting of applications or membership fees or premiums for health maintenance organization membership, or who receives no commission or other compensation directly dependent upon the business obtained and who does not solicit or accept from the public applications for health maintenance organization membership;

2. Employers or their officers or employees or the trustees of an employee benefit plan to the extent that the employers, officers, employees or trustees are engaged in the administration or operation of a program of employee benefits involving the use of health maintenance organization memberships; provided that the employers, officers, employees or trustees are not in any manner compensated directly or indirectly by the health maintenance organization issuing health maintenance organization memberships;

3. Banks or their officers and employees to the extent that the banks, officers and employees collect and remit charges by charging them against accounts of depositors on the orders of the depositors; or

4. A person or the employee of a person who has contracted to provide administrative, management or health care services to a health maintenance organization and who is compensated for those services by the payment of an amount calculated as a percentage of the revenues, net income or profit of the health maintenance organization, if that method of compensation is the sole basis for subjecting that person or the employee of the person to the provisions of this act.

C. The Commissioner may by rule exempt certain classes of persons from the requirement of obtaining a license if:

1. The functions they perform do not require special competence, trustworthiness or the regulatory surveillance made possible by licensing; or

2. Other existing safeguards make regulation unnecessary.

SECTION 17. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.17 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An insurance company licensed in this state, or a hospital or medical service corporation authorized to do business in this state, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of the Oklahoma Health Maintenance Organization Act. Notwithstanding any other law which may be inconsistent, any two (2) or more insurance companies, hospital or medical service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health

care by a health maintenance organization owned or operated by an insurer or its subsidiary.

B. Notwithstanding any provision of insurance and hospital or medical service corporation laws, an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

SECTION 18. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.18 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner shall make an examination of the affairs of a health maintenance organization and providers with whom the organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every three (3) years.

B. The State Commissioner of Health shall make an examination concerning the quality assurance program of the health maintenance organization and of any providers with whom the organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every three (3) years.

C. Every health maintenance organization and provider shall submit its books and records for examination and in every way

facilitate the completion of the examination. For the purpose of an examination, the Commissioner and the State Commissioner of Health may administer oaths to, and examine the officers and agents of, the health maintenance organization and the principals of the providers concerning their business.

D. The expenses of examinations under this section shall be assessed against the health maintenance organization being examined and remitted to the Commissioner or the State Commissioner of Health for whom the examination is being conducted.

E. In lieu of an examination, the Commissioner or the State Commissioner of Health may accept the report of an examination made by the Insurance Commissioner or the Commissioner of Public Health of another state.

SECTION 19. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.19 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A certificate of authority issued under the Oklahoma Health Maintenance Organization Act may be suspended or revoked, and an application for a certificate of authority may be denied, if the Insurance Commissioner finds that any of the following conditions exist:

1. The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under Section 3 of this act, unless amendments to those submissions have been filed with and approved by the Commissioner;

2. The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services that does not comply with the requirements of Sections 8 and 15 of this act;

3. The health maintenance organization does not provide or arrange for basic health care services;

4. The State Commissioner of Health certifies to the Commissioner that the health maintenance organization:

a. does not meet the requirements of Section 7 of this act, or

b. is unable to fulfill its obligations to furnish health care services;

5. The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

6. The health maintenance organization has failed to correct, within the time prescribed by subsection C of this section, any deficiency occurring due to the health maintenance organization's prescribed minimum net worth being impaired;

7. The health maintenance organization has failed to implement the grievance procedures required by Section 11 of this act in a reasonable manner to resolve valid complaints;

8. The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

9. The continued operation of the health maintenance organization would be hazardous to its enrollees; or

10. The health maintenance organization has otherwise failed substantially to comply with the provisions of this act.

B. In addition to or in lieu of suspension or revocation of a certificate of authority pursuant to this section, the applicant or health maintenance organization may be subjected to an administrative penalty of up to One Thousand Dollars ($1,000.00) for each cause for suspension or revocation.

C. The following shall pertain when insufficient net worth is maintained:

1. Whenever the Commissioner finds that the net worth maintained by any health maintenance organization subject to the

provisions of this act is less than the minimum net worth required to be maintained by Section 12 of this act, the Commissioner shall give written notice to the health maintenance organization of the amount of the deficiency and require filing with the Commissioner a plan for correction of the deficiency acceptable to the Commissioner and correction of the deficiency within a reasonable time, not to exceed sixty (60) days, unless an extension of time, not to exceed sixty (60) additional days, is granted by the Commissioner. A deficiency shall be deemed an impairment, and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the certificate of authority or for placing the health maintenance organization in conservation, rehabilitation or liquidation; and

2. Unless allowed by the Commissioner, no health maintenance organization or person acting on its behalf may, directly or indirectly, renew, issue or deliver any certificate, agreement or contract of coverage in this state, for which a premium is charged or collected, when the health maintenance organization writing the coverage is impaired, and the fact of impairment is known to the health maintenance organization or to the person. However, the existence of an impairment shall not prevent the issuance or renewal of a certificate, agreement or contract when the enrollee exercises an option granted under the plan to obtain a new, renewed or converted coverage.

D. A certificate of authority shall be suspended or revoked or an application or a certificate of authority denied or an administrative penalty imposed only after compliance with the requirements of this section.

1. Suspension or revocation of a certificate of authority or the denial of an application or the imposition of an administrative penalty pursuant to this section shall be by written order and shall be sent to the health maintenance organization or applicant by

certified or registered mail and to the State Commissioner of Health. The written order shall state the grounds, charges or conduct on which the suspension, revocation, denial or administrative penalty is based. The health maintenance organization or applicant may in writing request a hearing within thirty (30) days from the date of mailing of the order. If no written request is made, the order shall be final upon the expiration of thirty (30) days.

2. If the health maintenance organization or applicant requests a hearing pursuant to this section, the Commissioner shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail and to the State Commissioner of Health stating:

a. a specific time for the hearing, which may not be less than twenty (20) nor more than thirty (30) days after mailing of the notice of hearing, and

b. a specific place for the hearing, which may be either in Oklahoma County or in the county where the health maintenance organization's or applicant's principal place of business is located.

3. If a hearing is requested, the State Commissioner of Health or designated representative shall be in attendance and shall participate in the proceedings. The recommendations and findings of the State Commissioner of Health with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension or revocation of a certificate of authority, shall be conclusive and binding upon the Commissioner. After the hearing, or upon failure of the health maintenance organization to appear at the hearing, the Commissioner shall take whatever action is deemed necessary based on written findings and shall mail the decision to the health maintenance organization or applicant with a copy to the State Commissioner of Health. The

action of the Commissioner and the recommendation and findings of the State Commissioner of Health shall be subject to review under the Administrative Procedures Act.

E. The provisions of the Administrative Procedures Act shall apply to proceedings under this section to the extent they are not in conflict with paragraph 2 of subsection D of this section.

F. When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

G. When the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The Commissioner may, by written order, permit further operation of the organization found to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

SECTION 20. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.20 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the Insurance Commissioner pursuant to the law governing the rehabilitation, liquidation or conservation of insurance companies. The Commissioner may apply for

an order directing the Commissioner to rehabilitate, liquidate or conserve a health maintenance organization upon any one or more grounds set out in this act, or when in the Commissioner's opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

B. For the purpose of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries shall have the same priority as established by the Insurance Commissioner for policyholders and beneficiaries of insureds of insurance companies. If an enrollee is liable to a provider for services provided pursuant to and covered by the health care plan, that liability shall have the status of an enrollee claim for distribution of general assets. A provider who is obligated by statute or agreement to hold enrollees harmless from liability for services provided pursuant to and covered by a health care plan shall have a priority of distribution of the general assets immediately following that of enrollees and enrollees' beneficiaries as described herein, and immediately preceding the priority of distribution described in this act.

SECTION 21. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.21 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Whenever the Insurance Commissioner determines that the financial condition of a health maintenance organization is such that its continued operation might be hazardous to its enrollees, creditors, or the general public, or that it has violated any provision of this act, the Commissioner may, after notice and hearing, order the health maintenance organization to take action

reasonably necessary to rectify the condition or violation, including, but not limited to, one or more of the following:

1. Reduce the total amount of present and potential for benefits by reinsurance or other method acceptable to the Commissioner;

2. Reduce the volume of new business being accepted;

3. Reduce expenses by specified methods;

4. Suspend or limit the writing of new business for a period of time;

5. Increase the health maintenance organization's capital and surplus by contribution; or

6. Take other steps the Commissioner may deem appropriate under the circumstances.

B. For purposes of this section, the violation by a health maintenance organization of any law of this state to which the health maintenance organization is subject shall be deemed a violation of this act.

C. The Commissioner shall promulgate rules establishing uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors, or the general public and to set standards for evaluating the financial condition of any health maintenance organization. The standards shall be consistent with the provisions expressed in subsection A of this section.

D. The remedies and measures available to the Commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the Commissioner under the present provisions of law.

SECTION 22. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.22 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Insurance Commissioner may, after notice and hearing, promulgate reasonable rules necessary or proper to carry out the provisions of this act. The rules shall be subject to review in accordance with the Administrative Procedures Act.

SECTION 23. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.23 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Insurance Commissioner shall promulgate rules for collecting fees from health maintenance organizations.

SECTION 24. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.24 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner may, in lieu of suspension or revocation of a certificate of authority under Section 19 of this act, levy an administrative penalty in an amount not less than One Thousand Dollars ($1,000.00) nor more than Five Thousand Dollars ($5,000.00), if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations that gave rise to the penalty citation. The Commissioner may augment this penalty by an amount equal to the sum that is calculated to be the damages suffered by enrollees or other members of the public.

B. 1. If the Commissioner or the State Commissioner of Health shall for any reason have cause to believe that a violation of the Oklahoma Health Maintenance Organization Act has occurred or is threatened, the Commissioner or the State Commission of Health may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected

violation; and, in the event it appears that a violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.

2. Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the Commissioner or the State Commissioner of Health may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section are satisfied.

C. 1. The Commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in an act or practice in violation of the provisions of this act.

2. Within ten (10) days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices in violation of this act have occurred. The hearing shall be conducted pursuant to the Administrative Procedures Act.

D. In the case of any violation of the provisions of this act, if the Commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection C of this section, the Commissioner may institute a proceeding to obtain injunctive or other appropriate relief.

E. Notwithstanding any other provisions of this act, if a health maintenance organization fails to comply with the net worth requirement of this act, the Commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees.

SECTION 25. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.25 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as otherwise provided in this act, provisions of the insurance law and provisions of hospital or medical service corporation laws shall not be applicable to a health maintenance organization granted a certificate of authority under this act. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this act.

B. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

C. Any health maintenance organization authorized under this act shall not be deemed to be practicing medicine and shall be exempt from the provision of Title 59 of the Oklahoma Statutes relating to the practice of medicine.

SECTION 26. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.26 of Title 36, unless there is created a duplication in numbering, reads as follows:

All applications, filings and reports required under the Oklahoma Health Maintenance Organization Act shall be treated as public documents, except those which are trade secrets or privileged or confidential quality assurance, commercial or financial information, other than any annual financial statement that may be required under Section 9 of this act.

SECTION 27. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.27 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant obtained from that person or from a provider by a health maintenance organization shall be held in confidence and shall not be disclosed to any person except:

1. To the extent that it may be necessary to carry out the purposes of the Oklahoma Health Maintenance Organization Act;

2. Upon the express consent of the enrollee or applicant;

3. Pursuant to statute or court order for the production of evidence or the discovery thereof; or

4. In the event of claim or litigation between the person and the health maintenance organization wherein the data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against disclosure that the provider who furnished the information to the health maintenance organization is entitled to claim.

B. A person who, in good faith and without malice, takes an action or makes a decision or recommendation as a member, agency or employee of a health care review committee or who furnishes any records, information or assistance to such a committee shall not be subject to liability for civil damages or any legal action in consequence of the action, nor shall the health maintenance organization that established the committee or the officers, directors, employees or agents of the health maintenance organization be liable for the activities of the person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

C. 1. The information considered by a health care review committee and the records of their actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency, or in an appeal, if permitted, from the committee's findings

or recommendations. No member of a health care review committee, or officer, director or other member of a health maintenance organization or its staff engaged in assisting a committee, or a person assisting or furnishing information to a committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on such activities.

2. Information considered by a health care review committee and the records of its actions and proceedings that are used pursuant to paragraph 1 of subsection C of this section by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provision concerning discovery and use in legal actions as are the original information and records in the possession and control of a health care review committee.

D. To fulfill its obligations under Section 7 of this act, the health maintenance organization shall have access to treatment records and other information pertaining to the diagnosis, treatment or health status of an enrollee.

SECTION 28. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.28 of Title 36, unless there is created a duplication in numbering, reads as follows:

The State Commissioner of Health, in carrying out his or her obligations under the Oklahoma Health Maintenance Organization Act, may contract with qualified persons to make recommendations concerning the determinations required to be made by the State Commissioner of Health. The recommendations may be accepted in full or in part or rejected by the State Commissioner of Health.

SECTION 29. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.29 of Title 36, unless there is created a duplication in numbering, reads as follows:

No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a

health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the Insurance Commissioner and has sent to the health maintenance organization, information required by Sections 3B(1), (2), (3), (4), (5), and (12) of the NAIC Model Insurance Holding Company System Regulatory Act, and the offer, request, invitation, agreement or acquisition has been approved by the Commissioner. Approval by the Commissioner shall be governed by Section 3D(1) and (2) of the NAIC Model Insurance Holding Company System Regulatory Act.

SECTION 30. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.30 of Title 36, unless there is created a duplication in numbering, reads as follows:

Each employer, public or private, in this state which offers its employees a health benefit plan and employs not less than twenty-five (25) employees, and each employee benefit fund in this state which offers its members any form of basic health benefit, shall make available to and inform its employees or members of the option to enroll in at least one group practice health maintenance organization and one other health maintenance organization holding a valid certificate of authority which provides basic health care services in the geographic areas in which a substantial number of employees or members reside. Where there is a prevailing collective bargaining agreement, the selection of the health maintenance organization to be made available to the employees shall be made

under the agreement. No employer in this state shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other contract for the provision of basic health benefits to its employees. The employer or benefits fund shall pay to the health maintenance organization chosen by each employee or member an amount which does not financially discriminate against an employee who enrolls in the health maintenance organization. For purposes of the preceding sentence, an employer's contribution does not financially discriminate if the employer's method of determining the contributions on behalf of all employees is reasonable and is designed to assure employees a fair choice among health benefit plans.

SECTION 31. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.31 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Health maintenance organizations are permitted, but not required, to adopt coordination of benefits provisions to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two (2) or more group health insurance or health care plans.

B. If health maintenance organizations adopt coordination of benefits, the provisions must be consistent with the coordination of benefits provisions that are in general use in the state for coordinating coverage between two (2) or more group health insurance or health care plans.

C. To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the rules for coordination, health maintenance organizations shall make payments for services that are:

1. Received from nonparticipating providers;

2. Provided outside their service areas; or

3. Not covered under the terms of their group contracts or evidence of coverage.

SECTION 32. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2699.32 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. When a health maintenance organization in this state is declared insolvent by a court of competent jurisdiction, the Insurance Commissioner may levy an assessment on health maintenance organizations doing business in this state to pay claims for uncovered expenditures for enrollees who are residents of this state and to provide continuation of coverage for subscribers or enrollees not covered under Section 14 of this act. The Commissioner may not assess in any one calendar year more than two percent (2%) of the aggregate premium written by each health maintenance organization in this state during the previous calendar year.

B. The Commissioner may use funds obtained under subsection A of this section to pay claims for uncovered expenditures for subscribers or enrollees of an insolvent health maintenance organization who are residents of this state, provide for continuation of coverage for subscribers or enrollees who are residents of this state and are not covered under this act, and administrative costs. The Commissioner may by rule prescribe the time, manner and form for filing claims under this section or may require claims to be allowed by an ancillary receiver or the domestic liquidator or receiver.

C. 1. A receiver or liquidator of an insolvent health maintenance organization shall allow a claim in the proceeding in an amount equal to administrative and uncovered expenditures paid under this section.

2. Any person receiving benefits under this section for uncovered expenditures is deemed to have assigned the rights under the covered health care plan certificates to the Commissioner to the

extent of the benefits received. The Commissioner may require an assignment to it of such rights by any payee, enrollee, or beneficiary as a condition precedent to the receipt of any rights or benefits conferred by this section upon that person. The Commissioner is subrogated to these rights against the assets of an insolvent health maintenance organization held by a receiver or liquidator of another jurisdiction.

3. The assignment of subrogation rights of the Commissioner and allowed claim under this subsection have the same priority against the assets of the insolvent health maintenance organization as those possessed by the person entitled to receive benefits under this section or for similar expenses in the receivership or liquidation.

D. When assessed funds are unused following the completion of the liquidation of a health maintenance organization, the Commissioner shall distribute on a pro rata basis any amounts received under subsection A of this section which are not de minimis to the health maintenance organizations that have been assessed under this section.

E. The aggregate coverage of uncovered expenditures under this section shall not exceed Three Hundred Thousand Dollars ($300,000.00) with respect to one individual. Continuation of coverage shall not continue for more than the lesser of one year after the health maintenance organization coverage is terminated by insolvency or the remaining term of the contract. The Commissioner may provide continuation of coverage on any reasonable basis; including, but not limited to, continuation of the health maintenance organization contract or substitution of indemnity coverage in a form determined by the Commissioner.

F. The Commissioner may waive an assessment of a health maintenance organization if it would be or is impaired or placed in financially hazardous condition. A health maintenance organization which fails to pay an assessment within thirty (30) days after

notice shall be subject to a civil forfeiture of not more than One Thousand Dollars ($1,000.00) per day and suspension or revocation of its certificate of authority. An action taken by the Commissioner in enforcing the provisions of this section may be appealed by health maintenance organization in accordance with the Administrative Procedures Act.

SECTION 33. This act shall become effective November 1, 1998.

46-2-2162 CJ