STATE OF OKLAHOMA

1st Session of the 49th Legislature (2003)

COMMITTEE SUBSTITUTE
FOR
SENATE BILL 635 By: Monson

COMMITTEE SUBSTITUTE

[insurance and public health and safety - Health Maintenance Organization Act of 2003 - Risk-based Capital for Health Maintenance Organizations Act of 2003 – codification - 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 6901 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 "Health Maintenance Organization Act of 2003".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6902 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Health Maintenance Organization Act of 2003:

1. “Basic health care services” means the following medically necessary services:

a. preventive care,

b. emergency care,

c. inpatient and outpatient hospital and physician care,

d. diagnostic laboratory and diagnostic and therapeutic radiological services,

e. allopathic, osteopathic, chiropractic, podiatric, optometric, psychological, outpatient diagnostic treatment,

f. short-term rehabilitation and physical therapy,

g. emergency, short-term outpatient mental health, substance abuse diagnostic and medical treatment,

h. home health, and

i. preventive health services;

provided, however, such term does not include dental 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. “Copayment” means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid;

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

6. “Enrollee” means an individual who is covered by a health maintenance organization;

7. “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;

8. “Extension of benefits” means the continuation of coverage under a particular benefit provided under a contract following termination for an enrollee who is totally disabled on the date of termination;

9. “Grievance” means a written complaint, submitted in accordance with a health maintenance organization’s formal grievance procedure, by or on behalf of an enrollee regarding any aspect of the health maintenance organization relative to the enrollee;

10. “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;

11. “Group contract holder” means the person to which a group contract has been issued;

12. “Health maintenance organization” or “HMO” means a person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both;

13. “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 the person, or a person who advertises or otherwise holds himself or herself out to the public as a health maintenance organization producer;

14. “Individual contract” means a contract for health care services issued to and covering an individual. An individual contract may include the dependents of the subscriber;

15. “Insolvent” or “insolvency” means a process by which an organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction;

16. "Insurance Commissioner" means the Insurance Commissioner pursuant to the provisions of Title 36 of the Oklahoma Statutes;

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. "NAIC" means the National Association of Insurance Commissioners;

19. “Net worth” means the excess of total admitted assets over total liabilities, provided, total liabilities shall not include fully subordinated debt;

20. “Participating provider” means a provider as defined in paragraph 22 of this section who, under an express or implied contract with the health maintenance organization, 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;

21. “Person” means a natural or artificial person including, but not limited to, individuals, partnerships, associations, trusts or corporations;

22. “Provider” means a physician, hospital or other person licensed or otherwise authorized to furnish health care services;

23. “Replacement coverage” means the benefits provided by a succeeding carrier;

24. "State Commissioner of Health" means the State Commissioner of Health pursuant to the provisions of Section 1-106 of Title 63 of the Oklahoma Statutes;

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

26. “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 Insurance Commissioner.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6903 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 pursuant to the provisions of the Health Maintenance Organization Act of 2003. No person shall establish or operate a health maintenance organization in this state without obtaining a certificate of authority pursuant to the provisions of 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. All certificates of authority shall be perpetual and automatically renewed as of March 1 of each year, unless the health maintenance organization fails to qualify for renewal pursuant to the provisions of this act and any other applicable provisions of Title 36 of the Oklahoma Statutes.

B. Any health maintenance organization that has previously received a certificate of authority from the State Commissioner of Health, but has not received a certificate of authority from the Insurance Commissioner to operate as a health maintenance organization as of the effective date of this act shall submit an application for a certificate of authority, as provided in subsection C of this section, by March 1, 2004. Each applicant may continue to operate until such time as the Insurance Commissioner acts upon the application if the applicant continues to comply with the provisions of Title 63 of the Oklahoma Statutes, the rules promulgated pursuant thereto by the State Board of Health as they existed immediately prior to the effective date of this act, and

administrative orders entered by the State Commissioner of Health prior to the effective date of this act. In the event that an application is denied under the provisions of 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 National Association of Insurance Commissioners (NAIC), and shall be accompanied by the following:

1. A copy of the applicant's organizational documents including, but not limited to, 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, regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant;

3. A list of the names, addresses, official positions and biographical information, on forms acceptable to the NAIC, 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 made 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 the form of evidence of coverage to be issued to enrollees;

6. A copy of the form of group contract, if any, 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:

a. a copy of the applicant's most recent, regular certified financial statement,

b. an unaudited current financial statement, and

c. fully audited financial information as to the earnings and financial condition of each person controlling a domestic health maintenance organization pursuant to the provisions of subsection C of Section 1651 of Title 36 of the Oklahoma Statutes for the preceding five (5) fiscal years for each such acquiring party, or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence, and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement; provided, however, the Insurance Commissioner shall have the discretionary ability to waive the audit requirement based upon review of substantially similar financial disclosure statements submitted by the acquiring party;

8. A financial feasibility plan that includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve (12) months of operations as certified by an actuary or other qualified person acceptable to the Insurance Commissioner, 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 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 Insurance Commissioner, 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 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 provisions of 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;

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

16. An original, along with copies, of all documents required pursuant to the provisions of this subsection, with all required fees.

D. 1. The Insurance Commissioner may promulgate rules for the proper administration of this act and 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 Insurance 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 that the Insurance Commissioner may postpone the action for such further time, not exceeding an additional sixty (60) days, as necessary for proper consideration.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6904 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 an application for issuance of a certificate of authority from the Insurance Commissioner, the State Commissioner of Health shall certify to the Insurance Commissioner that the proposed health maintenance organization meets the requirements of Section 7 of this act, or

shall notify the Insurance Commissioner that the proposed health maintenance organization does not meet such requirements and shall specify in what respects the applicant is deficient.

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

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

2. Any deficiency identified by the State Commissioner of Health has been corrected and the State Commissioner of Health has certified to the Insurance 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 will 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 the provisions of Sections 13 and 15 of this act.

C. A certificate of authority shall be denied only after the Insurance 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 6905 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The powers of a health maintenance organization (HMO) 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 provider or subscriber contracts between affiliates or between the health maintenance organization and its parent;

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. Non-basic 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

paragraphs 1, 2 or 4 of subsection A of this section that may affect the financial soundness of the health maintenance organization. The Insurance Commissioner shall disapprove the exercise of power only if, in the Insurance 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 Insurance Commissioner does not disapprove such exercise of power within sixty (60) days of the filing, it shall be deemed approved.

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

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6906 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, officers, directors and partners in an amount that is not less than Two Hundred Fifty Thousand Dollars ($250,000.00) for each health maintenance organization, or a maximum of Five Thousand Dollars ($5,000.00) in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or the sum prescribed by the Insurance Commissioner.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6907 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Every health maintenance organization shall establish procedures that ensure that 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 non-institutional settings. The program shall include, but need not be limited to, 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 and recredentiating 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 that 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’s 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 an authorized 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.

G. The organization shall be required to establish a mechanism under which physicians participating in the plan may provide input into the plan's medical policy including, but not limited to, coverage of new technology and procedures, utilization review criteria and procedures, quality, credentialing and recredentialing criteria, and medical management procedures.

H. As used in this section "credentialing" or “recredentialing”, as applied to physicians and other health care providers, means the process of accessing and validating the qualifications of such persons to provide health care services to the beneficiaries of a health maintenance organization. “Credentialing” or “recredentialing” may include, but need not be limited to, an evaluation of licensure status, education, training, experience, competence and professional judgment. Credentialing or recredentialing is a prerequisite to the final decision of a health maintenance organization to permit initial or continued participation by a physician or other health care provider.

1. Physician credentialing and recredentialing shall be based on criteria as provided in the uniform credentialing application required by Section 1-106.2 of Title 63 of the Oklahoma Statutes, with input from physicians and other health care providers.

2. Organizations shall make information on credentialing and recredentialing criteria available to physician applicants and other health care providers, participating physicians, and other participating health care providers and shall provide applicants with a checklist of materials required in the application process.

3. When economic considerations are part of the credentialing and recredentialing decision, objective criteria shall be used and shall be available to physician applicants and participating

physicians. When graduate medical education is a consideration in the credentialing and recredentialing process, equal recognition shall be given to training programs accredited by the Accrediting Council on Graduate Medical Education and by the American Osteopathic Association. When graduate medical education is considered for optometric physicians, consideration shall be given for educational accreditation by the Council on Optometric Education.

4. Physicians or other health care providers under consideration to provide health care services under a managed care plan in this state shall apply for credentialing and recredentialing on the uniform credentialing application and provide the documentation as outlined by the plan's checklist of materials required in the application process.

5. A managed care plan shall determine whether a credentialing or recredentialing application is complete. If an application is determined to be incomplete, the plan shall notify the applicant in writing within ten (10) calendar days of receipt of the application. The written notice shall specify the portion of the application that is causing a delay in processing and explain any additional information or corrections needed.

6. In reviewing the application, the managed care plan shall evaluate each application according to the plan's checklist of materials required in the application process.

7. When an application is deemed complete, the plan shall initiate requests for primary source verification and malpractice history within seven (7) calendar days.

8. A malpractice carrier shall have twenty-one (21) calendar days within which to respond after receipt of an inquiry from a managed care plan. Any malpractice carrier that fails to respond to an inquiry within the allotted time frame may be assessed an administrative penalty by the State Commissioner of Health.

9. Upon receipt of primary source verification and malpractice history by the plan, the plan shall determine if the application is a clean application. If the application is deemed clean, a plan shall have forty-five (45) calendar days within which to credential or recredential a physician or other health care provider. As used in this subparagraph, "clean application" means an application that has no defect, misstatement of facts, improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing or recredentialing.

10. If a plan is unable to credential or recredential a physician or other health care provider due to an application's not being clean, the plan may extend the credentialing or recredentialing process for sixty (60) calendar days. At the end of sixty (60) calendar days, if the plan is awaiting documentation to complete the application, the physician or other health care provider shall be notified of the delay by certified mail. The physician or other health care provider may extend the sixty-day period upon written notice to the plan within ten (10) calendar days; otherwise the application shall be deemed withdrawn.

11. In no event shall the entire credentialing or recredentialing process exceed one hundred eighty (180) calendar days.

12. A managed care plan shall be prohibited from solely basing a denial of an application for credentialing or recredentialing on the lack of board certification or board eligibility and from adding new requirements solely for the purpose of delaying an application.

13. Any managed care plan that violates the provisions of this subsection may be assessed an administrative penalty by the State Commissioner of Health.

I. Plans shall not discriminate against enrollees with expensive medical conditions by excluding practitioners with practices containing a substantial number of these patients.

J. Plans shall, upon request, provide to a physician whose contract is terminated or not renewed for cause the reasons for termination or nonrenewal. Plans shall not contractually prohibit such requests.

K. No managed care plan shall engage in the practice of medicine or any other profession except as provided by law nor shall a plan include any provision in a provider contract that precludes or discourages a plan's providers from:

1. Informing a patient of the care the patient requires, including treatments or services not provided or reimbursed under the patient's plan; or

2. Advocating on behalf of a patient before the managed care plan.

L. Decisions by a managed care plan to authorize or deny coverage for an emergency service shall be based on the patient presenting symptoms arising from any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in serious:

1. Jeopardy to the health of the patient;

2. Impairment of bodily function; or

3. Dysfunction of any bodily organ or part.

M. Plans shall not deny an otherwise covered emergency service based solely upon lack of notification to the plan.

N. Plans shall compensate a provider for patient screening, evaluation, and examination services that are reasonably calculated to assist the provider in determining whether the condition of the patient requires emergency service. If the provider determines that the patient does not require emergency service, coverage for

services rendered subsequent to that determination shall be governed by the plan contract.

O. If within a period of thirty (30) minutes after receiving a request from a hospital emergency department for a specialty consultation, a plan fails to identify an appropriate specialist who is available and willing to assume the care of the enrollee, the emergency department may arrange for emergency services by an appropriate specialist that are medically necessary to attain stabilization of an emergency medical condition, and the plan shall not deny coverage for the services due to lack of prior authorization.

P. The reimbursement policies and patient transfer requirements of a plan shall not, directly or indirectly, require a hospital emergency department or provider to violate the federal Emergency Medical Treatment and Active Labor Act. If a member of a plan is transferred from a hospital emergency department facility to another medical facility, the plan shall reimburse the transferring facility and provider for services provided to attain stabilization of the emergency medical condition of the member in accordance with the federal Emergency Medical Treatment and Active Labor Act.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6908 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. Every group and individual contract holder is 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 as defined by Article 12 and paragraph 1 of subsection A of Section 12 of this act.

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 those provisions required in 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 to

refund any premiums. If services were received during the ten-day period, and the subscriber returns the contract to receive a refund of the premium paid, he or she must 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 that encourage misrepresentation as defined by Article 12 and 12A-1 of Title 36 of the Oklahoma Statutes.

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

D. Every health maintenance organization doing business in this state shall comply with the provisions of Article 36A of Title 36 of the Oklahoma Statutes.

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 Insurance Commissioner, subject to the provisions of subsections 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 Insurance Commissioner of this state for approval.

G. 1. Every form required by Section 8 of this act shall be filed with the Insurance 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 Insurance 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 is deemed approved if the Insurance Commissioner has taken no action. The filer must notify the Insurance 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 Insurance Commissioner may withdraw approval of a form, effective at the end of the thirty (30) days.

3. When a filing is disapproved or approval of a form is withdrawn, the Insurance 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 Insurance Commissioner has received the request for hearing.

H. The Insurance Commissioner may require the submission of 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 6909 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 covering the preceding calendar year. The report shall be on forms and shall include all forms prescribed by the National Association of Insurance Carriers (NAIC). The report shall be filed with the NAIC in electronic format, as approved the NAIC, along with applicable fees. In addition, the health maintenance organization shall file

with the Insurance Commissioner by the first day of March, unless otherwise stated:

1. Audited financial statements on or before June 1;

2. An actuarial opinion prepared and signed by a qualified actuary;

3. A list of the providers who have executed a contract that complies with the provisions of paragraph 1 of subsection D of Section 13 of this act; and

4. 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. Domestic health maintenance organizations shall file quarterly financial statements with the Insurance Commissioner on or before the forty-fifth day following the end of each calendar quarter other than the fourth quarter of each year. The report shall be on forms and shall include all forms prescribed by the NAIC. The report shall be filed with the NAIC in electronic format, as approved by the NAIC, along with applicable fees.

C. The Insurance Commissioner may require additional reports deemed necessary and appropriate to enable the Insurance 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 6910 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Every health maintenance organization (HMO) shall:

1. Provide to its subscribers a list of providers upon enrollment and re-enrollment;

2. Provide to its subscribers notice of any material change in the operation of the organization that will affect them directly, no later than thirty (30) days after such change;

3. Immediately notify an enrollee in writing of the termination of the enrollee's primary care provider and shall provide assistance to the enrollee in transferring to another participating primary care provider; and

4. Provide to subscribers information on:

a. how to obtain services,

b. where to obtain additional information on access to services, and

c. how to 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 6911 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 that has been approved by the Insurance Commissioner, after consultation with the State Commissioner of Health, to provide for the resolution of grievances initiated by enrollees. The health maintenance organization shall maintain a record of grievances received since the date of its last examination of grievances.

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

C. Health maintenance organizations shall comply with the requirements of an insurer as set out in Sections 1250.1 through 1250.15 of Title 36 of the Oklahoma Statutes.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6912 of Title 36, unless there is created a duplication in numbering, reads as follows:

With the exception of investments made in accordance with the provisions of paragraph 1 of subsection A of Section 5 of this act, the funds of a health maintenance organization shall be invested only in accordance with the provisions of article 16 of Title 36 of the Oklahoma Statutes.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6913 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 that the HMO shall thereafter maintain the minimum net worth required under paragraph 2 of this subsection.

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

a. One Million Five Hundred Thousand Dollars ($1,500,000.00),

b. two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the Insurance Commissioner on the first One Hundred Fifty Million Dollars ($150,000,000.00) of premium and one percent (1%) of annual premium on the premium in excess of One Hundred Fifty Million Dollars ($150,000,000.00),

c. an amount equal to the sum of three (3) months of uncovered health care expenditures as reported on the most recent financial statement filed with the Insurance 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 Insurance 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 Insurance Commissioner.

3. Every health maintenance organization licensed before the effective date of this act shall maintain a minimum net worth of the greater of Seven Hundred Fifty Thousand Dollars ($750,000.00) or:

a. twenty-five percent (25%) of the amount required by paragraph 2 of subsection A of Section 13 of this act by December 31, 2003,

b. fifty percent (50%) of the amount required paragraph 2 of subsection A of Section 13 of this act by December 31, 2004,

c. seventy-five percent (75%) of the amount required by paragraph 2 of subsection A of Section 13 of this act by December 31, 2005, and

d. one hundred percent (100%) of the amount required by paragraph 2 of subsection A of Section 13 of this act by December 31, 2005.

4. a. In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the Insurance Commissioner. An interest obligation relating to the repayment of any subordinated debt shall be similarly subordinated.

b. The interest expenses relating to the repayment of a fully subordinated debt shall be considered covered expenses.

c. A debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the Insurance Commissioner, shall not be considered a liability and shall be recorded as equity.

B. 1. Unless otherwise provided below, each health maintenance organization shall deposit with the Insurance Commissioner or, at the discretion of the Insurance Commissioner, with any organization or trustee acceptable to the Insurance 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 Insurance Commissioner, which at all times shall have a value of not less than Five Hundred Thousand Dollars ($500,000.00).

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

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

4. The deposit shall be used to protect the interests of the health maintenance organization’s enrollees and to ensure continuation of health care services to enrollees of a health maintenance organization that is in rehabilitation or conservation. The Insurance Commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If a health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the liquidation act.

5. The Insurance Commissioner may reduce or eliminate the deposit requirement if a health maintenance organization deposits with the State Treasurer, Insurance Commissioner, or other official body of the state or jurisdiction of domicile for the protection of all subscribers and enrollees of the health maintenance organization, wherever located, cash, acceptable securities or

surety, and delivers to the Insurance Commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

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

a. any unearned premium,

b. the payment of all claims for incurred health care expenditures, whether reported or unreported, that are unpaid and for which the organization is or may be liable, and

c. the expense of adjustment or settlement of those claims.

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

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

2. In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect a subscriber or an enrollee sums owed by the health maintenance organization.

3. No participating provider or the provider’s agent, trustee or assignee may maintain an action at law against a subscriber or

enrollee to collect sums owed by the health maintenance organization.

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

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

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

3. Insolvency reserves;

4. Acceptable letters of credit; or

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

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

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6914 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 (HMO) shall place an uncovered expenditures insolvency

deposit with the Insurance Commissioner or, at the discretion of the Insurance Commissioner, with an organization or trustee acceptable to the Insurance Commissioner and through which a custodial or controlled account is maintained, cash or securities that are acceptable to the Insurance 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 the provisions of this section.

B. The deposit required under this section is in addition to the deposit required under subsection B of Section 13 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 Insurance 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 Insurance Commissioner.

D. The deposit required under this section is in trust and may be used only as provided under the provisions of this section. The Insurance 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 Insurance Commissioner may by rule prescribe the time, manner and form for filing claims under the provisions of subsection D of this section.

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

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6915 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 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 Insurance Commissioner determines that the other health benefit plans lack sufficient health care delivery resources to ensure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, the Insurance Commissioner shall equitably allocate 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 Insurance Commissioner shall also equitably allocate 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. “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-three (63) 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 at 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, 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 16. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6916 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. No premium rate may be used by a health maintenance organization until such time as 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. Provided further, that the premium rates shall not be excessive, inadequate, unfair or discriminatory. A certification by a qualified actuary or other qualified person acceptable to the Insurance 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 Insurance 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 Insurance Commissioner disapproves the filing, the Insurance Commissioner shall notify the health maintenance organization. In the notice, the Insurance Commissioner shall specify the reasons for disapproval. A hearing will be conducted within thirty (30) days after a request in writing by the person filing. If the Insurance 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.

D. When contracting with educational entities within the meaning of Section 1306 of Title 74 of the Oklahoma Statutes, in setting health insurance premiums for active employees and for

retirees under sixty-five (65) years of age, health maintenance organizations shall set the monthly premium for active employees at a maximum of Ninety Dollars ($90.00) less than the monthly premium for retirees under sixty-five (65) years of age.

SECTION 17. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6917 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Health maintenance organization producers shall comply with all applicable statutes and provisions of Title 36 of the Oklahoma Statutes and rules relating to producer licensing, including the Oklahoma Producer Licensing Act.

B. The following persons shall not be required to hold a health maintenance organization producer license:

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 this act.

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

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

2. If other existing safeguards make regulation unnecessary.

SECTION 18. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6918 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 pursuant to the provisions of this act. Notwithstanding any other law which may be inconsistent, any two 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 in Title 36 of the Oklahoma Statutes, 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. An insurer or a hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers pursuant to such contracts.

SECTION 19. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6919 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner may make an examination of the affairs of any health maintenance organization, producers and providers with whom the organization has contracts, agreements or other arrangements pursuant to the provisions of Sections 309.1 through 309.7 of Title 36 of the Oklahoma Statutes.

B. The State Commissioner of Health may require a health maintenance organization to contract for 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 an examination. For the purpose of an examination, the Insurance 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. Any health maintenance organization examined shall pay the proper charges incurred in such examination, including the actual expense of the Insurance Commissioner or State Commissioner of Health or the expenses and compensation of any authorized representative and the expense and compensation of assistants and examiners employed therein. All expenses incurred in such examination shall be verified by affidavit and a copy shall be filed in the office of the Insurance Commissioner or the State Commissioner of Health.

E. In lieu of an examination, the Insurance Commissioner or State Commissioner of Health may accept the report of an examination made by the health maintenance organization regulatory entity of another state.

SECTION 20. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6920 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A certificate of authority issued under the Health Maintenance Organization Act of 2003 may be suspended or revoked, and a 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 (HMO) 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 Insurance 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 16 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 Insurance Commissioner that:

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

b. the health maintenance organization 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 frame 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 to the public; or

10. The health maintenance organization has otherwise failed to comply with every relevant provision of Titles 36 or 63 of the Oklahoma Statutes, or rules promulgated by the Insurance Commissioner or the State Board of Health.

B. In addition to or in lieu of suspension or revocation of a certificate of authority pursuant to the provisions of this section, the applicant or health maintenance organization may be subjected to

an administrative penalty of Five Thousand Dollars ($5,000.00) for each occurrence.

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

1. Whenever the Insurance 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 13 of this act, the Insurance Commissioner shall give written notice to the health maintenance organization of the amount of the deficiency and require filing with the Insurance Commissioner a plan for correction of the deficiency that is acceptable to the Insurance 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 Insurance 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; or

2. Unless allowed by the Insurance 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; provided, 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, denial of an application, or imposition of an administrative penalty by the Insurance Commissioner, pursuant to the provisions of 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 or 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 the provisions of this section, the Insurance Commissioner shall issue a written notice of hearing and send such notice 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. that any hearing shall be held at the office of the Insurance Commissioner.

If a hearing is requested, the State Commissioner of Health or a designee 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 Insurance Commissioner. After the hearing, or upon failure of the health maintenance organization to appear at the hearing, the Insurance Commissioner shall take whatever action is deemed necessary based on written findings. The Insurance Commissioner shall mail the decision to the health maintenance organization or applicant and a copy to the State Commissioner of Health.

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

F. If 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. If the certificate of authority of a health maintenance organization is revoked, the HMO 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. The HMO shall engage in no further advertising or solicitation whatsoever. The Insurance Commissioner may, by written order, permit further operation of the HMO if found to be in the best interests of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

SECTION 21. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6921 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 (HMO) 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 laws of this state governing the rehabilitation, liquidation or conservation of insurance companies. The Insurance Commissioner may apply for an order directing the Insurance Commissioner to rehabilitate, liquidate or conserve a health maintenance organization upon any one or more grounds set out in Articles 18 and 19 of Title 36 of the Oklahoma Statutes or when, in the Insurance 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 purpose of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries shall have the same priority as established by Article 19 of Title 36 of the Oklahoma Statutes 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 Title 36 of the Oklahoma Statutes.

SECTION 22. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6922 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 (HMO) is such that its continued operation might be hazardous to its enrollees, creditors or the general public, or that the HMO has violated any provision of the Health Maintenance Organization Act of 2003, the Insurance Commissioner may, after notice and opportunity for 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 liability for benefits by reinsurance or other method acceptable to the Insurance 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 Insurance 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. Rules of the Insurance Commissioner establishing criteria that the Insurance Commissioner may consider in making a determination that the condition of any insurer is such that continuation of such insurer's business may be hazardous to the public or to holders of its policies or certificates of insurance may be used by the Insurance Commissioner 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.

D. The remedies and measures available to the Insurance Commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the Insurance Commissioner under the provisions of Section 1904 of Title 36 of the Oklahoma Statutes.

SECTION 23. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6923 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Insurance Commissioner may promulgate rules necessary or proper to carry out the provisions of the Health Maintenance Organization Act of 2003.

SECTION 24. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6924 of Title 36, unless there is created a duplication in numbering, reads as follows:

Every health maintenance organization subject to the provisions of the Health Maintenance Organization Act of 2003 shall pay to the Insurance Commissioner the fees provided in Section 321 of Title 36 of the Oklahoma Statutes.

SECTION 25. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6925 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 the provisions of Section 20 of this act, levy an administrative penalty in an amount not to exceed Five Thousand Dollars ($5,000.00) for each occurrence 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 Insurance 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 Insurance Commissioner or the State Commissioner of Health shall for any reason have cause to believe that a violation of this act has occurred or is threatened, the Insurance Commissioner or State Commissioner 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 Insurance Commissioner or the State Commissioner of Health may deem appropriate under the circumstances; provided, however, unless consented to by the health maintenance organization, no order may result from a conference until the requirements of this section of this act are satisfied.

C. 1. The Insurance 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 thirty (30) 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 Administrative Procedures Act and judicial review shall be available as provided by that act.

D. In the case of any violation of the provisions of this act, if the Insurance 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 the provisions of subsection C of this section, the Insurance Commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the district court of Oklahoma County.

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 Insurance 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 26. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6926 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as otherwise provided in the Health Maintenance Organization Act of 2003, 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 the provisions of this act. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance law 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 provisions of Title 59 of the Oklahoma Statutes related to the practice of medicine.

SECTION 27. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6927 of Title 36, unless there is created a duplication in numbering, reads as follows:

All applications, filings and reports required under the Health Maintenance Organization Act of 2003 shall be treated as public records, except those which are trade secrets or privileged or confidential quality assurance, commercial or financial information. Annual financial statements that may be required under the provisions of Section 9 of this act shall be treated as public records.

SECTION 28. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6928 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. 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:

a. to the extent that it may be necessary to carry out the purposes of the Health Maintenance Organization Act of 2003,

b. upon the express consent of the enrollee or applicant,

c pursuant to statute or court order for the production of evidence or the discovery thereof, or

d. in the event of claim or litigation between the person and the health maintenance organization wherein the data or information is pertinent.

2. 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, agent 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 the committee's 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 the provisions of paragraph 1 of this subsection by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions as 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, a health maintenance organization shall have access to treatment records and other information pertaining to the diagnosis, treatment or health status of an enrollee.

SECTION 29. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6929 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 Health Maintenance Organization Act of 2003, 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 by the State Commissioner of Health.

SECTION 30. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6930 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. 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 complied with the provisions of Article 16A of Title 36 of the Oklahoma Statutes.

SECTION 31. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6931 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health maintenance organization is permitted, but not required, to adopt coordination of benefits provisions to avoid over insurance and to provide for the orderly payment of claims when an enrollee is covered by two (2) or more group health insurance or health care plans.

B. If a health maintenance organization adopts coordination of benefits, the provisions thereof shall 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 a health maintenance organization to meet its obligations as a secondary carrier under the rules for coordination, a health maintenance organization shall make payments for services that are:

1. Received from nonparticipating providers;

2. Provided outside its service areas; or

3. Not covered under the terms of its group contract or evidence of coverage.

SECTION 32. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6932 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 other 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 the provisions of Section 15 of this act. The Insurance 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 the prior calendar year.

B. The Insurance Commissioner may use funds obtained under the provisions of subsection A of this section to:

1. Pay claims for uncovered expenditures for subscribers or enrollees of an insolvent health maintenance organization who are residents of this state;

2. Provide for continuation of coverage for subscribers or enrollees who are residents of this state and are not covered under the provisions of Section 15 of this act; and

3. Pay administrative costs. The Insurance 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 Insurance Commissioner to the extent of the benefits received. The Insurance Commissioner may require an assignment to the Insurance Commissioner 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 Insurance 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 Insurance Commissioner and allowed claims 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 Insurance Commissioner shall distribute on a pro rata basis any amounts received under subsection A of this section that 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) for 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 Insurance 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 Insurance Commissioner.

F. The Insurance Commissioner may waive an assessment of a health maintenance organization if the HMO is or would be impaired or placed in a financially hazardous condition. A health maintenance organization that 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 Insurance Commissioner in enforcing the provisions of this section may be appealed by the health maintenance organization in accordance with the Administrative Procedures Act.

SECTION 33. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6933 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health maintenance organization shall provide basic health care services directly or by contract or agreement with other persons, corporations, institutions, associations, foundations or other legal entities, public or private, in accordance with the laws governing such professions and services.

B. Each health maintenance organization shall have a defined set of standards and procedures for selecting providers, including specialists, to serve enrollees. The standards and procedures shall be drafted in such a manner as to be applicable to all categories of providers and shall be utilized by the health maintenance organization in a manner that is without bias for or discrimination against a particular category or categories of providers.

C. With respect to chiropractic services, such covered services shall be provided on a referral basis within the network at the request of an enrollee who has a condition of an orthopedic or neurological nature if:

1. A referral is necessitated in the judgment of the primary care physician; and

2. Treatment for the condition falls within the licensed scope of practice of a chiropractic physician.

D. 1. Any health maintenance organization that offers services for vision care or medical diagnosis and treatment for the eye shall allow optometrists to be providers of those services.

2. Once a fee schedule has been negotiated, ophthalmologists and optometrists shall be paid equally for the same services so long as the services provided by the optometrists are within the scope of the practice of optometry.

3. No health maintenance organization shall require a provider of vision care or medical diagnosis and treatment for the eye to have hospital privileges if hospital privileges are not usual and customary for the services the provider provides.

4. With respect to optometric services, such covered services shall be provided on a referral basis within the medical group or network at the request of an enrollee who has a condition requiring vision care or medical diagnosis and treatment of the eye if:

a. a referral is necessitated in the judgment of the primary care physician, and

b. treatment for the condition falls within the licensed scope of practice of an optometrist.

5. Nothing in this subsection shall be construed to:

a. prohibit any health maintenance organization that offers services for vision care or medical diagnosis and treatment for the eye from determining the adequacy of the size of its network,

b. limit, expand or otherwise affect the scope of practice of optometry, or

c. alter, repeal, modify or affect the laws of this state except where such laws are in conflict or are inconsistent with the express provisions of this section.

6. Existing contracts shall comply with the requirements of this subsection upon issuance or renewal on or after the effective date of this act.

E. 1. A health maintenance organization shall not:

a. engage in the practice of medicine or any other profession except as provided by law, or

b. prohibit or restrict a primary care physician from referring a patient to a specialist within the network if such referral is deemed medically necessary in the judgment of the primary care physician.

2. A health maintenance organization shall provide basic health care services in a manner that is reasonably geographically

convenient to residents of the service area for which it seeks a license.

SECTION 34. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6934 of Title 36, unless there is created a duplication in numbering, reads as follows:

Health maintenance organizations may provide any services included in state or federal health care programs, such as state employee benefits, the state basic health benefits program, "Medicare," "Medicaid," "Champus" and Veterans Administrations and other health programs provided in whole or in part by state or federal funds, in accordance with the laws governing such programs.

SECTION 35. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6935 of Title 36, unless there is created a duplication in numbering, reads as follows:

Comprehensive health services as herein provided may be furnished to enrollees of health maintenance organizations outside this state only in accordance with the laws of the state or of the United States that govern the provision of such services in the state or place concerned; provided, that an enrollee may be reimbursed directly for emergency health care expenses incurred by the enrollee while temporarily outside the state, when such expenses would have been provided under the enrollee's program had the enrollee been within the state. Such reimbursement made by a health maintenance organization shall not be construed as an indemnity and no health maintenance organization shall be an insurer or make any contract of insurance of any kind whatsoever.

SECTION 36. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6936 of Title 36, unless there is created a duplication in numbering, reads as follows:

If any section, term or provision of this act shall be adjudged invalid for any reason, that judgment shall not affect, impair or invalidate any other section, term or provision of this act; but the

remaining sections, terms and provisions shall be and remain in full force and effect.

SECTION 37. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6937 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 "Risk-based Capital (RBC) for Health Maintenance Organizations Act of 2003".

SECTION 38. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6938 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Risk-based Capitol (RBC) for Health Maintenance Organizations Act of 2003:

1. “Adjusted Risk-based Capitol (RBC) report” means an RBC report which has been adjusted by the Insurance Commissioner in accordance with the provisions of subsection D of Section 39 of this act;

2. “Corrective order” means an order issued by the Commissioner specifying corrective actions which the Insurance Commissioner has determined are required;

3. “Domestic health maintenance organization” means a health maintenance organization domiciled in this state;

4. “Foreign health maintenance organization” means a health maintenance organization that is licensed to do business in this state under the Health Maintenance Organization Act of 2003, but is not domiciled in this state;

5. “NAIC” means the National Association of Insurance Commissioners;

6. “Health maintenance organization” means a health maintenance organization licensed under the Health Maintenance Organization Act of 2003. This definition does not include an organization that is licensed as either a life and health insurer or a property and casualty insurer under Title 36 of the Oklahoma Statutes and that is

otherwise subject to either life or property and casualty RBC requirements;

7. "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as these RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC;

8. "RBC level" means a health maintenance organization's Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC where:

a. "Company Action Level RBC" means, with respect to any health maintenance organization, the product of 2.0 and its Authorized Control Level RBC,

b. "Regulatory Action Level RBC" means the product of 1.5 and its Authorized Control Level RBC,

c. "Authorized Control Level RBC" means the number determined under the risk-based capital formula in accordance with the RBC Instructions, or

d. "Mandatory Control Level RBC" means the product of .70 and the Authorized Control Level RBC;

9. "RBC plan" means a comprehensive financial plan containing the elements specified in subsection B of Section 40 of this act. If the Insurance Commissioner rejects the RBC plan, and it is revised by the health maintenance organization, with or without the Insurance Commissioner's recommendation, the plan shall be called the "revised RBC plan";

10. "RBC report" means the report required in Section 39 of this act; and

11. "Total adjusted capital" means the sum of:

a. a health maintenance organization's statutory capital and surplus, or its net worth, as determined in accordance with the statutory accounting applicable to

the annual financial statements required to be filed under Section 9 of this act, and

b. such other items, if any, as the RBC instructions may provide.

SECTION 39. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6939 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A domestic health maintenance organization shall, on or prior to each March 1 filing date, prepare and submit to the Insurance Commissioner a report of its Risk-based Capital (RBC) levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, a domestic health maintenance organization shall file its RBC report:

1. With the NAIC in accordance with the RBC instructions; and

2. With the Insurance Commissioner in any state in which the health maintenance organization is authorized to do business, if the Insurance Commissioner has notified the health maintenance organization of its request in writing, in which case the health maintenance organization shall file its RBC report not later than the later of:

a. fifteen (15) days from the receipt of notice to file its RBC report with that state, or

b. the filing date.

B. A health maintenance organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account and may adjust for the covariance between, determined in each case by applying the factors in the manner set forth in the RBC instructions:

1. Asset risk;

2. Credit risk;

3. Underwriting risk; and

4. All other business risks and such other relevant risks as are set forth in the RBC instructions.

C. If a domestic health maintenance organization files an RBC report that, in the judgment of the Commissioner, is inaccurate, the Commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the health maintenance organization of the adjustment. The notice shall contain a statement of the reason for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report."

SECTION 40. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6940 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. "Company Action Level Event" means any of the following events:

1. The filing of an RBC report by a health maintenance organization that indicates that the health maintenance organization's total adjusted capital is greater than or equal to its Regulatory Action Level RBC, but less than its Company Action Level RBC;

2. Notification by the Insurance Commissioner to the health maintenance organization of an adjusted RBC report that indicates an event in paragraph 1 of this subsection, provided the health maintenance organization does not challenge the adjusted RBC report under Section 44 of this act; or

3. If, pursuant to the provisions of Section 44 of this act, a health maintenance organization challenges an adjusted RBC report that indicates the event in paragraph 1 of this subsection, the notification by the Commissioner to the health maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge.

B. In the event of a Company Action Level Event, the health maintenance organization shall prepare and submit to the Commissioner an RBC plan that shall:

1. Identify the conditions that contribute to the Company Action Level Event;

2. Contain proposals of corrective actions that the health maintenance organization intends to take and that would be expected to result in the elimination of the Company Action Level Event;

3. Provide projections of the health maintenance organization's financial results in the current year and at least the two (2) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

4. Identify the key assumptions affecting the health maintenance organization's projections and the sensitivity of the projections to the assumptions; and

5. Identify the quality of, and problems associated with, the health maintenance organization's business including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

C. The RBC plan shall be submitted:

1. Within forty-five (45) days of the Company Action Level Event; or

2. If the health maintenance organization challenges an adjusted RBC report pursuant to the provisions Section 44 of this act, within forty-five (45) days after notification to the health

maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge.

D. Within sixty (60) days after the submission by a health maintenance organization of an RBC plan to the Commissioner, the Commissioner shall notify the health maintenance organization whether the RBC plan will be implemented or whether, in the judgment of the Commissioner, the RBC plan is unsatisfactory. If the Commissioner determines that the RBC plan is unsatisfactory, the notification to the health maintenance organization shall state the reasons for the determination, and may list proposed revisions that will, in the judgment of the Commissioner, render the RBC plan satisfactory. Upon notification from the Commissioner, the health maintenance organization shall prepare a revised RBC plan, that may incorporate by reference any revisions proposed by the Commissioner, and shall submit the revised RBC plan to the Commissioner:

1. Within forty-five (45) days after the notification from the Commissioner; or

2. If the health maintenance organization challenges the notification from the Commissioner pursuant to the provisions of Section 44 of this act, within forty-five (45) days after a notification to the health maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge.

E. In the event of a notification by the Commissioner to a health maintenance organization that the health maintenance organization's RBC plan or revised RBC plan is unsatisfactory, the Commissioner may, at the Commissioner's discretion and subject to the health maintenance organization's right to a hearing pursuant to the provisions of Section 44 of this act, specify in the notification that the notification constitutes a Regulatory Action Level Event.

F. Every domestic health maintenance organization that files an RBC plan or revised RBC plan with the Commissioner shall file a copy of the RBC plan or revised RBC plan with the Insurance Commissioner in any state in which the health maintenance organization is authorized to do business if:

1. The state has an RBC provision substantially similar to subsection A of Section 45 of this act; and

2. The Insurance Commissioner of that state has notified the health maintenance organization of its request for the filing in writing, in which case the health maintenance organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

a. fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

b. the date on which the RBC plan or revised RBC plan is filed under subsections C and D of this section.

SECTION 41. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6941 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. “Regulatory Action Level Event” means, with respect to a health maintenance organization, any of the following events:

1. The filing of an RBC report by the health maintenance organization that indicates that the health maintenance organization’s total adjusted capital is greater than or equal to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;

2. Notification by the Commissioner to a health maintenance organization of an adjusted RBC report that indicates a Regulatory Action Level Event specified in paragraph 1 of this subsection, provided the health maintenance organization does not challenge the adjusted RBC report under Section 44 of this act;

3. If, pursuant to the provisions of Section 44 of this act, the health maintenance organization challenges an adjusted RBC report that indicates a Regulatory Action Level Event specified event in paragraph 1 of this subsection, the notification by the Commissioner to the health maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge;

4. The failure of the health maintenance organization to file an RBC report by the filing date, unless the health maintenance organization has provided an explanation for the failure that is satisfactory to the Commissioner and has corrected the failure within ten (10) days after the filing date;

5. The failure of the health maintenance organization to submit an RBC plan to the Commissioner within the time period provided in subsection C of Section 40 of this act;

6. Notification by the Commissioner to the health maintenance organization that:

a. the RBC plan or revised RBC plan submitted by the health maintenance organization is, in the judgment of the Commissioner, unsatisfactory, and

b. notification constitutes a Regulatory Action Level Event with respect to the health maintenance organization, provided the health maintenance organization has not challenged the determination under Section 44 of this act;

7. If, pursuant to the provisions of Section 44 of this act, the health maintenance organization challenges a determination by the Commissioner under paragraph 6 of this subsection, the notification by the Commissioner to the health maintenance organization that the Commissioner has, after a hearing, rejected the challenge;

8. Notification by the Commissioner to the health maintenance organization that the health maintenance organization has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the health maintenance organization to eliminate the Company Action Level Event in accordance with its RBC plan or revised RBC plan and the Commissioner has so stated in the notification, provided the health maintenance organization has not challenged the determination under Section 44 of this act; or

9. If, pursuant to the provisions of Section 44 of this act, the health maintenance organization challenges a determination by the Commissioner under paragraph 8 of this subsection, the notification by the Commissioner to the health maintenance organization that the Commissioner has, after a hearing, rejected the challenge.

B. In the event of a Regulatory Action Level Event the Commissioner shall:

1. Require the health maintenance organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

2. Perform such examination or analysis of the assets, liabilities and operations of the health maintenance organization as the Commissioner deems necessary, including a review of the HMO’s RBC plan or revised RBC plan; and

3. Subsequent to the examination or analysis, issue a corrective order specifying such corrective actions as the Commissioner shall determine are required.

C. In determining corrective actions, the Commissioner may take into account factors the Commissioner deems relevant with respect to the health maintenance organization based upon the Commissioner’s examination or analysis of the assets, liabilities and operations of the health maintenance organization including, but not limited to,

the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

1. Within forty-five (45) days after the occurrence of the Regulatory Action Level Event;

2. If the health maintenance organization challenges an adjusted RBC report pursuant to the provisions of Section 44 of this act and the challenge is not frivolous, in the judgment of the Commissioner, within forty-five (45) days after the notification to the health maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge; or

3. If the health maintenance organization challenges a revised RBC plan pursuant to the provisions of Section 44 of this act and the challenge is not frivolous, in the judgment of the Commissioner, within forty-five (45) days after the notification to the health maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge.

D. The Commissioner may retain such actuaries, investment experts and other consultants as may be necessary, in the judgment of the Commissioner, to review the health maintenance organization's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations, including contractual relationships of the health maintenance organization, and formulate the corrective order with respect to the health maintenance organization. The fees, costs and expenses relating to consultants shall be borne by the affected health maintenance organization or such other party as directed by the Commissioner.

SECTION 42. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6942 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. "Authorized Control Level Event" means any of the following events:

1. The filing of an RBC report by the health maintenance organization that indicates that the health maintenance organization’s total adjusted capital is greater than or equal to its Mandatory Control Level RBC, but less than its Authorized Control Level RBC;

2. The notification by the Commissioner to the health maintenance organization of an adjusted RBC report that indicates an Authorized Control Level Event as specified in paragraph 1 of this subsection; provided, the health maintenance organization does not challenge the adjusted RBC report under Section 44 of this act;

3. If, pursuant to the provisions of Section 44 of this act, the health maintenance organization challenges an adjusted RBC report that indicates the event in paragraph 1 of this subsection, notification by the Commissioner to the health maintenance organization that the commissioner has, after a hearing, rejected the health maintenance organization’s challenge;

4. The failure of the health maintenance organization to respond, in a manner satisfactory to the Commissioner, to a corrective order, provided the health maintenance organization has not challenged the corrective order under Section 44 of this act; or

5. If the health maintenance organization has challenged a corrective order under Section 44 of this act and the Commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health maintenance organization to respond, in a manner satisfactory to the Commissioner, to the corrective order subsequent to rejection or modification by the Commissioner.

B. In the event of an Authorized Control Level Event with respect to a health maintenance organization, the Commissioner shall:

1. Take such actions as are required under Section 41 of this act regarding a health maintenance organization with respect to which an Regulatory Action Level Event has occurred; or

2. If the Commissioner deems it to be in the best interests of the policyholders and creditors of the health maintenance organization and of the public, take such actions as are necessary to cause the health maintenance organization to be placed under regulatory control pursuant to the provisions of Articles 18 and 19 of Title 36 of the Oklahoma Statutes. In the event the Commissioner takes such actions, the Authorized Control Level Event shall be deemed sufficient grounds for the Commissioner to take action pursuant to the provisions of Articles 18 and 19 of Title 36 of the Oklahoma Statutes, and the Commissioner shall have the rights, powers and duties with respect to the health maintenance organization as provided in Articles 18 and 19 of Title 36 of the Oklahoma Statutes.

SECTION 43. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6943 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. "Mandatory Control Level Event" means any of the following events:

1. The filing of an RBC report which indicates that the health maintenance organization's total adjusted capital is less than its Mandatory Control Level RBC;

2. Notification by the Commissioner to the health maintenance organization of an adjusted RBC report that indicates a Mandatory Control Level Event specified in paragraph 1 of this subsection; provided, the health maintenance organization does not challenge the adjusted RBC report under Section 44 of this act; or

3. If, pursuant to the provisions of Section 44 of this act, the health maintenance organization challenges an adjusted RBC report that indicates the event in paragraph 1 of this subsection,

notification by the Commissioner to the health maintenance organization that the Commissioner has, after a hearing, rejected the health maintenance organization's challenge.

B. In the event of a Mandatory Control Level Event, the Commissioner shall take such actions as are necessary to place the health maintenance organization under regulatory control pursuant to the provisions of Article 18 and 19 of Title 36 of the Oklahoma Statutes. In that event, the Mandatory Control Level Event shall be deemed sufficient grounds for the Commissioner to take action pursuant to the provisions of Article 18 and 19 of Title 36 of the Oklahoma Statutes, and the Commissioner shall have the rights, powers and duties with respect to the health maintenance organization as provided in Article 18 and 19 of Title 36 of the Oklahoma Statutes. Notwithstanding any of the preceding provisions, the Commissioner may forego action for up to ninety (90) days after the Mandatory Control Level Event if the Commissioner finds there is a reasonable expectation that the Mandatory Control Level Event may be eliminated within the ninety-day period.

SECTION 44. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6944 of Title 36, unless there is created a duplication in numbering, reads as follows:

Upon the occurrence of any of the following events the health maintenance organization shall have the right to a confidential departmental hearing, on the record, at which the health maintenance organization may challenge any determination or action by the Commissioner. The health maintenance organization shall notify the Commissioner of its request for a hearing within five (5) days after the notification by the Commissioner under subsections A, B, C or D of this section. Upon receipt of the health maintenance organization's request for a hearing, the Commissioner shall set a date for the hearing, which shall be no less than ten (10), nor more

than thirty (30) days after the date of the health maintenance organization's request. The events include:

1. Notification to a health maintenance organization by the Commissioner of an adjusted RBC report;

2. Notification to a health maintenance organization by the Commissioner that:

a. the health maintenance organization's RBC plan or revised RBC plan is unsatisfactory, and

b. notification constitutes a Regulatory Action Level Event with respect to the health maintenance organization;

3. Notification to a health maintenance organization by the Commissioner that the health maintenance organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the health maintenance organization to eliminate the Company Action Level Event with respect to the health maintenance organization in accordance with its RBC plan or revised RBC plan; or

4. Notification to a health maintenance organization by the Commissioner of a corrective order with respect to the health maintenance organization.

SECTION 45. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6945 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. All RBC reports, to the extent the information is not required to be provided in a publicly available annual statement schedule, and RBC plans, including the results or report of any examination or analysis of a health maintenance organization performed pursuant to this statute and any corrective order issued by the Commissioner pursuant to examination or analysis, with respect to a domestic health maintenance organization or foreign health maintenance organization that are in the possession or

control of the Insurance Commissioner shall, by law, be confidential and privileged, shall not be subject to the provisions of the Open Records Act or the Administrative Procedures Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action; provided, however, the Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties.

B. Neither the Commissioner nor any person who received documents, materials or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to the provisions of subsection A of this section.

C. In order to assist in the performance of the Commissioner's duties, the Commissioner:

1. May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to the provisions of subsection A of this section, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities; provided, that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

2. May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with

notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

3. May enter into agreements governing the sharing and use of information consistent with this subsection.

D. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in paragraph 3 of subsection C of this section.

E. Except as otherwise required under the provisions of this act, the 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 a radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any health maintenance organization, or of any component derived in the calculation, by any health maintenance organization, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited. Provided, however, that if any materially false statement with respect to the comparison regarding a health maintenance organization's total adjusted capital to its RBC levels, or any of them, or an inappropriate comparison of any other amount to the health maintenance organizations' RBC levels is published in any written publication and the health maintenance organization is able to demonstrate to the Commissioner with substantial proof the falsity or inappropriateness of the statement, the health maintenance organization may publish an announcement in a

written publication if the sole purpose of the announcement is to rebut the materially false statement.

F. RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans shall be used by the Commissioner solely in monitoring the solvency of health maintenance organizations and the need for possible corrective action with respect to health maintenance organizations. Such instructions, reports and plans shall not be used by the Commissioner for ratemaking, considered or introduced as evidence in any rate proceeding, or used by the Commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that a health maintenance organization or any affiliate is authorized to write.

SECTION 46. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6946 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The provisions of this act are supplemental to any other provisions of the laws of this state, and shall not preclude or limit any other powers or duties of the Insurance Commissioner under such laws including, but not limited to, Articles 18 and 19 of Title 36 of the Oklahoma Statutes and promulgated rules relating to health maintenance organizations in hazardous financial condition.

B. The Commissioner may adopt reasonable rules necessary for the implementation of this act.

C. The Commissioner may exempt from the application of this act a domestic health maintenance organization that:

1. Writes direct business only in this state; and

2. Assumes no reinsurance in excess of five percent (5%) of direct premium written.

SECTION 47. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6947 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. A foreign health maintenance organization shall, upon the written request of the Insurance Commissioner, submit to the Commissioner an RBC report as of the end of the calendar year just ended the later of:

a. the date an RBC report would be required to be filed by a domestic health maintenance organization under this act, or

b. fifteen (15) days after the request is received by the foreign health maintenance organization.

2. A foreign health maintenance organization shall, at the written request of the Commissioner, promptly submit to the Commissioner a copy of any RBC plan that is filed with the Insurance Commissioner of any other state.

B. In the event of a Company Action Level Event, Regulatory Action Level Event or Authorized Control Level Event with respect to a foreign health maintenance organization, as determined under the RBC statute applicable in the state of domicile of the health maintenance organization or, if no RBC statute is in force in that state, under the provisions of this act, if the Insurance Commissioner of the state of domicile of the foreign health maintenance organization fails to require the foreign health maintenance organization to file an RBC plan in the manner specified under that state's RBC statute or, if no RBC statute is in force in that state, under the provisions of Section 40 of this act, the Commissioner may require the foreign health maintenance organization to file an RBC plan with the Commissioner. In such event, the failure of the foreign health maintenance organization to file an RBC plan with the Commissioner shall be grounds to order the health maintenance organization to cease and desist from writing new insurance business in this state.

C. In the event of a Mandatory Control Level Event with respect to a foreign health maintenance organization, if no domiciliary

receiver has been appointed for the foreign health maintenance organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign health maintenance organization, the Commissioner may make application to the District Court of Oklahoma County as permitted under Article 19 of Title 36 of the Oklahoma Statutes with respect to the liquidation of property of foreign health maintenance organizations found in this state, and the occurrence of the Mandatory Control Level Event shall be considered adequate grounds for the application.

SECTION 48. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6948 of Title 36, unless there is created a duplication in numbering, reads as follows:

There shall be no liability on the part of, and no cause of action shall arise against, the Insurance Commissioner or the Insurance Department or its employees or agents for any action taken by them in the performance of their powers and duties under this act.

SECTION 49. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6949 of Title 36, unless there is created a duplication in numbering, reads as follows:

If any provision of this act, or its application to any person or circumstance, is held invalid, that determination shall not affect the provisions or applications of this act that can be given effect without the invalid provision or application, and to that end the provisions of this act are severable.

SECTION 50. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6950 of Title 36, unless there is created a duplication in numbering, reads as follows:

All notices by the Insurance Commissioner to a health maintenance organization that may result in regulatory action under this act shall be effective upon the date the notice is postmarked by the United States Postal Service if transmitted by registered or

certified mail or, in the case of any other transmission, shall be effective upon the health maintenance organization's receipt of notice.

SECTION 51. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6951 of Title 36, unless there is created a duplication in numbering, reads as follows:

For RBC reports required to be filed by health maintenance organizations in 2003, the following requirements shall apply in lieu of the provisions of Sections 40, 41, 42 and 43 of this act:

1. In the event of a Company Action Level Event in a domestic health maintenance organization, the Insurance Commissioner shall take no regulatory action under this act;

2. In the event of a Regulatory Action Level Event under the provisions of paragraphs 1, 2, or 3 of subsection A of Section 41 of this act the Commissioner shall take the actions required under Section 40 of this act;

3. In the event of a Regulatory Action Level Event under paragraphs 4, 5, 6, 7, 8 or 9 of subsection A of Section 41 of this act or an Authorized Control Level Event, the Commissioner shall take the actions required under Section 41 of this act; or

4. In the event of a Mandatory Control Level Event in a health maintenance organization, the Commissioner shall take the actions required under Section 42 of this act.

SECTION 52. AMENDATORY 36 O.S. 2001, Section 1219, is amended to read as follows:

Section 1219. A. In the administration, servicing, or processing of any accident and health insurance policy, every insurer shall reimburse all clean claims of an insured, an assignee of the insured, or a health care provider within forty-five (45) calendar days after receipt of the claim by the insurer.

B. As used in this section:

1. "Accident and health insurance policy" or "policy" means any policy, certificate, contract, agreement or other instrument that provides accident and health insurance, as defined in Section 703 of this title, to any person in this state, and any subscriber certificates or any evidence of coverage issued by a health maintenance organization to any person in this state;

2. "Clean claim" means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt payment; and

3. "Insurer" means any entity that provides an accident and health insurance policy in this state, including but not limited to, a licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a health maintenance organization, a fraternal benefit society, a multiple employer welfare arrangement, or any other entity subject to regulation by the Insurance Commissioner.

C. If a claim or any portion of a claim is determined to have defects or improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment, the insured enrollee or subscriber, assignee of the insured enrollee or subscriber, or health care provider shall be notified in writing within thirty (30) calendar days after receipt of the claim by the insurer. The written notice shall specify the portion of the claim that is causing a delay in processing and explain any additional information or corrections needed. Failure of an insurer to provide the insured enrollee or subscriber, assignee of the insured enrollee or subscriber, or health care provider with the notice shall constitute prima facie evidence that the claim will be paid in accordance with the terms of the policy.

D. Upon receipt of the additional information or corrections which led to the claim’s being delayed and a determination that the

information is accurate, an insurer shall either pay or deny the claim or a portion of the claim within forty-five (45) calendar days.

E. Payment shall be considered made on:

1. The date a draft or other valid instrument which is equivalent to the amount of the payment is placed in the United States mail in a properly addressed, postpaid envelope; or

2. If not so posted, the date of delivery.

F. An overdue payment shall bear simple interest at the rate of ten percent (10%) per year.

G. In the event litigation should ensue based upon such a claim, the prevailing party shall be entitled to recover a reasonable attorney's fee to be set by the court and taxed as costs against the party or parties who do not prevail.

H. The provisions of this section shall not apply to the Oklahoma Life and Health Insurance Guaranty Association or to the Oklahoma Property and Casualty Insurance Guaranty Association.

SECTION 53. AMENDATORY 36 O.S. 2001, Section 1250.2, is amended to read as follows:

Section 1250.2 As used in the Unfair Claims Settlement Practices Act:

1. "Agent" means any individual, corporation, association, partnership, or other legal entity authorized to represent an insurer with respect to a claim;

2. "Claimant" means either a first party claimant, a third party claimant, or both, and includes such claimant's designated legal representatives and includes a member of the claimant's immediate family designated by the claimant;

3. "Commissioner" means the Insurance Commissioner;

4. "First party claimant" means an individual, corporation, association, partnership, or other legal entity, including a subscriber under any plan providing health services, asserting a

right to payment pursuant to an insurance policy or insurance contract for an occurrence of contingency or loss covered by such policy or contract;

5. "Insurance policy or insurance contract" means any contract of insurance, certificate, indemnity, medical or hospital service, suretyship, ~~or~~ annuity, or subscriber certificate or any evidence of coverage of a health maintenance organization issued, proposed for issuance, or intended for issuance by any entity subject to this Code;

6. "Insurer" means a person licensed by the Commissioner to issue or who issues any insurance policy or insurance contract in this state, including the State Insurance Fund;

7. "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

8. "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim; and

9. "Third party claimant" means any individual, corporation, association, partnership, or other legal entity asserting a claim against any individual, corporation, association, partnership, or other legal entity insured under an insurance policy or insurance contract.

SECTION 54. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-105e of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The State Department of Health shall:

1. Perform duties and responsibilities as directed by the State Commissioner of Health to ensure compliance with relevant provisions of this act; and

2. Fix and collect fees for the certification of compliance of health maintenance organizations pursuant to the provisions of Section 7 of the Health Maintenance Organization Act of 2003.

B. All actions of the Department shall be subject to the provisions of the Administrative Procedures Act.

C. Fees collected shall be deposited in the Public Health Special Fund in the State Treasury.

SECTION 55. REPEALER 63 O.S. 2001, Sections 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2508.1, 2509, 2510, 2511, 2512, 2513, 2514, 2525.2, 2525.3, 2525.4, 2525.5, 2525.6, and 2525.7, are hereby repealed.

SECTION 56. This act shall become effective November 1, 2003.

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