TITLE 365. INSURANCE DEPARTMENT
CHAPTER 40. HEALTH MAINTENANCE ORGANIZATIONS (HMO)

SUBCHAPTER 5. LIFE, ACCIDENT & HEALTH DIVISION AND CONSUMER ASSISTANCE AND CLAIMS DIVISION RULES

PART 1. GENERAL PROVISIONS

365:40-5-1. Definitions

When used in this Subchapter, the following words or terms shall have the following meaning unless the context of the sentence requires another meaning:

"Affiliation period" means a period that must expire before the coverage becomes effective.

"Bona fide association" means an association which:

(A) Has been actively in existence for at least 5 years;

(B) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) Does not condition membership in the association on any health-status-related factor that relates to an individual, including an employee of an employer or a dependent of an employee;

(D) Makes health coverage offered through the association available to all members regardless of any health-status related factor that relates to such members or individuals eligible for coverage through a member; and

(E) Does not make health coverage offered through the association available other than in connection with a member of the association.

"Child" means natural children, stepchildren, adopted children, children placed for adoption, and children under legal guardianship.

"Claim reimbursement" means repayment from an HMO to a subscriber for services rendered by a noncontracting provider, or direct payment from an HMO to a noncontracting provider.

"Eligible Dependent" means a spouse, an unmarried child under the age of eighteen (18) years, an unmarried child under the age of twenty-three (23) who is a full-time student and who is financially dependent upon the subscriber, and an unmarried child of any age who is medically certified as disabled and dependent upon the subscriber.

"Grievance" has the same meaning as in 36 O.S. § 6902 of the HMO Act.

"Group" means an employee group or another aggregation of individuals who wish to purchase or who have purchased HMO membership. The group shall be composed of at least two (2) individuals, and shall not be established on the basis of race. Unless specifically exempted in this Chapter, any provision addressed to groups shall apply to small and large groups.

"Health professionals" means professionals, including physicians, engaged in the delivery of health services who are licensed, certified, or practice under other authority consistent with State law.

"Inquiry" means an oral or written statement to the Department from a member or other resident of this state expressing misunderstanding, dissatisfaction or disagreement with an

activity of an HMO, or reporting a possible violation of this Chapter or the laws of this state by an HMO. Anonymous statements shall be considered as inquiries.

"Large group" means a group of at least 51 employees.

"Late enrollee" means, with respect to coverage under a group contract, a subscriber or dependent who enrolls under the contract other than during the first effective date in which the subscriber or dependent is eligible to enroll under the contract, or a special enrollment period.

"Non-basic health care services" means health care services other than basic health care services.

"Noncontracting provider" means a health service provider not having an HMO contract that includes financial hold harmless language as described in 36 O.S. § 6913.

"Out-of-area services" means the health care services that an HMO covers when its enrollees are outside of the service area.

"Physician" means any person holding a valid license to practice medicine and surgery, osteopathy, chiropractic, podiatry, optometry, or dentistry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes.

"Primary care physician" means a physician who supervises, coordinates, and provides initial and basic care to enrollees, and who initiates their referral for specialist care and maintains continuity of patient care.

"Replacement coverage" has the same meaning as in 36 O.S. § 6902 of the HMO Act.

"Service area" means the geographic area as defined through zip codes, census tracts, or other geographic subdivisions, found by the Department to be the area within which the HMO provides or arranges for basic and supplemental health care services that are available and accessible to its enrollees as required by the Act and this Chapter.

"Small group" means a group composed of not less than two and not more than 50 employees as defined in the Small Employers Health Insurance Reform Act, 36 O.S. § 6511, et seq.

"Special Enrollment Period" means a time when a plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer required such a statement as such time and provided the employee with notice of such requirement and the consequences of such requirement at such time.

(C) The employee's or dependent's coverage described in subparagraph 1

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions toward such coverage were terminated.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

PART 3. RATING SYSTEM

365:40-5-10. Definitions

When used in this Part the term "Rating System" means the method or combination of methods which the HMO uses to calculate enrollee premiums, and is limited to community rating, community rating by class, adjusted community rating or a combination of all. An HMO may fix rates of payment under either a system of community rating, community rating by class, adjusted community rating or under all three systems. However, the HMO may use only one such system for setting rates for any group at any one time.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-11. Community rating

Under community rating, rates of payments may be determined on a per-person or per-family basis and may vary with the number of persons in a family, but except as otherwise authorized in this paragraph, such rates must be equivalent for all individuals and for all families of similar composition. This does not preclude changes in the rates of payments for health services based on a community rating system which are established for new enrollments or re-enrollments and which changes do not apply to existing contracts until the renewal of such contracts. Only the following differentials in rates of payments may be established under such system:

(1) Nominal differentials in such rates may be established to reflect differences in marketing costs and the different administrative costs of collecting payments from the following categories of subscribers:

(A) Individual (non-group) subscribers (including their families).

(B) Small groups of subscribers.

(C) Large groups of subscribers.

(2) Nominal differentials in such rates may be established to reflect the compositing of the rates of payment in a systematic manner to accommodate group purchasing practices of the various employers.

(3) Differentials in such rates may be established for subscribers enrolled under any governmental authority or program authorized by United States Code, or under any health benefits program for employees of States, political subdivisions of States, and other public entities.

(4) An HMO may establish a separate community rate for separate regional components of the organization upon satisfactory demonstration of the following:

(A) Each such regional component is geographically distinct and separate from any other regional component.

(B) Enrollment is established with respect to the individual regional component, rather than with respect to the parent HMO.

(C) Each such regional component provides substantially the full range of basic health care services to its enrollees without extensive referral between components of the organization for such services, and without substantial utilization by any two such components of the same health care facilities. The separate community rate for each such regional component of the HMO must be based on the different costs of providing health services in such regions.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-12. Community rating by class

Under "community rating by class," rates are fixed by groups for individuals and families, and must be equivalent for all individuals or for all families in the same group. A class is actuarially derived or developed based on factors which reasonably predict differences in the use of HMO services. Age, sex, family size and marital status factors need not be justified.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-13. Adjusted community rating

Under "adjusted community rating" rates are fixed on the basis of revenue requirements for providing services to the group, except that rates for a group of less than 50 persons may not be fixed at rates greater than 115 percent of the rate that would be fixed under community rating or community rating by class.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-14. Rates to reflect risk-sharing arrangements

An HMO may establish differentials based on financial risk-sharing arrangements with organizations or entities which have contracted with the HMO to provide selected basic health care services to members of said organizations or entities, as permitted by 36 O.S. § 6902(1) and otherwise permitted by the HMO Act or this Chapter.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

PART 5. BASIC AND SUPPLEMENTAL HEALTH CARE SERVICES

365:40-5-20. Basic health care services

Basic health care services shall include:

(1) Physician services including consultant and referral services by a physician, and other health professional services as necessary to provide allopathic, osteopathic, chiropractic, podiatric, optometric, and psychological services. If a service of a physician may also be provided under applicable State law by another type of health professional, an HMO may provide the service through these other health professionals.

(2) Outpatient services including diagnostic services, treatment services and x-ray services, for patients who are ambulatory and may be provided in a non-hospital based health care facility or at a hospital.

(3) Inpatient hospital services including room and board, general nursing care, meals and special diets when medically necessary, use of operating room and related facilities, use of intensive care unit and services, x-ray services, laboratory, and other diagnostic tests, drugs, medications, biologicals, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, perfusion, and administration of whole blood and blood plasma.

(4) Outpatient services and inpatient hospital services including short-term rehabilitation services and physical therapy which the HMO expects can result in the significant improvement of an enrollee's condition within two months,

(5) Medically necessary emergency health services, which shall include instructions to enrollees on how to get medically necessary emergency health services both in and out of the service area.

(6) Twenty outpatient visits per enrollee per year, as may be necessary and appropriate for short-term evaluative or crisis intervention mental health services, or both.

(7) Diagnosis, medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs, including

(A) Diagnosis and medical treatment for the abuse of or addiction to alcohol and drugs including detoxification for alcoholism or drug abuse on either an outpatient or inpatient basis, whichever is medically determined to be appropriate, in addition to the other required basic health care services for the treatment of other medical conditions.

(B) Referral services for either medical or for nonmedical ancillary services. Medical ancillary services shall be a part of basic health care services; nonmedical ancillary services (such as vocational rehabilitation and employment counseling) and prolonged rehabilitation services in a specialized inpatient or residential facility need not be a part of basic health care services.

(8) Diagnostic laboratory and diagnostic and therapeutic radiological services in support of basic health care services.

(9) Home health services provided at an enrollee's home by health care personnel, as prescribed or directed by the responsible physician or their authority designated by the HMO.

(10) Preventive health services, which shall be made available to enrollees and shall include at least the following:

(A) Services for children from birth to age 21 as determined by the American Academy of Pediatrics in "Guidelines for Health Supervision";

(B) Immunizations for adults and children as recommended by the Advisory Committee on Immunization Practices

(ACIP) Centers for Disease Control and Prevention, except those required for foreign travel and employment;

(C) Periodic health evaluations for adults to include voluntary family planning services; and

(D) Preventive services identified through the HMO quality assurance program designed to contribute to achieving the U.S. Department of Health and Human Services "Healthy People 2010" objectives.

(11) Medically necessary eye care services for detection and treatment of diseases or injury to the eye.

(12) Inpatient and outpatient care for treatment of the birth defect known as cleft lip or cleft palate or both including medically necessary oral surgery, orthodontics, and otologic, audiological, and speech/language treatment.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-21. Supplemental health care services

Supplemental health care services of an HMO may include the following:

(1) Corrective appliances and artificial aids.

(2) Eyeglasses and hearing care not included as a basic health care service.

(3) Dental services.

(4) Mental health services not included as a basic health care service.

(5) Long-term physical therapy and rehabilitative services.

(6) Cosmetic surgery, unless medically necessary.

(7) Prescribed drugs and medicines incidental to outpatient care. Supplemental coverage for prescription drugs shall also provide coverage of off-label uses of prescription drugs used in the treatment of cancer or the study of oncology. Coverage shall include the approval of oncology (chemotherapeutic) drugs for off-label indications when used for malignant disease, when the safety and effectiveness of use for this indication has been recommended, supported and demonstrated by at least one controlled clinical trial published in a nationally recognized peer reviewed journal or when at least one of the standard pharmacy compendia (United States Pharmacopoeia Dispensing Information [USPDI], American Society of Health-System Pharmacists Drug Information [AHFS Drug Information] or American Medical Association Drug Evaluations [AMADE]) lists the drug to be accepted as safe and effective for this indication. This will not include the off-label use of these agents in the treatment of non-malignant disease.

(8) Ambulance services, unless medically necessary.

(9) Care for military service connected disabilities for which the enrollee is legally entitled to services and for which facilities are reasonably available to this enrollee.

(10) Care for conditions that State or local law requires be treated in a public facility.

(11) Custodial or domiciliary care.

(12) Experimental medical, surgical, or other experimental health care procedures, unless approved as a basic health care service by the policy making body of the HMO.

(13) Personal or comfort items and private rooms, unless necessary during inpatient hospitalization.

(14) Whole blood and blood plasma.

(15) Durable medical equipment for home use (such as wheel chairs, surgical beds, respirators, dialysis and machines).

(16) Health care services which are unusual or infrequently provided and not necessary for the protection of individual health, as approved by the Department upon application by the HMO. "Unusual or infrequently used health services" means those health services which are projected to involve fewer that 1 percent (1%) of the encounters per year for the entire HMO enrollment, or, those health services the provision of which, given the enrollment projection of the HMO and generally accepted staffing patterns, is projected will require less than 0.25 full time equivalent health professionals.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-22. Benefit changes

Each HMO shall provide to each group and individual enrollee a written statement of benefit changes for the upcoming benefit year. The statement shall identify clearly and concisely those aspects of the proposed benefits plan which differ from the current benefits plan. Such notice should be provided as soon as available, but at least thirty (30) days prior to the date by which the group or individual enrollees must choose coverage. When an employer, rather than an HMO, requests changes for the upcoming benefit year that does not allow for a notification of at least thirty (30) days, the HMO shall provide notice as soon as reasonably possible.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-23. Identification cards

The subscriber and enrollee identification card issued by an HMO shall clearly indicate the name, mailing address, and phone number for submission of requests for payment or reimbursement of claims. If the HMO requires claims to be submitted to an entity other than the licensed HMO, then the identification card shall disclose that requirement. The HMO shall not distribute a subscriber and enrollee identification card until its form has been approved by the Department.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

PART 7. POINT OF SERVICE OPTION

365:40-5-30. Definitions

When used in this Part, "point of service option" means a benefit that allows a member to submit claims for payment or reimbursement of nonemergency health services obtained from noncontracting providers. It also may mean a benefit for non-emergency services obtained from a contracting provider without a referral or authorization.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-31. Purpose/scope

(a) The provisions of this Part do not apply to emergency care.

(b) Each HMO shall submit this benefit for the Department's approval before offering the benefit to members.

(c) This benefit is optional, and the HMO has the following flexibility:

(1) The HMO is not required to offer this benefit;

(2) The HMO may decide which services will be offered or excluded;

(3) The HMO may limit the groups to whom this benefit is offered, but the benefit must be offered to all persons within the group;

(4) If individual contracts are offered, the HMO may limit the individuals to whom this benefit is offered;

(5) The HMO may set annual dollar limits on services provided through this benefit;

(6) The HMO may use enrollee cost-sharing for this benefit. This cost-sharing may be accomplished through premium, copayment or deductible; and,

(7) The HMO may require precertification of services provided through this benefit.

(d) Under no circumstances shall the member be required to pay for any portion of these services, other than as provided in the member's contract.

(e) The marketing materials of any HMO offering this benefit must be written in a manner so that the enrollee will easily understand the services included, the procedures to be followed, and the costs.

(f) This benefit may be supplemented by a reasonable deductible. The deductible should be set to discourage excessive use but must not be prohibitively high. Copayments cannot exceed 50% of the HMO's allowable charge for any single service.

(g) The offering of this benefit does not relieve the HMO of the duty to ensure that all basic health care services are available and accessible.

(h) The requirements of Part 23 of this Subchapter shall apply to any claims for payment or reimbursement submitted under this benefit.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-32. Responsibilities of the HMO

(a) Each HMO that offers a point of service option shall collect and report to the Department the number of enrollees who access the benefit, the types and volumes of services received, and the costs to enrollees and the HMO.

(b) Each HMO shall inform enrollees about the following:

(1) Any premium and cost-sharing charges;

(2) Annual out-of-pocket limits;

(3) Annual and maximum benefit limits for out-of-plan services; and,

(4) Potential financial liability for services for which payment could be denied because the service is not a covered benefit, or the dollar limit is exceeded.

(c) Each HMO shall file with the Department all marketing and educational material for the point of service option prior to use of that material.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

PART 9. HMO REQUIREMENTS AND PROHIBITIONS

365:40-5-40. Services to members

Within the HMO's service area, basic health care services and those supplemental health care services for which enrollees have contracted to be provided by the HMO shall be:

(1) Provided or arranged by the HMO, except as described in Parts 7, 13 and 19 of this Subchapter. Basic health care services shall be provided for HMO members as needed and without limitations as to time and cost.

(2) Available and accessible to each of the HMO's enrollees with reasonable promptness with respect to:

(A) Geographic location, hours of operation, and provisions for after-hours services (medically necessary emergency services shall be available and accessible twenty-four (24) hours a day, seven (7) days a week). An HMO that has a service area located in a non-metropolitan area may make a basic health care service available outside its service area if that basic health care service is not a primary care or emergency care service and if there is an insufficient number of providers of that basic health care service within the service area who will provide that service to enrollees of the HMO.

(B) Staffing patterns within generally accepted norms for meeting the projected enrollment needs.

(C) The type of health professional so that availability of health professionals is adequate to meet the enrollees' needs.

(3) Provided in a manner that assures continuity, except as described in Part 7 of this Subchapter, including but not limited to:

(A) Provision of a health professional who is primarily responsible for coordinating the enrollee's overall health care.

(B) Development of a health (including medical) record keeping system through which pertinent information relating to the health care of the patient is accumulated and is readily available to appropriate professionals.

(C) Coordination of the enrollee's participation in the selection of an alternative type of health care professional.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-41. Membership

(a) An HMO shall not expel or refuse to re-enroll any enrollee, nor refuse to enroll individual members of a group, or establish rules for eligibility that are based on health status factors, health care needs, or age of the enrollee or individual.

(b) An HMO shall not require an individual within a group to pay a higher premium or contribution than would a similarly situated individual, based on a health-status factor.
(c) Nothing in this Section prohibits an HMO from requiring that, as a condition of continued eligibility for enrollment, dependents of a subscriber, upon reaching a specified age, convert to non-group enrollment.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-42. Individual conversion contracts

An HMO shall not be required to offer or issue any new individual conversion contract to a subscriber or his or her enrolled dependents.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04; Amended at 33 Ok Reg 1724, eff 9-15-16]

365:40-5-43. Premiums/co-payments

(a) Each HMO shall provide or arrange basic health care services for a basic health care services payment which:

(1) Is paid on a periodic basis without regard to the dates these services are provided;
(2) Is fixed without regard to the frequency, extent, or kind of basic health care services furnished;
(3) Is fixed under a rating system which generates funds sufficient to meet the HMO's financial plan, and under which the rates are reasonable for the health services provided; and
(4) May be supplemented by nominal co-payments for specific basic health care services. Each HMO may establish one or more co-payment options calculated on the basis of a rating system.

(A) An HMO may not impose co-payment charges that exceed fifty (50) percent of the total cost of providing any single service to its enrollees, or in the aggregate more than:

(i) forty-five (45) percent of the total cost of providing all basic health care services; or
(ii) the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) An HMO shall not impose on any subscriber or enrollee, in any calendar year, co-payment charges of more than two hundred (200) percent of the annual premium charged for an option with no co-payments.
(C) Co-payments applied to a service must be equal for all providers unless the unequal co-payments are based on differences in the cost to the HMO for the service.

(b) Basic health care services shall be provided for an illness or injury covered under a workers' compensation law or an insurance policy. The HMO may charge or authorize the provider to charge:

(1) The insurance carrier, employer, or other entity which is required to pay for the services; and

(2) The enrollee, to the extent that the enrollee has been paid under the law or policy for the services.

(c) An HMO may require payments for supplemental health care services in addition to the payments for basic health care services. Or, an HMO may include supplemental health care services in the basic health care services for a basic health care service payment.

(1) Supplemental health services payments may be made in any agreed upon manner, such as prepayment or fee-for-service.

(2) Supplemental health services may be limited as to time and cost.

(d) The Commissioner has discretion to approve a cost-sharing arrangement which does not satisfy the limitations imposed by this subsection if the Commissioner finds that such cost-sharing arrangement will provide a reduction in premium costs.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04; Amended at 31 Ok Reg 1920, eff 9-15-14]

365:40-5-44. Internal grievance system

A grievance system shall be established and maintained by an HMO to provide reasonable procedures for the prompt and effective resolution of written grievances pursuant to the HMO Act.

(1) An HMO shall provide grievance forms to be given to enrollees who wish to register written grievances. Such forms shall include the address and telephone number to which grievances must be directed and shall also specify required time limits imposed by the HMO.

(2) The grievance system shall provide for written acknowledgement of any grievance within seven (7) days from the date the grievance is registered with the HMO. Each grievance shall be resolved or finally determined within one hundred twenty (120) days after the grievance is registered. This period may be extended in the event of a delay in obtaining the documents or records from a non-contracting provider necessary for the resolution of the grievance, or by the mutual written agreement of the HMO and the enrollee.

(3) An enrollee or any other person may seek the assistance of the Insurance Commissioner at any time whether or not a written grievance is submitted to an HMO by an enrollee.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04; Amended at 23 Ok Reg 2758, eff 7-14-06]

365:40-5-45. Guaranteed renewal

(a) Except as otherwise provided in this section, an HMO that issues a group contract must renew or continue in force such coverage at the option of the contractholder.

(b) An HMO may nonrenew or discontinue a group contract based only on one or more of the following conditions:

(1) The contractholder has failed to pay premiums or contributions in accordance with the terms of the contract or the HMO has not received timely premium payments.

(2) The contractholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the contract.

(3) The contractholder has failed to comply with a material provision of their group contract with the HMO that relates to rules for employer contributions or group participation.

(4) The HMO is ceasing to offer a particular type of coverage in a market.

(5) There are no longer enrollees who live or work in the service area.

(6) In the case of group health coverage that is made available only through a bona fide association, the membership of an employer in the association, on the basis of which the coverage is provided, ceases, but only if such coverage is terminated uniformly without regard to any health-status-related factors that relate to any covered individuals.

(c) An HMO shall not impose pre-existing condition limitations.

(d) An HMO may apply an affiliation period not to exceed two (2) months (or three (3) months for late enrollees). Affiliation periods shall be applied uniformly without regard to any health status-related factors. No premium shall be charged for the affiliation period. The HMO is not required to provide health care services or benefits during such period.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-46. Small group offering

An HMO shall accept every small group employer and every eligible individual of that employer that applies for coverage in accordance with the Oklahoma Small Employer Health Insurance Reform Act, 36 O.S. § 6511, et seq.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04

365:40-5-47. Special enrollment periods

(a) An HMO that issues a group contract shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the contract, or a dependent of such an employee if the dependent is eligible but not enrolled for coverage under such contract, to enroll for coverage under the terms of the contract if each of the following conditions is met:

(1) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent. For the purpose of this section, the terms "group health plan" and "health insurance coverage" have the same meaning ascribed in Section 2791 of the Federal Public Health Service Act;

(2) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or HMO, if applicable, required such a statement at such time and provided the employee with notice of such requirement and the consequences of such requirement at such time;

(3) The employee's or dependent's coverage described in paragraph (1) above:

(A) Was under a COBRA continuation provision or other continuation and the coverage under such provision was exhausted; or

(B) Was not under such a provision and the coverage was terminated as a result of loss of eligibility for the coverage, including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or the coverage was terminated as a result of the termination of employer contributions toward such coverage; and

(4) Under the terms of the plan, the employee requests such enrollment not later than thirty (30) days after the date in O.A.C. 365:40-5-47(a)(3)(A) or O.A.C. 365:40-5-47(a)(3)(B) occurred.

(b) For dependent beneficiaries, the HMO shall provide for a dependent special enrollment period described in Subsection (c) of this Section during which the person, or, if not otherwise enrolled, the employee may be enrolled under the contract as a dependent of the employee, and in the case of the birth or adoption of a child, the spouse of the employee may be enrolled as a dependent of the employee if such spouse is otherwise eligible for coverage, if:

(1) A group contract makes coverage available with respect to a dependent of an employee;

(2) The employee is a participant under the contract, or has met any waiting period applicable to becoming a participant under the contract, and is eligible to be enrolled under the contract except for a failure to enroll during a previous enrollment period; and

(3) A person becomes such a dependent of the employee through marriage, birth, or adoption or placement for adoption, the HMO shall provide for a dependent special enrollment period described in Subsection (c) of this Section during which the person, or, if not otherwise enrolled, the employee, may be enrolled under the contract as a dependent of the employee, and in the case of the birth or adoption of a child, the spouse of the employee may be enrolled as a dependent of the employee if such spouse is otherwise eligible for coverage.

(c) A dependent special enrollment period under Subsection (b) of this Section shall be a period of not less than thirty (30) days and shall begin on the later of:

(1) The date that dependent coverage is made available; or

(2) The date of the marriage, birth, adoption or placement for adoption.

(d) If an employee seeks to enroll a dependent during the first thirty (30) days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(1) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(2) In the case of a dependent's birth, as of the date of such birth; or

(3) In the case of dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

PART 11. COORDINATION OF BENEFITS

365:40-5-50. Purpose

The purpose of this subchapter is to permit, but not require, plans to include a coordination of benefits (COB) provision unless prohibited by federal law; to establish a uniform order of benefit determination under which plans, including HMOs, pay claims; and to avoid claim delays and misunderstandings that could otherwise result from the use of inconsistent or incompatible provisions amount Plans. It is contrary to the public policy of this state for a Plan to declare its coverage to be "excess" to all others, or always "secondary", or to reduce its benefits because of the existence of duplicate coverage in a manner other than as permitted by this regulation; or to reduce its benefits because a person covered by the Plan is eligible for any other coverage. It is requested that courts give effect to this public policy when they consider the interrelation of Plans with order of benefit determination rules which comply with this subchapter and Plans with order of benefit determination rules which differ from those set forth in this subchapter.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-51. Definitions

The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

"Allowable expense" means, unless otherwise mandated by law, any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made except where a statute requires a different definition. However, items of expense under coverage such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of allowable expense. A plan which provides benefits only for any such items of expense may limit its definition of allowable expense to like items of expense. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid. The difference between the cost of a private hospital room and the cost of a semi-private hospital room shall not be deemed to be an "Allowable Expense," except for the period of time during which the patient's confinement to a private hospital room is deemed medically necessary in terms of generally accepted medical practice.

"Plan" includes the following:

(A) Group and nongroup insurance contracts and subscriber contracts;

(B) Uninsured arrangements of group or group-type coverage;

(C) Group and nongroup coverage through closed panel plans;

(D) Group-type contracts;

(E) The medical care components of long-term care contracts, such as skilled nursing care;

(F) The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts;

(G) Medicare or other governmental benefits, as permitted by law, except as provided in a state plan under Medicaid. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program; and

(H) Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

"**Plan**" does not include:

(A) Hospital indemnity coverage benefits or other fixed indemnity coverage;

(B) Accident only coverage;

(C) Specified disease or specified accident coverage;

(D) Limited benefit health coverage;

(E) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;

(F) Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(G) Medicare supplement policies;

(H) A state plan under Medicaid; or

(I) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

"This plan" means that portion of the policy which provides the benefits that are subject to this subchapter.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04; Amended at 32 Ok Reg 1977, eff 9-15-15]

365:40-5-52. Effect on benefits

(a) **Determining benefits**. This section shall apply in determining the benefits as to a person covered under the Plan for any claim determination period if, for the allowable expense incurred as to such person during such period, the sum of:

(1) the benefits that would be payable under this Plan in the absence of this provision, and

(2) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.

(b) **Claim determination period**. As to any claim determination with respect to which this section is applicable, the benefits that would be payable under this Plan in the absence of this provision for the allowable expenses incurred as to such person during such claim determination period shall be reduced to the extent necessary to that the sum of such reduced benefits and all the benefits payable for such allowable expenses under all other Plans, except as provided in (c) of this section, shall not exceed the total of such allowable expenses. Benefits payable under

another Plan include the benefits that would have been payable had claim been duly made therefore.

(c) **Coordination of benefits**. The benefits of another Plan will be ignored for the purpose of determining the benefits under this Plan if:

(1) the other Plan which is involved in (b) of this section and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this plan have been determined, and

(2) the rules set forth in (d) of this section would require this Plan to determine its benefits before such other Plan.

(d) **Order of benefit determination**. For the purpose of (c) of this section, the rules establishing the order of benefit determination are:

(1) The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent.

(2) The following guidelines apply with respect to claims regarding dependent children:

(A) Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a plan which covers the person on which expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a Plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this paragraph regarding dependents, which results either in each Plan determining benefits before the other or in each Plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the Plan which does not have the provisions of this paragraph shall determine the order of benefits.

(B) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

(C) In the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parents without custody.

(D) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding (B) and (C) of this paragraph, the benefits of a Plan which covers the child as a dependent of

the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

(3) When (1) and (2) of this subsection do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period time shall be determined before the benefits of a Plan which has covered such person the shorter period of time, provided that:

(A) the benefits of a plan covering the person on whose expenses claim is based as a laid-off or retired employee, or dependent of such person, shall be determined after the benefits of any other Plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person; and

(B) if either Plan does not have a provision regarding laid-off or retired employees, which results in each Plan determining its benefits after the other, then the provisions of (A) above shall not apply.

(4) When a claim under a Plan with a COB provision involves another Plan which also has a COB provision, the carriers involved should use the rules in (1) through (3) of this subsection to decide the order in which the benefits payable under the respective plans will be determined. Note:

(A) In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within 24 hours after the prior Plan terminated. Thus, neither a change in the amount of scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another, (e.g. single employer to multiple employer Plan, or vice versa, or single employer to a Taft-Hartley Welfare Plan) would constitute the start of a new Plan for purposes of this paragraph.

(B) If a claimant's effective date of coverage under a given Plan is subsequent to the date the carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, the absence of specific information to the contrary, the carrier shall assume, for purposes of this paragraph, that the claimant's length of time covered under that plan shall be measured from claimant's effective date of coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group coverage, then the carrier shall request the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time his coverage under that Plan has been in force.

(5) Some Plans have order of benefit determination rules not consistent with this section which declare that the Plan's coverage is "excess" to all others, or "always secondary". This occurs because:

(A) certain Plans may not be subject to insurance section; or

(B) some group contracts have not yet been conformed to this section pursuant to the effective date.

(6) A Plan with order of benefit determination rules which complies with this section (herein called a Complying Plan) may coordinate its benefits with a Plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in this section (herein called a Noncomplying Plan) on the following basis:

(A) If the Complying Plan is the Primary Plan, it shall pay or provide its benefits on a primary basis.

(B) If the Complying Plan is the Secondary Plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the Complying Plan were the Secondary plan. In such a situation, such payment shall be the limit of the Complying Plan's liability.

(C) If the Noncomplying Plan does not provide the information needed by the Complying Plan to determine its benefits within a reasonable time after it is requested to do so, the Complying Plan shall assume that the benefits of the Noncomplying Plan are identical to its own, and shall pay its benefits accordingly. However, the Complying Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncomplying Plan.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-53. Right to receive and release necessary information

For the purpose of determining the applicability of and implementing the terms of this section of this Plan or any provision of similar purpose of any other Plan, the insurer or service plan may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the insurer or service plan deems to be necessary for such purposes. Any person claiming benefits under this plan shall furnish to the insurer or service plan such information as may be necessary to implement this section. Occasionally this will necessitate a carrier making payment as the primary carrier with a right of recovery in the event that subsequent investigation proves that payment as a secondary carrier should have been made.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-54. Benefit payments

Carriers shall use the following claims administration procedures to expedite claim payments where COB is involved:

(1) **Improving exchange of benefit information.**

(A) There should be continued and improved education of claim personnel stressing accurate and prompt completion of the HIC Duplicate Coverage Inquiry (DUP-1) Form by the inquiring carrier and the responding carrier. This education

effort should also be encouraged through local claim associations. An HMO may use a form substantially similar to the HIC Duplicate Coverage Inquiry (DUP-1) Form if approved by the Insurance Commissioner prior to its use.

(B) Claim personnel should be encouraged to make every effort, including use of the telephone, to speed up exchange of COB information. All carriers shall respond to inquiries at least thirty (30) days from receipt of such inquiries.

(C) Carriers should encourage building a local date file of other group plans in the area, with at least basic information on group health plans for major employers.

(2) **Time limits for payment.** Each carrier shall establish a time limit after which full or partial payment should be made. When payment of a claim is necessarily delayed for reasons other than the application of a COB provision, investigation of other valid coverage should be conducted concurrently so as to create no further delay in the ultimate payment on benefits.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-55. Subrogation

The concept of coordination of benefits is clearly distinguishable from that of subrogation. Provisions for either may be included in a group health insurance policy without compelling the inclusion or exclusion of the other.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-56. Small claim waivers

Carriers shall waive the investigation of possible other coverage for COB purposes on claims less than fifty dollars ($50), but if additional liability is incurred to raise the small claim above fifty dollars ($50), the entire liability may be included in the COB computation.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-57. Public education

Each carrier has an affirmative obligation to urge its respective group policyholder-clients to take reasonable steps to assure that those insured by the group policy or subscriber contract have been exposed to reasonably concise explanations, with as little technical terminology as is commensurate with accuracy, as to the purpose and operation of COB. Such educational effort may take the form of articles in the company magazines or newspapers, speeches before the appropriate labor organization in the case of a unionized company, brochures added to pay envelopes, notices on the company bulletin board, material used by personnel department in counseling employees, and the like.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-58. Applicability

(a) Group policies or contracts which are in force at the time of promulgation of this subchapter which contain an "excess" clause, "anti-duplication" provision, or any other provision by whatever name designated under which benefits would be reduced because of other existing coverages, other than the COB provisions established in this subchapter, shall be brought into compliance by the later of the next anniversary or renewal date of the group policy or contract or the expiration of the applicable collectively bargained contract, pursuant to which they are written, if any.

(b) The definition of "Plan" in Section 51 of this Subchapter applies to plans that are delivered, issued for delivery, or renewed on or after January 1, 2016. A contract that is in force on January 1, 2016, must be brought into compliance with the definition of "Plan" on the next anniversary date or renewal date of the contract, or the expiration of any applicable collective bargaining contract under which it was written.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04; Amended at 32 Ok Reg 1978, eff 9-15-15]

365:40-5-59. Facility of payment

Whenever payments which should have been made under this Plan in accordance with this section have been made under any other Plans, the insurer or service plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this section, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the insurer or service plan shall be fully discharged from liability under this Plan.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-60. Right of recovery

Whenever payment has been made by the insurer with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this section, the insurer or service plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the insurer or service plan shall determine:

(1) any persons to or for or with respect to whom such payments were made;
(2) any other insurers; or
(3) service plans or any other organizations.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

PART 13. TERMINATION OF MEMBERS, PROVIDERS AND CONTINUATION OF BENEFITS

365:40-5-70. Termination of group or individual contracts

(a) An HMO desiring to either terminate or not renew a group or individual contract shall provide at least sixty (60) days advance notice of termination. Except, an HMO may terminate or not renew a contract with less than sixty (60) days notice for cause such as failure to pay premiums or fraud.

(b) A group contract or individual contract shall not be terminated except as described in Part 15 of this Subchapter and O.A.C. 365:40-5-45.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-71. Termination of providers

An HMO shall implement a policy governing termination of providers. The policy shall include at least:

(1) Provisions for at least ninety (90) days advance notice of contract termination by either the HMO or the provider, with additional provisions for contract termination by the HMO with less than ninety (90) days notice for cause;

(2) Methods by which the termination policy shall be made known to providers and members at the time of enrollment and on a periodic basis;

(3) Written notification to each member at least thirty (30) days prior to the termination or withdrawal of a member's primary physician from the HMO's provider network and of any other physician or provider currently treating the member. The Department may waive the 30-day prior notice requirement if the HMO demonstrates that immediate termination is necessary for the protection of health, safety and welfare of members, or if the HMO demonstrates that the provider has not complied with the termination requirements under the contract; and

(4) Assurance of continued coverage of services, under certain conditions, consistent with the following:

(A) Every plan shall establish procedures governing termination of a participating provider who is terminated for reasons other than cause. The procedures shall include assurance of continued coverage of services, at the contract terms and price by a terminated provider for up to ninety (90) calendar days from the date of notice to the covered person for a covered person who:

(i) Has a degenerative and disabling condition or disease;

(ii) Has entered the third trimester of pregnancy. Additional coverage of services by the terminated provider shall continue through at lest six (6) weeks of postpartum evaluation; or

(iii) Is terminally ill.

(B) If a participating provider voluntarily chooses to discontinue participation as a network provider in a plan, the plan shall permit a covered person to continue an ongoing course of treatment with the disaffiliated provider during a transitional period:

(i) of up to ninety (90) days from the date of notice to the plan of the provider's disaffiliation from the plan's network, or

(ii) that includes delivery and postpartum care if the covered person has entered the third trimester of pregnancy at the time of the provider's disaffiliation.

(C) If a provider voluntarily chooses to discontinue participation as a network provider participating in a plan, such provider shall give at least a ninety-day notice of the disaffiliation to the plan. The plan shall immediately notify the disaffiliated provider's patients of that fact.

(D) Notwithstanding the provisions of paragraph 1 of this subsection, continuing care shall be authorized by the plan during the transitional period only if the disaffiliated provider agrees to:

(i) continue to accept reimbursement from the plan at the rates applicable prior to the start of the transitional period s payment in full,

(ii) adhere to the plan's quality assurance requirements and to provide to the plan necessary medical information related to such care, and

(iii) otherwise adhere to the plan's policies and procedures, including, but not limited to, policies and procedures regarding references, and obtaining preauthorization and treatment plan approval from the plan.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-72. Continuation of benefits

(a) If group or individual contracts are terminated by the HMO, provision shall be made for continuation of benefits to enrollees who, on the date of termination, are confined in an inpatient facility until their discharge or expiration of benefits according to the group or individual contract, and provision shall be made for pregnant enrollees through delivery and discharge. An HMO is not required to continue further benefits for an enrollee or group terminated for cause.

(b) Each HMO shall 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, continuation of benefits for enrollees who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits, and continuation of
benefits for pregnant enrollees through delivery and discharge. The Department shall require the plan to include one or more of the following:

(1) Insurance to cover the expenses to be paid for continued benefits after the HMO's insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the HMO'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; and

(5) Any other arrangements to assure that benefits are continued as specified above.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-73. Disenrollment for cause

An HMO may disenroll an individual member of a group for cause such as failure to pay premiums or copayments, fraud, or misuse of identification card or if the enrollee's behavior is abusive, disruptive, threatening, or uncooperative to the extent that continued membership in the HMO seriously impairs the HMO's ability to furnish services to either the enrollee or other enrollees. Before disenrolling the enrollee, the HMO shall:

(1) Make a serious effort to resolve the problem presented by the enrollee, including the use or attempted use of the HMO's grievance procedures;

(2) Ascertain that the enrollee's behavior does not directly result from an existing medical condition; and

(3) Document the problems, efforts, and medical conditions that demonstrate the HMO's conformity to this section.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-74. Certification of creditable coverage

(a) For the purpose of this Section, "creditable coverage" shall have the same meaning as described in Section 2701(c) of the Federal Public Health Service Act.

(b) An HMO shall issue to individuals and members of a group a certificate of creditable coverage when individual or group coverage terminates. Said certificates shall be issued in accordance with the requirements and specifications of Sections 2701(c), (d), and (e) of the Federal Public Health Service Act.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

PART 15. DISCONTINUATION OF HMO

365:40-5-80. Notice

An HMO shall give the Department at least one hundred eighty (180) days written notice of any decision to cease doing business. The HMO must submit for the Department's approval all notices, press releases, conversion agreements, memorandums of understanding, or other marketing or informational materials prior to their release and effective dates.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-81. Individual market

(a) If an HMO elects to discontinue offering a particular contract form for health coverage offered in the individual market, coverage under such form shall be discontinued only if:

(1) The HMO provides notice to the Department and to each covered individual provided coverage under this contract form of such discontinuation at least ninety (90) days prior to the date of the discontinuation of such coverage;

(2) The HMO offers to each individual provided coverage under this contract form the option to purchase any other individual health coverage currently being offered by the HMO for individuals in such market in the state; and

(3) In exercising the option to discontinue coverage of this contract form and in offering the option of coverage under subparagraph (b)(2),1 the HMO acts uniformly without regard to any health-status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

(b) If an HMO elects to discontinue offering all health coverage in the individual market in this state, health coverage shall be discontinued only if:

(1) The HMO provides notice to the Department and to each individual of such discontinuation at least one hundred eighty (180) days prior to the date of the expiration of such coverage; and

(2) All health coverage issued or delivered for issuance in the state in the individual market is discontinued and coverage under such health coverage in such market is not renewed.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-82. Group market

(a) An HMO may discontinue offering a particular contract form of group health coverage offered in the small-group market or large-group market only if:

(1) The HMO provides notice to the Department and to each contractholder provided coverage under this form in such market, and to participants and beneficiaries covered under such coverage, of such discontinuation at least ninety (90) days prior to the date of the discontinuation of such coverage;

(2) The HMO offers to each contractholder provided coverage under this form in such market the option to purchase any other health coverage currently being offered by the HMO in such market; and

(3) In exercising the option to discontinue coverage of this form and in offering the option of coverage under subparagraph (a)(2) above, the HMO acts uniformly without regard to the claims experience of those contractholders or any health-status-related factor that relates to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(b) In any case in which an HMO elects to discontinue offering all health coverage in the small-group market or the large-group market, or both, in this state, health coverage shall be discontinued only if:

(1) The HMO provides notice to the Department and to each contractholder, and participants and beneficiaries covered

under such coverage, of such discontinuation at least one hundred eighty (180) days prior to the date of the discontinuation of such coverage; and

(2) All health coverage issued or delivered for issuance in this state in such markets is discontinued and coverage under such health coverage in such market is not renewed.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-83. Market reentry

In the case of a discontinuation in the group or individual markets, the HMO may not provide for the issuance of any group or individual health coverage in this state during the 5-year period beginning on the date of the discontinuation of the last health coverage not renewed.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

PART 17. CONFIDENTIALITY OF MEDICAL INFORMATION AND LIABILITY

365:40-5-90. Responsibility of HMO

(a) The HMO shall protect the confidentiality of its enrollees from public disclosure of confidential and medical information, however, this shall not be construed to prevent the Department or other legally constituted agencies of the State or Federal Government or peer review organizations from completing medical record reviews or obtaining information as required under applicable laws or rules.

(b) The HMO shall have access to treatment records and other information pertaining to the diagnosis, treatment or health status of any enrollee.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

PART 19. REQUEST FOR ASSISTANCE AND PROMPT PAY FORMS

365:40-5-100. Request for assistance

(a) The Department shall expeditiously advise an HMO of each inquiry the Department receives regarding that HMO. Such inquiries need not be handled through the HMO's written grievance system.

(b) The Department shall provide a form that an enrollee may use to request assistance of the Department. The Department shall review such requests and consider whether or not the request for assistance raises issues of compliance with the HMO Act or the rules. If the Department has reason to believe that a violation exists, then the matter shall be considered by the Department and a determination shall be made by the Department as to the appropriate action to be taken.

(c) The Department shall not refer an inquiry or complaint to an HMO prior to investigating the matter if the Department has reason to believe that referring the inquiry or complaint may compromise the Department's ability to enforce the HMO Act or this Chapter.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-101. Prompt Pay Form and Requirements

The Prompt Pay Form as set forth in Appendix G of this Chapter shall be used in reporting violations of the prompt pay requirements. The person filing the form shall submit the original form to the Consumer Assistance and Claims Division of the Department and a copy to the entity accused of the prompt pay violation named in the form.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

PART 21. GEOGRAPHIC SERVICE AREA VARIATIONS

365:40-5-110. Accessibility of providers

(a) The Department shall presume a proposed service area to be reasonable if the mean travel time is thirty (30) minutes or less from six equidistant points on the area boundary to the nearest primary and emergency care delivery sites within that area.

(b) The Department shall consider approving service areas with distances of greater than thirty (30) minutes to primary and emergency care providers, based on the following.

(1) Primary or emergency care providers are not available in the area;

(2) Primary or emergency care providers are available but do not meet the HMO's reasonable credentialing requirements;

(3) Primary or emergency care providers are unwilling or unable to enter a reasonable health services contract with the HMO; or

(4) Residents of the area customarily travel longer than 30 minutes to reach primary or emergency care providers.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-111. Marketing and enrolling

(a) All marketing, enrollment, or informational materials produced by the HMO shall specify the approved geographic service area within which contracting providers are reasonably available and accessible.

(b) The Department recognizes that under some circumstances, persons who neither live nor work in the service area desire to enroll in an HMO. Those may include, but are not limited to, the following persons.

(1) Retirees;

(2) Persons living or working at or near the service area boundary, and whose neighbors are eligible for enrollment;

(3) Employees who have been relocated;

(4) Persons whose best or only health coverage option is an HMO, despite the additional travel time required;

(5) Persons who customarily choose to travel to the service area for their health services; or

(6) Family members living apart from one another, as a result of circumstances such as legal separation or divorce.

(c) The HMO must ensure that each subscriber living and working outside the service area, upon enrolling, signs a form showing understanding that his or her residence falls outside the service area and agreeing to seek all services, except emergency services as defined in the HMO contract, within the approved service area.
(d) Nothing in this section, or in the Department's approval of an HMO, shall be construed as authorization for the plan to enroll, solicit, or market to, any person who resides outside this state.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-112. Geographic area filings
(a) Each HMO shall describe its proposed service area in terms of political boundaries, zip codes, or geographic boundaries.
(b) Each HMO shall provide to the Department a map of the complete service area clearly showing the service area boundaries, main traffic arteries, and any physical barriers such as mountains and rivers. The HMO shall show on the map the location of ambulatory and hospital providers. The HMO must mark six equidistant points along the boundary, and calculate mean travel time from those six points to the nearest primary and emergency services sites.
(c) The HMO shall provide the information required in this Section in its license application filed pursuant to 36 O.S. § 6903.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

PART 23. REIMBURSEMENT OF CLAIMS

365:40-5-120. Purpose
The purpose of this Part is to ensure that claims for payment or reimbursement shall be processed timely and that settlements shall be paid in full and that prompt pay is received.
[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]
365:40-5-121. Requirement to reimburse claims for point of service
No HMO shall be required to reimburse claims for non-authorized out-of-network services other than emergency services unless the HMO offers a point of service option pursuant to Part 7 of this Subchapter.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-122. Responsibilities
An HMO or its employees and agents shall not:
(1) Pay claims reviewers based on reductions, unless the reductions are based on uniformly applied protocols designed to detect billing errors and duplicate charges;
(2) Compel a subscriber or provider to:

(A) Accept less than the full settlement of a claim; or

(B) File suit to obtain full settlement; or

(3) Knowingly misrepresent reimbursement criteria or time limits to a subscriber, provider, or their representatives.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-123. Reimbursement criteria

(a) An HMO that pays or reimburses claims shall disclose the criteria that establish how and whether a claim for services delivered by a participating or non-participating provider shall be paid. The disclosed criteria shall specify any documents required to be filed with a claim.

(b) If an HMO requires providers to use a uniform claim or billing form, the forms shall be either:

(1) The CMS-1500, or its successor, for outpatient billing and claim submission; or

(2) The UB-92, or its successor, for hospital billing and claim submission.

(c) An HMO shall furnish to providers the following information with the uniform claim or billing form:

(1) The amount the HMO shall pay the provider for the services rendered; and

(2) Notice that the provider shall bill the HMO directly for its portion of the charges if the subscriber has paid the applicable copayment or deductible.

(d) If an HMO requires the use of a claim transmittal form, the evidence of coverage shall include a convenient method for the subscriber to request the form. The form shall be sent to the subscriber within five (5) days after request.

(e) If an HMO uses reasonable and customary charge determinations to authorize settlements, it shall:

(1) Base such determinations on prevailing charges for health services and supplies common to a geographic area; and

(2) Furnish or arrange to furnish the rationale and data sources for a determination, within ten (10) days after receipt of a provider's request for this information and for no more than a nominal copying fee.

(f) A claim shall be reimbursed identically in amount whether a subscriber or provider submits the claim.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-124. Claims payment report

(a) Upon the request of the Insurance Commissioner and in a time frame as specified by the Insurance Commissioner, HMOs shall file with the Department a periodic report on compliance with provisions in Titles 36 of the Oklahoma Statutes and this Part regarding reimbursement of claims within certain time periods.

(b) Each report shall be accompanied by a statement signed by a member of the Board of Directors or executive management attesting to the accuracy of the report.

(c) Any HMO that delegates any claim payment functions shall require the delegated entity or entities to prepare the required report for claims the entity processes including the required attestation.
(d) Each HMO shall collect and submit all required report(s) as a complete package.
(e) These reports shall be in such form and context as directed by the Department.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-125. Elements of a clean claim

(a) **Required clean claim elements.** A provider submits a clean claim by providing the required data elements specified in O.A.C. 365:40-5-123 to an HMO along with any attachments and additional elements information of which the provider has been properly notified pursuant to O.A.C. 365:40-5-126.
(b) **Attachments.** The Center for Medicare and Medicaid Services has developed a variety of manuals that identify various attachments required of different providers for specific services. An HMO may use the appropriate Medicare standards for attachments in order to properly process claims for certain types of services. An HMO shall only require as attachments information that is either contained in or in the process of being incorporated into a patient's medical or billing record maintained by the provider. Before any attachments may be required, the HMO shall satisfy the notification procedures set forth in O.A.C. 365:40-5-126.
(c) **Additional clean claim elements.** Before any additional clean claim elements may be required, the HMO shall satisfy the notification procedures set forth in O.A.C. 365:40-5-126. An HMO shall only require as additional clean claim elements information that is either contained in or in the process of being incorporated into a patient's medical or billing record maintained by the provider.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-126. Disclosure requirements

(a) An HMO shall not require an attachment or an additional element unless it has given the provider the disclosure mandated by this Section at least sixty (60) calendar days before requiring the attachment or additional element as an element of the clean claim.
(b) An HMO shall not revise its requirements for data elements, attachments or additional elements unless it has given the provider the disclosure mandated by this Section at least sixty (60) calendar days before requiring the data element, attachment or additional element.
(c) The HMO shall not require claims filed during the sixty (60) day period after receipt of the disclosure to include the required attachment or additional element identified in the disclosure.
(d) Methods of disclosure may include one or more of the following:
(1) A written notice to all affected providers.

(2) Updated revisions to the provider manual or other document that sets forth the claims filing procedures; or

(3) Amendments to provider contracts that specify clean claim elements.

(e) If the provider contract requires mutual agreement of the parties as the sole mechanism for requiring attachments or additional elements, then the written notice specified in this Section shall not supersede the requirement for mutual agreement.

(f) All notices shall identify with specificity the attachment(s) or additional elements(s) required for a clean claim.

(g) The disclosure required by this Section shall be presumed received by the provider in the manner provided in O.A.C. 365:40-5-129.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-127. Disclosure of processing procedures

(a) In contracts with providers, or in the provider manual or other document that sets forth the procedure for filing claims as required by O.A.C. 365:40-5-122, or by any other method mutually agreed upon by the contracting parties, an HMO shall disclose to its providers:

(1) The mailing address, including a physical address, where claims are to be sent for processing whether it be the address of the HMO, a delegated claims processor, or any other entity, including a clearing house or a repricing company designated by the HMO to receive claims;

(2) The telephone number to which providers' questions and concerns regarding claims may be directed; and

(3) The mailing address, including physical address, of any separate claims processing centers for specific types of services, if applicable.

(b) An HMO shall provide no less than sixty (60) calendar days prior written notice of any changes of address for submission of claims, and of any changes of delegation of claims payment functions, to all affected providers with whom the HMO has contracts. Except an HMO may provide less than sixty (60) days notice in situations beyond the control of the HMO.

(c) After a change of claims payment address or a change in delegation of claims payment functions, an HMO shall not premise the denial of a clean claim upon a provider's failure to file a clean claim within any contracted time period for claim filing, unless timely written notice has been given to the provider.

(d) If an HMO has delegated its claims processing functions to a third party, the delegation agreement must provide that the claims processing entity shall comply with the requirements of this Part and applicable law. Any delegation agreement or provision may not be construed to limit the HMO's authority or responsibility to comply with all applicable statutory and regulatory requirements.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-128. Failure to promptly pay

(a) An HMO that fails to comply with the requirements in Titles 36 of the Oklahoma Statutes regarding reimbursement of claims and with this Part shall pay the greater of:

(1) The penalty amount for late payment referred to in applicable provisions in Title 36 of the Oklahoma Statutes; or

(2) The contracted penalty rate for late payment set forth in the contract between the provider and the HMO.

(b) Failure to pay the correct amount on a clean claim in accordance with the contract or denial of a clean claim for which payment should have been made that results in a failure to comply with the requirements of applicable provisions in Title 36 of the Oklahoma Statutes and this Part is considered a violation and may be subject to administrative penalties as set forth in HMO Act.

(c) Any amount previously paid or any charge for a non-covered service shall be deducted from the payment.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-129. Date of claim receipt

(a) A provider and an HMO may agree by contract to establish a procedure to create a rebuttable presumption regarding the date of claim receipt.

(b) If a provider and HMO do not by contract agree to a method for the establishment of a rebuttable presumption, then the procedures set forth in subsections (c) through (e) of this Section shall be used to establish a rebuttable presumption to demonstrate the date of claim receipt.

(c) The provider shall maintain a claims summary report to identify each claim and identify the batch to which multiple claims were a part. The claims summary report shall be used as a means of confirming the number of claims submitted.

(d) The summary report shall accompany each batched filing, except for electronic submissions.

(e) The provider shall submit a claim or a multiple claim batch by one of the following methods, as appropriate:

(1) United States mail first class. Claim(s) submitted by United States mail first class will be considered received on the seventh business day after the date the claim(s) was placed in the mail;

(2) Certified mail. Claim(s) submitted by certified mail will be considered received on the date the delivery receipt is signed;

(3) Overnight delivery. Claim(s) submitted by overnight delivery will be considered received on the date the delivery receipt is signed;

(4) Electronically. Claim(s) submitted electronically will be considered received on the date of verification of receipt by the HMO or the HMO's clearinghouse. Claims are to be accompanied by any system-generated proof of transmission. If the HMO or its clearinghouse do not confirm receipt or reject the transmission within 24 hours of submission, the provider or the provider's clearinghouse shall provide the confirmation

date conditional upon the provider or the provider's clearinghouse verifying the claim(s) contained the correct payor identification;

(5) Facsimile. Claim(s) submitted by facsimile will be considered received on the date of the facsimile confirmation, or if the transmission occurs after the HMO's working hours, on the HMO's next working day; or

(6) Hand delivery. Claim(s) submitted by hand delivery will be considered received on the date the delivery receipt is signed.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]

365:40-5-130. Terms of contracts

Contracts between HMOs and providers shall not include terms that:

(1) Exceed the maximum number of days established for reimbursement of claims pursuant to applicable provisions in Title 36 of the Oklahoma Statutes;

(2) Requires the provider to contact the HMO to inquire about the status of a claim; or

(3) Waive the provider's right to recover reasonable attorney fees, if such provider is the prevailing party in litigation, pursuant to applicable provisions in Title 36 of the Oklahoma Statutes.

[**Source:** Added at 21 Ok Reg 77, eff 11-1-03 (emergency); Added at 21 Ok Reg 1672, eff 7-14-04]