

1 **SENATE FLOOR VERSION**

2 February 20, 2017

3 SENATE BILL NO. 518

By: Smalley and Marlatt

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6 An Act relating to health maintenance organizations;  
7 amending 36 O.S. 2011, Section 6907 and Section 6913,  
8 as amended by Section 19, Chapter 275, O.S.L. 2014  
9 (36 O.S. Supp. 2016, Section 6913), which relate to  
10 reasonable standards of quality of care and liability  
11 of subscriber for health maintenance organization  
12 debts; declaring provider compensation reasonable  
13 under certain standards; defining out-of-network  
14 provider; prohibiting out-of-network providers from  
15 charging health maintenance organization patients  
16 more than a certain amount; and providing an  
17 effective date.

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

19 SECTION 1. AMENDATORY 36 O.S. 2011, Section 6907, is  
20 amended to read as follows:

21 Section 6907. A. Every health maintenance organization shall  
22 establish procedures that ensure that health care services provided  
23 to enrollees shall be rendered under reasonable standards of quality  
24 of care consistent with prevailing professionally recognized  
standards of medical practice. The procedures shall include  
mechanisms to assure availability, accessibility and continuity of  
care.

1 B. The health maintenance organization shall have an ongoing  
2 internal quality assurance program to monitor and evaluate its  
3 health care services, including primary and specialist physician  
4 services and ancillary and preventive health care services across  
5 all institutional and noninstitutional settings. The program shall  
6 include, but need not be limited to, the following:

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

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

- 12 a. the health maintenance organization's scope and  
13 purpose in quality assurance,
- 14 b. the organizational structure responsible for quality  
15 assurance activities,
- 16 c. contractual arrangements, where appropriate, for  
17 delegation of quality assurance activities,
- 18 d. confidentiality policies and procedures,
- 19 e. a system of ongoing evaluation activities,
- 20 f. a system of focused evaluation activities,
- 21 g. a system for credentialing and recredentialing  
22 providers, and performing peer review activities, and  
23  
24

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

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

6 a. problem assessment, identification, selection and  
7 study,

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

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

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

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

21 C. The organization shall record proceedings of formal quality  
22 assurance program activities and maintain documentation in a  
23 confidential manner. Quality assurance program minutes shall be  
24 available to the State Commissioner of Health.

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

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

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

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

20 H. As used in this section "credentialing" or  
21 "rec credentialing", as applied to physicians and other health care  
22 providers, means the process of accessing and validating the  
23 qualifications of such persons to provide health care services to  
24 the beneficiaries of a health maintenance organization.

1 "Credentialing" or "recredentialing" may include, but need not be  
2 limited to, an evaluation of licensure status, education, training,  
3 experience, competence and professional judgment. Credentialing or  
4 recredentialing is a prerequisite to the final decision of a health  
5 maintenance organization to permit initial or continued  
6 participation by a physician or other health care provider.

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

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

16 3. When economic considerations are part of the credentialing  
17 and recredentialing decision, objective criteria shall be used and  
18 shall be available to physician applicants and participating  
19 physicians. When graduate medical education is a consideration in  
20 the credentialing and recredentialing process, equal recognition  
21 shall be given to training programs accredited by the Accrediting  
22 Council on Graduate Medical Education and by the American  
23 Osteopathic Association. When graduate medical education is  
24 considered for optometric physicians, consideration shall be given

1 for educational accreditation by the Council on Optometric  
2 Education.

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

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

16 6. In reviewing the application, the health maintenance  
17 organization (HMO) shall evaluate each application according to the  
18 plan's checklist of materials required in the application process.

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

22 8. A malpractice carrier shall have twenty-one (21) calendar  
23 days within which to respond after receipt of an inquiry from a  
24 health maintenance organization (HMO). Any malpractice carrier that

1 fails to respond to an inquiry within the allotted time frame may be  
2 assessed an administrative penalty by the State Commissioner of  
3 Health.

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

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

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

4 12. A health maintenance organization shall be prohibited from  
5 solely basing a denial of an application for credentialing or  
6 recredentialing on the lack of board certification or board  
7 eligibility and from adding new requirements solely for the purpose  
8 of delaying an application.

9 13. Any HMO that violates the provisions of this subsection may  
10 be assessed an administrative penalty by the State Commissioner of  
11 Health.

12 I. Health maintenance organizations shall not discriminate  
13 against enrollees with expensive medical conditions by excluding  
14 practitioners with practices containing a substantial number of  
15 these patients.

16 J. Health maintenance organizations shall, upon request,  
17 provide to a physician whose contract is terminated or not renewed  
18 for cause the reasons for termination or nonrenewal. Health  
19 maintenance organizations shall not contractually prohibit such  
20 requests.

21 K. No HMO shall engage in the practice of medicine or any other  
22 profession except as provided by law nor shall an HMO include any  
23 provision in a provider contract that precludes or discourages a  
24 health maintenance organization's providers from:



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

4 2. Advocating on behalf of a patient before the HMO.

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

12 1. Jeopardy to the health of the patient;

13 2. Impairment of bodily function; or

14 3. Dysfunction of any bodily organ or part.

15 M. Health maintenance organizations shall not deny an otherwise  
16 covered emergency service based solely upon lack of notification to  
17 the HMO.

18 N. Health maintenance organizations shall compensate a provider  
19 for patient screening, evaluation, and examination services that are  
20 reasonably calculated to assist the provider in determining whether  
21 the condition of the patient requires emergency service. The  
22 compensation shall be presumed to be reasonable if it is based at  
23 one hundred thirty percent (130%) of the Medicare payment rate for  
24 the same or similar services in the same geographic area. If the

1 provider determines that the patient does not require emergency  
2 service, coverage for services rendered subsequent to that  
3 determination shall be governed by the HMO contract.

4 O. Providers that choose to not contract with an HMO are deemed  
5 out-of-network. Any out-of-network provider who provides emergency  
6 services to an HMO enrollee may not charge the enrollee for amounts  
7 other than applicable copayments or deductibles.

8 P. If within a period of thirty (30) minutes after receiving a  
9 request from a hospital emergency department for a specialty  
10 consultation, a health maintenance organization fails to identify an  
11 appropriate specialist who is available and willing to assume the  
12 care of the enrollee, the emergency department may arrange for  
13 emergency services by an appropriate specialist that are medically  
14 necessary to attain stabilization of an emergency medical condition,  
15 and the HMO shall not deny coverage for the services due to lack of  
16 prior authorization.

17 ~~P.~~ Q. The reimbursement policies and patient transfer  
18 requirements of a health maintenance organization shall not,  
19 directly or indirectly, require a hospital emergency department or  
20 provider to violate the federal Emergency Medical Treatment and  
21 Active Labor Act. If a member of an HMO is transferred from a  
22 hospital emergency department facility to another medical facility,  
23 the HMO shall reimburse the transferring facility and provider for  
24 services provided to attain stabilization of the emergency medical

1 condition of the member in accordance with the federal Emergency  
2 Medical Treatment and Active Labor Act.

3 SECTION 2. AMENDATORY 36 O.S. 2011, Section 6913, as  
4 amended by Section 19, Chapter 275, O.S.L. 2014 (36 O.S. Supp. 2016,  
5 Section 6913), is amended to read as follows:

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

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

15 a. One Million Five Hundred Thousand Dollars  
16 (\$1,500,000.00),

17 b. two percent (2%) of annual premium revenues as  
18 reported on the most recent annual financial statement  
19 filed with the Commissioner on the first One Hundred  
20 Fifty Million Dollars (\$150,000,000.00) of premium and  
21 one percent (1%) of annual premium on the premium in  
22 excess of One Hundred Fifty Million Dollars  
23 (\$150,000,000.00),  
24

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

5 d. an amount equal to the sum of:

6 (1) eight percent (8%) of annual health care  
7 expenditures, except those paid on a capitated  
8 basis or managed hospital payment basis, as  
9 reported on the most recent financial statement  
10 filed with the Commissioner, and

11 (2) four percent (4%) of annual hospital expenditures  
12 paid on a managed hospital payment basis, as  
13 reported on the most recent financial statement  
14 filed with the Commissioner.

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

18 a. twenty-five percent (25%) of the amount required by  
19 paragraph 2 of this subsection by December 31, 2003,

20 b. fifty percent (50%) of the amount required by  
21 paragraph 2 of this subsection by December 31, 2004,

22 c. seventy-five percent (75%) of the amount required by  
23 paragraph 2 of this subsection by December 31, 2005,

24 and

1           d.    one hundred percent (100%) of the amount required by  
2                paragraph 2 of this subsection by December 31, 2006.

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

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

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

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

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

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

8           4. The deposit shall be used to protect the interests of the  
9 health maintenance organization's enrollees and to ensure  
10 continuation of health care services to enrollees of a health  
11 maintenance organization that is in rehabilitation or conservation.  
12 The Commissioner may use the deposit for administrative costs  
13 directly attributable to a receivership or liquidation. If a health  
14 maintenance organization is placed in receivership or liquidation,  
15 the deposit shall be an asset subject to the provisions of the  
16 Uniform Insurers Liquidation Act.

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

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

4 a. any unearned premium,

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

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

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

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

21 2. In the event that the participating provider contract has  
22 not been reduced to writing as required by this subsection or that  
23 the contract fails to contain the required prohibition, the  
24 participating provider shall not collect or attempt to collect from

1 a subscriber or an enrollee sums owed by the health maintenance  
2 organization.

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

7 4. Providers that choose to not contract with an HMO are deemed  
8 "out-of-network". Any out-of-network provider who provides  
9 emergency services to an HMO enrollee may not charge the enrollee  
10 for amounts other than applicable copayments or deductibles.

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

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

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



- 1        3. Insolvency reserves;
- 2        4. Acceptable letters of credit; or
- 3        5. Any other arrangements to ensure continuation of benefits as
- 4 specified above.

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

10        SECTION 3. This act shall become effective November 1, 2017.

11        COMMITTEE REPORT BY: COMMITTEE ON RETIREMENT AND INSURANCE  
12        February 20, 2017 - DO PASS

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