

**TITLE 365. INSURANCE DEPARTMENT
CHAPTER 10. LIFE, ACCIDENT AND HEALTH**

RULEMAKING ACTION:

PERMANENT final adoption

RULES:

Subchapter 1	General Provisions
Part 1.	General Provisions
365:10-1-15	Eliminating unfair discrimination on basis of children as single
applicant [AMENDED]	
365:10-1-16	Providing insurance policy information [NEW]
365:10-1-31	Definitions [AMENDED]
365:10-1-32	Requirements for use of HCFA form 1500 and HCFA form 149
[AMENDED]	
Subchapter 5.	Minimum Standards; Contract Guidelines
Part 15.	Small Employer Health Insurance Reform Regulation
365:10-5-150	Statement of purpose [AMENDED]
365: 10-5-155	Restrictions relating to premium rates [AMENDED]
365:10-5-164	Uniform Health Questionnaire [NEW]
Part 17.	Actuarial Opinion and Memorandum Regulation
365:10-5-177	Description of actuarial memorandum including an asset adequacy
analysis [AMENDED]	
Subchapter 29.	External Review Regulations [NEW]
365:10-29-1.	Purpose [NEW]
365:10-29-2.	Applicability and Scope [NEW]
365:10-29-3.	Definitions [NEW]
365:10-29-4.	Notice of Right to an External Review and External Review
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365:10-29-5.	Authorization to Disclose Protected Health Information [NEW]
365:10-29-6.	External Review Requests [NEW]
365:10-29-7.	Notice of Initial Determination [NEW]
365:10-29-8.	Independent Review Organization Application [NEW]
365:10-29-9.	Independent Review Organization Recordkeeping and Reporting
Requirements [NEW]	
365:10-29-10.	Health Carrier Recordkeeping and Reporting Requirements [NEW]
Appendix PP	Notice of Appeal Rights [NEW]
Appendix QQ	External Review Request Form [NEW]
Appendix RR	Application for Registration as an Independent Review
Organization [NEW]	
Appendix SS	Independent Review Organization External Review Annual Report
Form [NEW]	
Appendix TT	Health Carrier External Review Annual Report Form [NEW]
Appendix UU	Policy Holder's Authorization to Release Insurance Policy
Information to Agent of Record [NEW]	
Appendix VV	Uniform Health Questionnaire [NEW]

AUTHORITY: Insurance Commissioner; 36 O.S. § 307.1, 36 O.S. § 4061, 36 O.S. § 6475.5(A)(3), 36 O.S. § 6475.6(A)(2), 36 O.S. § 6475.12(G), 36 O.S. § 6526

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Superseded rules:

Subchapter 1.	General Provisions
Part 1.	General Provisions
365:10-1-15	Eliminating unfair discrimination on basis of children as single applicants [AMENDED]
Subchapter 29.	External Review Regulations [NEW]
365:10-29-1.	Purpose [NEW]
365:10-29-2.	Applicability and Scope [NEW]
365:10-29-3.	Definitions [NEW]
365:10-29-4.	Notice of Right to an External Review and External Review Procedures [NEW]
365:10-29-5.	Authorization to Disclose Protected Health Information [NEW]
365:10-29-6.	External Review Requests [NEW]
365:10-29-7.	Notice of Initiation Determination [NEW]
365:10-29-8.	Independent Review Organization Application [NEW]
365:10-29-9.	Independent Review Organization Recordkeeping and Reporting Requirements [NEW]
365:10-29-10.	Health Carrier Recordkeeping and Reporting Requirements [NEW]
Appendix PP	Notice of Appeal Rights [NEW]
Appendix QQ	External Review Request Form [NEW]
Appendix RR	Application for Registration as an Independent Review Organization [NEW]

Appendix SS Independent Review Organization External Review Annual Report Form [NEW]

Appendix TT Health Carrier External Review Annual Report Form [NEW]

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ANALYSIS:

The definition of "qualifying event" was amended in 365:10-1-15 to encourage insurers issuing individual accident and health policies within the state to participate in an annual open enrollment period for children under the age of 19. During the annual open enrollment period, children under the age of (19) shall be offered coverage on a guaranteed issue basis, without any limitations or riders based on health status.

New rule 365:10-1-16 designates that insurers shall use the "Policy Holder's Authorization To Release Insurance Policy Information To Agent Of Record" form, specified in Appendix UU, or a substantially similar form to comply with 36 O.S §1435.41. 365:10-1-31 and 32 are amended to change reference from ICD 9 to ICD 10.

The amendment to 365:10-5-150 deletes a reference to the reinsurance program because it was legislatively repealed in 2010. The amendment to 365:10-5-155 removes group size as a case characteristic because 36 O.S. § 6512(7) does not permit group size as a case characteristic. Pursuant to 36 O.S. § 6519(D), new rule 365:10-5-164 requires all small employer carriers that obtain health status information from a small employer to use the uniform health questionnaire specified in Appendix VV prior to offering coverage. The purpose of the amendment to 365:10-5-177 is to avoid duplicative procedure by requiring the appointed actuary to only submit the regulatory asset adequacy issues summary to the insurance company's domestic regulator.

The new Subchapter 29 creates rules for the implementation and regulation of the Uniform Health Carrier External Review Act. 365:10-29-1 sets forth the purpose of new subchapter 29. 365:10-29-2 sets forth the applicability and scope of subchapter 29. 365:10-29-3 sets forth that all terms used in subchapter 29 shall have the same meaning as defined in 36 O.S. § 6475.4(B). 365:10-29-4 provides for the manner a health carrier shall provide notice as set out in the Notice of Appeal Rights form in Appendix PP. 365:10-29-5 requires that health carriers providing notice shall provide a form authorizing the health care provider to disclose protected health information as set out in the Oklahoma State Department of Health Standard Authorization form, ODH 206, or in the alternative, a form that complies with 45 CFR § 164.508 and 43A O.S. § 1-109. 365:10-29-6 provides for the manner a covered person or authorized representative shall request an external review as set out in the External Review Request form in Appendix QQ. 365:10-29-7 provides that a Notice of Initial Determination shall be made in writing to the same address as the External Review Request form in Appendix QQ. 365:10-29-8 references the Application for Registration as an Independent Review Organization form in

Appendix RR as the application to be used by independent review organizations seeking approval to conduct external reviews. 365:10-29-9 relates to the recordkeeping and reporting requirements that each independent review organization shall follow as set out in the Independent Review Organization External Review Annual Report form in Appendix SS. 365:10-29-10 relates to the recordkeeping and reporting requirements each health carrier shall follow as set out in the Health Carrier External Review Annual Report form in Appendix TT.

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PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING RULES ARE CONSIDERED FINALLY ADOPTED AS SET FORTH IN 75 O.S., SECTION 308.1(A), WITH AN EFFECTIVE DATE OF JULY 14, 2012:

**SUBCHAPTER 1. GENERAL PROVISIONS
PART 1. GENERAL PROVISIONS**

365:10-1-15. Eliminating unfair discrimination on basis of children as single applicants

(a) **Purpose.** The purpose of this section is to eliminate the act of denying benefits or coverage unfairly in the issuance, terms and conditions of insurance contracts and in underwriting criteria of insurance carriers. It is not intended to prohibit reasonable and justifiable differences in premium rates based upon sound actuarial principles or actual or reasonably anticipated experience.

(b) **Definitions.**

(1) "Child only" policy means an individual health benefit policy ~~issued on or after September 23, 2010,~~ which provides coverage to an individual under the age of nineteen (19). This shall not include health benefit policies that cover children under the age of nineteen (19) as a dependent;

(2) "Insurer" includes:

(A) every person engaged in the business of making contracts of insurance or indemnity,

(B) a nonprofit hospital service and medical indemnity corporation, and

(C) a health maintenance organization; and

(3) "Qualifying event" ~~includes birth, means adoption, or a marriage, dissolution of marriage, death of a parent, loss of employer sponsored insurance, loss of eligibility under the Oklahoma Medicaid Program, a loss of existing health insurance coverage~~ including loss of eligibility in the SoonerCare or SoonerStart programs, 56 O.S. §§ 1010.1 through 1010.13 and 1011.1 through 1011.11, ~~entry of a valid court order mandating the child be covered, or loss of other existing coverage~~ for any reason other than fraud, misrepresentation or failure to pay premium. "Qualifying event" shall also mean entry of a valid order mandating the child be covered if there is no employer sponsored coverage available to the parent ordered to provide health insurance to the child.

(c) **Enrollment.**

(1) Enrollment only allowed during certain ~~periods~~ period.

(A) Insurers issuing child only policies on or after September 23, 2010 shall only accept applications for coverage during the open enrollment ~~periods~~ period outlined in this section.

(B) Enrollment outside the open enrollment ~~periods~~ period shall be prohibited, except upon the occurrence of a qualifying event.

~~(2) For the year 2011, insurers offering child only policies shall hold an open enrollment period from July 15, 2011 through August 15, 2011. During this open enrollment period, all children under the age of nineteen (19) shall be offered coverage on a guaranteed issue basis, without any limitations or riders based on health status. Insurers shall use such rates as have been filed and approved by the Insurance Commissioner.~~

~~(2)(3) Beginning January 1, 2012, insurers offering child only policies shall hold an open enrollment period that begins on June 1 and ends on July 31 each year, each January and July, for the duration of the entire month. During these the annual open enrollment periods period, all children under the age of nineteen (19) shall be offered coverage on a guaranteed issue basis, without any limitations or riders based on health status. Insurers shall use such rates as have been filed and approved by the Insurance Commissioner.~~

~~(3)(4) Notice of the open enrollment opportunity and open enrollment dates for new applicants, as well as the opportunity to enroll due to a qualifying event, shall be displayed prominently on the insurer's website throughout the year.~~

~~(4)(5) Applications for coverage during an open enrollment period shall become effective on the first day of the month following receipt of the completed application, except that if mutually agreed upon by the applicant and the insurer an alternative effective date may be selected.~~

~~(5)(6) Nothing contained in this section shall alter the ability of an applicant to obtain a child only policy outside the open enrollment period upon the occurrence of a qualifying event. Non-health eligibility underwriting rules may be applied to child-only coverage, provided such eligibility rules are uniformly applied to all applicants applying for child-only coverage.~~

~~(6) Insurers shall use such rates as have been filed and approved by the Insurance Commissioner.~~

~~(e)(d)~~ **Insurer participation.** Only insurers that participate in the most recent open enrollment period shall be permitted to write child only policies. Any insurer not participating in the most recent open enrollment period shall be prohibited from issuing child only policies until the commencement of the next subsequent open enrollment period, regardless of whether the policy is issued as a result of a qualifying event.

~~(f)(e)~~ **Penalty for violations.** Noncompliance with this section may result, after proper notice and hearing, in an administrative action and penalty.

365:10-1-16. Providing insurance policy information

(a) An insurer shall provide to any insurance producer authorized to sell life insurance products, whose appointment has been terminated for any reason other than the reasons set forth in 36 O.S. § 1435.13 and who is still the agent of record or servicing agent and has not been replaced by another servicing agent upon termination, information relating to the policy of the person who purchased a product from such producer if the insured has signed a form authorizing the release of the information.

(b) This requirement does not apply to any policy sold or serviced by the insurance producer while associated with the insurer's captive distribution system.

(c) Insurers shall use the "Policy Holder's Authorization To Release Insurance Policy Information To Agent Of Record" specified in Appendix UU or a substantially form to comply with this requirement.

SUBCHAPTER 1. GENERAL PROVISIONS

PART 3. STANDARDIZED HEALTH CLAIM FORMS

365:10-1-31. Definitions

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

"ADA-1990 Dental Claim Form" means the uniform dental claim form approved by the American Dental Association for use by dentists.

"CDT-1 Codes" means the current dental terminology, and its successors, required by the American Dental Association.

"CPT-4 Codes" means the current procedural terminology published by the American Medical Association.

"HCFA" means the federal Health Care Financing Administration of the United States Department of Health and Human Services.

"HCFA Form 1491" means the health insurance claim form and its electronic successor or equivalent published by HCFA for use by health care practitioners to be used in filing claims for transportation and/or ambulance services.

"HCFA Form 1500" means the health insurance claims form and its electronic successor or equivalent published by HCFA for use by health care practitioners.

"HCFA Form UB-82" means the health insurance claim form and its electronic successor or equivalent published by HCFA for use by hospitals.

"HCFA Form UB-92" means the health insurance claim form and its electronic successor or equivalent published by HCFA for use by hospitals.

"HCPCS" means HCFA's current common procedure coding system.

"Health care practitioner" means:

- (A) a chiropractor licensed under [59 O.S. §161.1 et seq.](#),
- (B) a corporation or partnership of health care practitioners as defined in this section and licensed under [59 O.S. §510](#),
- (C) a dentist licensed under [59 O.S. §328.60 et seq.](#),
- (D) a nurse licensed under [59 O.S. §567.1 et seq.](#),
- (E) a certified registered nurse anesthetist licensed under 59 O.S. §567.51,
- (F) a nurse-midwife licensed under 59 O.S. §577.1 et seq.,
- (G) an ophthalmologist licensed under [59 O.S. §481 et seq.](#),
- (H) an optometrist licensed under [59 O.S. §581 et seq.](#),
- (I) a physician licensed under [59 O.S. §481 et seq.](#),
- (J) a podiatrist licensed under [59 O.S. §135.1 et seq.](#),
- (K) a psychologist licensed under [59 O.S. §1351 et seq.](#),
- (L) therapists:
 - (i) a speech therapist licensed under [59 O.S. §1601 et seq.](#),

- (ii) a physical therapist licensed under [59 §887.1 et seq.](#),
- (iii) an occupational therapist licensed under [59 O.S. §888.1 et seq.](#)
- (M) an osteopath licensed under [59 O.S. §620 et seq.](#),
- (N) a licensed social worker under [59 O.S. §1261.1 et seq.](#),
- (O) a licensed professional counselor licensed under [59 O.S. §1901 et seq.](#)

"Hospital" means a hospital as defined in [63 O.S. §§1-701](#).

"ICD-9 ~~10-CM~~ Codes" means the current disease codes in the international classification of diseases published by the United States Department of Health and Human Services.

"Third party payor" means a person that administers or provides reimbursement for health care benefits on an expense incurred basis including:

- (A) Health Maintenance Organization issued a certificate of authority in accordance with [63 O.S. §2501, et seq.](#),
- (B) health insurer or nonprofit health service plan authorized to offer health insurance policies or contracts in this State in accordance with [36 O.S. §2601, et seq.](#), or
- (C) third party administrator registered under [36 O.S. §1441 et seq.](#)

365:10-1-32. Requirements for use of HCFA Form 1500 and HCFA Form 1491

- (a) Health care practitioners shall use the HCFA Form 1500 and instructions provided by HCFA for use of the HCFA Form 1500 when filing claims with third party payors for professional services. HCFA Form 1491 may be used instead of the HCFA Form 1500 when filing claims for transportation and/or ambulance services.
- (b) The requirement set forth in 365:10-1-32(a) does not apply to:
 - (1) dental services which are billed by dentists using the ADA-1990 Dental Claim Form and CDT-1 Codes, or
 - (2) pharmacists or pharmacies which are filing claims for prescription drugs.
- (c) A third party payor may not require a health care practitioner to use any coding system for the filing of claims for health care services other than the following:
 - (1) HCPCS Codes,
 - (2) **ICD-9 ~~10-CM~~** Codes, or
 - (3) CPT Codes.
- (d) Except as provided in 365:10-1-36(c), a third party payor may not require a health care practitioner to use any other description with a code or to furnish additional information with the initial submission of a HCFA Form 1500 except under the following circumstances:
 - (1) when the procedure code used describes a treatment or service which is not otherwise classified, or
 - (2) when the procedure code is followed by modifiers in which case the practitioner may use the HCFA Form 1500 to explain the modifiers.
- (e) A health care practitioner may use the HCFA Form 1500 to indicate the form is an amended version of a form previously submitted to the third party payor by inserting the word "amended" in Box 19, currently titled "Reserved for Local Use".
- (f) A health care practitioner whose billing is based on the amount of time involved shall indicate the number of units in Box 24G, currently titled "Days or Units", of the HCFA Form 1500 if it is not used to specify the number of days of treatment.

SUBCHAPTER 5. MINIMUM STANDARDS; CONTRACT GUIDELINES
PART 15. SMALL EMPLOYER HEALTH INSURANCE REFORM REGULATION

365:10-5-150. Statement of purpose

(a) This Part is intended to implement the provisions of the Small Employer Health Insurance Reform Act. The general purposes of the Act and this Part are to provide for the availability of health insurance coverage to small employers, regardless of their health status or claims experience; to regulate insurer rating practices and establish limits on differences in rates between health benefit plans; to ensure renewability of coverage; to establish limitations on underwriting practices, eligibility requirements and the use of preexisting condition exclusions; to provide for development of "basic" and "standard" health insurance plans to be offered to all small employers; ~~to provide for establishment of a reinsurance program~~ to direct the basis of market competition away from risk selection and toward the efficient management of health care; and to improve the overall fairness and efficiency of the small group health insurance market.

(b) The Act and this Part are intended to promote broader spreading of risk in the small employer marketplace. The Act and Part are intended to regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers. Carriers that provide health benefit plans to small employers are intended to be subject to all of the provisions of the Act and this Part.

365:10-5-155. Restrictions relating to premium rates

(a) **Separate rate manuals required.**

(1) A small employer carrier shall develop a separate rate manual for each class of Business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to 365:10-5-155(a). To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion.

(2) **Modification of rating method requirements.**

(A) A small employer carrier shall not modify the rating method used in the rate manual for a class of business until the change has been approved as provided in 365:10-5-155(a)(2). The Commissioner may approve a change to a rating method if the Commissioner finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Act and this Part.

(B) A carrier may modify the rating method for a class of business only with prior approval of the Commissioner. A carrier requesting to change the rating method for a class of business shall make a filing with the Commissioner at least thirty (30) days prior to the proposed date of the change. The filing shall contain at least the following information:

- (i) The reasons the change in rating method is being requested;
- (ii) A complete description of each of the proposed modifications to the rating method;

(iii) A description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals (and a description of the types of groups or individuals) whose premium rates may change by more than ten percent (10%) due to the proposed change in rating method (not generally including increases in premium rates applicable to all small employers in a health benefit plan);

(iv) A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and

(v) A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of [36 O.S.Supp.1994, §6515](#).

(C) For the purpose of 365:10-5-155 a change in rating method shall mean:

(i) A change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business;

(ii) A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business;

(iii) A change in the method of allocating expenses among health benefit plans in a class of business; or

(iv) **A "ten percent charge in premium" test.**

(I) A change in rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds ten percent (10%).

(II) For the purpose of 365:10-5-155 (a)(2)(C)(iv)(I), a change in a rating factor considered over a twelve (12) month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier shall consider the cumulative effect of all such changes in applying the ten percent (10%) test under 365:10-5-155(a)(2)(C)(iv)(I).

(b) Case characteristics and rate factors.

(1) The rate manual developed pursuant to 356:10-5-155(a) shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

(2) A small employer carrier may not use case characteristics other than age, gender, industry, geographic area, and family composition ~~and group size~~, as specified in [36 O.S.Supp.1994, §6512\(7\)](#), without the prior approval of the Commissioner. A small employer carrier seeking such an approval shall make a filing with the Commissioner for a change in rating method under 365:10-5-155(a)(2).

(3) A small employer carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case

characteristics shall be applied without regard to the risk characteristics of a small employer.

(4) The rate manual developed pursuant to 365:10-5-155(a) shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference.

(5) Differences among base premium rates for health benefit plans shall be based solely upon the reasonable and objective differences in the design and benefits of the health benefit plans and shall not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier shall apply case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

(6) The rate manual developed pursuant to 365:10-5-155(a) shall provide for premium rates to be developed in a two step process. In the first step, a base premium rate shall be developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of [36 O.S.Supp.1994, §6515](#), to reflect the risk characteristics of the group.

(7) A premium charged to a small employer for a health benefit plan shall not include a separate application fee, underwriting fee, or any other separate fee or charge.

(8) A small employer carrier shall allocate administrative expenses to the basic and standard health benefit plans on no less favorable of a basis than expenses are allocated to other health benefit plans in the class of business. The rate manual developed pursuant to 365:10-5-155(a) shall describe the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed.

(9) Each rate manual developed pursuant to 365:10-5-155(a) shall be maintained by the carrier for a period of six (6) years. Updates and changes to the manual shall be maintained with the manual.

(10) The rate manual and rating practices of a small employer carrier shall comply with any guidelines issued by the Commissioner.

~~e) If group size is used as a case characteristic by a small employer carrier, the highest rate factor associated with a group size classification shall not exceed the lowest rate—~~

~~(d)~~**(c) The restrictions related to changes in premium rates in [36 O.S.Supp.1994, §6515\(A\)\(3\) and \(7\)](#), shall be applied as follows:**

(1) A small employer carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates.

(2) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed to be the change in the base premium rate for the purposes of [36 O.S.Supp.1994, §6515\(A\)\(3\)\(c\) and 36 O.S.Supp.1994, §6515\(A\)\(7\)\(a\)](#).

(3) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of [36 O.S.Supp.1994, §6515\(A\)\(3\)\(c\)](#) and [36 O.S.Supp.1994, §6515\(A\)\(7\)\(a\)](#).

(4) If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than twenty percent (20%), the carrier shall make a filing with the Commissioner containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made within thirty (30) days of the beginning of the rating period.

(5) A small employer carrier shall keep on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.

~~(e)~~(d) **Revised premium rate.**

(1) Except as provided in [365:10-5-155\(e\)\(2\)](#) thru (4), a change in premium rate that is no more than the following:

(A) The base premium rate for the small employer (as shown in the rate manual as revised for the rating period), multiplied by

(B) One plus the sum of:

(i) The risk load applicable to the small employer during the previous rating period, and

(ii) Fifteen percent (15%) (prorated for periods of less than one year).

(2) In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the following:

(A) The base premium rate for the small employer given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period, multiplied by

(B) One plus the lesser of:

(i) The change in the base rate or

(ii) The percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new small employers, multiplied by

(C) One plus the sum of:

(i) The risk load applicable to the small employer during the previous rating period and

(ii) Fifteen percent (15%) (prorated for periods of less than one year).

(3) In the case of a health benefit plan described in [36 O.S.Supp.1994, §6515\(A\)\(6\)](#), if the current premium rate for the health benefit plan exceeds the ranges set forth in [36 O.S.Supp.1994, §6515\(A\)](#), the formulae set forth in [365:10-5-155\(e\)\(1\)](#) and (2) will be applied as if the fifteen percent (15%) adjustment provided in [365:10-5-155\(e\)\(1\)\(B\)\(ii\)](#) and [365:10-5-155\(e\)\(2\)\(C\)\(ii\)](#) were a zero percent adjustment.

(4) Notwithstanding the provisions of 365:10-5-155(e)(1) and (2), a change in premium rate for a small employer shall not produce a revised premium rate that would exceed the limitations on rates provided in [36 O.S.Supp.1994, §6515\(A\)\(2\)](#).

~~(f)~~(e) **Taft-Hartley trust waiver request.**

(1) A representative of a Taft-Hartley trust (including a carrier upon the written request of such a trust) may file in writing with the Commissioner a request for the waiver of application of the provisions of 36 O.S.Supp.1994, §6515(A), with respect to such trust.

(2) A request made under 365:10-5-155(f)(1) shall identify the provisions for which the trust is seeking the waiver and shall describe, with respect to each provision, the extent to which application of such provision would:

- (A) Adversely affect the participants and beneficiaries of the trust; and
- (B) Require modifications to one or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained.

365:10-5-164. Uniform Health Questionnaire

(a) Small employer carriers are not required to obtain health status information from a small employer prior to offering coverage to that small employer; however, if a small employer carrier seeks to obtain health status information for any reason, the carrier must use the form specified in Appendix VV.

(b) Small employer carriers are required to accept and use the uniform health questionnaire specified in Appendix VV beginning on the date that is six months after the effective date of this rule section. Small employer carriers may not vary the content of the form and may not ask for any other health status information from a small employer or its employees.

(c) A small employer carrier must accept a copy of the uniform health questionnaire as though it were an original.

(d) A small employer carrier shall consider information in a Uniform Questionnaire current for no less than 60 days after the date it is signed by the employee. During that time, no small employer carrier may require an employee to fill out the Uniform Health Questionnaire again or to affirm that the information is current.

(e) In connection with the issuance of coverage, the small employer carrier may require a small employer to complete the carrier's unique application for coverage, but that application may not include any health status inquiry or question related to the health of an employee or dependent.

PART 17. ACTUARIAL OPINION AND MEMORANDUM REGULATION

365:10-5-177. Description of actuarial memorandum including an asset adequacy analysis

(a) **General.**

(1) In accordance with Section 4061 of the Oklahoma Insurance Code, the appointed actuary shall prepare a memorandum to the company describing the analysis done in support of his or her opinion regarding the reserves. The memorandum shall be made available for examination by the Commissioner upon his or her request but shall be returned to the company after such examination and shall not be considered a record of the Insurance Department or subject to automatic filing with the Commissioner.

(2) In preparing the memorandum, the appointed actuary may rely on, and include as a part of his or her own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of Rule 365:10-5-173(b) of this regulation, with respect to the areas covered in such memoranda, and so state in their memoranda.

(3) If the Commissioner requests a memorandum and no such memorandum exists or if the Commissioner finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board or the standards and requirements of this regulation, the Commissioner may designate a qualified actuary to review the opinion and prepare such supporting memorandum as is required for review. The reasonable and necessary expense of the independent review shall be paid by the company but shall be directed and controlled by the Commissioner.

(4) The reviewing actuary shall have the same status as an examiner for purposes of obtaining data from the company and the work papers and documentation of the reviewing actuary shall be retained by the Commissioner; provided, however, that any information provided by the company to the reviewing actuary and included in the work papers shall be considered as material provided by the company to the Commissioner and shall be kept confidential to the same extent as is prescribed by law with respect to other material provided by the company to the Commissioner pursuant to the statute governing this regulation. The reviewing actuary shall not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the insurer pursuant to this regulation for any one of the current year or the preceding three (3) years.

(5) In accordance with Section 4061 of the Oklahoma Insurance Code, the appointed actuary shall prepare a regulatory asset adequacy issues summary, the contents of which are specified in Subsection (c). The regulatory asset adequacy issues summary will be submitted to the company's domestic regulator no later than March 15 of the year following the year for which a statement of actuarial opinion based on asset adequacy is required. The regulatory asset adequacy issues summary is to be kept confidential to the same extent and under the same conditions as the actuarial memorandum.

(b) **Details of the memorandum documenting asset adequacy analysis.** When an actuarial opinion is provided, the memorandum shall demonstrate that the analysis has been done in accordance with the standards for asset adequacy referred to in Rule 365:10-5-173(d) of this regulation and any additional standards under this regulation. It shall specify:

(1) For reserves:

(A) Product descriptions including market description, underwriting and other aspects of a risk profile and the specific risks the appointed actuary deems significant;

(B) Source of liability in force;

(C) Reserve method and basis;

(D) Investment reserves;

(E) Reinsurance arrangements

(F) Identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis;

(G) Documentation of assumptions to test reserves for the following (The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.):

(i) Lapse rates (both base and excess);

(ii) Interest crediting rate strategy;

- (iii) Mortality;
 - (iv) Policyholder dividend strategy;
 - (v) Competitor or market interest rate;
 - (vi) Annuitization rates;
 - (vii) Commissions and expenses; and
 - (viii) Morbidity.
- (2) For assets:
 - (A) Portfolio descriptions, including a risk profile disclosing the quality, distribution and types of assets;
 - (B) Investment and disinvestment assumptions;
 - (C) Source of asset data;
 - (D) Asset valuation bases;
 - (E) Documentation of assumptions made for (The documentation of the assumptions shall be such that an actuary reviewing the actuarial memorandum could form a conclusion as to the reasonableness of the assumptions.):
 - (i) Default costs;
 - (ii) Bond call function;
 - (iii) Mortgage prepayment function;
 - (iv) Determining market value for assets sold due to disinvestment strategy; and
 - (v) Determining yield on assets acquired through the investment strategy.
- (3) Analysis basis:
 - (A) Methodology;
 - (B) Rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;
 - (C) Rationale for degree of rigor in analyzing different blocks of business (include in the rationale the level of "materiality" that was used in determining how rigorously to analyze different blocks of business);
 - (D) Criteria for determining asset adequacy (include in the criteria the precise basis for determining if assets are adequate to cover reserves under "moderately adverse conditions" or other conditions as specified in relevant actuarial standards of practice); and
 - (E) Effect of federal income taxes, reinsurance and other relevant factors.
- (4) Summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis;
- (5) Summary of results; and
- (6) Conclusions.
- (c) **Details of the regulatory asset adequacy issues summary.**
 - (1) The regulatory asset adequacy issues summary shall include:
 - (A) Descriptions of the scenarios tested (including whether those scenarios are stochastic or deterministic) and the sensitivity testing done relative to those scenarios. If negative ending surplus results under certain tests in the aggregate, the actuary should describe those tests and the amount of additional reserve as of the valuation date which, if held, would eliminate the negative aggregate surplus values. Ending surplus values shall be determined by either extending the projection period until the in force and associated assets and liabilities at the end of the projection period are immaterial or by adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in force.

- (B) The extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different than the assumptions used in the previous asset adequacy analysis;
 - (C) The amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion;
 - (D) Comments on any interim results that may be of significant concern to the appointed actuary. For example, the impact of the insufficiency of assets to support the payment of benefits and expenses and the establishment of statutory reserves during one or more interim periods;
 - (E) The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested; and
 - (F) Whether the actuary has been satisfied that all options whether explicit or embedded, in any asset or liability (including but not limited to those affecting cash flows embedded in fixed income securities) and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.
- (2) The regulatory asset adequacy issues summary shall contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and shall be signed and dated by the appointed actuary rendering the actuarial opinion.
- (d) **Conformity to standards of practice.** The memorandum shall include the statement: "Actuarial methods, considerations and analyses used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum."
- (e) **Use of assets supporting the interest maintenance reserve and the asset valuation reserve.**
- (1) An appropriate allocation of assets in the amount of the interest maintenance reserve (IMR), whether positive or negative, shall be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the asset valuation reserve (AVR); these AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.
 - (2) The amount of the assets used for the AVR shall be disclosed in the table of reserves and liabilities of the opinion and in the memorandum. The method used for selecting particular assets or allocated portions of assets shall be disclosed in the memorandum.
- (f) **Documentation.** The appointed actuary shall retain on file, for at least seven (7) years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the bases for assumptions and the results obtained.

SUBCHAPTER 29. EXTERNAL REVIEW REGULATIONS

365:10-29-1. Purpose

The purpose of this subchapter is to set forth rules regarding external review regulations as authorized by the Uniform Health Carrier External Review Act ("the Act"), 36 O.S. § 6475.1 et seq. The general purposes of the Act and this Subchapter are to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons

have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in the Act.

365:10-29-2. Applicability and scope

This Subchapter shall apply to all health carriers, except as excluded from the Act by 36 O.S. § 6475.4(B).

365:10-29-3. Definitions

For the purpose of this Subchapter, all terms shall have the meanings set forth in 36 O.S. § 6475.3.

365:10-29-4. Notice of right to an external review and external review procedures

A health carrier providing notification of the right of a covered person to request an external review pursuant to 36 O.S. § 6475.5(A) shall either provide the notice contained in Appendix PP or provide a notice no longer than two pages which includes substantially similar language in a font size no smaller than 10 point.

365:10-29-5. Authorization to disclose protected health information

A health carrier providing an authorization form to a covered person regarding the disclosure of protected health information pursuant to 36 O.S. § 6475.5(B)(3) shall either provide the form as set out in the Oklahoma State Department of Health Standard Authorization, ODH 206, which may be accessed at [http://www.ok.gov/health/Organization/HIPAA Privacy Rules/Oklahoma Standard Authorization on forms.html](http://www.ok.gov/health/Organization/HIPAA%20Privacy%20Rules/Oklahoma%20Standard%20Authorization%20on%20forms.html), or, in the alternative, a form that complies with 45 CFR § 164.508 and 43A O.S. § 1-109.

365:10-29-6. External review requests

A covered person or authorized representative requesting an external review pursuant to 36 O.S. § 6475.6 shall do so by submission of the External Review Request Form as set out in Appendix QQ.

365:10-29-7. Notice of initial determination

A notice of initial determination issued pursuant to Section 6475.8(C), 6475.9(B), 6475.10(A), or 6475.10(C) of Title 36 shall, in addition to providing notice of a right to appeal external review ineligibility to the Commissioner, provide that appeals shall be made in writing to the Oklahoma Insurance Department, Five Corporate Plaza, 3625 NW 56th Street, Suite 100, Oklahoma City, OK, 73112-4511.

365:10-29-8. Independent review organization application

An independent review organization seeking approval to conduct external reviews pursuant to 36 O.S. § 6475.12(D) shall submit the application in Appendix RR as instructed, including all materials required by the application. Approval by this application will be effective until December 31 of the calendar year following the year of receipt for all new applications, and for two years following the expiration of the current approval for all renewals.

365:10-29-9. Independent review organization recordkeeping and reporting requirements

Each independent review organization approved to conduct external reviews pursuant to 36 O.S. § 6475.12(D) shall maintain written records for the information required by 36 O.S. § 6475.15(A)(3) and Appendix SS, and shall submit Appendix SS within 31 calendar days of the end of each calendar year.

365:10-29-10. Health carrier recordkeeping and reporting requirements

Each health carrier subject to the Act shall maintain written records for the information required by 36 O.S. § 6475.15(B)(3) and Appendix TT, and each health carrier that has received at least one external review request during the calendar year shall submit Appendix TT within 31 calendar days of the end of each calendar year.

APPENDIX PP. NOTICE OF APPEAL RIGHTS [NEW]

NOTICE OF APPEAL RIGHTS

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment.

You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered.

Contact¹ us when you:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.¹

Appeals: All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to [INSERT ADDRESS OF WHERE APPEALS SHOULD BE SENT TO THE HEALTH CARRIER] within **180 days** of the date you receive our denial.² We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of information that we have that pertains to your claims. We will notify you of our decision in writing. Once our internal appeal process is exhausted (or waived by us), you may be entitled to file a request for external review.³

External Review³: We have denied your request for the provision of or payment for a health care service or course of treatment. You may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you request by submitting a request for external review within **4 months** after receipt of this notice to the Oklahoma Insurance Department, which can be contacted by mail at 3625 NW 56th Street, Oklahoma City, OK, 73112-4511, or by phone at 800-522-0071 or 405-521-2828. For standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may be entitled to file a request for external review of our denial. For details, please review your Benefit Plan Document, contact us or contact your state insurance department.¹

¹ See address and telephone number on the enclosed Explanation of Benefits if you have questions about this notice.

² Unless your plan or any applicable state law allows you additional time.

³ See your Benefit Plan Document for your state's appeal process and to determine if you're eligible to request an external review in your state (e.g. some state appeal processes require you to complete your insurer's appeal process before filing an external review request unless waived by your insurer; while some states do not have such a requirement).

APPENDIX QQ. EXTERNAL REVIEW REQUEST FORM [NEW]

This **EXTERNAL REVIEW REQUEST FORM** must be filed with the Oklahoma Insurance Department within **FOUR (4) MONTHS** after receipt from your insurer of a denial of payment on a claim or request for a health care service or treatment.

EXTERNAL REVIEW REQUEST FORM

APPLICANT NAME _____

Please Check One: Covered person/Patient Authorized Representative

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Covered Person Phone #: Home (_____) _____ Work (_____) _____

INSURANCE INFORMATION

Insurer/HMO Name: _____

Covered Person Insurance ID#: _____

Insurance Claim/Reference #: _____

Insurer/HMO Mailing Address: _____

City: _____ State: _____ Zip: _____

Insurer Telephone #: (_____) _____

EMPLOYER INFORMATION

Employer's Name: _____

Employer's Phone #: (____)_____

Is the insurance you have through your employer a self-funded plan? _____. If you are not certain please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Phone #: (____)_____

Medical Record #: _____

REASON FOR HEALTH CARRIER DENIAL (Please check one)*

The health care service or treatment is not medically necessary.

The health care service or treatment is experimental or investigational.

*You can describe in your own words the health care service or treatment in dispute using the attached pages below.

EXPEDITED REVIEW

If you need a fast decision, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function. Is this a request for an expedited appeal? Yes No

SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I, _____, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize by insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Oklahoma Insurance Department. I understand that the independent review organization and the Oklahoma Insurance Department will use this information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

Signature of Covered Person (or legal representative)*

Date

*(Parent, Guardian, Conservator or Other – Please Specify)

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

Signature of Covered Person (or legal representative)*
*(Parent, Guardian, Conservator or Other—Please Specify)

Date

Address of Authorized Representative: _____

City: _____ State: _____ Zip: _____

Phone #: Daytime (_____) _____ Evening (_____) _____

WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL FOUR (4) ITEMS BELOW ARE INCLUDED*)

1. **YES**, I have included this completed application form signed and dated.
2. **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;
3. **YES****, I have enclosed the letter from my health carrier or utilization review company that states:
 - (a) Their decision is final and that I have exhausted all internal review procedures;
 - or
 - (b) They have waived the requirement to exhaust all of the health carrier's internal review procedures.

**You may make a request for external review without exhausting all internal review procedures under certain circumstances. You should contact the Oklahoma Insurance Department for more information.

4. **YES**, I have included a copy of my certificate of coverage or my insurance policy benefit booklet, which lists the benefits under my health benefit plan.

*Call the Oklahoma Insurance Department at 800-522-0071 or 405-521-2828 if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

If you are requesting a standard external review, send all paperwork to:

Oklahoma Insurance Department
External Review
Five Corporate Plaza
3625 NW 56th Street, Suite 100
Oklahoma City, OK, 73112-4511

If you are requesting an expedited external review, call the Insurance Department at 800-522-0071 or 405-521-2828 before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

**CERTIFICATION OF TREATING HEALTH CARE PROVIDER
FOR EXPEDITED CONSIDERATION OF A PATIENT'S EXTERNAL REVIEW
APPEAL**

NOTE TO THE TREATING HEALTH CARE PROVIDER

Patients can request an external review when a health carrier has denied a health care service or course of treatment on the basis of a utilization review determination that the requested health care service or course of treatment does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. The Oklahoma Insurance Department oversees external appeals. The standard external review process can take up to 45 days from the date the patient's request for external review is received by our department. Expedited external review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited external review must be completed at most within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #: (_____) _____ Fax #: (_____) _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

Patient's Insurer Member ID#: _____

CERTIFICATION

I hereby certify that: I am a treating health care provider for _____

_____ (hereafter referred to as ‘the patient’); that adherence to the time frame for conducting a standard external review of the patient’s appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient’s ability to regain maximum function; and that, for this reason, the patient’s appeal of the denial by the patient’s health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

Treating Health Care Provider’s Name (Please Print)

Signature

Date

**PHYSICIAN CERTIFICATION
EXPERIMENTAL/INVESTIGATIONAL DENIALS
(To Be Completed by Treating Physician)**

I hereby certify that I am the treating physician for _____
(covered person's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements:

In my medical opinion as the Insured's treating physician, I hereby certify to the following: (Please check all that apply) (NOTE: Requirements #1 - #3 below must all apply for the covered person to qualify for an external review).

1) <input type="checkbox"/>	The covered person has a terminal medical condition, or a life threatening condition, or a seriously debilitating condition.
2) <input type="checkbox"/>	The covered person has a condition that qualifies under one or more of the following: [please indicate which description(s) apply]:
i. <input type="checkbox"/>	Standard health care services or treatments have not been effective in improving the covered person's condition;
ii. <input type="checkbox"/>	Standard health care services or treatments are not medically appropriate for the covered person; or
iii. <input type="checkbox"/>	There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.
3) <input type="checkbox"/>	The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.
4) <input type="checkbox"/>	The health care service or treatment I have recommended would significantly less effective if not promptly initiated. Explain: _____ _____
5) <input type="checkbox"/>	It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments. Explain: _____ _____

**APPENDIX RR. APPLICATION FOR REGISTRATION AS AN INDEPENDENT
REVIEW ORGANIZATION [NEW]**

Oklahoma Insurance Department
 Five Corporate Plaza
 3526 NW 56th Street, Suite 100
 Oklahoma City, OK 73112
 405-521-2828

Initial Application
 Renewal

Application for Registration as an Independent Review Organization

Type of Entity: Corporation Partnership LLC Other _____

Contact Information for Application

Legal Name of Applicant	State of Domicile	Federal EIN	
Contact Person (Name and Title)	Phone ()	Email	
Business Address (Do not use PO Box)	City	State	Zip
Mailing Address (if different from business address)	City	State	Zip

Contact Information for Initiating External Reviews (also to be made available to carriers and consumers)

Contact Person (Name and Title) or Department	Phone ()	Email	
Mailing Address	City	State	Zip
Website	Toll-Free Telephone Number	Fax ()	
Other Contact Information			

A

Applicant Attestation and Certification

Applicant certifies that it will notify the Oklahoma Insurance Department immediately if its accreditation is lost with the American Accreditation Healthcare Commission/URAC. Applicant acknowledges that the Oklahoma Insurance Department may terminate this license if the applicant loses accreditation or no longer satisfies the minimum requirements for licensure.

Applicant acknowledges that payment of any fees associated with any external reviews conducted pursuant to 36 O.S. § 6475.1 et seq. are the sole responsibility of the health carrier whose medical decision is being reviewed. Applicant understands that it has no recourse against the Oklahoma Insurance Department or the state of Oklahoma to the extent that any health carrier fails to pay any medical reviewer fees. Applicant authorizes the Oklahoma Insurance Department to verify information with any federal, state, or local government agency, insurance company or accrediting organization.

Applicant acknowledges and represents that it understands and will comply with Oklahoma's insurance laws and the rules of the Oklahoma Insurance Department. Applicant hereby represents that it will comply with all requirements imposed under 36 O.S. § 6475.1 et seq. and assures that no conflict of interest or improper controlling interest as outlined in the statute exists. Applicant further agrees to maintain and provide to the Oklahoma Insurance Department the information set out in 36 O.S. § 6475.15.

I certify that, under penalty of perjury, I am the person named herein and know the contents thereof, and that all of the information submitted in this application and its attachments is true and complete. I attest that I have the authority and capacity to execute this certification on behalf of the applicant. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license denial or revocation and may subject me to civil or criminal penalties.

Signature of person who completed application

Signature of Officer, Director, or Board Member

Printed Name

Printed Name

Title

Title

Date

Date

Please provide the following documents:

1. A copy of the most recent certificate from American Accreditation HealthCare Commission/URAC for Independent Review Organizations.
2. A schedule of fees.
3. A copy of the current Certificate of Authority provided by the Oklahoma Secretary of State.

Please submit this application and all required attachments to:

Oklahoma Insurance Department
External Review Program
Five Corporate Plaza
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112

**APPENDIX SS. INDEPENDENT REVIEW ORGANIZATION EXTERNAL REVIEW
ANNUAL REPORT FORM [NEW]**

Oklahoma Insurance Department

Independent Review Organization External Review Annual Report Form

External Review Annual Summary for 20__ _____		Due by January 31 for the previous calendar year.	
Each independent review organization (IRO) shall submit an annual report with information for each health carrier in the aggregate on external reviews performed in Oklahoma only.			
1. IRO name:		Filing date:	
2. IRO license/certification no:			
3. IRO address:			
City, State, Zip:			
4. IRO Website:			
5. Name of person completing this form:			
Email:	Phone:	Fax:	
6. Person responsible for regulatory compliance and quality of external reviews:			
Name:		Title:	
7. Total number of requests for external review received from the Oklahoma Insurance Department during the reporting period:			
8. Number of standard external reviews:			
9. Average number of days IRO required to reach a final decision in standard reviews:			
10. Number of expedited reviews completed to a final decision:			
11. Average number of days IRO required to reach a final decision in expedited reviews:			
12. Number of medical necessity reviews decided in favor of the health carrier:			
Briefly list procedures denied:			

13. Number of medical necessity reviews decided in favor of the covered person:		
Briefly list procedures approved:		
14. Number of experimental/investigational reviews decided in favor of the health carrier:		
Briefly list procedures denied:		
15. Number of experimental/investigational reviews decided in favor of the covered person:		
Briefly list procedures approved:		
16. Number of reviews terminated as the result of a reconsideration by the health carrier:		
17. Number of reviews terminated by the covered person:		
18. Number of reviews declined due to possible conflict with	health carrier:	
	covered person:	
	health care provider:	
Describe possible conflicts of interest:		
19. Number of reviews declined due to other reasons not reflected in #18 above:		
Briefly list these reasons:		

Please submit to:
Oklahoma Insurance Department
Five Corporate Plaza
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112-4511

**APPENDIX TT. HEALTH CARRIER EXTERNAL REVIEW ANNUAL REPORT
FORM [NEW]**

Oklahoma Insurance Department

Health Carrier External Review Annual Report Form

External Review Annual Summary for 20__ __		Due by January 31 for the previous calendar year.	
Each health carrier shall submit an annual report with information in the aggregate by State and by type of health benefit plan.			
1. Health carrier name:		Filing date:	
2. Health carrier address:			
City, State, Zip:			
3. Health carrier Website:			
4. Name of person completing this form:			
Email:	Phone:	Fax:	
5. Total number of external review requests received from the Oklahoma Insurance Department during the reporting period:			
6. From the total number of external review requests provided in Question 5, the number of requests determined eligible for a full external review:			

Please submit to:
 Oklahoma Insurance Department
 Five Corporate Plaza
 3625 NW 56th Street, Suite 100
 Oklahoma City, OK 73112-4511

**APPENDIX UU. POLICY HOLDER'S AUTHORIZATION TO RELEASE
INSURANCE POLICY INFORMATION TO AGENT OF RECORD [NEW]**

**POLICY HOLDER'S AUTHORIZATION TO RELEASE INSURANCE POLICY
INFORMATION TO AGENT OF RECORD**

Pursuant to 36 O.S. § 1435.41(A), an insurer shall provide to any insurance producer authorized to sell life insurance products, whose appointment has been terminated for any reason other than the reasons set forth in 36 O.S. § 1435.13 and who is still the agent of record or servicing agent and has not been replaced by another servicing agent upon termination, information relating to the policy of a person who purchased a product from such producer if the policy holder and the insured have signed the following form authorizing the release of the information.

Policy Holder's Full Name:

Policy Holder's Address:

Last four digits of Policy Holder's SSN:

Type of Insurance Policy:

Policy Number:

Name of Insurance Company:

Insurance Company Address:

AUTHORIZATION

I, (Policy Holder's name) _____, hereby authorize and request (Insurance Company Name) _____ to release information related to the aforementioned policy to the Producer of record in accordance with 36 O.S. §, 1435.41 (A):

Producer's Name: _____

Oklahoma License Number: _____

Address:

Disclosure shall be limited to the following specific types of information:

Use of this information shall be limited to the following purpose(s):

I understand that any cancellation or modifications of this authorization must be in writing, and that I have a right to receive a copy of this authorization. A photocopy of this authorization shall be as effective and valid as the original.

This authorization shall remain valid until: _____

I furthermore release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information.

Policy Holder Signature:

Date: _____

Insured's Signature (if Insured is not also the Policy Holder):

Date: _____

APPENDIX VV. Uniform Health Questionnaire [NEW]

UNIVERSAL HEALTH QUESTIONNAIRE	OKLAHOMA
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Individual Health Statement	Employer Plan Name
EMPLOYEE NAME:	

Enrollment, please circle one. If waiving coverage, please see next box. Employee Only Employee/Spouse Employee/Child(ren) Employee/Family	Waiving Medical (please check box) <input type="checkbox"/>	City, State, County and Zip Code of Residential Address:
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1. **Only the Individual(s) Requesting Coverage at this Time Should be Listed.** Check here if additional dependent children are listed on a separate attachment. (Be sure to include their sex, birthdate, height and weight.)

Employee	Sex	Social Security Number	Tobacco Use?	Birthdate	Height (ft., in.)	Weight (lbs.)
Spouse	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F			
Dependent Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F			
Dependent Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F			
Dependent Child	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F			

2. **Answer all questions:** Within the last **five** years has anyone applying for coverage consulted, received treatment, by a doctor, psychiatrist, psychologist, or other practioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.)

a. <input type="checkbox"/> AIDS or HIV b. <input type="checkbox"/> Diabetes c. <input type="checkbox"/> Infertility d. <input type="checkbox"/> Endocrine/Metabolic e. <input type="checkbox"/> Pancreas f. <input type="checkbox"/> Live/Hepatitis h. <input type="checkbox"/> Immune System h. <input type="checkbox"/> Blood Disorder i. <input type="checkbox"/> Epilepsy/Seizure j. <input type="checkbox"/> Heart	k. <input type="checkbox"/> Paralysis/Paresis l. <input type="checkbox"/> Tumor/Cyst/Growth m. <input type="checkbox"/> Systemic or Discoid Lupus n. <input type="checkbox"/> Lung or Respiratory o. <input type="checkbox"/> Alcohol or Drug Use p. <input type="checkbox"/> Kidney/Bladder/Urinary q. <input type="checkbox"/> Circulatory/Vascular r. <input type="checkbox"/> Digestive/Stomach/Intestina s. <input type="checkbox"/> Central Nervous System t. <input type="checkbox"/> Pituitary/Adrenal/Growth Disorder	u. <input type="checkbox"/> Birth Defects/Congenital Abnormalities v. <input type="checkbox"/> Arthritis/Bone/Joint/Muscle/Prostetic Device w. <input type="checkbox"/> Mental/Nervous/Emotional/Eating Disorder x. <input type="checkbox"/> Stroke/Brain/Neurological y. <input type="checkbox"/> Transplant <input type="checkbox"/> Recommended <input type="checkbox"/> Pending <input type="checkbox"/> Complete z. <input type="checkbox"/> Advised to have surgery or course of treatment not yet determined aa. <input type="checkbox"/> Cancer: Type: _____ Stage: _____ <input type="checkbox"/> Surgery <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation b. <input type="checkbox"/> Using: <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair cc. <input type="checkbox"/> Other _____ ..	<input type="checkbox"/> Yes <input type="checkbox"/> No
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3. Is any female currently pregnant? If so, provide due date _____ Check applicable boxes: <input type="checkbox"/> C Section Planned <input type="checkbox"/> Multiple Births Expected (# _____) <input type="checkbox"/> Complications: <input type="checkbox"/> Past or <input type="checkbox"/> Present	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has anyone applying for coverage incurred medical expenses in excess of \$5,000 in the past 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has anyone applying for coverage been prescribed medications in the past 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does anyone applying for coverage have a known condition that requires on-going treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Question Number	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Names of Prescription Medication	Dosage	Still Taking Medication
							<input type="checkbox"/> Yes <input type="checkbox"/> No

							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

Certification and Authorization: I acknowledge that I have read all sections of this Uniform Health Questionnaire (Questionnaire) and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge. I understand and agree that neither my employer nor any insurance producers have any authority to waive my complete answer to any question, agree to insurability, alter any contract, or waive any carrier's other rights or requirements.

I understand and agree that any information obtained in connection with this Questionnaire will be used by small employer carrier(s) to determine eligibility for coverage, underwriting and for any other purposes related to providing coverage. On behalf of my eligible family dependents and myself, I authorize any provider of health services or supplies, insurance company, health care clearinghouse, pharmacy benefit manager, and any other person with knowledge or records to release information to any small employer carrier, its agents and legal representatives, about any and all health-related services and supplies provided or to be provided to me or my eligible family dependents. I understand that I may request a copy of this Questionnaire. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document will become a part of the contract when coverage is approved and issued.

LAST 4 DIGITS OF SSN:

DATE:

You are NOT required to share this information with your employer. You may, at your discretion, return this completed questionnaire in a sealed envelope. Please write your name on the outside of the envelope for easy identification.