

ENGROSSED HOUSE
BILL NO. 2201

BY: COX, BRYANT, BOYD,
KINNAMON, ISAAC and
TYLER of the HOUSE

and

BROWN of the SENATE

(INSURANCE - COMPREHENSIVE HEALTH INSURANCE PLAN

ACT - CODIFICATION -

EFFECTIVE DATE)

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

SECTION 1. NEW LAW A new section of law to be codified
in the Oklahoma Statutes as Section 4451 of Title 36, unless there
is created a duplication in numbering, reads as follows:

This act shall constitute Article 44B of the
Insurance Code and shall be known and may be cited
as the "Comprehensive Health Insurance Pan Act".

SECTION 2. NEW LAW A new section of law to be
codified in the Oklahoma Statutes as Section 4452
of Title 36, unless there is created a duplication
in numbering, reads as follows:

The purpose of the Comprehensive Health Insurance Plan Act is to
provide access to health insurance coverage to all residents of
Oklahoma who are denied adequate health insurance and are considered
uninsurable.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4453 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Comprehensive Health Insurance Plan Act:

1. "Administering carrier" means the insurer or third-party administrator designated under Section 8 of this act;
2. "Benefits plan" means the coverage to be offered by the plan to eligible persons pursuant to the Comprehensive Health Insurance Plan Act;
3. "Board" means the board of directors of the plan;
4. "Commissioner" means the Commissioner of the Oklahoma Department of Insurance;
5. "Department" means the Oklahoma Department of Insurance;
6. "Eligible person" means a resident of this state who qualifies under Section 11 of this act, whether or not the person is legally responsible for the payment of medical expenses incurred on the person's behalf;
7. "Health care services" means any services or products included in the furnishing to any individual of medical care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing or healing human illness or injury;
8. "Health insurance" means any hospital and medical expense insured policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, short-term policy or contracts, as defined in the Oklahoma Statutes. The term does not include insurance arising out of the Workers' Compensation Act, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance;

9. "Health maintenance organization" means such organization as defined in Section 2503 of Title 63 of the Oklahoma Statutes;

10. "Hospital" means an institution as defined in Section 1-701 of Title 63 of the Oklahoma Statutes;

11. "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer or health plan;

12. "Insurer" means any insurance company authorized to transact health insurance business in this state or licensed pursuant to Section 2504 of Title 63 of the Oklahoma Statutes to provide comprehensive health maintenance services, including, but not limited to:

- a. multiple employer trusts,
- b. self-insured groups,
- c. third-party administrators,
- d. nonprofit hospital service and medical indemnity corporations, and
- e. health maintenance organizations;

13. "Medical assistance" means health care benefits provided under Oklahoma Medicaid laws;

14. "Medicare" means coverage under both Part A and Part B of Title XVIII of the Social Security Act, 42 U.S.C., Section 1395 et seq., as amended;

15. "Member" means any insurer participating in the plan;

16. "Plan" means the comprehensive health insurance plan established by this article;

17. "Plan of operation" means the framework for operation of the plan, including articles, bylaws, and operating rules, adopted by the board of directors of the plan;

18. "Resident" means a person who has resided in Oklahoma for at least six (6) months;

19. "Skilled nursing facility" means a facility as defined in and licensed under the Nursing Home Care Act; and

20. "Therapist" means a licensed physical, occupational, speech or respiratory therapist.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4454 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. There is hereby created a nonprofit entity to be known as the Oklahoma Comprehensive Health Insurance Plan.

B. The Commissioner shall hold an organizational meeting of the plan no later than October 1, 1992. The Commissioner shall give notice of the time and place of the organizational meeting to all potential plan members.

C. The plan shall operate subject to the supervision and control of the board of directors selected by the members of the plan. The initial board shall be composed of thirteen (13) board members. The Commissioner shall be a member of the plan and shall also serve as the chairman of the board or shall designate such chairman. The board shall at all times to the extent possible, include at least one representative of a domestic insurance company licensed to transact health insurance, one representative of a domestic nonprofit health care service plan, and one member of the general public who is not associated with the medical profession, a hospital or an insurer.

D. The members of the board shall be appointed for a term of two (2) years. If the members of the plan fail to make the initial appointments required by this subsection within sixty (60) days following the first organizational meeting, the Commissioner shall make those appointments. The Commissioner shall appoint a qualified person to fill a vacancy on the board for the balance of any unexpired term.

E. Members of the board may be reimbursed for actual and necessary expenses from the Comprehensive Health Insurance Plan subject to the limitations provided by the plan of operation

required by subsection F of this section and shall receive no other compensation, perquisite or allowance.

F. The board shall submit a plan of operation to the Commissioner and any amendments to it necessary or suitable to assure the fair, reasonable and equitable administration of the plan.

G. The Commissioner shall, after notice and hearing, approve the plan of operation, provided such is determined to assure the fair, reasonable and equitable administration of the plan. The plan of operation shall become effective upon approval in writing by the Commissioner consistent with the date on which coverage under the Comprehensive Health Insurance Plan Act is made available. If the board fails to submit a plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or any time thereafter fails to submit necessary amendments to the plan of operation, the Commissioner shall, after notice and hearing, adopt and promulgate such rules as are necessary or advisable to effectuate the provisions of the Comprehensive Health Insurance Plan Act. The rules of the Commissioner shall continue in force until modified by the Commissioner or superseded by a subsequent plan of operation submitted by the board and approved by the Commissioner.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4455 of Title 36, unless there is created a duplication in numbering, reads as follows:

The plan of operation submitted by the board to the Commissioner shall:

1. Establish procedures for the handling and accounting of assets and money of the plan;
2. Establish regular times and places for the meetings of the board of directors;
3. Establish reimbursement guidelines, limitations, and procedures for members of the board of directors;

4. Establish procedures for records to be kept of all financial transactions and for an annual fiscal report reporting to the Commissioner;

5. Select an administering carrier in accordance with Section 8 of this act;

6. Develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment in the plan and to maintain public awareness of the plan;

7. Establish procedures under which applicants and participants may have grievances reviewed by an impartial body and reported to the board; and

8. Contain additional provisions necessary and proper for the execution of the power and duties of the plan.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4456 of Title 36, unless there is created a duplication in numbering, reads as follows:

The plan shall have general powers and authority granted under the laws of this state to insurance companies licensed to transact health insurance and in addition thereto, the specific authority to:

1. Enter into contracts as are necessary or proper to carry out the provisions and purposes of the Comprehensive Health Insurance Plan Act, including the authority, with the approval of the Commissioner, to enter into contracts with similar plans of other states for the joint performance of common administrative functions;

2. Take such legal action as necessary to avoid the payment of improper claims against the plan or the coverage provided by or through the plan; no suits or legal action for punitive damages, or pain and suffering, or mental anguish will be allowed by the insured;

3. Establish appropriate rates, rate schedules, rate adjustments, expense allowances, claim reserve formulas and any other actuarial function appropriate to the operation of the plan;

4. Issue policies of insurance in accordance with the requirements of the Comprehensive Health Insurance Plan Act;

5. Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the plan, policy, and other contract design, and any other function within the authority of the plan; and

6. Establish rules, conditions and procedures for reinsuring risks.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4457 of Title 36, unless there is created a duplication in numbering, reads as follows:

The plan shall be subject to and responsible for examination by the Commissioner. Not later than April 15 of each year, the board shall submit to the Commissioner an audit financial report for the preceding calendar year in a form approved by the Commissioner.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4458 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The board shall select an administering carrier through a competitive bidding process to administer the plan. The board shall evaluate bids submitted based on criteria established by the board which shall include:

1. The proven ability of the applicant to handle accident and health insurance;

2. The efficiency of the applicant's claim paying procedures;

3. An estimate of charges for administering the plan; and

4. The applicant's ability to administer the plan in a cost efficient manner.

B. The administering carrier shall serve for a period of three (3) years subject to removal by the board for cause. At least one (1) year prior to the expiration of each three-year period of service by the administering carrier the board shall invite all

interested parties, including the current administering carrier, to submit bids to serve as the administering carrier for the succeeding three-year period. Selection of the administering carrier for the succeeding period shall be made at least six (6) months prior to the end of the current three-year period.

C. The administering carrier shall perform all eligibility and administrative claims payment functions relating to the plan including:

1. Establishment of a premium billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis as determined by the board, which shall not be more frequent than monthly billing; and

2. Performance of all necessary functions to assure timely payment of the benefits to covered persons under the plan including:

- a. making available information relating to the proper manner of submitting a claim for benefits to the plan and distributing forms upon which submission shall be made,
- b. evaluating the eligibility of each claim for payment by the plan, and
- c. notifying each claimant within sixty (60) days after receiving a properly completed and proof of loss whether the claim is accepted, rejected, or compromised.

D. The administering carrier shall submit regular reports to the board regarding the operation of the plan. The frequency, content, and form of the report shall be as determined by the board.

E. The administering carrier shall pay claims expenses from the premium payments received or on behalf of plan participants. If the administering carrier's payment for claims expenses exceed the portion of premiums allocated by the board for payment of claims

expenses, the board shall provide to the insurer additional funds for payment of claims expenses.

F. Following the close of each calendar year, the administering carrier shall determine net written and earned premiums, the expense of administration and the paid and incurred losses for the year and report this information to the board and the Commissioner on a form prescribed by the Commissioner.

G. The administering carrier shall be compensated as provided in the plan of operation for its expenses incurred in the performance of services.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4459 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Following the close of each calendar year, the administering carrier shall determine the net premium, being premiums less administrative expense allowances, the plan expenses and claim expenses losses for the year, taking into account investment income and other appropriate gains and losses.

B. Coverage pursuant to the plan shall commence within thirty (30) days after the Fund initially attains an amount in excess of Five Million Dollars (\$5,000,000.00).

C. If income exceeds actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board for investment purposes and to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4460 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. There is hereby created within the State Treasury the Comprehensive Health Care Fund. The Fund shall be administered by the administering carrier in accordance with the plan of operation.

B. The Fund shall consist of premiums collected for the benefit plan provided pursuant to the Comprehensive Health Insurance Plan Act, and any monies received by the plan in the form of gifts, grants, or from any other source intended to be used for the purposes specified in the Comprehensive Health Insurance Plan Act.

C. The Fund shall be excluded from budget and expenditure limitations. Reimbursements made to or for the benefit of eligible persons shall be exempt from the Central Purchasing Act.

D. 1. The monies deposited in the Fund shall at no time become monies of the state and shall not become part of the general budget of the Insurance Commissioner or any other state agency. Except as otherwise authorized by this subsection, no monies from the Fund shall be transferred for any purpose to any other state agency or any account of the Insurance Commissioner or be used for the purpose of contracting with any other state agency or reimbursing any other state agency for any expense.

2. Monies in the Fund shall only be expended for:

- a. reimbursements for the benefit of or to eligible persons,
- b. compensation of the administering carrier; and
- c. costs incurred by the administering carrier, the board of directors, or the Insurance Commissioner for the administration of the provisions of the Comprehensive Health Insurance Plan Act.

Any costs incurred by the plan or the Insurance Commissioner pursuant to the provisions of the Comprehensive Health Insurance Plan Act shall not exceed the actual expenditures made to implement the provisions of said act.

3. Payment of claims from the Fund shall not become or be construed to be an obligation of this state. No claims submitted for reimbursement from the Fund shall be paid with state monies.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4461 of Title 36, unless there is created a duplication in numbering, reads as follows:

There shall be no liability on the part of and no cause of action of any nature shall arise against members of the board, employees of the board, the Insurance Commissioner or employees of the Insurance Department, for any action or omission by them in the performance of their official powers and duties under the Health Insurance and Health Benefits Association Act. Such immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4462 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Any individual person, who has been a resident of the state for at least six (6) months and continues to be a resident of this state, shall be eligible for coverage if evidence is provided of:

1. Rejection or refusal of two carriers to issue substantially similar insurance for health reasons; and

2. A refusal of two carriers to issue substantially similar insurance except at a rate exceeding the plan rate by at least two hundred percent (200%) unless the board determines that the rates quoted by the two carriers are unfairly excessive or discriminatory.

B. The board shall promulgate a list of medical or health conditions for which a person shall be eligible for plan coverage without applying for health insurance pursuant to subsection A of this section. Persons who can demonstrate the existence or history of any medical or health conditions on the list promulgated by the board shall be eligible to apply directly to the plan for coverage. The list shall be effective on the first day of the operation of the plan and may be amended from time to time as may be appropriate.

C. A person shall not be eligible for coverage under the plan if:

1. The person is at the time of plan application eligible for health care benefits pursuant to any Medicaid state plan or Medicaid state program;

2. The person previously terminated plan coverage unless twelve (12) months have lapsed since such termination;

3. The plan has paid out Three Hundred Fifty Thousand Dollars (\$350,000.00) in benefits on behalf of the person;

4. The person is an inmate of a public institution or eligible for public programs;

5. A health care provider, a government sponsored program, or a government agency pays the premium for the person or reimburses the person for payment of the premium; or

6. The person is medically eligible for group insurance.

D. Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan providing the insured's immediate past premium exceeded two hundred percent (200%) of the plan rate.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4463 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The plan shall offer in an annually renewable policy major medical expense coverage to every eligible person. Major medical expense coverage offered by the plan shall pay an eligible person's covered expenses, subject to a limit on the deductible and coinsurance payments authorized by the Comprehensive Health Insurance Plan Act, up to a lifetime limit of Three Hundred Fifty Thousand Dollars (\$350,000.00) per covered individual. The maximum limit under this paragraph shall not be altered by the board, but an actuarially equivalent benefit may be substituted by the board.

B. Covered expenses shall be the reasonable and customary charge in the locality for the following services and articles when necessary and prescribed by a licensed health care provider practicing within the scope of his or her profession as authorized by state law. Such covered expenses shall at minimum include, but not be limited to, the following services or related items:

1. Hospital services, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, except that inpatient hospitalization for the treatment of mental and emotional disorders, or alcohol, drug, or chemical dependency or abuse shall be limited to a total of fifteen (15) inpatient days;

2. Professional services for the diagnosis or treatment of injuries, illnesses, or conditions other than mental or dental, which are rendered by a health care provider, or at the direction of a health care provider, by a staff of registered or licensed practical nurses, or other health care providers;

3. Outpatient professional visits for the diagnosis or treatment of one or more mental or nervous conditions or alcohol, drug, or chemical dependency or abuse, provided payment for such service shall be not more than at a maximum of Twenty Dollars (\$20.00) per visit, with a maximum of one visit per week, up to a maximum of seven (7) weeks during a calendar year, by one or more physicians, psychologists, or community mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners;

4. Manipulative therapy, provided the maximum reimbursement for such service shall be Twenty Dollars (\$20.00) per visit, with a maximum of one visit per week and a maximum of ten visits per year;

5. Drugs requiring a physician's prescription, during the thirty-day period following a three-day hospital stay, a maximum of One Thousand Dollars (\$1,000.00) per year;

6. Services of a licensed skilled nursing facility for not more than sixty (60) days during a policy year after a hospital stay of at least three (3) days and beginning not more than thirty (30) days after the hospital confinement;

7. Services of a home health agency up to a maximum of forty-five visits per year provided such visits begin after a hospital stay of at least three (3) days and begin not more than thirty (30) days after the hospital confinement;

8. Services of a licensed hospice for not more than sixty (60) days during a policy year provided such visits begin after a hospital stay of at least three (3) days and begin not more than thirty (30) days after the hospital confinement;

9. Use of radium or other radioactive materials;

10. Oxygen;

11. Anesthetics;

12. Prostheses, other than dental;

13. Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which it is prescribed;

14. Diagnostic x-rays and laboratory tests;

15. Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, in case of emergency, up to One Hundred Dollars (\$100.00); and

16. Processing of blood, including but not limited to collecting, testing, fractionating, and distributing cost of blood; blood is not covered.

C. The board shall design and employ cost-containment measures, managed care programs, and requirements such as, but not limited to, preadmission certification and concurrent inpatient review and large case management to make the plan more cost effective.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4464 of Title 36, unless there is created a duplication in numbering, reads as follows:

Covered expenses shall not include the following:

1. Services for which a charge is not made in the absence of insurance or which there is no legal obligation on the part of the patient to pay;

2. Services and charges made for the benefits provided under the laws of the United States, including but not limited to Medicare and Medicaid, military service connected disabilities, medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, and medical services financed on behalf of citizens by the United States;

3. Benefits which would duplicate the provision of services or payment of charges for any care for an injury, disease or condition for which either of the following applies:

- a. claims arising out of and in the course of employment subject to workers' compensation, and
 - b. benefits that are payable without regard to fault under a coverage required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance;
4. Care which is primarily for a custodial or domiciliary purpose;
 5. Services the provision of which are not within the scope of the license or certificate of the institution or individual rendering the services;
 6. That part of any charge for services or articles rendered or prescribed by a health care provider which exceeds the prevailing charge in the locality where the service is provided, or a charge for services or articles not medically necessary;
 7. Services rendered prior to the effective date of coverage under this plan for the person on whose behalf the expense is incurred;
 8. Routine physical examinations including examinations to determine the need for eyeglasses and hearing aids;
 9. Illness or injury due to an act of war;
 10. Service of a blood donor and any fee for failure to replace the first three pints of blood provided to an eligible person each calendar year;
 11. Personal supplies or services provided by a health care facility or any other nonmedical or nonprescribed supply or service;
 12. Experimental services or supplies. "Experimental" means a service or supply not recognized by the appropriate medical board as normal mode of treatment for the illness or injury involved;
 13. Eye surgery if corrective lenses would alleviate the problem;

14. Routine maternity charges for a pregnancy. Provided, complications of pregnancy expenses shall be covered as a sickness; and

15. Treatment of the teeth, surrounding tissue, gums and tooth sockets unless due to accidental injury of natural teeth or the treatment of malignant tumors.

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4465 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Premiums charged for plan coverage shall not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage.

B. Rates and rate schedules for premiums may be adjusted for appropriate risk factors such as age and area variation in claim cost and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices.

C. Separate schedules of premium rates based on sex, age and geographical location may apply for individual risks.

D. The plan shall determine the standard risk rate by calculating the average group or individual rate charged by the five largest insurers offering coverage in the state comparable to the plan coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for plan coverage shall not be more than one hundred fifty percent (150%) of rates established as applicable for individual or group standard risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this section. In no event shall plan rates exceed four hundred percent

(400%) of rates applicable to individual or group standard risks. All rates and rate schedules shall be submitted to the Commissioner for approval.

E. The plan coverage defined in subsection C of Section 13 of this act shall provide for a choice of inpatient and outpatient deductibles of Five Hundred Dollars (\$500.00) or One Thousand Dollars (\$1,000.00).

F. Subject to the limitations provided in subsection G of this section, a mandatory coinsurance requirement shall be imposed at the rate of twenty percent (20%) for inpatient hospital expenses, chemotherapy, kidney dialysis, and outpatient surgical procedures and fifty percent (50%) for outpatient expenses, other than outpatient surgical procedures, in excess of the mandatory deductible.

G. There shall be a maximum of three inpatient deductibles per family per year.

H. There shall be a maximum of three outpatient deductibles per family per year.

I. The maximum aggregate out-of-pocket payments for eligible expenses by the insured's coinsurance inpatient charges shall be paid at twenty percent (20%) until out-of-pocket expenses reach a maximum of Two Thousand Dollars (\$2,000.00) plus selected deductible.

J. Outpatient expenses, other than chemotherapy, kidney dialysis, and outpatient surgical procedures, shall be paid at fifty percent (50%) by the insured.

K. The maximum lifetime benefit per covered individual is Three Hundred Fifty Thousand Dollars (\$350,000.00).

SECTION 16. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4466 of Title 36, unless there is created a duplication in numbering, reads as follows:

Plan coverage shall exclude charges or expenses incurred during the first twelve (12) months following the effective date of coverage as to a condition if:

1. The condition has manifested itself within the six-month period immediately preceding the effective date of coverage in such a manner as would cause an ordinarily prudent person to need diagnosis, care or treatment; or

2. Medical advice, care or treatment was recommended or received for the condition within the six-month period immediately preceding the effective date of coverage.

SECTION 17. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4467 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An employer is authorized to make payroll deduction from the compensation of an employee for the portion of the plan policy premium that the employee is responsible for, and an employer shall contribute the same dollar amount of the cost of that policy on behalf of the employee that the employer contributes for other similar employees for health insurance.

B. An employer shall offer and make available to dependent family members of an employee covered by the plan the same group plan offered to other employees of the group. The employer shall charge a dependent family member a premium equal to that amount charged to other employees and shall contribute the difference between the amount the employer would pay for the employee under its group family coverage and the amount the employer has paid to the plan on behalf of the employee pursuant to subsection A of this section. In no event shall an employer be required to pay more for a family with the employee being a high risk than for a standard family in the employer's group plan.

SECTION 18. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4468 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except Medicaid.

B. The plan shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the plan may be reduced or refused as a set-off against any amount recoverable under this subsection.

SECTION 19. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4469 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A plan policy offered under the Comprehensive Health Insurance Plan Act shall contain provisions under which the plan is obligated to renew the contract until the first day on which the individual in whose name the contract is issued first becomes eligible for Medicare coverage, except that in a family policy covering both husband and wife, the remaining spouse shall become the named insured.

B. The plan shall not change the rates for plan policies except on a class basis with a clear disclosure in the policy of the right of the plan to do so.

C. A plan policy offered under the Comprehensive Health Insurance Plan Act shall provide any covered family member the right to continue the policy as the named insured or through a conversion

policy upon the death of the person in whose name the contract was issued or upon the divorce, annulment or dissolution of marriage or legal separation of the spouse from the person in whose name the contract was issued by election to do so within a period of time specified in the contract, provided the survivor is otherwise eligible.

SECTION 20. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4470 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Commissioner shall promulgate and adopt rules to implement the provisions of the Comprehensive Health Insurance Plan Act and promulgate and adopt any other rules deemed necessary in order to carry out the provisions of the Comprehensive Health Insurance Plan Act.

SECTION 21. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4471 of Title 36, unless there is created a duplication in numbering, reads as follows:

Commencing on September 1, 1992, the Oklahoma Insurance Department shall notify all licensed health insurance agents of the Comprehensive Health Insurance Plan Act benefits and rates.

SECTION 22. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4472 of Title 36, unless there is created a duplication in numbering, reads as follows:

Neither the participation in the plan as participating insurers, the establishment of rates, forms or procedures nor any other joint or collective action required by the Comprehensive Health Insurance Plan Act shall be the basis of any legal action, criminal or civil liability or penalty against the plan or any participating insurers.

SECTION 23. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4473 of Title 36, unless there is created a duplication in numbering, reads as follows:

The plan established pursuant to the Comprehensive Health Insurance Plan Act shall receive a one hundred percent (100%) credit against the tax imposed by Section 624 of Title 36 of the Oklahoma Statutes.

SECTION 24. This act shall become effective September 1, 1992.

Passed the House of Representatives the 9th day of March, 1992.

Speaker of the House of
Representatives

Passed the Senate the ____ day of _____, 1992.

President of the Senate