

STATE OF OKLAHOMA

2nd Session of the 44th Legislature (1994)

COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 2256

By: Thomas

COMMITTEE SUBSTITUTE

An Act relating to insurance; creating the "Accountable Health Company Act of 1994"; providing definitions; requiring certain entities to be licensed as an accountable health company; requiring certain plans to comply with act; requiring certain minimum percentages of group participation in plans; providing for certain exceptions by Insurance Commissioner; requiring Commissioner to develop certain plans; providing for certain benefits and features of plans; requiring Commissioner to complete plans by certain dates; providing for certain technical committee; prohibiting denial of coverage; providing exceptions to denial of coverage; allowing denial to persons outside service area; requiring guaranteed issue to a small employer; allowing refusal of coverage under certain conditions; prohibiting enrollment of certain groups under certain circumstances; requiring notice of terms of renewal; providing grounds for refusal to renew; allowing minimum enrollment requirements; providing grounds for termination or nonrenewal; prohibiting denial of coverage for certain preexisting conditions; providing exceptions; allowing certain waiting periods; providing credit for certain coverage; providing rating restrictions for premium rates; requiring use of standard formats; requiring minimum percentages of certain information to be submitted by electronic means; requiring fair marketing; prohibiting certain activities; allowing certain information to be distributed; prohibiting certain contracts with agents; requiring denial of coverage to be in writing; stating application of act to certain third party administrators; requiring certain services from network providers; providing for certain incentives to network providers; requiring companies to file quality assurance programs; stating information to be included in programs; requiring companies to provide certain incentives to use certain physicians; excluding certain policies from application of act; providing for certain review by the Commissioner; providing definitions; providing for coverage; establishing the Small Employer Reinsurance Program Board; stating membership and terms of Board; providing for travel reimbursement; requiring a plan of operation; providing for adoptions of plan by the Commissioner; stating content of the plan; providing for notification and application to operate as a certain carrier; prohibiting certain actions by a reinsuring carrier; allowing plans to apply to become certain carriers; stating factors for application; allowing Commissioner to rescind approval under certain conditions; requiring plans to file certain premiums; stating powers of program; allowing reinsuring carrier to reinsure with the program; requiring certain level of claims for reinsurance; requiring Board to

adjust level of claims; allowing termination of certain persons' reinsurance; allowing certain reduction in premium rates; requiring application of managed care techniques; allowing Board to establish premium rates; stating certain requirements for premium rates; requiring certain report; authorizing certain assessment by Commissioner; requiring development of certain standards by the Board; providing for application of act; providing for codification; and providing an 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 6520 of Title 36, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Accountable Health Company Act of 1994".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6521 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Accountable Health Company Act of 1994:

1. "Accountable health company" means any form of business organization which provides a health benefits plan for residents of this state and which meets the requirements of this act;

2. "Commissioner" means the Insurance Commissioner;

3. "Guaranteed health benefits plan" mean the plan that is adopted by the Insurance Commissioner in accordance with this section;

4. "Late enrollee" means an employee or dependent who requests enrollment in a guaranteed health benefits plan after the initial enrollment period that is provided under the terms of the guaranteed health benefits plan if the initial enrollment period is at least thirty-one (31) days. An employee or dependent shall not be considered a late enrollee if:

a. the person:

- (1) at the time of the initial enrollment period was covered under a public or private health insurance policy or any other health benefits plan,

- (2) lost coverage under a public or private health insurance policy or any other health benefits plan due to termination of employment or eligibility of the employee, the termination of the other plan's coverage, the death of the spouse or divorce, and
 - (3) requests enrollment within thirty-one (31) days after the termination of coverage that is provided under a public or private health insurance or other health benefits plan, or
- b. a court orders that coverage be provided for a spouse or minor child under a health benefits plan of a covered employee and the person requests enrollment within thirty-one (31) days after the court order is issued;

5. "Network provider" means a professional or institutional health care provider that is employed by or has a written contract with an accountable health company;

6. "Preexisting condition" means, with respect to coverage under a guaranteed health benefits plan issued by an accountable health company or other insurer, a condition that during the twelve-month period immediately preceding the first date of the coverage has been diagnosed or treated or for which an ordinarily prudent person would seek treatment; and

7. "Small employer" means an employer who employs at least two (2) but fewer than one hundred (100) eligible employees in the United States on a typical business day during any one calendar year.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6522 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Any entity which provides a health benefits plan in this state including a licensed insurance company, not-for-profit hospital service or medical indemnity corporation, a fraternal benefit society, a multiple employer welfare arrangement, a health maintenance organization, a prepaid health plan, or any other

entity providing a plan of health benefits shall be licensed as an accountable health company.

B. The appropriate state regulatory agency, upon demonstration that the requirements of this act have been met, may license the entity as an accountable health company.

C. Upon licensure by the appropriate state regulatory agency an accountable health company may sue and be sued and have such powers and exercise such other rights as are in accordance with law.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6523 of Title 36, unless there is created a duplication in numbering, reads as follows:

Beginning January 1, 1995, each group health benefits plan that is offered or issued by an accountable health company to a small employer shall meet the requirements of Sections 6 through 13 of this act.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6524 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An accountable health company shall ensure that at least the following specified percentages of individuals who are covered by group health benefits plans of the company are covered by group health benefit plans that meet the requirements of Sections 14 and 15 of this act:

1. In 1996, twenty percent (20%);
2. In 1997, forty percent (40%);
3. In 1998, seventy percent (70%); and
4. In 1999 and thereafter, one hundred percent (100%).

B. An accountable health company shall ensure that at least the following specified percentages of individuals who are covered by the health benefits plans of the company are covered by health benefits plans that meet the requirements of Section 16 of this act:

1. In 1996, ten percent (10%);
2. In 1997, twenty percent (20%);
3. In 1998, forty percent (40%); and

4. In 1999 and thereafter, fifty percent (50%).

C. Compliance with subsections A and B of this section shall be determined for each calendar year on the basis of the average number of individuals who are covered by health benefits plans of the accountable health company during that year.

D. The Insurance Commissioner may grant exceptions or make adjustments to the requirements established in subsection A of this section for health benefits plans that are offered in areas in which the development of a sufficient number of accountable health companies that comply with the provisions of this act is unlikely to result in a competitive market within the applicable period.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6525 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner shall develop the guaranteed health benefits plan including form and level of coverage to be made available pursuant to other provisions of this act.

B. The Insurance Commissioner shall determine benefit levels, cost sharing levels, exclusions and limitations for the guaranteed health benefits plan. The Commissioner shall determine whether the plan should be exempt from any statutory provisions otherwise applicable to group health insurance policies; provided however, the guaranteed health benefits plan shall not, in any event, be exempt from the provisions of Sections 6054 through 6057 of this title.

1. The plans established by the Commissioner shall include cost containment features such as:

- a. utilization review of health care services, including review of medical necessity of hospital and physician services,
- b. case management,
- c. contracting with hospitals, physicians and other health care providers and pharmacists; provided, however, the terms and conditions of such a contract shall not discriminate against or among the classes

of practitioners specified in Section 6054 of this title. Any practitioner or pharmacist willing to meet the terms and conditions of a standard provider contract, and willing to sign the contract, shall not be excluded from participating as a network provider in the guaranteed health benefit plan, and

d. reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions;

2. The Commissioner shall complete the health benefits plans described in this section no later than October 1, 1994. An accountable health company must offer the guaranteed health benefits plan promulgated by the Commissioner, no later than January 1, 1995.

C. The Insurance Commissioner shall appoint an advisory committee of up to fourteen (14) members to provide advice on the development of the guaranteed health benefits plan. The committee shall, at all times, include at least one (1) physician from each of the six (6) classes of physicians listed in Section 725.2 of Title 59 of the Oklahoma Statutes. Other members appointed to the committee shall represent pharmacists, insurance carriers, health maintenance organizations, prepaid health plans, hospital service and medical indemnity corporations, an insurance consumer, and at least one representative of a small employer as defined by this act.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6526 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as otherwise provided, an accountable health company may not exclude from coverage any employee or a spouse or a dependent child of an employee of a covered group.

B. Subsection A of this section does not apply to a period in which an employee is excluded from coverage under the guaranteed health benefits plan pursuant to an employer requirement that imposes a minimum period of service before the employee is eligible for coverage.

C. An accountable health company may deny enrollment to employees or family members of an employer if the employees or family members are located outside of the service area of the accountable health company and if the denial is applied uniformly without regard to health status or insurability.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6527 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as provided in subsection B of this section, an accountable health company shall offer a guaranteed health benefits plan to a small employer without regard to health status or claims experience.

b. On approval of the appropriate state regulatory agency, an accountable health company may refuse to enroll a new employer group in a health benefits plan or in a geographic area served by the plan if the accountable health company demonstrates that its financial or administrative capacity to serve previously enrolled groups and individuals would be impaired. An accountable health company that refuses to enroll a new group may not enroll a group of the same or larger size until the later of:

1. The date on which the appropriate state regulatory agency determines that the accountable health company has the capacity to enroll the new group;

2. The date of which the accountable health company enrolls the new group; or

3. One hundred eighty (180) days after the date on which the appropriate state regulatory agency granted the accountable health company the authority to refuse to enroll the new group.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6528 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. At least thirty (30) days before the date of expiration of a health benefits plan, an accountable health company that provides a health benefits plan to a small employer shall provide for notice of the terms for renewal of the plan. The notice shall include an explanation of the extent to which any increase in

premiums is due to actual or expected claims experience of the individuals covered under the small employer's health benefits plan contract.

B. An accountable health company may refuse to review or may terminate a small group health benefits plan only for:

1. Nonpayment of premiums;
2. Fraud or misrepresentation;
3. Failure to maintain minimum participating rates;
4. Repeated misuse of a provider network provision;
5. Relocation of the covered individual or group to a place

outside the geographic service area of the accountable health company.

C. An accountable health company may require that a minimum percentage of employees who are not covered under a spouse's or parent's employer's health benefits plan be enrolled in a plan if the percentage is applied uniformly to all plans that are offered to employers of comparable size.

D. An accountable health company is not required to renew a health benefits plan with respect to an employer or individual if the accountable health company:

1. Elects not to renew all of its health benefits plans that are issued to employers or individuals in this state; or
2. Provides notice of termination to the appropriate regulatory agency and to each employer or individual covered under a plan at least ninety (90) days before the expiration date of the plan. If the accountable health company terminates coverage, the accountable health company may not issue a health benefits plan to an employer in this state during the five-year period beginning on the termination date of the last plan that was not renewed.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6529 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as provided in subsection B of this section, a health benefits plan may not deny, limit or condition the coverage or benefits based on a person's health status, claims experience,

receipt of health care or medical history or a lack of evidence of insurability.

B. A health benefits plan may not exclude coverage for preexisting conditions, except that:

1. A health benefits plan may exclude coverage for preexisting conditions for a period of not more than twelve (12) months. the exclusion of coverage does not apply to services that are furnished to newborns who are otherwise covered from the time of their birth.

2. Credit of one month shall be given for each month of continuous coverage that the individual was covered under another health benefits plan issued by an accountable health company if under the previous coverage the individual was continuously covered. For the purposes of this paragraph, "continuously covered" means, with respect to particular services, the period beginning on the date an individual is enrolled under a health benefits plan and ending on the date the individual is no longer enrolled for a continuous period of more than sixty (60) days.

3. A late enrollee may be excluded from coverage for up to eighteen (18) months with respect to services related to the treatment of a preexisting condition.

C. On request of an accountable health company, a person who provides coverage during a period of continuous coverage with respect to a covered individual shall promptly disclose the coverage provided to the covered individual, the period of the coverage and the benefits provided under the coverage.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6530 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Premium rates for health benefits plans subject to this act including the guaranteed health benefits plan are governed by the rating restrictions contained in Sections 6511 through 6518 of Title 36 of the Oklahoma Statutes.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6531 of Title 36,

unless there is created a duplication in numbering, reads as follows:

A. An accountable health company shall use standard formats for billing information, claims receipt, data collection and electronic data interchange as specified by the United States Secretary of Health and Human Services.

B. An accountable health company shall ensure that it receives at least the following specified percentages of all claims via electronic media:

1. By December 31, 1996, ten percent (10%);
2. By December 31, 1997, twenty percent (20%);
3. By December 31, 1998, thirty percent (30%);
4. By December 31, 1999, forty percent (40%);
5. By December 31, 2000, and thereafter, fifty percent (50%).

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6532 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An accountable health company shall fairly market health benefits plan coverage, including the basic benefit plan, to eligible small employers in the state.

B. No accountable health company or its agent shall, directly or indirectly, engage in the following activities:

1. Discourage an employer from filing an application for a health benefits plan because of the health status, claims experience, industry, occupation or geographic location of the employer;

2. Encourage or direct an employer to seek a health benefits plan from another insurer because of the health status, claims experience, industry, occupation or geographic location of the employer.

C. This section does not prohibit an accountable health company from providing information regarding the geographic service area of the accountable health company.

D. Except as provided in subsection C of this section, no accountable health company shall directly or indirectly enter into

any contract, agreement, or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefits plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of a small employer. If an agent is compensated on the basis of a percentage of premium, that percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic location of a small employer.

E. An accountable health company shall provide reasonable compensation to an agent, if any, for the sale of a basic benefit plan to a small employer.

F. No accountable health company may terminate, fail to renew, or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, industry, occupation, or geographic location of small employers whose coverage is placed by the agent with the accountable health company.

G. No accountable health company or agent may induce or in any way encourage a small employer to exclude an employee from health coverage or benefits provided in connection with employment.

H. Any denial by an accountable health company of a small employer's application for coverage shall be in writing and shall state the reason or reasons for denial.

I. If an accountable health company enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services related to the offering of health benefits plans to small employers, the third-party administrator shall be subject to this act as if it were an accountable health company.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6533 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Health care services that are covered by a health benefits plan shall be available from network providers including:

1. Inpatient and outpatient hospital services;
2. Physician services;
3. Diagnostic services; and
4. Preventive care, including prenatal and well-baby care.

B. An accountable health company shall require or create substantial financial incentives for enrollees in health benefits plans to use the services of network providers.

C. An accountable health company shall employ financial or other incentives that encourage its network providers to provide quality care, to provide quality service and to control total costs.

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6534 of Title 36, unless there is created a duplication in numbering, reads as follows:

An accountable health company shall file a quality assurance program with the appropriate state regulatory agency that includes:

1. Procedures and criteria for determining whether network providers have appropriate credentials;
2. Procedures and criteria for monitoring and analyzing the quality of services furnished by the network providers of an accountable health company;
3. The use, if appropriate, of providers designated as centers of excellence;
4. Procedures for monitoring the satisfaction of enrolled individuals for soliciting and disposing of grievances; and
5. Procedures and criteria for taking appropriate action against network providers that do not provide quality care.

SECTION 16. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6535 of Title 36, unless there is created a duplication in numbering, reads as follows:

An accountable health company shall require or provide substantial financial incentives to each individual covered by a health benefits plan to have all services covered by the plan coordinated by a physician or group of physicians, including but not necessarily limited to primary care physicians.

SECTION 17. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6536 of Title 36, unless there is created a duplication in numbering, reads as follows:

The provisions of this act shall not apply to any policy that is issued on an individual basis or that is accident-only, credit, dental, vision, medicare supplement, long term care, specified disease, hospital indemnity, disability income insurance, or automobile medical payment insurance.

SECTION 18. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6537 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner shall contract to perform a periodic review of the effectiveness of various types of health benefits plans.

B. The Commissioner shall make available the findings from the review under this section.

SECTION 19. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6538 of Title 36, unless there is created a duplication in numbering, reads as follows:

In Sections 19 through 30 of this act, unless the context otherwise requires:

1. "Board" means the Small Employer Reinsurance Program Board;

2. "Geographic service area" means a geographic area, as approved by the director and based on the accountable health plan's certificate of authority to transact insurance in this state, within which the accountable health plan is authorized to provide coverage;

3. "Plan of operation" means the plan of operation of the Small Employer Reinsurance Program;

4. "Program" means the Small Employer Reinsurance Program;

5. "Reinsuring carrier" means an accountable health company that participates in the Small Employer Reinsurance Program.

SECTION 20. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6539 of Title 36, unless there is created a duplication in numbering, reads as follows:

A reinsuring carrier is subject to the provisions of Sections 19 through 30 of this act.

SECTION 21. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6540 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Small Employer Reinsurance Program Board is established in the Insurance Department consisting of the Commissioner or the designee of the Commissioner and eight (8) members who are appointed by the Commissioner and who shall serve terms of six (6) years. In appointing members to the Board, the Commissioner shall include representatives of small employers, reinsuring carriers and other persons determined to be qualified by the Commissioner. At least five members of the Board shall be representatives of reinsuring carriers and shall be selected from persons who are nominated in this state pursuant to procedures and guidelines that are developed by the Commissioner.

B. The Commissioner shall fill any vacancy on the Board. The Commissioner may remove a board member for cause.

C. Members of the board are not eligible to receive compensation, but appointed members are eligible for reimbursement of expenses pursuant to the State Travel Reimbursement Act, Section 500.1 et seq. of Title 74 of the Oklahoma Statutes.

D. Within one hundred eighty (180) days after the appointment of the initial Board, the Board shall submit to the Commissioner a plan of operation. Thereafter, the Board may submit to the Commissioner any amendments to the plan that are necessary or

suitable for the fair, reasonable and equitable administration of the Program. After notice and hearing, the Commissioner may approve the plan if the Commissioner finds that the plan would assure the fair, reasonable and equitable administration of the Program and would provide for the sharing of Program gains or losses on an equitable and proportionate basis in accordance with the provisions of Sections 26 through 37 of this act. The plan of operation becomes effective on the written approval of the Commissioner.

E. If the Board fails to submit a suitable plan within one hundred eighty (180) days after the initial appointment of the Board, after notice and hearing the Commissioner shall adopt a temporary plan of operation. The Commissioner shall amend or rescind any plan adopted under this subsection at the time a plan is submitted by the Board and approved by the Commissioner.

SECTION 22. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6541 of Title 36, unless there is created a duplication in numbering, reads as follows:

The plan of operation shall:

1. Establish procedures for the handling and accounting of Program assets and monies and for an annual fiscal reporting to the Commissioner;

2. Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

3. Establish procedures for reinsuring risks in accordance with Sections 19 through 30 of this act;

4. Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the Program;

5. Establish a method for applying the dollar thresholds contained in Sections 19 through 30 of this act in the case of reinsuring carriers that pay or reimburse health care providers through capitation or salary; and

6. Provide for any other matters that are necessary for the implementation of administration of the Program.

SECTION 23. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6542 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Within thirty (30) days after the plan of operation is approved by the Commissioner pursuant to Section 21 of this act, or the guaranteed health benefits plan is approved by the Commissioner pursuant to Section 6 of this act, whichever occurs later, each accountable health company shall notify the Commissioner of its intention to operate as a risk assuming carrier or reinsuring carrier. An accountable health company that seeks to operate as a risk assuming carrier shall file an application pursuant to Section 24 of this act. The Commissioner shall establish an application process for accountable health plans that seek to change their status under this section. The accountable health company's decision to operate as a risk assuming carrier or reinsuring carrier is binding for a five-year period, except that the Commissioner may permit the accountable health company to modify its decision at any time for good cause shown. If an accountable health company has been acquired by another carrier, the Commissioner may waive or modify the five-year time period.

B. A reinsuring carrier that applies and is approved to operate as a risk assuming carrier shall not continue to reinsure any health benefits plan with the Program. That carrier shall pay a prorated assessment based on business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

C. Participation in the Program as a reinsuring carrier, the establishment of rates, forms or procedures or any other joint or collective action required by Sections 19 through 30 of this act shall not be the basis of any legal action or civil or criminal penalty imposed against the Program or any of its reinsuring carriers.

SECTION 24. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6543 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An accountable health company may file in a form and manner prescribed by the Commissioner an application to become a risk assuming carrier.

B. The Commissioner shall consider the following factors in evaluating an application filed pursuant to subsection A of this section:

1. The carrier's financial condition;
2. The carrier's history of rating and underwriting small groups;
3. The carrier's commitment to market fairly to all small employers in this state or its established geographic service area; and
4. The carrier's experience with managing the risk of small employer groups.

C. The Commissioner shall give public notice that an accountable health company has applied to be a risk assuming carrier and shall provide at least a sixty-day period for public comment before making a decision on the application. If the application is not acted on within ninety (90) days after the Commissioner receives the application, the carrier may request a hearing.

D. The Commissioner may rescind the approval granted to a risk assuming carrier under this section if the Commissioner finds that:

1. The carrier's financial condition no longer supports the assumption of risk;
2. The carrier fails to market fairly to all small employers in this state or its established geographic service area; or
3. The carrier fails to provide coverage to eligible small employers.

E. An accountable health company that elect to become a risk assuming carrier is not subject to Sections 19 through 30 of this act.

SECTION 25. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6544 of Title 36, unless there is created a duplication in numbering, reads as follows:

Within sixty (60) days after the effective date of this act, each accountable health company shall file with the Commissioner the net health insurance premium that is derived from health benefits plans that are delivered or issued for delivery to small employers in this state in the previous calendar quarter.

SECTION 26. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6545 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Small Employer Reinsurance Program shall have the same powers and authority that are granted under the laws of this state to insurance companies and health care services organizations licensed to transact business in this state, except that the Program shall not have the power to issue health benefits plans directly to groups or individuals.

B. The Program may:

1. Enter into contracts to carry out the provisions of this article. With the approval of the Commissioner, the Program may enter into contracts with similar programs in other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

2. Sue and be sued and may take legal action to recover any assessments and penalties for, on behalf of or against the Program or a reinsuring carrier;

3. Take legal action to avoid the payment of improper claims against the Program;

4. Define the health benefits plans for which reinsurance will be provided and issue reinsurance policies;

5. Establish rules, conditions and procedures for reinsuring risks under the Program;

6. Establish actual functions as appropriate for the operation of the Program;

7. Assess reinsuring carriers pursuant to Section 36 of this act and make advance interim assessments. Any interim assessments made shall be credited as offset against any regular assessment due following the close of the fiscal year;

8. Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the Program; and

9. Borrow money to effect the purposes of the Program. Any notes or other evidences of indebtedness of the Program that are not in default are legal investments for carriers and may be carried as admitted assets.

SECTION 27. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6546 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A reinsuring carrier may reinsure with the Small Employer Reinsurance Program as follows:

1. With respect to a basic health benefits plan, the Program shall reinsure the level of coverage that is provided. With respect to other plans, the Program shall reinsure up to the level of coverage that is provided in a basic health benefits plan.

2. An accountable health company may reinsure an entire employer group within sixty (60) days after the commencement of the group's coverage under a health benefits plan.

3. A reinsuring carrier may reinsure an eligible employee or dependent within sixty (60) days after the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty (60) days after the commencement of coverage.

B. The Program shall not reinsure a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for the

employee or dependent of Twenty-five Thousand Dollars (\$25,000.00) in one calendar year for benefits covered by the Program. The reinsuring carrier is responsible for ten percent (10%) of the next Twenty-five Thousand Dollars (\$25,000.00) of benefit payments during a calendar year, and the Program shall reinsure the remainder. The liability of a reinsuring carrier under this subsection shall not exceed Twenty-seven Thousand Five Hundred Dollars (\$27,500.00) in any calendar year with respect to any reinsured individual.

C. The Board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefits plans in this state. The adjustment shall not be more than the annual change in the medical component of the consumer price index for all urban consumers of the United States Department of Labor, Bureau of Labor Statistics, unless the Board proposes and the Commissioner approves a lower adjustment factor.

D. An accountable health company may terminate reinsurance with the Program for one or more of the reinsured employees or dependents of a small employer on the anniversary date of the guaranteed health benefits plan.

E. Premium rates that are charged for reinsurance by the program to a health care service organization that is federally qualified under 42 U.S.C., Section 300(c)(2)(A) and that is subject to requirements that limit the amount of risk that may be ceded to the Program and that are more restrictive than those specified in subsection B of this section shall be reduced to reflect that portion of the risk above the amount that is set forth in subsection B of this section and that may not be ceded to the Program, if any.

F. A reinsuring carrier shall apply all managed care and claims handling techniques consistently with respect to reinsured and nonreinsured business, including utilization review, individual case management, preferred provider provisions and other managed care provisions or methods of operation.

SECTION 28. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6547 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As part of the plan of operation, the Board shall establish a method for determining premium rates to be charged by the Program for reinsuring small employers and individuals. The method shall include a system for the classification of small employers which reflect the types of case characteristics commonly used by accountable health companies in this state and shall provide for the development of base reinsurance premium rates that shall be multiplied by the factors set forth in subsection B of this section to determine the premium rates for the Program. Subject to the approval of the Commissioner, the Board shall establish premium rates. The premium rates shall be set at levels that reasonably approximate gross premiums that are charged to small employers by accountable health companies for health benefits plans with benefits similar to the guaranteed health benefits plan, adjusted to reflect retention levels that are required under this chapter.

B. Premium rates for the Program shall be as follows:

1. An entire small employer group may be reinsured for a rate that is one and one-half (1 1/2) times the base reinsurance premium rate for the group established pursuant to this section.

2. An eligible employee or dependent may be reinsured for a rate that is five (5) times the base reinsurance premium rate for the individual established pursuant to this section.

C. The Board shall periodically review the method established under subsection A of this section to assure that it reasonably reflects the claims experience of the Program. The Board may propose changes to the method that are subject to the approval of the Commissioner.

D. The Board may consider adjustments to the premium rates charged by the Program to reflect the use of effective cost containment and managed care arrangements.

SECTION 29. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6548 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Before March 1 of each year, the Board shall determine and report to the Commissioner the net loss of the Program for the previous calendar year, including administrative expenses and incurred losses for the year taking into account investment income and other appropriate gains and losses. Any net loss for the year shall be recouped by assessments of reinsuring carries.

B. The Commissioner shall assess all insurers, hospital and medical service corporations, health care services organizations and other entities that participate in the reinsurance mechanism for the losses of the Small Employer Reinsurance Program including any administrative or other expenses that are incurred by the Department in administering the Program. The Commissioner may employ and contract with persons who are necessary to administer this article and shall pay these persons from the assessments.

SECTION 30. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6549 of Title 36, unless there is created a duplication in numbering, reads as follows:

The provisions of this act apply to health benefits plans that are offered, issued or renewed from and after July 1, 1995.

SECTION 31. This act shall become effective January 1, 1995.

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