ENGROSSED SENATE
BILL NO. 819

By: Fisher of the Senate

and

Cox of the House

[health insurance - modifying Small Employer Health Insurance Reform Act - effective date - emergency]

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

SECTION 1. AMENDATORY Section 1, Chapter 329, O.S.L. 1992 (36 O.S. Supp. 1993, Section 6511), is amended to read as follows:

Section 6511. ~~This act~~ Sections 6511 through 6518 and Sections 5 through 15 of this act shall be known and may be cited as the "Small Employer Health Insurance Reform Act".

SECTION 2. AMENDATORY Section 2, Chapter 329, O.S.L. 1992 (36 O.S. Supp. 1993, Section 6512), is amended to read as follows:

Section 6512. As used in ~~this act~~ the Small Employer Health Insurance Reform Act:

1. "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Insurance Commissioner that a small employer carrier is in compliance with the provisions of Section ~~5~~ 6515 of this ~~act~~ title, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions

and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans;

2. "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person;

3. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

~~3.~~ 4. "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to Section 10 of this act;

5. "Board" means the board of directors of the program established pursuant to Section 8 of this act;

6. "Carrier" means any entity which provides health insurance in this state. For the purposes of ~~this act~~ the Small Employer Health Insurance Reform Act, carrier includes a licensed insurance company, not-for-profit hospital service or medical indemnity corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

~~4.~~ 7. "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of ~~this act~~ the Small Employer Health Insurance Reform Act. A small employer carrier shall not use case characteristics, other

than age, gender, industry, geographic area, family composition and group size, without prior approval of the Insurance Commissioner;

~~5.~~ 8. "Class of business" means all or a separate grouping of small employers established pursuant to Section ~~4~~ 6514 of ~~this act~~ the Small Employer Health Insurance Reform Act;

~~6.~~ 9. "Commissioner" means the Insurance Commissioner;

~~7.~~ 10. "Committee" means the Health Benefit Plan Committee created pursuant to Section 10 of this act;

11. "Control" (including the terms "controlling", "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact in the manner provided in Section 1654 of this title. The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect;

12. "Department" means the Insurance Department;

~~8.~~ 13. "Dependent" means a spouse, an unmarried child under the age of eighteen (18), an unmarried child who is a full-time student under the age of twenty-three (23) and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent;

14. "Eligible employee" means an employee who works on a full-time basis and has a normal work week of twenty-four (24) or more

hours. The term includes a sole proprietor, a partner of a partnership, and associates of a limited liability company, if the sole proprietor, partner or associate is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis;

~~9.~~ 15. "Established geographic service area" means a geographic area, as approved by the Commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage;

~~10.~~ 16. a. "Health benefit plan" means any hospital or medical policy or certificate~~,~~; contract of insurance provided by a not-for-profit hospital service or medical indemnity plan; or prepaid health plan or health maintenance organization subscriber contract.

b. Health benefit plan does not include accident-only, credit, dental, vision, Medicare supplement, long-term care, ~~specified disease, hospital indemnity,~~ or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, any plan certified by the Oklahoma Basic Health Benefits Board, or automobile medical payment insurance.

c. "Health benefit plan" shall not include policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance, provided that the carrier offering such policies or certificates complies with the following:

(1) the carrier files on or before March 1 of each year a certification with the Commissioner that

contains the statement and information described in division (2) of this subparagraph,

(2) the certification required in division (1) of this subparagraph shall contain the following:

(a) a statement from the carrier certifying that policies or certificates described in this subparagraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance, and

(b) a summary description of each policy or certificate described in this subparagraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age, gender or other factors) charged for such policies and certificates in this state, and

(3) in the case of a policy or certificate that is described in this subparagraph and that is offered for the first time in this state on or after the effective date of this act, the carrier files with the Commissioner the information and statement required in division (2) of this subparagraph at least thirty (30) days prior to the date such a policy or certificate is issued or delivered in this state;

~~11.~~ 17. "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

~~12.~~ 18. "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty-one (31) days. However, an eligible employee or dependent shall not be considered a late enrollee if:

a. the individual meets each of the following:

(1) the individual was covered under qualifying previous coverage at the time of the initial enrollment,

(2) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse or divorce, and

(3) the individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage,

b. the individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period, or

c. a court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order;

19. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case

characteristics for newly issued health benefit plans with the same or similar coverage;

~~13.~~ 20. "Plan of operation" means the plan of operation of the program established pursuant to Section 8 of this act;

21. "Premium" means all monies paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan;

~~14.~~ 22. "Program" means the Oklahoma Small Employer Health Reinsurance Program created pursuant to Section 8 of this act;

23. "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

a. medicare or medicaid,

b. an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan, or

c. an individual health insurance policy, including coverage issued by a health maintenance organization, fraternal benefit society and those entities set forth in Section 2501 et seq. of Title 63 of the Oklahoma Statutes, that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that such policy has been in effect for a period of at least one (1) year;

24. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect;

~~15.~~ 25. "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to Section 8 of this act;

26. "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Section 2501 et seq. of Title 63 of the Oklahoma Statutes to provide health care services to covered individuals;

27. "Risk-assuming carrier" means a small employer carrier whose application is approved by the Commissioner pursuant to Section 7 of this act;

28. "Small employer" means any person, firm, corporation, partnership, limited liability company or association that is actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than ~~twenty-five (25)~~ fifty (50) eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state income taxation, shall be considered one employer;

~~16.~~ 29. "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state;

~~17. "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person; and~~

~~18. "Control" (including the terms "controlling", "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person,~~

~~directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact in the manner provided in Section 1654 of this title. The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect~~ and

30. "Standard health benefit plan" means a health benefit plan developed pursuant to Section 10 of this act.

SECTION 3. AMENDATORY Section 3, Chapter 329, O.S.L. 1992 (36 O.S. Supp. 1993, Section 6513), is amended to read as follows:

Section 6513. A. ~~This act~~ The Small Employer Health Insurance Reform Act shall apply to any group health benefit plan that provides coverage to two (2) or more employees of a small employer in this state and to individual health benefits plans providing coverage for the employees of a small employer which may include the employer when three (3) or more of such individual plans are sold to a small employer if any of the following conditions are met:

1. Any portion of the premium or benefits is paid by or on behalf of the small employer;

2. An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

3. The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125 or Section 106 of the United States Internal Revenue Code.

B. 1. Except as provided in paragraph 2 of this subsection, for the purposes of ~~this act~~ the Small Employer Health Insurance

Reform Act, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by ~~this act~~ the Small Employer Health Insurance Reform Act shall apply as if all health benefit plans issued to small employers in this state by such affiliated carriers were issued by one carrier, unless on or before July 1, 1992, the respective affiliate carriers operated with separate books of business as insurers of health benefit plans in which event each such affiliate carrier shall be treated as a separate carrier.

2. An affiliated carrier that is a health maintenance organization having a license under Section 2501 et seq. of Title 63 of the Oklahoma Statutes may be considered to be a separate carrier for the purposes of ~~this act~~ the Small Employer Health Insurance Reform Act.

C. Unless otherwise authorized by the Insurance Commissioner, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier.

SECTION 4. AMENDATORY Section 5, Chapter 329, O.S.L. 1992 (36 O.S. Supp. 1993, Section 6515), is amended to read as follows:

Section 6515. A. Premium rates for health benefit plans subject to ~~this act~~ the Small Employer Health Insurance Reform Act shall be subject to the following provisions:

1. The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%);

2. For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate;

3. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

a. the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers,

b. any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business, and

c. any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business;

4. Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer;

5. Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to Section 9 of this act;

6. A small employer carrier may utilize industry as a case characteristic in establishing premium rates; provided, the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than fifteen percent (15%);

~~6.~~ 7. In the case of health benefit plans issued prior to the effective date of ~~this act~~ the Small Employer Health Insurance Reform Act, a premium rate for a rating period may exceed the ranges set forth in paragraphs 1 and 2 of subsection A of this section for a period of three (3) years following the effective date of ~~this act~~ the Small Employer Health Insurance Reform Act. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

a. the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the

small employer carrier is actively enrolling new small employers, and

b. any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business;

~~7.~~ 8. Small employer carriers shall:

a. apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups within the same class of business which differ only by amounts attributable to plan design and do not reflect differences due to claims experience, health status and duration of coverage,

b. treat all health benefit plans issued or renewed in the same calendar month as having the same rating period;

~~8.~~ 9. For the purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs;

~~9.~~ 10. The Insurance Commissioner may establish rules to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of ~~this act~~ the Small Employer Health Insurance Reform Act, including:

a. assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan

design, not including differences due to claims experience, health status or duration of coverage, and

b. prescribing the manner in which case characteristics may be used by small employer carriers.

B. A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage.

C. The Commissioner may suspend for a specified period the application of paragraph 1 of subsection A of this section as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the Commissioner either that the suspension is reasonably necessary in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6519 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. As a condition of transacting business in this state with small employers, every small employer carrier shall actively offer to small employers at least two (2) health benefit plans. One health benefit plan offered by each small employer carrier shall be a basic health benefit plan and one plan shall be a standard health benefit plan.

2. a. A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any

eligible small employer that applies for either such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this act.

b. In the case of a small employer carrier that establishes more than one class of business pursuant to Section 6514 of Title 36 of the Oklahoma Statutes, the small employer carrier shall maintain and issue to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each class of business so established. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(1) the criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan,

(2) the criteria are not related to the health status or claim experience of the small employer,

(3) the criteria are applied consistently to all small employers applying for coverage in the class of business, and

(4) the small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

The provisions of this subparagraph shall not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.

3. A small employer is eligible under paragraph 2 of this subsection if it employed at least one or more eligible employees within this state on at least fifty percent (50%) of its working days during the preceding calendar quarter.

4. The provisions of this subsection shall be effective one hundred eighty (180) days after the Insurance Commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to Section 10 of this act; provided, that if the Small Employer Health Reinsurance Program created pursuant to Section 8 of this act is not yet operative on that date, the provisions of this paragraph shall be effective on the date that the program begins operation.

B. 1. A small employer carrier shall file with the Commissioner, in a format and manner prescribed by the Commissioner, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this paragraph may be used by a small employer carrier beginning thirty (30) days after it is filed unless the Commissioner disapproves its use.

2. The Commissioner at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this act.

C. Health benefit plans covering small employers shall comply with the following provisions:

1. A health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than:

a. a condition that would have caused an ordinarily prudent person to seek medical advise, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage,

b. a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage, or

c. a pregnancy existing on the effective date of coverage;

2. A health benefit plan may exclude coverage for late enrollees for the greater of eighteen (18) months or for an eighteen-month preexisting condition exclusion; provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen (18) months from the date the individual enrolls for coverage under the health benefit plan;

3. a. Except as provided in subparagraph d of this paragraph, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

b. A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

c. (1) Except as provided in division (2) of this subparagraph, in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying

existing coverage in determining whether the applicable percentage of participation is met.

(2) With respect to a small employer, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

d. A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage; and

4. a. If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in paragraph 2 of this subsection.

b. Except as permitted under paragraphs 1 and 2 of this subsection, a small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

D. 1. A small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection A of this section in the case of the following:

a. to a small employer, where the small employer is not physically located in the carrier's established geographic service area,

b. to an employee, when the employee does not work or reside within the carrier's established geographic service area, or

c. within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the Commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

2. A small employer carrier that cannot offer coverage pursuant to subparagraph c of paragraph 1 of this subsection may not offer coverage in the applicable area to new cases of employer groups with more than fifty (50) eligible employees or to any small employer groups until the later of one hundred eighty (180) days following each such refusal or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services to small employer groups.

E. A small employer carrier shall not be required to provide coverage to small employers pursuant to subsection A of this section for any period of time for which the Commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection A of this section would place the small employer carrier in a financially impaired condition.

SECTION 6. 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:

A. 1. Within thirty (30) days after the plan of operation is approved by the Insurance Commissioner pursuant to Section 8 of this

act, each small employer carrier shall notify the Commissioner of the carrier's intention to operate as a risk-assuming carrier or a reinsuring carrier. A small employer carrier seeking to operate as a risk-assuming carrier shall make an application pursuant to Section 7 of this act.

2. The decision shall be binding for a five-year period except that the initial decision shall be binding for two (2) years. The Commissioner may permit a carrier to modify its decision at any time for good cause shown.

3. The Commissioner shall establish as application process for small employer carriers seeking to change their status under this subsection. In the case of a small employer carrier that has been acquired by another such carrier, the Commissioner may waive or modify the time periods established in paragraph 2 of this subsection.

B. A reinsuring carrier that applies and is approved to operate as a risk-assuming carrier shall not be permitted to continue to reinsure any health benefit plan with the program. Such a carrier shall pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.

SECTION 7. 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:

A. A small employer carrier may apply to become a risk-assuming carrier by filing an application with the Insurance Commissioner in a form and manner prescribed by the Commissioner.

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

1. The carrier's financial condition;

2. The carrier's history of rating and underwriting small employer groups;

3. The carrier's commitment to market fairly to all small employers in the state or its established geographic service area, as applicable; and

4. The carrier's experience with managing the risk of small employer groups.

C. The Commissioner shall provide public notice of an application by a small employer carrier to be a risk-assuming carrier and shall provide at least a sixty-day period for public comment prior to making a decision on the application. If the application is not acted upon within ninety (90) days after the receipt of the application by the Commissioner, 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 will no longer support the assumption of risk from issuing coverage to small employers in compliance with Section 5 of this act without the protection afforded by the program;

2. The carrier has failed to market fairly to all small employers in this state or its established geographic service area, as applicable; or

3. The carrier has failed to provide coverage to eligible small employers as required in Section 5 of this act.

E. A small employer carrier electing to be a risk-assuming carrier shall not be subject to the provisions of Section 8 of this act.

SECTION 8. 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. A reinsuring carrier shall be subject to the provisions of this section.

B. There is hereby created a nonprofit entity to be known as the "Oklahoma Small Employer Health Reinsurance Program".

C. 1. The program shall operate subject to the supervision and control of the board. Subject to the provisions of paragraph 2 of this subsection, the board shall consist of eight (8) members appointed by the Insurance Commissioner plus the Commissioner, or his or her designated representative, who shall serve as an ex officio member of the board.

2. a. In selecting the members of the board, the Commissioner shall include representatives of small employers and small employer carriers and such other individuals determined to be qualified by the Commissioner. At least five (5) members of the board shall be representatives of carriers and shall be selected from individuals nominated in this state pursuant to procedures and guidelines developed by the Commissioner.

b. In the event that the program becomes eligible for additional financing pursuant to paragraph 3 of subsection L of this section, the board shall be expanded to include two additional members who shall be appointed by the Commissioner. In selecting the additional members of the board, the Commissioner shall choose individuals who represent organizations offering categories of health insurance not already represented on the board, including but not limited to excess or stoploss health insurance. The expansion of the board under this subsection shall continue for the period that the program continues to be eligible for additional financing pursuant to paragraph 3 of subsection L of this section.

3. The initial board members shall be appointed as follows: two of the members to serve a term of two (2) years; three of the members to serve a term of four (4) years; and three of the members to serve a term of six (6) years. Subsequent board members shall serve for a term of three (3) years. A board member's term shall continue until his or her successor is appointed.

4. A vacancy on the board shall be filled by the Commissioner. A board member may be removed by the Commissioner for cause.

D. Within sixty (60) days after the effective date of this act, each small employer carrier shall make a filing with the Commissioner containing the carrier's net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.

E. Within one hundred eighty (180) days after the appointment of the initial board, the board shall submit to the Commissioner a plan of operation and, thereafter, any amendments thereto necessary or suitable to ensure the fair, reasonable and equitable administration of the program. The Commissioner may, after notice and hearing, approve the plan of operation if the Commissioner determines it to be suitable to ensure the fair, reasonable and equitable administration of the program, and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the Commissioner.

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

G. 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 the provisions of this section;

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 methodology for applying the dollar thresholds contained in this section in the case of carriers that pay or reimburse health care providers through capitation or salary; or

6. Provide for any additional matters necessary for the implementation and administration of the program.

H. The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:

1. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this act, including the authority, with the approval of the Commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

2. Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;

3. Take any legal action necessary to avoid the payment of improper claims against the program;

4. Define the health benefit plans for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this act;

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

6. Establish actuarial functions as appropriate for the operation of the program;

7. Assess reinsuring carriers in accordance with the provisions of subsection L of this section, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments 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, policy and other contract design, and any other function within the authority of the program; and

9. Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets;

I. A reinsuring carrier may reinsure with the program as provided for in this subsection:

1. With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan;

2. A small employer carrier may reinsure an entire employer group within sixty (60) days following the commencement of the group's coverage under a health benefit plan;

3. A reinsuring carrier may reinsure an eligible employee or dependent of a small employer within a period of sixty (60) days following the commencement of coverage of the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within sixty (60) days of the commencement of his or her coverage;

4. a. The program shall not reimburse 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 such employee or dependent of Five Thousand Dollars ($5,000.00) in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for ten percent (10%) of the next Fifty Thousand Dollars ($50,000.00) of benefit payments during a calendar year, and the program shall reinsure the remainder. A reinsuring carrier's liability under this subparagraph shall not exceed a maximum limit of Ten Thousand Dollars ($10,000.00) in any one (1) calendar year with respect to any reinsured individual.

b. 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 benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Department of Labor, Bureau of Labor Statistics,

unless the board proposes and the Commissioner approves a lower adjustment factor;

5. A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan;

6. Premium rates charged for reinsurance by the program to a health maintenance organization that is federally qualified under 42 U.S.C. Sec. 300c(c)(2)(A), and as such is subject to requirements that limit the amount of risk that may be ceded to the program that is more restrictive than those specified in paragraph 4 of this subsection, shall be reduced to reflect that portion of the risk above the amount set forth in paragraph 4 of this subsection that may not be ceded to the program, if any; and

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

J. 1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates which shall be multiplied by the factors set forth in paragraph 2 of this subsection to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the Commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to

the standard health benefit plan, adjusted to reflect retention levels required under this act.

2. Premiums for the program shall be as follows:

a. 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 paragraph, and

b. 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 paragraph. However, in no event shall the reinsurance premium for any entire group be less than five (5) times the lesser of:

(1) the lowest base reinsurance rate applicable to any insured employee, or

(2) the lowest base reinsurance rate applicable to any insured dependent in the group.

3. The board periodically shall review the methodology established under paragraph 1 of this subsection, including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the Commissioner.

4. 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.

K. If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in Section 6515 of Title 36 of the Oklahoma Statutes.

L. 1. Prior to March 1 of each year, the board shall determine and report to the Commissioner the program net loss 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.

2. Any net loss for the year shall be recouped by assessments of reinsuring carriers.

a. The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers. The assessment formula shall be based on:

(1) each reinsuring carrier's share of the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers, and

(2) each reinsuring carrier's share of the premiums earned in the preceding calendar year from newly issued health benefit plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring carriers.

b. The formula established pursuant to subparagraph a of this paragraph shall not result in any reinsuring carrier having an assessment share that is less than fifty percent (50%) nor more than one hundred fifty percent (150%) of an amount which is based on the proportion of the reinsuring carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers to the total premiums earned in the preceding calendar year from health benefit plans delivered or issued for

delivery to small employers in this state by all reinsuring carriers.

c. The board may, with approval of the Commissioner, change the assessment formula established pursuant to subparagraph a of this paragraph from time to time as appropriate. The board may provide for the shares of the assessment base attributable to total premium and to the previous year's premium to vary during a transition period.

d. Subject to the approval of the Commissioner, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. Sec. 300, et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

3. a. Prior to March 1 of each year, the board shall determine and file with the Commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

b. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed five percent (5%) of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers, the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the Commissioner within ninety (90) days following the end of the calendar year in which the losses were incurred. The evaluation shall

include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file a report with the Commissioner within ninety (90) days following the end of the applicable calendar year, the Commissioner may evaluate the operations of the program and implement such amendments to the plan of operation the Commissioner deems necessary to reduce future losses and assessments.

c. If assessments in each two (2) consecutive calendar years exceed five percent (5%) of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers, the program shall be eligible to receive additional financing as provided in Section 9 of this act.

4. If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, "future losses" includes reserves for incurred but not reported claims.

5. Each reinsuring carrier's proportion of the assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the reinsuring carriers with the board.

6. The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

7. A reinsuring carrier may seek from the Commissioner a deferment from all or part of an assessment imposed by the board.

The Commissioner may defer all or part of the assessment of a reinsuring carrier if the Commissioner determines that the payment of the assessment would place the reinsuring carrier in a financially impaired condition. If all or part of an assessment against a reinsuring carrier is deferred, the amount deferred shall be assessed against the other participating carriers in a manner consistent with the basis for assessment set forth in this subsection. The reinsuring carrier receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessments.

M. Neither the participation in the program as reinsuring carriers, the establishment of rates, forms or procedures, nor any other joint or collective action required by this act shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers either jointly or separately.

N. The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to agents for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into consideration the need to ensure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide on-going service to the smaller employer, the levels of compensation currently used in the industry and the overall costs of coverage to small employers selecting these plans.

O. The program shall be exempt from any and all taxes.

SECTION 9. 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:

A. If assessments authorized in Section 8 of this act in each of two (2) consecutive calendar years exceed five percent (5%) of total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers, the board shall be authorized to additionally assess all health insurers doing business in this state.

1. For purposes of this section, "health insurer" includes all carriers providing health benefit plans, including excess or stoploss health insurance, to citizens of this state.

2. Each health insurer's assessment shall be determined by multiplying the total assessment of all health insurers as determined in subsection B of this section by a fraction, the numerator of which equals the number of individuals in this state covered under health insurance policies (including by way of excess or stoploss coverage) by each health insurer, and the denominator of which equals the total number of all individuals in this state covered under health insurance policies (including by way of excess or stoploss coverage) by all health insurers, all determined as of the end of the prior calendar year.

3. The board shall make reasonable efforts designed to ensure that each insured individual is counted only once with respect to any assessment. For that purpose, the board shall require each health insurer that obtains excess or stoploss insurance to include in its count of insured individuals all individuals whose coverage is reinsured (including by way of excess or stoploss coverage) in whole or part. The board shall allow a health insurer who is an excess or stoploss insurer to exclude from its number of insured individuals those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stoploss insurer for the purpose of determining its assessment under this subsection.

4. Each health insurer's assessment shall be determined by the board based on annual statements and other reports deemed to be necessary by the board and filed by the health insurer with the board. The board may use any reasonable method of estimating the number of insureds of a health insurer if the specific number is unknown. With respect to health insurers that are reinsurers or excess or stoploss insurers, the board may use any reasonable method of estimating the number of persons insured by each reinsurer or excess or stoploss insurer.

5. A health insurer may petition the Commissioner for an abatement or deferment of all or part of an assessment imposed by the board. The Commissioner may abate or defer, in whole or in part, the assessment if, in the opinion of the Commissioner, payment of the assessment would endanger the ability of the health insurer to fulfill its contractual obligations. In the event an assessment against a health insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other health insurers in a manner consistent with the basis for assessments set forth in this section. The health insurer receiving such abatement or deferment shall remain liable to the program for the deficiency for four (4) years.

B. The amount of additional financing to be provided to the program shall be equal to the amount by which total assessments in the preceding two (2) calendar years exceed five percent (5%) of total premiums earned during that period from small employers from health benefit plans delivered or issued for delivery in this state by reinsuring carriers. If the program has received additional financing in either of the two (2) previous calendar years pursuant to this subsection, the amount of additional financing shall be subtracted from the amount of total assessments for the purpose of the calculation in the previous sentence.

C. Additional financing received by the program pursuant to this section shall be distributed to reinsuring carriers in proportion to the assessments paid by such carriers over the previous two (2) calendar years.

SECTION 10. 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. The Insurance Commissioner shall appoint a Health Benefit Plan Committee. The committee shall be composed of representatives of carriers, small employers and employees, health care providers, third-party administrators and agents.

B. The committee shall recommend the form and level of coverages to be made available by small employer carriers pursuant to Section 5 of this act.

C. The committee shall recommend benefit levels, cost sharing levels, exclusions and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall also design a basic health benefit plan and a standard health benefit plan which contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

1. The plans recommended by the committee may 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. selective contracting with hospitals, physicians and other health care providers,

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

e. other managed care provisions.

2. The committee shall submit the health benefit plans described in paragraph 1 of this subsection to the Commissioner for approval within one hundred eighty (180) days after the appointment of the committee.

SECTION 11. 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:

The board, in consultation with members of the committee, shall study and report at least every three (3) years to the Insurance Commissioner on the effectiveness of Sections 5 through 15 of this act. The report shall analyze the effectiveness of Sections 5 through 15 of this act in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency and fairness of the small group health insurance marketplace. The report shall address whether carriers and agents are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of Sections 5 through 15 of this act. The report may contain recommendations for market conduct or other regulatory standards or action.

SECTION 12. 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:

The Insurance Commissioner may promulgate rules in accordance with Article I of the Administrative Procedures Act, Section 250.2 et seq. of Title 75 of the Oklahoma Statutes, for the implementation and administration of the Small Employer Health Insurance Reform Act.

SECTION 13. 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. Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in this state. If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan.

B. 1. Except as provided in paragraph 2 of this subsection, no small employer carrier or agent shall, directly or indirectly, engage in the following activities:

a. encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer, or

b. encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

2. The provisions of paragraph 1 of this subsection shall not apply with respect to information provided by a small employer carrier or agent to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

C. 1. Except as provided in paragraph 2 of this subsection, no small employer carrier 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 benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic location of the small employer.

2. Paragraph 1 of this subsection shall not apply with respect to a compensation arrangement that provides compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the small employer.

D. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent, if any, for the sale of a basic or standard health benefit plan.

E. No small employer carrier 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, occupation or geographic location of the small employers placed by the agent with the small employer carrier.

F. No small employer carrier or agent may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

G. Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

H. The Insurance Commissioner may promulgate rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

I. 1. A violation of this section by a small employer carrier or an agent shall be an unfair trade practice under Section 1204 et seq. of Title 36 of the Oklahoma Statutes.

2. If a small employer carrier 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 benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

SECTION 14. 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:

The Insurance Commissioner may promulgate rules to require small employer carriers, as a condition of transacting business with small employers in this state after the effective date of this act, to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier after December 31, 1993. The Commissioner may prescribe such terms for the reissue of coverage as the Commissioner finds are reasonable and necessary to provide continuity of coverage to small employers.

SECTION 15. 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:

In the event that the Congress of the United States enacts laws superseding this act, the Insurance Commissioner may suspend implementation of any portion of this act. In such case, the Commissioner shall notify the Governor, President Pro Tempore of the Senate and the Speaker of the House of Representatives.

SECTION 16. This act shall become effective July 1, 1994.

SECTION 17. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

Passed the Senate the 14th day of March, 1994.

President of the Senate

Passed the House of Representatives the ____ day of _____, 1994.

Speaker of the House of Representatives