STATE OF OKLAHOMA

2nd Session of the 44th Legislature (1994)

HOUSE BILL NO. 2256 By: Thomas

AS INTRODUCED

An Act relating to insurance; amending Sections 2, 3, 4, 5, 6, 7 and 8, Chapter 329, O.S.L. 1992 (36 O.S. Supp. 1993, Sections 6512, 6513, 6514, 6515, 6516, 6517 and 6518), which relate to the Small Employer Health Insurance Reform Act; adding and modifying definitions; clarifying statutory references; changing certain references; requiring certain approval of accountable health plans; requiring certain conditions for doing business; requiring plans to provide a certain health benefit plan; requiring certain minimum percentages of group participation in plans; providing for certain benefits; requiring Commissioner to develop certain rules; prohibiting denial of coverage; providing exceptions allowing minimum enrollment requirements; prohibiting denial of coverage for certain preexisting conditions; allowing certain waiting periods; providing credit for waiting period; defining term; requiring use of standard formats for certain information; prohibiting certain acts by plans; allowing certain information on service areas; allowing certain marketing of plans; requiring certain services from participating providers; providing for certain incentives to participating providers; requiring

plans to file certain quality assurance program; stating information to be included in program; requiring plans to offer certain programs; requiring plans to provide certain incentives to use certain physicians; excluding application of certain laws to plans; requiring certain report by the Commissioner; stating content of report; requiring minimum percentages of certain information to be submitted by electronic means; 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. 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~~ Section 6511 et seq. of this title:

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. "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~~ accountable health plan to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

3. "Standard health benefit plan" means a plan that is adopted by the Legislature and that is offered by the accountable health plans in accordance with the provisions of Section 6513.4 of this title;

4. "~~Carrier~~ Accountable health plan" means any entity which provides a health ~~insurance~~ benefit plan in this state. For the purposes of this act, ~~carrier~~ accountable health plan 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.~~ 5. "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the ~~small employer carrier~~ accountable health plan 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. ~~A small employer carrier~~ An accountable health plan 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.~~ 6. "Class of business" means all or a separate grouping of small employers established pursuant to Section ~~4~~ 6514 of this ~~act~~ title;

~~6.~~ 7. "Commissioner" means the Insurance Commissioner;

~~7.~~ 8. "Department" means the Insurance Department;

~~8.~~ 9. "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.~~ 10. "Established geographic service area" means a geographic area, as approved by the Commissioner and based on the ~~carrier's~~ certificate of authority of the accountable health plan to transact

insurance in this state, within which the ~~carrier~~ plan is authorized to provide coverage;

~~10.~~ 11. "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~~, health maintenance organization subscriber contract, prepaid health plan as defined in Section 2503 of this title, or multiple employer welfare arrangements. 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;

~~11.~~ 12. "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.~~ 13. "Late enrollee" means an employee or dependent who requests enrollment in a health benefit plan after the initial enrollment period that is provided under the terms of the health benefit plan if the initial enrollment period is at least thirty (30) 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 benefit plan,

(2) lost coverage under a public or private health insurance policy or any other health benefit plan due to the termination or the employee employment

or eligibility, the termination of the other plan's coverage, the death of the spouse or divorce, or

(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 benefit plan,

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

c. a court order that requires coverage be provided for a spouse or minor child under a covered employee's health benefit plan and the person requests enrollment within thirty (30) days after the court order is issued;

14. "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~~ accountable health plan to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

~~13.~~ 15. "Participating provider" means a professional or institutional health care provider that is employed by or has a written contract with an accountable health plan;

16. "Preexisting condition" means, with respect to coverage under a health benefit plan issued by an accountable health plan, 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;

17. "Premium" means all monies paid by a small employer and eligible employees as a condition of receiving coverage from ~~a small~~

~~employer carrier~~ an accountable health plan, including any fees or other contributions associated with the health benefit plan;

~~14.~~ 18. "Rating period" means the calendar period for which premium rates established by ~~a small employer carrier~~ an accountable health plan are assumed to be in effect;

~~15.~~ 19. "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)~~ one hundred (100) 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. "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state;~~

~~17.~~ 20. "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.~~ 21. "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.

SECTION 2. 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~~ Section 6511 et seq. of this title 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~~ benefit 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. This act shall not apply to any policy that is issued on an individual basis.

C. 1. Except as provided in paragraph 2 of this subsection, for the purposes of this act, ~~carriers~~ accountable health plans that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one ~~carrier~~ plan and any restrictions

or limitations imposed by this act shall apply as if all health benefit plans issued to small employers in this state by such affiliated ~~carriers~~ plans 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~~ plan.

2. An affiliated ~~carrier~~ accountable health plan that is a health maintenance organization having a license under Section 2501 et seq. of Title 63 of the Oklahoma Statutes or a prepaid health plan may be considered to be a separate ~~carrier~~ plan for the purposes of this act.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6513.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

An entity may offer, issue or otherwise provide a health benefit plan only if the entity is approved as an accountable health plan by the licensing agency based on a determination that the entity meets the applicable requirements of this title.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6513.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

Beginning July 1, 1994, as a condition of doing business in this state, each accountable health plan issuing new health benefit plans shall offer a standard health benefit plan to qualified small employers. A small employer qualifies for this guaranteed offer of coverage if the small employer has not provided a health benefit plan to its employees for a period of at least ninety (90) days immediately prior to when the small employer applies for coverage with the accountable health plan. The accountable health plan shall provide a standard health benefit plan to each qualified small employer without regard to health status of the employees or claims

experience if the small employer agrees to make the premium payments and to satisfy any other reasonable provisions of the plan that are not inconsistent with the requirements of this title.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6513.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As a condition of doing business in this state, each accountable health plan issuing any new health benefit plans shall be required to ensure that at a minimum the following specified percentages of individuals who are enrolled in the group health benefit plan are covered by a health benefit plan that meets the requirements of Sections 19 through 21 of this act:

1. By January 1, 1997, twenty percent (20%);

2. By January 1, 1988, forty percent (40%);

3. By January 1, 1999, seventy percent (70%); and

4. By January 1, 2000 and thereafter, ninety percent (90%).

B. As a condition of doing business in this state, each accountable health plan issuing new health benefit plans shall be required to ensure that at a minimum the following specified percentage of individuals who are enrolled in the individual health benefit plans are covered by health benefit plans that meet the requirements of Section 22 of this act:

1. By January 1, 1997, ten percent (10%);

2. By January 1, 1998, twenty percent (20%);

3. By January 1, 1999, thirty-five percent (35%); and

4. By January 1, 2000 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 enrolled in a group or individual health benefit plan of the accountable health plan during that year.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6513.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The standard health benefit plan shall provide benefit and cost-sharing levels that are consistent with the basic method of operation and the benefit plans of health care services organizations.

B. The Commissioner shall develop rules to prevent accountable health plan providers from circumventing the provisions of this act through the structuring of agent commissions.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6513.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as otherwise provided in subsection B of this Section, an accountable health plan may not deny coverage to any eligible employee or a spouse or a dependent child of the eligible employee.

B. An employee may be denied coverage under the health benefit plan pursuant to an employer requirement that imposes a minimum period of service before the employee is eligible for coverage.

C. An accountable health plan may deny enrollment to an employee or family members of an employee if the employee or family members are located outside the service area of the accountable health plan 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 6513.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

An accountable health plan shall not deny coverage under the plan to any person who would have been eligible for coverage on the date the employer applied for the coverage except for underwriting considerations related to health status and who has been

continuously covered for a one-year period under a health benefit plan or a health insurance policy other than a policy issued by or in connection with a state high-risk insurance pool. A person is deemed to be continuously covered for a one-year period if the person is insured at the beginning and end of the one-year period and has had no breaks in coverage during that period totaling more than thirty-one (31) days.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6513.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

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

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6513.8 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as provided in subsection B of this section, the standard health benefit plan may not deny, limit or condition the coverage or benefits offered under the plan based on the health status, claims experience, receipt of health care or medical history or a lack of evidence of insurability of a person.

B. The standard health benefit plan shall not deny coverage under a health plan for a preexisting condition, except that:

1. The standard health benefit plan may exclude coverage for the preexisting condition 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 were otherwise covered from the time of their birth. Provided;

A credit of one (1) month off of the twelve (12) month waiting period shall be given for each month of continuous coverage that the

individual was covered under another health benefits plan issued by an accountable health plan 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 or a self-insured group health plan as defined in 26 U.S.C. 5000(b)(1) and ending on the date the individual is no longer enrolled for a continuous period of more than sixty (60) days; and

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

C. Upon the request of an accountable health plan, a person or entity which provides coverage during a period of continuous coverage with respect to a covered individual shall promptly disclose the coverage provided to the individual, the period of the coverage and the benefits provided under the coverage.

SECTION 11. AMENDATORY Section 4, Chapter 329, O.S.L. 1992 (36 O.S. Supp. 1993, Section 6514), is amended to read as follows:

Section 6514. A. ~~A small employer carrier~~ An accountable health plan may establish a class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

1. The ~~small employer carrier~~ accountable health plan uses more than one type of system for the marketing and sale of health benefit plans to small employers;

2. The ~~small employer carrier~~ accountable health plan has acquired a class of business from another small employer carrier; or

3. The ~~small employer carrier~~ accountable health plan provides coverage to one or more association groups that meet the

requirements of an association as set forth in Section 4501 of this title.

B. ~~A small employer carrier~~ An accountable health plan may establish up to nine separate classes of business under subsection A of this section.

C. The Insurance Commissioner may establish rules to provide for a period of transition in order for ~~a small employer carrier~~ an accountable health plan to come into compliance with subsection B of this section in the instance of acquisition of an additional class of business from another ~~small employer carrier~~ accountable health plan.

D. The Commissioner may approve the establishment of additional classes of business upon application to the Commissioner and a finding by the Commissioner that such action would enhance the efficiency and fairness of the small employer marketplace.

SECTION 12. 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~~ Section 6511 et seq. of this title 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~~ accountable health plan is no longer enrolling new small employers, the ~~small employer carrier~~ accountable health plan 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~~ accountable health plan 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~~ accountable health plan'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~~ accountable health plan'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. ~~A small employer carrier~~ An accountable health plan 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. In the case of health benefit plans issued prior to ~~the effective date of this act~~ September 1, 1992, 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~~ September 1, 1992. 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~~ accountable health plan is no longer enrolling new small employers, the ~~small employer carrier~~ accountable health plan 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~~ accountable health plan 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 of the plan for the class of business;

7. ~~Small employer carriers~~ Accountable health plans 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. 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. The Insurance Commissioner may establish rules to implement the provisions of this section and to assure that rating practices used by ~~small employer carriers~~ accountable health plans are consistent with the purposes of this act, including:

a. assuring that differences in rates charged for health benefit plans by ~~small employer carriers~~ accountable health plans 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~~ accountable health plans.

B. ~~A small employer carrier~~ An accountable health plan shall not transfer a small employer involuntarily into or out of a class of business. ~~A small employer carrier~~ An accountable health plan 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~~ an accountable health plan for one or more rating periods upon a filing by the ~~small employer carrier~~ accountable health plan and a finding by the Commissioner either that the suspension is reasonably necessary in light of the financial condition of the ~~small employer carrier~~ accountable health plan or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

SECTION 13. AMENDATORY Section 6, Chapter 329, O.S.L. 1992 (36 O.S. Supp. 1993, Section 6516), is amended to read as follows:

Section 6516. A. A health benefit plan subject to ~~this act~~ Section 6511 et seq. of this title shall be renewable with respect to all eligible employees and dependents, at the option of the small employer, except in any of the following cases:

1. Nonpayment of the required premiums;

2. Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives;

3. Noncompliance with the ~~carrier's~~ minimum group participation requirements of an accountable health plan;

4. Noncompliance with the ~~carrier's~~ employer contribution requirements of a plan;

5. Repeated misuse of provider network provisions;

6. The ~~small employer carrier~~ accountable health plan elects to nonrenew all of its health benefit plans issued to small employers in this state. In such a case the ~~carrier~~ plan shall:

a. provide advance notice of its decision under this paragraph to the Insurance Commissioner in each state in which it is licensed, and

b. provide notice of the decision not to renew coverage to all affected small employers and to the Commissioner in each state in which an affected covered individual is known to reside at least one hundred eighty (180) days prior to the nonrenewal of any health benefit plan ~~by the carrier~~. Notice to the Commissioner under this subparagraph shall be provided at least three (3) working days prior to the notice to the affected small employers; or

7. The Commissioner finds that the continuation of the coverage would:

a. not be in the best interests of the policyholders or certificate holders, or

b. impair the ~~carrier's~~ plan's ability to meet its contractual obligations. In such instance the Commissioner may assist affected small employers in finding replacement coverage.

B. ~~A small employer carrier~~ An accountable health plan that elects not to renew a health benefit plan under paragraph 6 of subsection A of this section shall be prohibited from writing new business in the small employer market in this state for a period of five (5) years from the date of notice to the Commissioner.

C. In the case of ~~a small employer carrier~~ an accountable health plan doing business in one established geographic service area of the state, the provisions of this section shall apply only to the ~~carrier's~~ plan's operations in such service area.

SECTION 14. AMENDATORY Section 7, Chapter 329, O.S.L. 1992 (36 O.S. Supp. 1993, Section 6517), is amended to read as follows:

Section 6517. In connection with the offering for sale of any health benefit plan to a small employer, ~~a small employer carrier~~ an accountable health plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

1. The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

2. The provisions of the health benefit plan concerning the ~~small employer carrier's~~ accountable health plan's right to change premium rates and factors, other than claim experience, that affect changes in premium rates;

3. The provisions relating to renewability of policies and contracts; and

4. The provisions relating to any preexisting condition provision.

SECTION 15. AMENDATORY Section 8, Chapter 329, O.S.L. 1992 (36 O.S. Supp. 1993, Section 6518), is amended to read as follows:

Section 6518. A. Each ~~small employer carrier~~ accountable health plan shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices

are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

B. Each ~~small employer carrier~~ accountable health plan shall file with the Insurance Commissioner annually on or before March 15 an actuarial certification certifying that the ~~carrier~~ plan is in compliance with ~~this act~~ Section 6511 et seq. of this title and that the rating methods of the ~~small employer carrier~~ accountable health plan are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the Commissioner. A copy of the certification shall be retained by the ~~small employer carrier~~ accountable health plan at its principal place of business.

C. ~~A small employer carrier~~ An accountable health plan shall make the information and documentation described in subsection A of this section available to the Commissioner upon request. Except in cases of violations of this act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the Commissioner to persons outside of the Department except as agreed to by the ~~small employer carrier~~ accountable health plan or as ordered by a court of competent jurisdiction.

SECTION 16. 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:

An accountable health plan shall use standard formats for billing information, data collection and electronic data interchange as specified in Section 6581 of this title or by the United States Secretary of Health and Human Services.

SECTION 17. 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. An accountable health plan or its agent or broker shall not:

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

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

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

C. Notwithstanding any law to the contrary, an accountable health plan may market health benefit plans to a group or groups of small employers from the same or different industries that elect to pool their risks on a voluntary basis.

SECTION 18. 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. The following health care services that are covered by a standard health benefit plan shall be available from participating providers:

1. Inpatient and outpatient hospital services;

2. Physician services;

3. Diagnostic services;

4. Preventive care, including prenatal care and well-baby care.

B. An accountable health plan shall require or create substantial financial incentives for enrollees in health benefit plans to use the services of participating providers.

C. An accountable health plan shall employ financial incentives that encourage participating providers to provide quality care, to provide quality service and to control total costs.

SECTION 19. 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:

An accountable health plan shall file a quality assurance program with the Commissioner that includes:

1. Procedures and criteria used for determining whether participating providers have appropriate credentials, provided nothing in this act shall prevent accountable health plans from selecting participating providers of the plans choice;

2. Procedures and criteria used for monitoring and analyzing the quality of services furnished by the participating providers of an accountable health plan;

3. The use, if appropriate, of providers designated as centers of excellence;

4. Procedures used for monitoring the satisfaction of enrolled individuals and for soliciting and disposing of grievances; and

5. Procedures and criteria used for taking appropriate action against participating providers that do not provide care that meets a certain quality.

SECTION 20. 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:

An accountable health plan shall operate for persons enrolled in a plan:

1. A health improvement program. The program shall promote healthy life-styles, screening for diseases, immunizations and other appropriate measures;

2. Beginning January 1, 1999, a chronic diseases health improvement program; and

3. An education program on the implications of treatment alternatives.

SECTION 21. 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:

An accountable health plan shall require or provide substantial financial incentives to each individual receiving services covered by a plan to have all of the services coordinated by a designated physician or group of physicians, including primary care physicians.

SECTION 22. 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:

Notwithstanding any law to the contrary, the basic health benefit plan developed pursuant to Section 6 of this act shall not be subject to the requirements of Sections 6055 and 6060 of this title or Sections 1-2604 and 1-2605 of Title 63 of the Oklahoma Statutes.

SECTION 23. 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:

On or before December 31, 1995, and at least every three (3) years thereafter the Commissioner shall report on the effectiveness of this act. The report shall address the impact of Section 4 of this act on premium rates and plan availability and the overall impact of this act on the small employer health insurance marketplace. The report shall provide data on the effect of similar market reform laws in other states, if available. The report may contain recommendations for actions to improve the overall effectiveness, efficiency and fairness of the small employer health insurance marketplace, for market conduct or for other regulatory standards or action.

SECTION 24. 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. By January 1, 1996, but not prior to twelve (12) months after approval of a form by the American National Standards Institute, an accountable health plan shall receive twenty-five percent (25%) of its claim submissions from providers by electronic means in a form approved by the American National Standards Institute. By January 1, 1997, but not prior to thirty-six (36) months after approval of a form by the American National Standards Institute, an accountable health plan shall receive fifty percent (50%) of its claim submissions by electronic means.

B. By January 1, 1996, but not prior to twelve (12) months after approval of a form by the American National Standards Institute, an accountable health plan shall remit twenty-five percent (25%) of its claim payments to providers by electronic means in a form approved by the American National Standards Institute. By January 1, 1997, but not prior to thirty-six (36) months after approval of a form by the American National Standards Institute, an accountable health plan shall remit fifty percent (50%) of its claim payments by electronic means.

C. By January 1, 1996, but not prior to twelve (12) months after approval of a form by the American National Standards Institute, an accountable health plan shall conduct twenty-five percent (25%) of its eligibility verification transactions with providers by electronic means in a form approved by the American National Standards Institute. By January 1, 1997, but not prior to thirty-six (36) months after approval of a form by the American National Standards Institute, an accountable health plan shall conduct fifty percent (50%) of its eligibility verifications by electronic means.

SECTION 25. 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:

In Sections 25 through 36 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 plan that participates in the Small Employer Reinsurance Program.

SECTION 26. 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 reinsuring carrier is subject to the provisions of Sections 25 through 36 of this act.

SECTION 27. 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. 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 28. 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:

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 25 through 36 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 Section 25 through 36 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 29. 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. Within thirty (30) days after the plan of operation is approved by the Commissioner pursuant to Section 27 of this act, or the health benefit plan is approved by the Commissioner pursuant to Section 6 of this act, whichever occurs later, each accountable health plan shall notify the Commissioner of its intention to operate as a risk assuming carrier or reinsuring carrier. An accountable health plan that seeks to operate as a risk assuming carrier shall file an application pursuant to Section 30 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 plan'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 plan to modify its decision at any time for good cause shown.

If an accountable health plan 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 benefit 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 Section 25 through 36 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 30. 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. An accountable health plan 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 plan 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 plan that elect to become a risk assuming carrier is not subject to Sections 26 through 37 of this act.

SECTION 31. 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:

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

SECTION 32. 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:

A. The 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 benefit 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 benefit 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 33. 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:

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

1. With respect to a basic health benefit 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 benefit plan.

2. An accountable health plan may reinsure an entire employer group within sixty (60) days after the commencement of the group's coverage under a health benefit 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 Five Thousand Dollars ($5,000.00) in one calendar year for benefits covered by the Program. The reinsuring carrier is 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. The liability of a reinsuring carrier's under this subsection shall not exceed Ten Thousand Dollars ($10,000.00) 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 benefit plans in this 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 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 plan 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 health benefit 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 34. 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. 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 plans 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 plans for health benefit plans with benefits similar to the basic 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 35. 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:

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 36. 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:

As part of the plan of operation, the Board shall develop standards that set forth the manner and minimum levels of compensation to be paid to producers for the sale of basic health benefit plans. In establishing the standards, the Board shall consider the need to assure the Board availability of coverage, the objectives of the program, the time and effort expended in placing the coverage, the need to provide service to the small employer, the levels of compensation currently used in the industry and the overall costs of coverage to small employers selecting these plans.

SECTION 37. 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:

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

SECTION 38. This act shall become effective January 1, 1995.

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