

ENROLLED SENATE
BILL NO. 1040

By: Hendrick, Roberts,
Douglass, Fisher,
Gustafson, Smith, Snyder,
Stipe and Wright of the
Senate

and

Dunlap of the House

An Act relating to health care; amending 63 O.S. 1991, Section 2510, as amended by Section 10, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1995, Section 2510), which relates to regulations concerning health maintenance organizations and prepaid plans, and amending 74 O.S. 1991, Section 1306, as last amended by Section 15, Chapter 10, O.S.L. 1993, and Section 11, Chapter 400, O.S.L. 1992, as amended by Section 11, Chapter 359, O.S.L. 1993 (74 O.S. Supp. 1995, Sections 1306 and 1371), which relate to the State and Education Employees Group Insurance Act; establishing certain criteria for setting premium; blending employee and retiree premiums; deleting obsolete language; and providing an effective date.

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

SECTION 1. AMENDATORY 63 O.S. 1991, Section 2510, as amended by Section 10, Chapter 343, O.S.L. 1993 (63 O.S. Supp. 1995, Section 2510), is amended to read as follows:

Section 2510. A. No health maintenance organization or prepaid health plan, or representative thereof, shall cause or knowingly permit the use of advertising which is untrue or misleading, or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive.

1. A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan;

2. A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan, if such benefit or advantage or absence of limitation, exclusion or disadvantage does in fact exist;

3. An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration

given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage therefor, to expect benefits, services, charges or other advantages which evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

B. An enrollment may not be canceled or nonrenewed except for the failure to pay the charge for such coverage or, in the case of Title XIX enrollees for loss of eligibility for medical assistance, or for such other reasons as may be promulgated by the Department.

C. No health maintenance organization or prepaid health plan, unless licensed as an insurer, may use in its name, contracts or literature, any of the words "insurance," "casualty," "surety," "mutual" or any other words descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state.

D. When contracting with educational entities within the meaning of Section 1303 of Title 74 of the Oklahoma Statutes, effective for the plan year beginning July 1, 1997, and for each year thereafter, in setting health insurance premiums for active employees and for retirees under sixty-five (65) years of age, health maintenance organizations, self-insured plans and prepaid plans shall set the monthly premium for active employees at a maximum of Ninety Dollars (\$90.00) less than the monthly premium for retirees under sixty-five (65) years of age.

SECTION 2. AMENDATORY 74 O.S. 1991, Section 1306, as last amended by Section 15, Chapter 10, O.S.L. 1993 (74 O.S. Supp. 1995, Section 1306), is amended to read as follows:

Section 1306. ~~(1)~~ The State and Education Employees Group Insurance Board shall administer and manage the group insurance plans and the flexible benefits plan and, subject to the provisions of the State and Education Employees Group Insurance Act, Section 1301 et seq. and the State Employees Flexible Benefits Act, Section 1341 et seq. of this title, shall have the following powers and duties:

~~(a)~~ 1. The preparation of specifications for such insurance plans as the Board may be directed to offer;

~~(b)~~ 2. The authority and duty to request bids through the Purchasing Division of the Department of Central Services for a contract to be the claims administrator for all or any part of such insurance and benefit plans as the Board may be directed to offer;

~~(c)~~ 3. The determination of the methods of claims administration under such insurance and benefit plans as the Board may be directed to offer;

~~(d)~~ 4. The determination of the eligibility of employees and their dependents to participate in each of the Group Insurance Plans and in such other insurance and benefit plans as the Board may be directed to offer and the eligibility of employees other than education employees to participate in the Life Insurance Plan provided that evidence of insurability shall not be a requirement in determining an employee's initial eligibility;

~~(e)~~ 5. The determination of the amount of employee payroll deductions and the responsibility of establishing the procedure by which such deduction shall be made;

~~(f)~~ 6. The establishment of a grievance procedure by which a three-member grievance panel shall act as an appeals body for complaints by insured employees regarding the allowance and payment of claims, eligibility, and other matters. Except for grievances settled to the satisfaction of both parties prior to a hearing, any

person who requests in writing a hearing before the grievance panel shall receive a hearing before the panel. The grievance procedure provided by this paragraph shall be the exclusive remedy available to insured employees having complaints against the insurer. Such grievance procedure shall be subject to the Oklahoma Administrative Procedures Act, ~~Sections 301 through 325~~ Section 250 et seq. of Title 75 of the Oklahoma Statutes including provisions thereof for review of agency decisions by the district court. The grievance panel shall schedule a hearing regarding the allowance and payment of claims, eligibility and other matters within sixty (60) days from the date the grievance panel receives a written request for a hearing unless the panel orders a continuance for good cause shown. Upon written request by the insured employee to the grievance panel and received not less than ten (10) days before the hearing date, the grievance panel shall cause a full stenographic record of the proceedings to be made by a competent court reporter at the insured employee's expense;

~~(g)~~ 7. The continuing study of the operation of such insurance and benefit plans as the Board may be directed to offer including such matters as gross and net costs, administrative costs, benefits, utilization of benefits, and claims administration;

~~(h)~~ 8. The administration of the Health, Dental and Life Insurance Reserve Fund or Funds, the Flexible Benefits Revolving Fund and the Education Employees Group Insurance Reserve Fund;

~~(i)~~ 9. The auditing of the claims paid pursuant to the provisions of the State and Education Employees Group Insurance Act, the State Employees Flexible Benefits Act and the State Employees Disability Program Act;

~~(j)~~ ~~(1)~~ 10. a. To select and contract with federally qualified Health Maintenance Organizations under the provisions of 42 U.S.C., Section 300e et seq. or with Health Maintenance Organizations licensed by the Department of Health pursuant to Sections 2501 through 2510 of Title 63 of the Oklahoma Statutes for consideration by employees as an alternative to the state self-insured health plan, and to transfer to the HMOs such funds as may be approved for an employee electing HMO alternative services.

~~(2)~~ b. HMO contracts shall provide for a risk adjustment factor for adverse selection, that may occur as determined by the Board, based on generally accepted actuarial principles.

c. Effective for the plan year beginning July 1, 1997, and for each year thereafter, in setting health insurance premiums for active employees and for retirees under sixty-five (65) years of age, HMOs, self-insured organizations and prepaid plans shall set the monthly premium for active employees at a maximum of Ninety Dollars (\$90.00) less than the monthly premium for retirees under sixty-five (65) years of age;

~~(k)~~ 11. For the fiscal year beginning July 1, 1992, to assess and collect a four percent (4%) fee from such contracted HMOs to offset the costs of administration, and to appropriate and pay to the Benefits Council Administration Fund an amount equal to fifty percent (50%) of said fee within ten (10) days of collection;

~~(l)~~ 12. To contract for re-insurance, catastrophic insurance, or any other type of insurance deemed necessary by the Board;

~~(m)~~ 13. The Board, pursuant to the provisions of ~~Sections 301 through 325~~ Section 250 et seq. of Title 75 of the Oklahoma Statutes, shall adopt such rules and regulations consistent with the provisions of the State and Education Employees Group Insurance Act as it deems necessary to carry out its statutory duties and responsibilities;

~~(n)~~ 14. The Board shall contract for claims administration services with a private insurance carrier or a company experienced in claims administration of any insurance that the Board may be directed to offer. No contract for claims administration services shall be made unless such contract has been offered for bids through the Purchasing Division of the Department of Central Services. The Board shall contract with a private insurance carrier or other experienced claims administrator to process claims with software that is normally used for its customers;

~~(o)~~ 15. The Board shall contract for utilization review services with a company experienced in utilization review, data base evaluation, market research, and planning and performance of the health insurance plan;

~~(p)~~ 16. The Board shall approve the amount of employee premiums and dependent premiums for such insurance plans as the Board shall be directed to offer for each fiscal year no later than March 1 of the previous fiscal year. The Board shall submit notice of the amount of employee premiums and dependent premiums along with an actuarial projection of the upcoming fiscal year's enrollment, employee contributions, employer contributions, investment earnings, paid claims, internal expenses, external expenses and changes in liabilities to the Director of the Office of State Finance and the Director of the Legislative Service Bureau no later than March 1 of the previous fiscal year.

Effective for the plan year beginning July 1, 1997, and for each year thereafter, in setting health insurance premiums for active employees and retirees under sixty-five (65) years of age, the Board shall set the monthly premium for active employees at a maximum of Ninety Dollars (\$90.00) less than the monthly premium for retirees under sixty-five (65) years of age;

~~(q)~~ 17. Before December 1 of each year the Board shall submit to the Director of the Office of State Finance a report outlining the financial condition for the previous fiscal year of all insurance plans offered by the Board. The report shall include a complete explanation of all reserve funds and the actuarial projections on the need for such reserves. The report shall include and disclose an estimate of the future trend of medical costs, the impact from HMO enrollment, antiselection, changes in law, and other contingencies that could impact the financial status of the plan. The Director of the Office of State Finance shall make written comment on the report and shall provide such comment, along with the report submitted by the Board, to the Governor, the President Pro Tempore of the Senate, the Speaker of the House of Representatives and the Chairman of the Oklahoma State Employees Benefits Council by January 15;

~~(r)~~ 18. The Board shall establish a prescription drug card network for the fiscal year beginning July 1, 1990;

~~(s)~~ 19. The Board shall have the authority to intercept monies owing to plan participants from other state agencies, when those participants in turn, owe money to the Board. The Board shall be required to adopt rules and regulations ensuring the participants due process of law;

~~(t)~~ 20. The Board is authorized to make available to eligible employees supplemental health care benefit plans to include but not

be limited to long-term care, deductible reduction plans and employee co-payment reinsurance. Premiums for said plans shall be actuarially based and the cost for such supplemental plans shall be paid by the employee; and

~~(u)~~ 21. There is hereby created as a joint committee of the State Legislature, the Joint Liaison Committee on State and Education Employees Group Insurance Benefits, which Joint Committee shall consist of three members of the Senate to be appointed by the President Pro Tempore thereof and three members of the House of Representatives to be appointed by the Speaker thereof. The Chairman and Vice Chairman of the Joint Committee shall be appointed from the membership thereof by the President Pro Tempore of the Senate and the Speaker of the House of Representatives, respectively, one of whom shall be a member of the Senate and the other shall be a member of the House of Representatives. At the beginning of the first regular session of each Legislature, starting in 1991, the Chairman shall be from the Senate; thereafter the chairmanship shall alternate every two (2) years between the Senate and the House of Representatives.

The Joint Liaison Committee on State and Education Employees Group Insurance Benefits shall function as a committee of the State Legislature when the Legislature is in session and when the Legislature is not in session. Each appointed member of said committee shall serve until his or her successor is appointed.

The Joint Liaison Committee on State and Education Employees Group Insurance ~~Benefit~~ Benefits shall serve as a liaison with the State and Education Employees Group Insurance Board regarding advice, guidance, policy, management, operations, plans, programs and fiscal needs of said Board. Said Board shall not be bound by any action of the Joint Committee.

~~(v) For the fiscal year beginning July 1, 1993, certain duties and responsibilities of the Board shall be transferred to the Oklahoma State Employees Benefits Council pursuant to the provisions of the Oklahoma State Employees Benefits Act. During the fiscal year beginning July 1, 1992, the Board shall cease activities related to the implementation of said transferred duties and responsibilities for the next fiscal year and implement all reasonable actions to ensure the effective and efficient transfer of said duties and responsibilities to the Oklahoma State Employees Benefits Council.~~

SECTION 3. AMENDATORY Section 11, Chapter 400, O.S.L. 1992, as amended by Section 11, Chapter 359, O.S.L. 1993 (74 O.S. Supp. 1995, Section 1371), is amended to read as follows:

Section 1371. A. All participants must use a portion or all of their flexible benefit allowance to purchase at least the basic plan. On or before January 1 of each year, the Council shall design the basic plan for the next plan year to insure that the basic plan provides adequate coverage to all participants. All benefit plans, whether offered by the Board, a health maintenance organization or other vendors shall at least meet the minimum requirements set by the Council for the basic plan.

B. The Board shall offer health, dental, disability, life and dental coverage to all participants and their dependents. For health, dental, disability and life coverage, the Board shall offer plans at the basic benefit level established by the Council, and in addition, may offer benefit plans that provide an enhanced level of benefits. The Board shall be responsible for determining the plan design and the benefit price for the plans that they offer. Effective for the plan year beginning July 1, 1997, and for each year thereafter, in setting health insurance premiums for active

employees and for retirees under sixty-five (65) years of age, the Board shall set the monthly premium for active employees at a maximum of Ninety Dollars (\$90.00) less than the monthly premium for retirees under sixty-five (65) years of age.

The benefits price for the basic plan during a plan year shall not exceed the flexible benefits allowance for the same plan year. The Council shall approve the plan designs to assure that they meet the minimum benefit levels.

Nothing in this subsection shall be construed as prohibiting the Board from offering additional medical plans, provided that any medical plan offered to participants shall meet or exceed the benefits provided in the medical portion of the basic plan.

C. In lieu of electing any of the preceding medical benefit plans, a participant may elect medical coverage by any health maintenance organization made available to participants by the Council. The benefit price of any health maintenance organization shall be determined annually by a sealed bid process conducted through the Central Purchasing Division of the Department of Central Services. All plans offered by health maintenance organizations meeting the bid requirements as determined by the Council shall be accepted. Provided, however, the Council shall have the authority to reject the bid or restrict enrollment in any health maintenance organization for which the benefit price is determined to be excessive by the Council. In making such determination the Council shall examine the most recent financial data of the health maintenance organization and shall consider the prices charged for comparable plans offered to other groups. All bidders shall submit along with their bid a notarized, sworn statement as provided by Section 85.22 of this title. The Council shall have the authority to reject any plan that does not meet the bid requirements.

Effective for the plan year beginning July 1, 1997, and for each year thereafter, in setting health insurance premiums for active employees and for retirees under sixty-five (65) years of age, HMOs, self-insured organizations and prepaid plans shall set the monthly premium for active employees at a maximum of Ninety Dollars (\$90.00) less than the monthly premium for retirees under sixty-five (65) years of age.

D. Nothing in this section shall be construed as prohibiting the Council from offering additional qualified benefit plans or currently taxable benefit plans.

E. Each employee of a participating employer who meets the eligibility requirements for participation in the flexible benefits plan shall make an annual election of benefits under the plan during an enrollment period to be held prior to the beginning of each plan year. The enrollment period dates will be determined annually and will be announced by the Council, providing the enrollment period shall end no later than thirty (30) days before the beginning of the plan year.

Each such employee shall make an irrevocable advance election for the plan year or the remainder thereof pursuant to such procedures as the Council shall prescribe. Any such employee who fails to make a proper election under the plan shall, nevertheless, be a participant in the plan and shall be deemed to have purchased the default benefits described in this section.

F. The Council shall prescribe the forms that participants will be required to use in making their elections, and may prescribe deadlines and other procedures for filing the elections.

G. Any participant who, in the first year for which he or she is eligible to participate in the plan, fails to make a proper election under the plan in conformance with the procedures set forth

in this section or as prescribed by the Council shall be deemed automatically to have purchased the default benefits. The default benefits shall be the same as the basic plan benefits. Any participant who, after having participated in the plan during the previous plan year, fails to make a proper election under the plan in conformance with the procedures set forth in this section or prescribed by the Council, shall be deemed automatically to have purchased the same benefits which the participant purchased in the immediately preceding plan year, except that the participant shall not be deemed to have elected coverage under the health care reimbursement account plan or the dependent care reimbursement account plan.

H. Benefit plan contracts with the Board, health maintenance organizations, and other third party insurance vendors shall provide for a risk adjustment factor for adverse selection that may occur, as determined by the Council, based on generally accepted actuarial principles.

SECTION 4. This act shall become effective July 1, 1996.

Passed the Senate the 29th day of April, 1996.

President of the Senate

Passed the House of Representatives the 3rd day of April, 1996.

Speaker of the House of Representatives