

SHORT TITLE: Insurance; Oklahoma High Risk Pool; emergency.

STATE OF OKLAHOMA

1st Session of the 46th Legislature (1997)

SENATE BILL NO. 193

By: Hendrick

AS INTRODUCED

An Act relating to insurance; amending Section 2, Chapter 250, O.S.L. 1995, as amended by Section 2, Chapter 249, O.S.L. 1996, Section 4, Chapter 250, O.S.L. 1995, as amended by Section 3, Chapter 249, O.S.L. 1996, Section 12, Chapter 250, O.S.L. 1995, as amended by Section 7, Chapter 249, O.S.L. 1996 (36 O.S. Supp. 1996, Sections 6532, 6534 and 6542), which relate to the Health Insurance High Risk Pool Act; expanding definitions; expanding persons eligible for coverage; prohibiting application of certain provisions of law to federally defined eligible individuals; providing for exemption and waiver of certain waiting periods for certain applicant; and declaring an emergency.

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

SECTION 1. AMENDATORY Section 2, Chapter 250, O.S.L. 1995, as amended by Section 2, Chapter 249, O.S.L. 1996 (36 O.S. Supp. 1996, Section 6532), is amended to read as follows:

Section 6532. As used in the Health Insurance High Risk Pool Act:

1. "Agent" means any person who is licensed to sell health insurance in this state;

2. "Board" means the Board of Directors of the Health Insurance High Risk Pool;

3. "Church plan" has the meaning given such term under Section 3(33) of the Employee Retirement Income Security Act of 1974;

4. "Credible coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

- a. a group health plan,
- b. health insurance coverage,
- c. Part A or B of Title XVIII of the Social Security Act,
- d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 of such act,
- e. Chapter 55 of Title 10, U.S. Code,
- f. a medical care program of the Indian Health Service or of a tribal organization,
- g. a state health benefits risk pool,
- h. a health plan offered under Chapter 89 of Title 5, U.S. Code,
- i. a public health plan as defined in federal regulations, or
- j. a health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);

5. "Federally defined eligible individual" means an individual:

- a. for whom, as of the date on which the individual seeks coverage under Section 6531 et seq. of this title, the aggregate of the periods of creditable coverage, as defined in Section 1D of the Employee Retirement Income Security Act of 1974, is eighteen (18) or more months,
- b. whose most recent prior creditable coverage was under a group health plan governmental plan, church plan or

health insurance coverage offered in conjunction with any such plan,

- c. who is not eligible for coverage under a group health plan, part A or B of Title XVIII of the Social Security Act, or a state plan under Title XIX of such Act or any successor program and who does not have other health insurance coverage,
- d. with respect to whom the most recent coverage under a COBRA continuation provision or under a similar state program, elected such coverage, and
- e. who has exhausted such continuation coverage under such provision or program, if the individual elected the continuation coverage described in paragraph 5 of this section;

6. "Governmental plan" has the same meaning given such term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan;

7. "Group health benefit plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care as defined in Section 3N of the Employee Retirement Income Security Act of 1974 and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise;

8. "Health insurance" means any individual or group hospital or medical expense-incurred policy or health care benefits plan or contract. The term does not include any policy governing short-term accidents only, a fixed-indemnity policy, a limited benefit policy, a specified accident policy, a specified disease policy, a Medicare supplement policy, a long-term care policy, medical payment or personal injury coverage in a motor vehicle policy, coverage issued

as a supplement to liability insurance, a disability policy, or workers' compensation;

~~4.~~ 9. "Insurer" means any individual, corporation, association, partnership, fraternal benefit society, or any other entity engaged in the health insurance business, except insurance agents and brokers. This term shall also include not-for-profit hospital service and medical indemnity plans, health maintenance organizations, preferred provider organizations, prepaid health plans, the State and Education Employees Group Health Insurance Plan, and any reinsurer reinsuring health insurance in this state, which shall be designated as engaged in the business of insurance for the purposes of Section 6531 et seq. of this act title;

~~5.~~ 10. "Medical care" means amounts paid for:

- a. the diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,
- b. transportation primarily for and essential to medical care referred to in paragraph 1 of this section, and
- c. insurance covering medical care referred to in paragraphs 1 and 2 of this section;

11. "Medicare" means coverage under Parts A and B of Title XVIII of the Social Security Act (Public Law 74-271, 42 U.S.C., Section 1395 et seq., as amended);

~~6.~~ 12. "Pool" means the Health Insurance High Risk Pool;

~~7.~~ 13. "Physician" means a doctor of medicine and surgery, doctor of osteopathic medicine, doctor of chiropractic, doctor of podiatric medicine, doctor of optometry, and, for purposes of oral and maxiofacial surgery only, a doctor of dentistry, each duly licensed by this state;

~~8.~~ 14. "Plan" means the comprehensive health insurance benefit plan as adopted by the Board of Directors of the Health Insurance High Risk Pool, or by rule; and

~~9.~~ 15. "Reinsurer" means any insurer as defined in Section 103 of this title from whom any person providing health insurance to Oklahoma insureds procures insurance for itself as the insurer, with respect to all or part of the health insurance risk of the person.

SECTION 2. AMENDATORY Section 4, Chapter 250, O.S.L. 1995, as amended by Section 3, Chapter 249, O.S.L. 1996 (36 O.S. Supp. 1996, Section 6534), is amended to read as follows:

Section 6534. A. Except as otherwise provided in this section, any person who maintains a primary residence in this state for at least one (1) year or is a federally defined eligible individual shall be eligible for coverage under the plan of the Health Insurance High Risk Pool including:

1. The spouse of the insured; and
2. Any dependent unmarried child of the insured, from the moment of birth. Such coverage shall terminate at the end of the premium period in which the child marries, ceases to be a dependent of the insured, or attains the age of nineteen (19) years, whichever occurs first. However, if the child is a full-time student at an accredited institution of higher learning, the coverage may continue while the child remains unmarried and a full-time student, but not beyond the premium period in which the child reaches the age of twenty-three (23) years.

B. 1. No person is eligible for coverage under the Pool plan unless such person has been rejected by at least two insurers for coverage substantially similar to the plan coverage. As used in this paragraph, rejection includes an offer of coverage with a material underwriting restriction or an offer of coverage at a rate equal to or greater than the Pool plan rate. No person is eligible for coverage under the plan if such person has, on the date of issue

of coverage under the plan, equivalent coverage under another health insurance contract or policy.

2. No person who is currently receiving, or is entitled to receive, health care benefits under any federal or state program providing financial assistance or preventive and rehabilitative social services is eligible for coverage under the plan.

3. No person who is covered under the plan and who terminates coverage is again eligible for coverage unless twelve (12) months has elapsed since the coverage was terminated; provided, however, this provision shall not apply to an applicant who is a federally defined eligible individual. The Board of Directors of the Health Insurance High Risk Pool may waive the twelve-month waiting period under circumstances to be determined by the Board.

4. No person on whose behalf the plan has paid out Five Hundred Thousand Dollars (\$500,000.00) in covered benefits is eligible for coverage under the plan.

5. No inmate incarcerated in any state penal institution or confined to any narcotic detention, treatment, and rehabilitation facility shall be eligible for coverage under the plan; provided, however, this provision shall not apply with respect to an applicant who is a federally defined eligible individual.

C. The Board may establish an annual enrollment cap if the Board determines it is necessary to limit costs to the plan.

D. The coverage of any person who ceases to meet the eligibility requirements of this section may be terminated at the end of the month in which an individual no longer meets the eligibility requirements.

SECTION 3. AMENDATORY Section 12, Chapter 250, O.S.L. 1995, as amended by Section 7, Chapter 249, O.S.L. 1996 (36 O.S. Supp. 1996, Section 6542), is amended to read as follows:

Section 6542. A. 1. The plan shall offer as one basic option an annually renewable policy with coverage as specified in this

section for each eligible person, except, that if an eligible person is also eligible for Medicare coverage, the plan shall not pay or reimburse any person for expenses paid by Medicare.

2. Any person whose health insurance is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan. If such coverage is applied for within sixty (60) days after the involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage shall be the date of termination of the previous coverage.

3. The plan shall provide that, upon the death, annulment of marriage or divorce of the individual in whose name the contract was issued, every other person covered in the contract may elect within sixty (60) days to continue coverage under a continuation or conversion policy.

4. No coverage provided to a person who is eligible for Medicare benefits shall be issued as a Medicare supplement policy.

B. The plan shall offer as a minimum major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered under the plan shall pay an eligible person's covered expenses, subject to the limits on the deductible and coinsurance payments authorized under subsection E of this section up to a lifetime limit of Five Hundred Thousand Dollars (\$500,000.00) per covered individual. The maximum limit under this paragraph shall not be altered by the Board of Directors of the Health Insurance High Risk Pool, and no actuarially equivalent benefit may be substituted by the Board.

C. Except for a health maintenance organization and prepaid health plan or preferred provider organization utilized by the Board or a covered person, the usual customary charges for the following services and articles, when prescribed by a physician, shall be covered expenses:

1. Hospital services;
2. Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental, which are rendered by a physician or by others at the direction of a physician;
3. Drugs requiring a physician's prescription;
4. Services of a licensed skilled nursing facility for eligible individuals, ineligible for Medicare, for not more than one hundred eighty (180) calendar days during a policy year, if the services are the type which would qualify as reimbursable services under Medicare;
5. Services of a home health agency, if the services are of a type which would qualify as reimbursable services under Medicare;
6. Use of radium or other radioactive materials;
7. Oxygen;
8. Anesthetics;
9. Prosthesis, other than dental prosthesis;
10. Rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;
11. Diagnostic x-rays and laboratory tests;
12. Oral surgery for partially or completely erupted, impacted teeth and oral surgery with respect to the tissues of the mouth when not performed in connection with the extraction or repair of teeth;
13. Services of a physical therapist;
14. Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;
15. Processing of blood, including, but not limited to, collecting, testing, fractioning, and distributing blood; and
16. Services for the treatment of alcohol and drug abuse, but the plan shall be required to make a fifty percent (50%) co-payment and the payment of the plan shall not exceed Four Thousand Dollars (\$4,000.00).

Usual and customary charges shall not exceed the reimbursement rate for charges as set by the State and Education Employees Group Insurance Board.

D. 1. Covered expenses shall not include the following:

- a. any charge for treatment for cosmetic purposes, other than for repair or treatment of an injury or congenital bodily defect to restore normal bodily functions,
- b. any charge for care which is primarily for custodial or domiciliary purposes which do not qualify as eligible services under Medicaid,
- c. any charge for confinement in a private room to the extent that such charge is in excess of the charge by the institution for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician,
- d. that part of any charge for services or articles rendered or provided by a physician or other health care personnel which exceeds the prevailing charge in the locality where the service is provided, or any charge for services or articles not medically necessary,
- e. any charge for services or articles the provision of which is not within the authorized scope of practice of the institution or individual providing the service or articles,
- f. any expense incurred prior to the effective date of the coverage under the plan for the person on whose behalf the expense was incurred,
- g. any charge for routine physical examinations in excess of one every twenty-four (24) months,

- h. any charge for the services of blood donors and any fee for the failure to replace the first three (3) pints of blood provided to an eligible person annually, and
- i. any charge for personal services or supplies provided by a hospital or nursing home, or any other nonmedical or nonprescribed services or supplies.

2. The plan may provide an option for a person to have coverage for the expenses set out in paragraph 1 of this subsection or any benefits payable under any other health insurance policy or plan, commensurate with the deductible and coinsurance selected.

E. 1. The plan shall provide for a choice of annual deductibles per person covered for major medical expenses in the amounts of Five Hundred Dollars (\$500.00), One Thousand Dollars (\$1,000.00), One Thousand Five Hundred Dollars (\$1,500.00), Two Thousand Dollars (\$2,000.00), Five Thousand Dollars (\$5,000.00) and Seven Thousand Five Hundred Dollars (\$7,500.00), plus the additional benefits payable at each level of deductible; provided, if two individual members of a family satisfy the applicable deductible, no other members of the family shall be required to meet deductibles for the remainder of that calendar year.

2. The schedule of premiums and deductibles shall be established by the Board.

3. Rates for coverage issued by the Pool may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing coverage.

4. Separate schedules of premium rates based on age may apply for individual risks.

5. Rates are subject to approval by the Insurance Commissioner.

6. Standard risk rates for coverages issued by the Pool shall be established by the Board, subject to the approval of the Insurance Commissioner, using reasonable actuarial techniques, and

shall reflect anticipated experiences and expenses of such coverage for standard risks.

7. a. The rating plan established by the Board shall initially provide for rates equal to one hundred twenty-five percent (125%) of the average standard risk rates of the five largest insurers doing business in the state.
- b. Any change to the initial rates shall be based on experience of the plan and shall reflect reasonably anticipated losses and expenses. The rates shall not increase more than five percent (5%) annually with a maximum rate not to exceed one hundred fifty percent (150%) of the average standard risk rates.
8. a. A Pool policy may contain provisions under which coverage is excluded during a period of twelve (12) months following the effective date of coverage with respect to a given covered person's preexisting condition, as long as:
 - (1) the condition manifested itself within a period of six (6) months before the effective date of coverage, or
 - (2) medical advice or treatment for the condition was recommended or received within a period of six (6) months before the effective date of coverage; provided, however, this provision shall not apply to a person who is a federally defined eligible individual.
- b. The Board shall waive the twelve-month period if the person had continuous coverage under another policy with respect to the given condition within a period of six (6) months before the effective date of coverage under the Pool plan. The Board shall also waive any

preexisting waiting periods for an applicant who is a federally defined eligible individual.

9. a. No amounts paid or payable by Medicare or any other governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may be made or recognized as claims under such policy, or be recognized as or towards satisfaction of applicable deductibles or out-of-pocket maximums, or to reduce the limits of benefits available, ~~and~~.
- b. The Board shall have a cause of action against a covered person for any benefits paid to a covered person which should not have been claimed or recognized as claims because of the provisions of this paragraph, or because otherwise not covered.

SECTION 4. 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.

46-1-0176

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