

SHORT TITLE: Oklahoma State Employees Benefits Act; allowing female participants to choose their gynecologist; effective date; emergency.

STATE OF OKLAHOMA

1st Session of the 46th Legislature (1997)

SENATE BILL NO. 752

By: Campbell

AS INTRODUCED

An Act relating to state employee benefits; amending Section 11, Chapter 400, O.S.L. 1992, as last amended by Section 8, Chapter 288, O.S.L. 1996 (74 O.S. Supp. 1996, Section 1371), which relates to health care provider contracts; allowing female participants to choose their gynecologist; providing an effective date; and declaring an emergency.

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

SECTION 1. AMENDATORY Section 11, Chapter 400, O.S.L. 1992, as last amended by Section 8, Chapter 288, O.S.L. 1996 (74 O.S. Supp. 1996, 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 offer a high deductible health benefit plan which, after meeting the higher deductible amount, shall have the same coinsurance and benefit limits as the basic benefit plan but with a higher deductible amount and with copayments which are no greater than the basic benefit plan. 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. A participant may elect the high deductible health benefit plan offered by the Board and any excess flexible benefit allowance remaining after payment of the higher deductible benefit price may be deposited in a medical ~~saving~~ savings account established in accordance with the Medical ~~Saving~~ Savings Account Act. Any excess flexible benefit allowance deposited in a medical saving account shall not be considered taxable compensation.

D. 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.

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

F. All of the preceding medical benefit plans shall allow female participants in such plans to choose their own gynecologists for both wellness checks and any preventative or post-operative care that is agreed to by the primary care physician.

G. 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.

~~G.~~ H. 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.

~~H.~~ I. 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.

~~I.~~ J. 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 2. This act shall become effective July 1, 1997.

SECTION 3. 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.

46-1-0797

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