

ENGROSSED HOUSE AMENDMENT

TO

ENGROSSED SENATE BILL NO. 1527

By: Snyder of the Senate

and

Liotta of the House

An Act relating to insurance; amending Section 2, Chapter 329, O.S.L. 1992, as last amended by Section 2, Chapter 304, O.S.L. 1998 (36 O.S. Supp. 1999, Section 6512), which relates to the Small Employer Health Insurance Reform Act; modifying definitions; providing an effective date; and declaring an emergency.

AMENDMENT NO. 1. Strike the title, enacting clause and entire bill and insert

"An Act relating to insurance; amending Section 2, Chapter 329, O.S.L. 1992, as last amended by Section 2, Chapter 304, O.S.L. 1998 (36 O.S. Supp. 1999, Section 6512), which relates to the Small Employer Health Insurance Reform Act; modifying definitions; defining terms; requiring legislative fiscal impact reports concerning mandated health benefits; specifying contents of reports; providing for codification; providing an effective date; and declaring an emergency.

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

SECTION 1. AMENDATORY Section 2, Chapter 329, O.S.L. 1992, as last amended by Section 2, Chapter 304, O.S.L. 1998 (36 O.S. Supp. 1999, Section 6512), is amended to read as follows:

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

1. "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Insurance Commissioner that a small employer

carrier is in compliance with the provisions of Section 6515 of this title, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans;

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

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

4. "Board" means the board of directors of the program established pursuant to Section § 6522 of this ~~act~~ title;

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

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

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

7. "Class of business" means all or a separate grouping of small employers established pursuant to Section 6514 of the Small Employer Health Insurance Reform Act;

8. "Commissioner" means the Insurance Commissioner;

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

10. "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;

11. "Department" means the Insurance Department;

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

13. "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. The term "eligible employee" may include, at the discretion of the small employer, leased employees working for a small employer twenty-four (24) hours or more per week, provided:

- a. if leased employees are included, every leased employee working the required twenty-four (24) hours or more shall be entitled to enroll in the health benefit plan,
- b. the leased and nonleased employees shall be aggregated for purposes of determining the minimum criteria to meet the normal enrollment standards of the carrier, and
- c. the small employer provides appropriate verification of the employment status of the leased employee.

The provisions of this paragraph shall not be construed to require a small employer to include leased employees as eligible employees for purposes of coverage in a health benefit plan;

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

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

b. "Health benefit plan" does not include accident-only, credit, dental, vision, Medicare supplement, long-term

care, or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, any plan certified by the Oklahoma Basic Health Benefits Board, or automobile medical payment insurance.

- c. "Health benefit plan" shall not include policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance, provided that the carrier offering such policies or certificates complies with the following:
- (1) the carrier files on or before March 1 of each year a certification with the Commissioner that contains the statement and information described in division (2) of this subparagraph,
  - (2) the certification required in division (1) of this subparagraph shall contain the following:
    - (a) a statement from the carrier certifying that policies or certificates described in this subparagraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance, and
    - (b) a summary description of each policy or certificate described in this subparagraph, including the average annual premium rates (or range of premium rates in cases where premiums vary by age, gender or other factors) charged for such policies and certificates in this state, and
  - (3) in the case of a policy or certificate that is described in this subparagraph and that is

offered for the first time in this state on or after ~~the effective date of this act~~ July 1, 1994, the carrier files with the Commissioner the information and statement required in division (2) of this subparagraph at least thirty (30) days prior to the date such a policy or certificate is issued or delivered in this state;

16. "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;

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

a. the individual meets each of the following:

- (1) the individual was covered under qualifying previous coverage at the time of the initial enrollment,
- (2) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse or divorce, and
- (3) the individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage,

b. the individual is employed by an employer which offers multiple health benefit plans and the individual

elects a different plan during an open enrollment period, or

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

18. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

19. "Plan of operation" means the plan of operation of the program established pursuant to Section § 6522 of this ~~act~~ title;

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

21. "Program" means the Oklahoma Small Employer Health Reinsurance Program created pursuant to Section § 6522 of this ~~act~~ title;

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

- a. Medicare or Medicaid,
- b. an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan, or
- c. an individual health insurance policy, including coverage issued by a health maintenance organization, fraternal benefit society and those entities set forth

in Section 2501 et seq. of Title 63 of the Oklahoma Statutes, that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that such policy has been in effect for a period of at least one (1) year;

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

24. "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to Section ~~§~~ 6522 of this ~~act~~ title;

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

26. "Risk-assuming carrier" means a small employer carrier whose application is approved by the Commissioner pursuant to Section ~~7~~ 6521 of this ~~act~~ title;

27. "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 fifty (50) eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state income taxation, shall be considered one employer; and

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

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 354 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. "Mandated health benefit" means a statute, state board or commission's official action, or an administrative rule of this state which requires a health benefit plan to do any of the following:

1. Permit a person covered under the health benefit plan to obtain treatment or services from a particular type of health care provider, including, but not limited to, requiring a health maintenance organization, preferred provider plan, or other plan to contract with or credential a health care provider or providers for participation in the plan or plans;

2. Provide coverage for the treatment of a particular disease, condition or other health care need;

3. Provide coverage of a particular type of health care treatment or service, or of equipment, supplies or drugs used in connection with a health care treatment or service;

4. Provide coverage for particular persons because of their relation to the covered individual or legal status with respect to the covered individual, or for any other reason; or

5. Require network arrangements contrary to those currently contracted by the health benefit plan.

B. The State Senate and the Oklahoma House of Representatives fiscal staffs shall jointly submit a report on the fiscal impact of any mandated health benefit as defined in this section affecting any health benefit plan to the Governor, President Pro Tempore of the Senate, and the Speaker of the House of Representatives. Such report shall be considered by the legislature and the executive branch prior to the final adoption of any mandated health benefit.

C. Any report prepared pursuant to subsection B of this section shall assess, to the extent possible when relevant data is

available, all of the following social impact factors which are relevant to the type of mandated health benefit created, expanded or continued by this act:

1. The number of this state's residents who use the treatments or services covered by the mandated health benefit;

2. The extent to which individuals under subsection A of this section use those treatments or services; and

3. The availability of health benefit plan coverage for such treatments or services.

D. Any report prepared pursuant to subsection B of this section shall assess, to the extent possible when relevant data is available, all of the following financial impact factors which are relevant to the type of mandated health benefit created, expanded or continued by this act:

1. Whether the mandated health benefit would increase the use of the treatments or services covered by the mandated health benefit;

2. The impact of the mandated health benefit on total costs of health care in the state;

3. Whether the mandated health benefit would increase the administrative costs of health benefit plans and the premium costs to policyholders;

4. The number of persons who would be eligible for coverage under the mandated health benefit and the availability of coverage for those persons without the mandated health benefit; and

5. The number of persons currently enrolled in self-insured plans that are not subject to the mandated health benefit.

E. In preparing the report, the fiscal staff shall use outside sources as is necessary to obtain relevant data. If relevant data is not available to address any of the listed social and financial impact factors, the report shall be prepared without an assessment of those factors.

As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection G of Section 6060.3 of Title 36 of the Oklahoma Statutes.

SECTION 3. This act shall become effective July 1, 2000.

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."

Passed the House of Representatives the 18th day of April, 2000.

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Speaker of the House of  
Representatives

Passed the Senate the \_\_\_\_ day of \_\_\_\_\_, 2000.

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President of the Senate