ENGROSSED HOUSE
BILL NO. 2725

By: Thornbrugh of the House

and

Smith of the Senate

An Act relating to insurance; amending 36 O.S. 1991, Sections 4423 and 4424, as last amended by Section 1, Chapter 180, O.S.L. 1997 (36 O.S. Supp. 1999, Section 4424), which relate to the Long-Term Care Insurance Act; providing an exception for certain entities from requirements of the Long-Term Care Insurance Act; modifying certain definition; amending Section 3, Chapter 329, O.S.L. 1992, as last amended by Section 1, Chapter 360, O.S.L. 1999 (36 O.S. Supp. 1999, Section 6513), which relates to the Small Employer Health Insurance Reform Act; eliminating prohibition against certain ceding arrangements; requiring certain health benefit plans to provide coverage for wigs or other scalp prostheses; providing for procedures, requirements, and limitations; defining terms; providing for rules; 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 36 O.S. 1991, Section 4423, is amended to read as follows:

Section 4423. A. The requirements of the Long-Term Care Insurance Act shall apply to policies, other than life care community policies delivered or issued for delivery in this state on or after November 1, 1987. The requirements of the Long-Term Care Insurance Act shall apply to life care community policies delivered or issued for delivery in this state on or after November 1, 1989.

B. Notwithstanding any other provision, the Long-Term Care Insurance Act shall not apply to the following:

1. Residential care homes licensed pursuant to the Oklahoma Residential Care Act;

2. Assisted living centers and continuum of care facilities licensed pursuant to the Oklahoma Continuum of Care and Assisted Living Act; or

3. Facilities licensed pursuant to the Oklahoma Nursing Home Care Act.

C. The Long-Term Care Insurance Act is not intended to supersede the obligations of entities subject to said act to comply with the substance of other applicable insurance laws insofar as they do not conflict with the Long-Term Care Insurance Act, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not apply to long-term care insurance. A policy which is not advertised, marketed or offered as long-term care insurance need not meet the requirements of the Long-Term Care Insurance Act. The Long-Term Care Insurance Act is not intended to require life care communities to be licensed insurers. Life care communities which are not licensed insurers shall not be subject to the provisions of the Insurance Code or the jurisdiction of the Insurance Commissioner, except as provided in the Long-Term Care Insurance Act.

SECTION 2. AMENDATORY 36 O.S. 1991, Section 4424, as last amended by Section 1, Chapter 180, O.S.L. 1997 (36 O.S. Supp. 1999, Section 4424), is amended to read as follows:

Section 4424. Unless the context requires otherwise, the definitions in this section apply throughout the Long-Term Care Insurance Act~~, Section 4421 et seq. of this title~~.

1. a. "Long-term care insurance" means any insurance policy or rider, including qualified long-term care insurance contracts, which are advertised, marketed, offered or designed primarily to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically

necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital.

b. This term includes group and individual health policies or riders or group and individual life policies or annuities or riders which provide, directly or as a supplement, coverage for long-term care, whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, life care communities, or any similar organization.

c. This term also includes a policy or rider which provides for payment of long-term care benefits based upon cognitive impairment or the loss of functional capacity.

d. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage or related asset-protection coverage, catastrophic coverage, comprehensive coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

e. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical

conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

f. Notwithstanding any other provision contained herein, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this act.

2. "Applicant" means:

a. in the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits, and

b. in the case of a group long-term care insurance policy, the proposed certificate holder.

3. "Certificate" means any certificate issued under a group long-term care insurance policy, which certificate has been delivered, or issued for delivery, in this state.

4. "Group long-term care insurance" means a long-term care insurance policy which is delivered, or issued for delivery, in this state and issued to:

a. one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof or for members or former members, or a combination thereof, of the labor organizations, or

b. any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

(1) is composed of individuals, all of whom are or were actively engaged in the same profession, trade or occupation, and

(2) has been maintained in good faith for purposes other than insurance, or

c. an association, a trust, or the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the Insurance Commissioner that the association or associations shall have at the outset of transacting long-term care insurance in this state a minimum of one hundred (100) persons in the association or associations and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least one (1) year; and shall have a constitution and bylaws which provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees. Thirty (30) days after such filing the association or associations shall be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements, or

d. a group other than as described in subparagraphs a, b and c of this paragraph, subject to a finding by the Commissioner that:

(1) the issuance of the group policy is not contrary to the best interest of the public,

(2) the issuance of the group policy would result in economies of acquisition or administration, and

(3) the benefits are reasonable in relation to the premiums charged.

5. "Life care community" means any arrangement pursuant to which a person contracts for a place of residence and personal care services, including but not limited to services which progress from independent living to semi-dependent nursing care to acute nursing care, in consideration of a payment or payments of fees prior to the delivery of services and accommodations. Life care community shall not include the following:

a. traditional ~~residential~~ landlord and tenant agreements utilizing periodic rental and security deposit payments,

b. residential care homes licensed pursuant to the Oklahoma Residential Care Act,

c. assisted living centers and continuum of care facilities licensed pursuant to the Oklahoma Continuum of Care and Assisted Living Act, or

d. facilities licensed pursuant to the Oklahoma Nursing Home Care Act.

6. "Policy" means any policy, contract, certificate, subscriber agreement, rider or endorsement delivered, or issued for delivery, in this state by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization, life care community, or any similar organization.

7. "Qualified long-term care insurance contract" means any:

a. individual or group insurance contract if the contract meets the requirements of Section 7702(B) of the Internal Revenue Code, as amended, and if~~,~~:

~~1.~~ (1) the only insurance protection provided under the contract is coverage of qualified long-term care services,

~~2.~~ (2) the contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to contracts where Medicare is a secondary payor, or where the contract makes per diem or other periodic payments without regard to expenses,

~~3.~~ (3) the contract is guaranteed renewable,

~~4.~~ (4) the contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed. All refunds of premiums and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund of the aggregate premium paid under the contract may be allowed in the event of death of the insured or a complete surrender or cancellation of the contract, and

~~5.~~ (5) the contract contains the consumer protection provisions set forth in Section 7702(B)(g) of the Internal Revenue Code~~,~~, or

b. life insurance contract which provides long-term care coverage by rider or as part of the contract if the contract complies with the applicable provisions of Section 7702(B) of the Internal Revenue Code, as amended.

8. "Qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance for personal care services for which an insured is eligible under a qualified long-term care insurance contract, and which are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

SECTION 3. AMENDATORY Section 3, Chapter 329, O.S.L. 1992, as last amended by Section 1, Chapter 360, O.S.L. 1999 (36 O.S. Supp. 1999, Section 6513), is amended to read as follows:

Section 6513. A. The Small Employer Health Insurance Reform Act shall apply to any group health benefit plan that provides coverage to two (2) or more eligible employees of a small employer in this state and to individual health benefits plans providing coverage for the eligible 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 or Section 106 of the United States Internal Revenue Code.

B. 1. Except as provided in paragraph 2 of this subsection, for the purposes of the Small Employer Health Insurance Reform Act, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by the Small Employer Health Insurance Reform Act shall apply as if all health benefit plans issued to small employers in this state by such affiliated carriers 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.

2. An affiliated carrier that is a health maintenance organization having a license under Section 2501 et seq. of Title 63 of the Oklahoma Statutes may be considered to be a separate carrier for the purposes of the Small Employer Health Insurance Reform Act.

~~C. Unless otherwise authorized by the Insurance Commissioner, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent (50%) of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier.~~

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.9 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Any health benefit plan, including the State and Education Employees Group Health Insurance Plan, that is offered, issued, or renewed in this state on or after January 1, 2001, that provides medical and surgical benefits with respect to the treatment of cancer and other conditions treated by chemotherapy or radiation therapy shall provide coverage for wigs or other scalp prostheses necessary for the comfort and dignity of the covered person.

B. The coverage provided for by this section shall be subject to the same annnual deductibles, copayments, or coinsurance limits as established for all other covered benefits under the health benefit plan not to exceed Two Hundred Dollars ($200.00).

C. A health benefit plan shall provide notice to each insured or enrollee under such plan regarding the coverage required by this section in the plan's evidence of coverage and shall provide additional written notice of the coverage to the insured or enrollee as follows:

1. In the next mailing made by the plan to the insured or enrolled employee;

2. As part of any yearly informational packet sent to the enrollee; or

3. Not later than December 1, 2000;

whichever is earlier.

D. As used in this act, "health benefit plan" means any plan or arrangement as defined in subsection D of Section 6060.8 of Title 36 of the Oklahoma Statutes. However, this section shall not apply to policies or certificates issued to individuals or groups with fifty (50) or fewer employees.

E. The Insurance Commissioner shall promulgate any rules necessary to implement the provisions of this section.

SECTION 5. This act shall become effective July 1,2000.

SECTION 6. 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 13th day of March, 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