

ENROLLED SENATE
BILL NO. 1233

By: Monson and Coffee of the
Senate

and

Wells and Phillips of the
House

An Act relating to insurance; amending 36 O.S. 2001, Sections 6532, 6534, 6535, 6536, 6538 and 6542, which relate to the Health Insurance High Risk Pool and the Oklahoma Health Care Authority; providing definitions; modifying outline; clarifying language concerning plans; amending reference to Pool plan rate; amending certain eligibility reference; requiring the Board of Directors of the Health Insurance High Risk Pool to adopt alternative health insurance plans; deleting obsolete language; providing discretionary benefit structures; providing time period for request for proposals; clarifying payment of assessment to the Insurance Commissioner; deleting certain provisions concerning cost-containment measures; allowing Board to implement disease management programs; requiring the Board to implement a multi-tier pharmacy benefit design; requiring the Board to make a certain annual report and recommendations concerning cost-containment measures; modifying duties of the administering insurer; requiring the Board to select a case manager or managers; providing for competitive bid of case managers; establishing criteria when evaluating bids; providing term of service for case managers; providing time period for invitations to bid and selection of case managers; providing for termination of service; providing for acceptance of bids upon termination of service of other case managers; providing duties of case managers; providing for payment of direct and indirect expenses of case managers; defining "direct and indirect expenses"; allowing the Board to provide financial incentives to case managers; clarifying language concerning the basic option; amending 74 O.S. 2001, Sections 1321 and 1365, which relate to state and education employee benefits; amending reference; authorizing the Oklahoma State Employees Benefits Council to renegotiate rates in certain circumstances; defining extraordinary circumstance; prohibiting certain unilateral changes to the contract; requiring certain duties of the Oklahoma State Employees Benefits Council and State and Education Employees Group Insurance Board; requiring development of service

areas; exempting participating health maintenance organizations from offering enrollment in every service area; exempting participating health maintenance organizations from being mandated to offer a Medicare supplement plan; providing an exception; requiring participating health maintenance organization to meet standardized benefit plan; allowing participating health maintenance organizations to offer certain enhancements; providing maximum time period for payment of premiums; requiring the Oklahoma Health Care Authority to conduct a certain feasibility study and supply a report; requiring the Health Insurance High Risk Pool to assist in the study as needed; providing for noncodification; 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. 2001, 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. "Primary plan" means the comprehensive health insurance benefit plan adopted by the Board of Directors of the Health Insurance High Risk Pool which meets all requirements of federal law as a plan required to be offered by the Pool;

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

~~3.~~ 4. "Church plan" has the meaning given such term under Section 3(33) of the Employee Retirement Income Security Act of 1974;

~~4.~~ 5. "Creditable 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.~~ 6. "Federally defined eligible individual" means an individual:

- a. for whom, as of the date on which the individual seeks coverage under the Health Insurance High Risk Pool Act, 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 this paragraph ~~5~~ of this section;

~~6.~~ 7. "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.~~ 8. "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.~~ 9. "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;

~~9.~~ 10. "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 title;

~~10.~~ 11. "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.~~ 12. "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);

~~12.~~ 13. "Pool" means the Health Insurance High Risk Pool;

~~13.~~ 14. "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 maxillofacial surgery only, a doctor of dentistry, each duly licensed by this state;

~~14.~~ 15. "Plan" means any of the comprehensive health insurance benefit ~~plan~~ plans as adopted by the Board of Directors of the Health Insurance High Risk Pool, or by rule; ~~and~~

~~15.~~ 16. "Alternative plan" means any of the comprehensive health insurance benefit plans adopted by the Board of Directors of the Health Insurance High Risk Pool other than the primary plan; and

17. "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 36 O.S. 2001, 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 any of the plan plans 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 any of the Pool plan plans unless such person has been rejected by at least two insurers for coverage substantially similar to the primary 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 primary Pool plan rate rates. No person is eligible for coverage under any of the plan plans if such person has, on the date of issue of coverage under any of the plan plans, ~~equivalent~~ coverage equivalent to the primary plan under another health insurance contract or policy. This paragraph shall not apply to federally defined eligible individuals.

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 any of the plan plans.

3. No person who is covered under any of the plan plans 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 any of the ~~plan~~ plans have paid out an aggregate from any or all offered plans of Five Hundred Thousand Dollars (\$500,000.00) in covered benefits is eligible for coverage under any of the ~~plan~~ plans.

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 any of the ~~plan~~ plans; 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~~ plans. However, federally defined eligible individuals shall be guaranteed access to the Pool without regard to any enrollment caps that are set for nonfederally defined eligible individuals.

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 36 O.S. 2001, Section 6535, is amended to read as follows:

Section 6535. A. There is hereby created a nonprofit legal entity to be known as the "Health Insurance High Risk Pool". All insurers and reinsurers providing health insurance or reinsurance, as a condition of doing business in this state, shall be members of the Pool.

B. 1. The Pool shall operate under the supervision and approval of a nine-member Board of Directors appointed by the Insurance Commissioner. The Board shall consist of:

- a. two representatives of domestic insurance companies licensed to do business in this state,
- b. one representative of a not-for-profit hospital service and medical indemnity plan,
- c. one representative of a health maintenance organization,
- d. one member from a health-related profession,
- e. one member from the general public, who is not associated with the medical profession, a hospital, or an insurer,
- f. one member to represent a group considered to be "uninsurable",
- g. one representative of reinsurers, and
- h. one representative from the providers of small group plans licensed to do business in this state.

2. The original Board shall be appointed for the following terms:

- a. three members for a term of one (1) year,
- b. three members for a term of two (2) years, and
- c. three members for a term of three (3) years.

3. All terms after the initial term shall be for three (3) years.

4. The Board shall elect one of its members as chairperson.

5. Members of the Board may be reimbursed from monies of the Pool for actual and necessary expenses incurred by them in the performance of their official duties as members of the Board, but shall not otherwise be compensated for their services.

6. The Board shall adopt a primary plan and one or more alternative plans pursuant to this act and submit ~~its the~~ articles, bylaws, and operating rules for each plan adopted to the Insurance Commissioner for approval. ~~If the Board fails to adopt a plan and suitable articles, bylaws, and operating rules within one hundred eighty (180) days after the appointment of the Board, the Insurance Commissioner shall promulgate rules to effectuate the provisions of this act, and such rules shall remain in effect until superseded by a plan and articles, bylaws and operating rules submitted by the Board and approved by the Commissioner.~~ The Board shall reimburse the Insurance Commissioner for any direct and actual administrative costs associated with administering the provisions of this act from monies collected by the Board.

7. Notwithstanding Section 6542 of this title, in addition, the Board shall adopt alternative health insurance plans that will provide options for its members including different co-payment structures, coinsurance, and deductible amounts. The Board may also offer different benefit structures at its discretion. The Board shall issue a request for proposal for the primary plan and one or more alternative plans every two (2) years beginning January 1, 2003.

SECTION 4. AMENDATORY 36 O.S. 2001, Section 6536, is amended to read as follows:

Section 6536. The Board of Directors of the Health Insurance High Risk Pool shall:

1. Establish administrative and accounting procedures for the operation of the Pool;

2. Establish procedures under which applicants and participants in the ~~plan~~ plans adopted by the Board may have grievances reviewed by an impartial body and reported to the Board;

3. Select an administering insurer in accordance with Section 6538 of this title;

4. Levy and collect assessments from all insurers and reinsurers to provide for claims paid under the ~~plan~~ plans adopted by the Board and for administrative expenses incurred or estimated to be incurred during the period for which assessment is made. The level of assessments shall be established by the Board in accordance with Section 6539 of this title. Assessment of the insurers shall occur at the end of each calendar year and shall be due and payable within thirty (30) days of receipt of the assessment notice by the insurer to the Insurance Commissioner;

5. In addition to assessments required pursuant to paragraph 4 of this subsection, collect an organizational assessment or assessments from all insurers and reinsurers as necessary to provide for expenses which have been incurred or are estimated to be incurred prior to the receipt of the first calendar year assessments. Organizational assessments shall be equal for all insurers and reinsurers, but shall not exceed One Hundred Dollars (\$100.00) per insurer for all such assessments. Such assessments are due and payable within thirty (30) days of receipt of the assessment notice by the insurer;

6. Require that all policy forms issued by the Board conform to standard forms as approved by the Insurance Commissioner;

7. Develop a program to publicize the existence of the ~~plan~~ plans adopted by the Board, the eligibility requirements of the ~~plan~~ plans, and the procedures for enrollment in the ~~plan~~ plans, and to maintain public awareness of the plan; ~~and~~

~~8. Design and employ cost-containment measures and requirements which may include preadmission certification, home health care, hospice care, negotiated purchase of medical and pharmaceutical supplies and individual case management. The Board may employ a plan case manager or managers to supervise and manage the medical care or coordinate the supervision and management of the medical care with the administering insurer. The Board may employ other persons if the positions have been outlined in the Board's plan and approved by the Insurance Commissioner and are necessary to fulfill the duties and responsibilities of the Board~~

8. Implement disease management programs, at the Board's discretion, to improve health status for congestive heart failure, diabetes, asthma, coronary artery disease, chronic renal failure, and other diseases as appropriate;

9. Implement a multi-tier pharmacy benefit design; and

10. Prior to February 1 of each year, report to the President Pro Tempore of the Senate, Speaker of the House of Representatives, and Governor concerning the status of the Health Insurance High Risk Pool and the effect of cost-containment measures implemented. Further, in such report, the Board shall make recommendations to the Legislature concerning any other cost-containment measures that would be beneficial to the Pool.

SECTION 5. AMENDATORY 36 O.S. 2001, Section 6538, is amended to read as follows:

Section 6538. A. The Board of Directors of the Health Insurance High Risk Pool shall select an administering insurer who shall be an insurer as defined in this act, through a competitive bidding process, to administer the plan. The Board shall evaluate the bids submitted under this subsection based on criteria established by the Board, which criteria shall include, but not be limited to, the following:

1. The administering insurer's proven ability to handle large group accident and health insurance policies and claims;
2. The efficiency of the administering insurer's claims-paying procedures; and
3. An estimate of total charges for administering the plan.

B. The administering insurer shall serve for a period of two (2) years. At least one (1) year prior to the expiration of each two-year period of service by an administering insurer, the Board shall invite all reasonably interested potential administering insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding two-year period. The selection of the administering insurer for the succeeding two-year period shall be made at least six (6) months prior to the end of the current two-year period. The Board may terminate the service of the administering insurer at any time if the Board determines that the administering insurer has failed to perform their duties effectively according to the contract established. In this case, the Board will accept bids from other potential administering insurers to serve the remainder of the vacated term.

C. The Board may select more than one administering insurer to perform the different functions involved in administering the plan.

D. The administering insurer shall:

1. Perform all eligibility and administrative claims-payment functions relating to the plan;
2. Pay an agent's referral fee as established by the Board to each agent who refers an applicant to the plan, if the applicant is accepted. The selling or marketing of the plan shall not be limited to the administering insurer or its agents. The referral fees shall be paid by the administering insurer from moneys received as premiums for the plan;
3. Establish a premium billing procedure for collection of premiums from persons insured under the plan;
4. Perform all necessary functions to assure timely payment of benefits to covered persons under the plan, including, but not limited to, the following:

- a. making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made,
- b. evaluating the eligibility of each claim for payment under the plan, and
- c. notifying each claimant within thirty (30) days after receiving a properly completed and executed proof of loss, whether the claim is accepted, rejected, or compromised;

5. Submit regular reports to the Board regarding the operation of the plan. The frequency, content, and form of the reports shall be determined by the Board;

6. Following the close of each calendar year, determine net premiums, reinsurance premiums less administrative expenses allowance, the expense of administration pertaining to the reinsurance operations of the Pool, and the incurred losses for the year, and report this information to the Board and to the Insurance Commissioner; ~~and~~

7. Pay claims expenses from the premium payments received from, or on behalf of, covered persons under the plan. If the payments by the administering insurer for claims expenses exceed the portion of premiums allocated by the Board for the payment of claims expenses, the Board shall provide through assessment the additional funds necessary for payment of claims expenses; and

8. Conduct bill review to check for appropriate coding, duplication, excessive charges and billing errors.

E. 1. The administering insurer shall be paid, as provided in the contract of the Pool, for direct and indirect expenses incurred in administering the Pool.

2. As used in this subsection, the term "direct and indirect expenses" includes the portion of the audited administrative costs, printing expenses, claims administration expenses, management expenses, building overhead expenses and other actual operating and administrative expenses of the administering insurer which are approved by the Board as allocable to the administration of the plan and included in the bid specifications.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6538.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Board of Directors of the Health Insurance High Risk Pool shall select a case manager or managers through a competitive bidding process, to provide case management services for the Pool. The Board shall evaluate the bids submitted under this subsection based on criteria established by the Board, which criteria shall include, but not be limited to, the following:

1. The case manager or managers' proven ability to handle large group accident and health insurance case management and its understanding of health care delivery systems;

2. The cost savings attributed to the case manager or managers' services; and

3. An estimate of total charges for providing case management services to the Pool.

B. The case manager or managers shall serve for a period of two (2) years beginning January 1, 2003. Prior to the expiration of each two-year period of service by a case manager, the Board shall invite all reasonably interested potential case managers, including the current case manager or managers, to submit bids to serve as a case manager for the succeeding two-year period. The selection of the case manager or managers for the succeeding two-year period shall be made at least four (4) months prior to the end of the current two-year period. The Board may terminate the service of a case manager at any time if the Board determines that the case manager has failed to perform the duties effectively according to the contract established. In this case, the Board will accept bids from other potential case managers to serve the remainder of the vacated term.

C. A case manager's duties shall include:

1. Assessing, planning, implementing, coordinating, monitoring and evaluating the options and services required to meet a member's health needs;

2. Performance of utilization review, to include concurrent review of inpatient skilled and rehabilitation services, emergency room retrospective review for appropriateness, frequency, and/or chronic disease indicators;

3. Authorization processes based upon nationally recognized criteria for elective inpatient and outpatient services;

4. Multidisciplinary complex case management for high risk pregnancy, transplants, neonates, and other complex cases; and

5. Providing other cost-containment measures as adopted by the Board.

D. 1. The case manager shall be paid, as provided in the contract of the Pool, for direct and indirect expenses incurred in providing case management service for the Pool.

2. As used in this subsection, the term "direct and indirect expenses" includes the portion of the printing expenses, case management expenses, management expenses, building overhead expenses and other actual operating and administrative expenses of the case manager which are approved by the Board as allocable to case management of the plan and included in the bid specifications.

E. The Health Insurance High Risk Pool may provide financial incentives to the case manager or managers based upon savings and outcomes attributed to such case manager or managers.

SECTION 7. AMENDATORY 36 O.S. 2001, Section 6542, is amended to read as follows:

Section 6542. A. 1. The primary plan shall offer as ~~one~~ the 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 or fraud may apply for coverage under any of the plan plans offered by the Board. If such coverage is applied for within sixty-three (63) 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 primary 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-three (63) 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 primary plan shall offer comprehensive coverage to every eligible person who is not eligible for Medicare. Comprehensive coverage offered under the primary 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 in the primary plan:

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 in the primary plan 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 primary 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 primary 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~~ plans 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. The provisions of this paragraph 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.

- 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 8. AMENDATORY 74 O.S. 2001, Section 1321, is amended to read as follows:

Section 1321. The Board shall have the authority to determine all rates and life, dental and health benefits. All rates shall be compiled in a comprehensive Schedule of Benefits. The Schedule of Benefits shall be available for inspection during regular business hours at the office of the State and Education Employees Group Insurance Board. The Board shall have the authority to annually adjust the rates and benefits based on claim experience. The annual adjustment shall be made no later than the ~~bid-submission~~ contract award date for health maintenance organizations set by the Oklahoma State Employees Benefits Council, which for the plan year beginning July 1, 2001, shall be set no later than the third Friday of December of each year. The next plan year shall begin January 1, 2002, and on January 1 each year thereafter. For the plan year beginning January 1, 2002, and for each year thereafter, the date shall be set no later than the third Friday of August of each year. The Board may approve a mid-year adjustment provided the need for an adjustment is substantiated by an actuarial determination or more current experience rating. The only publication or notice requirements that shall apply to the Schedule of Benefits shall be those requirements provided in the Oklahoma Open Meeting Act. It is the intent of the Legislature that the benefits provided not include cosmetic dental procedures except for certain orthodontic procedures as adopted by the Board.

SECTION 9. AMENDATORY 74 O.S. 2001, Section 1365, is amended to read as follows:

Section 1365. A. The Oklahoma State Employees Benefits Council shall have the following duties, responsibilities and authority with respect to the administration of the plan:

1. To construe and interpret the plan, and decide all questions of eligibility in accordance with this act and the Code;
2. To select those benefits which shall be made available to participants under the plan, according to this act, and other applicable laws and rules;
3. To retain or employ qualified agencies, persons or entities to design, develop, communicate, implement or administer the plan;
4. To prescribe procedures to be followed by participants in making elections and filing claims under the plan;
5. To prepare and distribute information communicating and explaining the plan to participating employers and participants. The State and Education Employees Group Insurance Board, Health Maintenance Organizations, or other third-party insurance vendors

may be directly or indirectly involved in the distribution of communicated information to participating state agency employers and state employee participants subject to the following conditions:

- a. the Council shall verify all marketing and communications information for factual accuracy prior to distribution,
- b. the Board or vendors shall provide timely notice of any marketing, communications, or distribution plans to the Council and shall coordinate the scheduling of any group presentations with the Council, and
- c. the Board or vendors shall file a brief summary with the Council outlining the results following any marketing and communications activities;

6. To receive from participating employers and participants such information as shall be necessary for the proper administration of the plan, and any of the benefits offered thereunder;

7. To furnish the participating employers and participants such annual reports with respect to the administration of the plan as are reasonable and appropriate;

8. To keep reports of benefit elections, claims and disbursements for claims under the plan;

9. To appoint an executive director who shall serve at the pleasure of the Council. The executive director shall employ or retain such persons in accordance with this act and the requirements of other applicable law, including but not limited to actuaries and certified public accountants, as he or she deems appropriate to perform such duties as may from time to time be required under this act and to render advice upon request with regard to any matters arising under the plan subject to the approval of the Council. The executive director shall have not less than seven (7) years of group insurance administration experience on a senior managerial level or not less than three (3) years of flexible benefits experience on a senior managerial level. Any actuary or certified public accountant employed or retained under contract by the Council shall have not less than three (3) years' experience in group insurance or employee benefits administration. The compensation of all persons employed or retained by the Council and all other expenses of the Council shall be paid at such rates and in such amounts as the Council shall approve, subject to the provisions of applicable law;

10. To negotiate for best and final offer through competitive negotiation 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 participants as an alternative to the health plans offered by the Board, and to transfer to the health maintenance organizations such funds as may be approved for a participant electing health maintenance organization alternative services. Such HMOs may offer coverage

through a point-of-service plan, subject to the guidelines established by the Council.

The Oklahoma State Employees Benefits Council may, however, renegotiate rates with successful bidders after contracts have been awarded if there is an extraordinary circumstance. An extraordinary circumstance shall be limited to insolvency of a participating health maintenance organization, dissolution of a participating health maintenance organization or withdrawal of another participating health maintenance organization at any time during the calendar year. Nothing in this section of law shall be construed to permit either party to unilaterally alter the terms of the contract;

11. To retain as confidential information the initial Request For Proposal offers as well as any subsequent bid offers made by the health plans prior to final contract awards as a part of the best and final offer negotiations process for the benefit plan;

12. To promulgate administrative rules for the competitive negotiation process;

13. To require vendors offering coverage through the Council, including the Board, to provide such enrollment and claims data as is determined by the Council. The Oklahoma State Employees Benefits Council with the cooperation of the Department of Central Services acting pursuant to Section 85.1 et seq. of this title, shall be authorized to retain as confidential, any proprietary information submitted in response to the Council's Request For Proposal. Provided, however, that any such information requested by the Council from the vendors shall only be subject to the confidentiality provision of this paragraph if it is clearly designated in the Request For Proposal as being protected under this provision. All requested information lacking such a designation in the Request For Proposal shall be subject to Section 24A.1 et seq. of Title 51 of the Oklahoma Statutes. From the state plan and health maintenance organizations, data provided shall include the current Health Plan Employer Data and Information Set (HEDIS);

14. To purchase any insurance deemed necessary for providing benefits under the plan, provided that the only indemnity plan selected by the Council shall be the indemnity plan offered by the Board, and to transfer to the Board such funds as may be approved for a participant electing a benefit plan offered by the Board;

15. To communicate deferred compensation programs as provided in Section 1701 of this title;

16. To assess and collect reasonable fees from the Board, and from such contracted health maintenance organizations and third party insurance vendors to offset the costs of administration as determined by the Council. The Council shall have the authority to transfer income received pursuant to this subsection to the Board for services provided by the Board;

17. To accept, modify or reject elections under the plan in accordance with this act and the Code;

18. To promulgate election and claim forms to be used by participants;

19. To take all steps deemed necessary to properly administer the plan in accordance with this act and the requirements of other applicable law; and

20. To manage, license or sell software developed for and acquired by the Council, whether or not such software is patented or copyrighted. The Council shall have the authority to license and sell such software or any rights to such software without declaring such property to be surplus. All proceeds from any such sale shall be deposited in the Benefits Council Administration Revolving Fund and used to defray the costs of administration.

B. The Council members shall discharge their duties as fiduciaries with respect to the participants and their dependents of the plan, and all fiduciaries shall be subject to the following definitions and provisions:

1. A person or organization is a fiduciary with respect to the Council to the extent that the person or organization:

- a. exercises any discretionary authority or discretionary control respecting administration or management of the Council,
- b. exercises any authority or control respecting disposition of the assets of the Council,
- c. renders advice for a fee or other compensation, direct or indirect, with respect to any participant or dependent benefits, monies or other property of the Council, or has any authority or responsibility to do so, or
- d. has any discretionary authority or discretionary responsibility in the administration of the Council;

2. The Council may procure insurance indemnifying the members of the Council from personal loss or accountability from liability resulting from a member's action or inaction as a member of the Council;

3. Except for a breach of fiduciary obligation, a Council member shall not be individually or personally responsible for any action of the Council;

4. Any person who is a fiduciary with respect to the Council shall be entitled to rely on representations made by participants, participating employers, third party administrators and beneficiaries with respect to age and other personal facts concerning a participant or beneficiaries, unless the fiduciary knows the representations to be false;

5. Each fiduciary shall discharge his or her duties and responsibilities with respect to the Council and the plan solely in

the interest of the participants and beneficiaries of the plan according to the terms hereof, for the exclusive purpose of providing benefits to participants and their beneficiaries, with the care, skill, prudence and diligence under the circumstances prevailing from time to time that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims; and

6. The duties and responsibilities allocated to each fiduciary by this act or by the Council shall be the several and not joint responsibility of each, and no fiduciary shall be liable for the act or omission of any other fiduciary unless:

- a. by his or her failure to properly administer his or her specific responsibility he or she enabled such other person or organization to commit a breach of fiduciary responsibility, or
- b. he or she knowingly participates in, or knowingly undertakes to conceal, an act or omission of another person or organization, knowing such act or omission to be a breach, or
- c. having knowledge of the breach of another person or organization, he or she fails to make reasonable efforts under the circumstances to remedy said breach.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1366.1 of Title 74, unless there is created a duplication in numbering, reads as follows:

Notwithstanding any other provision of law to the contrary, for contracts relating to the plan year beginning January 1, 2003, and for each plan year thereafter, the Oklahoma State Employees Benefits Council and the State and Education Employees Group Insurance Board shall:

- a. develop geographic service areas and list the zip codes contained in such service areas. Each participating health maintenance organization shall not be required to offer enrollment in every service area as a condition to participation in the State Account,
- b. not require participating health maintenance organizations to offer a Medicare supplement plan. However, if the participating health maintenance organization offers a Medicare supplement plan to other entities within this state then it shall be required to offer a Medicare supplement plan,
- c. require participating health maintenance organizations to meet the standardized benefit plan as required by the Oklahoma State Employees Benefits Council. However, participating health maintenance organizations may offer enhancements in an effort to make their plans more attractive and competitive, and

- d. ensure that all premiums are paid to participating health maintenance organizations within sixty (60) calendar days from receipt of the bill.

SECTION 11. NEW LAW A new section of law not to be codified in the Oklahoma Statutes reads as follows:

On or before January 1, 2003, the Oklahoma Health Care Authority shall conduct a feasibility study and make a report to the President Pro Tempore of the Senate, Speaker of the House of Representatives, and the Governor concerning the feasibility of covering applicants to the Health Insurance High Risk Pool under Medicaid programs. The Health Insurance High Risk Pool shall assist the Oklahoma Health Care Authority in conducting such study as needed.

SECTION 12. This act shall become effective July 1, 2002.

SECTION 13. 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 Senate the 20th day of May, 2002.

Presiding Officer of the Senate

Passed the House of Representatives the 22nd day of May, 2002.

Presiding Officer of the House
of Representatives