

STATE OF OKLAHOMA

1st Session of the 49th Legislature (2003)

HOUSE BILL HB1152

By: Pettigrew

AS INTRODUCED

An Act relating to insurance; creating the Oklahoma Health Insurance Consumer Choice Act; defining terms; allowing certain insurance providers to offer health benefit plans not subject to state-mandated health benefits; requiring listing of state-mandated benefits; requiring written notice of choice of benefits available; requiring Insurance Commissioner to issue report; providing for promulgation of rules by Insurance Commissioner; amending 36 O.S. 2001, Section 6512, which relates to the Small Employer Health Insurance Reform Act; modifying definition of eligible employee; providing for codification; and providing an effective date.

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

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4530 of Title 36, unless there is created a duplication in numbering, reads as follows:

Sections 1 through 5 of this act shall be known and may be cited as the "Oklahoma Health Insurance Consumer Choice Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4531 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Oklahoma Health Insurance Consumer Choice Act:

1. "Health benefits plan" means any individual, blanket, or group plan, policy, or contract for health care services, issued or delivered by a health care insurer, health maintenance organization, or hospital and medical service corporation, excluding plans, policies, or contracts providing health care benefits or health care services pursuant to the Workers' Compensation Laws and mandatory liability laws; and

2. a. "State-mandated health benefits" means coverages for health care services or benefits, required by state law or state regulations, requiring the reimbursement or utilization related to a specific illness, injury, or condition of the covered person, or inclusion of a specific category of licensed health care practitioner to be provided to the covered person in a health benefits plan for a health-related condition of a covered person. Provided, that for the purposes of the options provided by this act, state-mandated health benefits which may be excluded in whole or in part shall not include any health care services or benefits which were mandated by federal law, and
- b. "State-mandated health benefits" does not mean standard provisions or rights required to be present in a health benefit plan pursuant to state law or state regulations unrelated to a specific illness, injury or condition of the insured, including, but not limited to, those related to continuation of benefits found in Article 45 of the Oklahoma Insurance Code.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4532 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Every group accident and health insurer, hospital and medical service corporation, or health maintenance organization transacting health or accident and health insurance in this state may offer, as an option, a group health benefits plan which, either in whole or in part, does not provide state-mandated health benefits on group health benefits plans under state law.

B. Every accident and health insurer transacting individual major medical insurance in this state may offer, as an option, an individual health benefits plan which, either in whole or in part,

does not provide state-mandated health benefits on individual health benefit plans under state law.

C. In each sale of health policies or health contracts in which the proposed insured has selected a health benefits plan which, either in whole or in part, does not provide state-mandated health benefits, the accident and health insurer, hospital and medical service corporation, or health maintenance organization shall:

1. Provide to the proposed insured written notice as required in subsection D of this section; and

2. a. Obtain from the proposed insured a rejection in writing that the insured or eligible employee of a group policy has rejected a health benefits plan providing state-mandated health benefits, and

b. The signed rejection shall include a listing of the standard provisions and state-mandated health benefits rejected by the insured or eligible employee.

D. The written notice required in subsection C of this section shall state in the written application or enrollment form for the health benefits plan the following language in bold type: "You have the option to select an alternative health insurance policy or health plan which is not subject to all of the state-mandated health benefits normally required in insurance policies or contracts in Oklahoma. Some examples of state-mandated health benefits which may be rejected by you include maternity and newborn coverage, in-vitro fertilization, diabetes and pediatric preventative care. Please consult your agent as to which state health benefits are excluded in this policy. This alternative health insurance policy or contract may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits coverages than those normally imposed on health insurance policies in Oklahoma. If you select this option, please consult with your insurance agent to discover the degree to which the

alternative health insurance policy or contract does not provide health and medical benefits equal to those policies subject to state-mandated health benefits. If you are eligible for a health insurance policy, your insurance agent may offer you an alternative health insurance policy or health plan not fully subject to state-mandated benefits."

E. Failure to provide the written notice or rejection as required in this section shall result in the proposed insured, enrollee, or certificate holder selecting a health benefits plan subject to all applicable state-mandated health benefits and services.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4533 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner shall issue a report by June 30 and December 31 of each year to the State Legislature.

B. The report shall include the number of policies written in the State of Oklahoma with the limited mandate option and the number of policies written in the State of Oklahoma with the full mandate option.

C. Every health insurer licensed to conduct business in this state shall provide to the Commissioner any information requested by the Commissioner in order to issue its report.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4534 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Insurance Commissioner may promulgate rules necessary to implement the provisions of this act.

SECTION 6. AMENDATORY 36 O.S. 2001, 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. "Basic health benefit plan" means a lower cost health benefit plan adopted by the state for small employer groups;

5. "Board" means the board of directors of the program established pursuant to Section 6522 of this title;

6. "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;

7. "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 and family composition, without prior approval of the Insurance Commissioner. Group size shall not be used as a case characteristic;

8. "Class of business" means all or a separate grouping of small employers established pursuant to Section 6514 of this title. Group size shall not be used as a class of business;

9. "Commissioner" means the Insurance Commissioner;

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)~~ twenty-nine (29) 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;

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, 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 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 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 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 6521 of this 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;

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

29. "Standard health benefit plan" means the health benefit plan adopted by the state for small employers.

SECTION 7. This act shall become effective November 1, 2003.

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