ENGROSSED SENATE
BILL NO. 1879

By: Adelson and Rabon of the Senate

and

Morgan (Danny) of the House

[Health Insurance High Risk Pool Act – notice – definition - assessment – emergency]

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

SECTION 1. AMENDATORY 36 O.S. 2001, Section 4509, is amended to read as follows:

Section 4509. A. ~~In the case of an employee whose insurance is terminated under a group policy providing hospital, medical or surgical, or Christian Science care and treatment expense benefits, or contract of hospital or medical service or indemnity, such employee and his dependents shall remain insured under the policy for a period of at least thirty (30) days after such termination, unless during such period the employee and his dependents shall otherwise become entitled to similar insurance from some other source.~~

~~B. If an employee has been covered for at least six (6) months under any group accident and health insurance policy delivered in this state, providing hospital, medical or surgical, or Christian Science care and treatment expense benefits, or under a contract of hospital or medical service or indemnity, and the individual employee has had his employment terminated or the group itself is terminated, then the termination shall not affect coverage of the insured or his dependents for any continuous loss which commenced while the insurance was in force. The extension of benefits beyond the period the insurance was in force may be predicated upon the~~

~~continuous total disability of the person insured or his or her dependents or the expenses incurred in connection with a plan of surgical treatment, which shall include maternity care and delivery expenses, which commenced prior to the termination. The coverage for the extension of benefits shall be for the maximum benefits under the terminated policy or for a time period of not less than three (3) months in the case of basic coverage or six (6) months in the case of major medical coverage. Premium monies may be charged for the period of the extension of benefits. The premiums charged shall be the premiums which would have been charged for the coverage provided under the group policy or contract had termination not occurred.~~

An employee whose insurance is terminated after participating under a group policy for at least three (3) consecutive months immediately prior to termination shall, for such employee and dependents of the employee, remain continuously insured for up to six (6) months under the group policy or another group policy providing similar benefits as the employee had participated in three (3) consecutive months immediately prior to termination. Policies subject to this subsection shall provide continuation of group coverage for employees or members and their eligible dependents for all health-plan-sponsoring employers who employ less than twenty (20) full-time-equivalent employees for one-half (1/2) of the working days in the previous calendar year, excluding federal employees and church employees pursuant to Section 414e of the Internal Revenue Code. A notice of continuation shall be provided at the initial or subsequent enrollment of the group. The notice shall provide information to the participant concerning:

1. The time period for making the election;

2. The amount of the premium;

3. The date the policyholder must receive the written election and first premium;

4. The length of time an employee and dependents may continue coverage; and

5. Any other continuation opportunities, such as conversion.

B. Continuation of group coverage under subsection A of this section shall be requested in writing within thirty-one (31) days following the date of termination of the employee. An employee, member or dependent electing continuation shall pay to the group carrier, on a monthly basis in advance, the amount of contribution required by the carrier, plus five percent (5%) of the group rate for the insurance being continued under the group policy on the due date of each payment. The written election of continuation of the employee, member or dependent, together with the first contribution required to establish contributions on a monthly basis in advance, shall be given to the employer within thirty-one (31) days of the date coverage would otherwise terminate. Subsequent monthly payments shall be due from the continuation employee upon receipt of billings from the carrier to the continuation employee, subject to the terms established by the carrier. Any claims incurred by the continuation employee shall be charged to the carrier's general small group pool and not charged to the prior group policy claims incurred. Continuation shall not terminate until the earliest of:

1. Six (6) months after the date the election is made;

2. The date on which failure to make timely payments would terminate coverage;

3. The date on which the group coverage terminates in its entirety;

4. The date on which the covered person is or could be covered under Medicare;

5. The date on which the covered person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy, hospital or medical service subscriber

contract, medical practice or other prepayment plan, or any other plan or program;

6. The date the covered person is eligible for similar benefits under any arrangement of coverage for individuals in a group; or

7. The date that similar benefits are provided or available to the covered person pursuant to or in accordance with the requirements of any state or federal law, with the exception of the Health Insurance High Risk Pool Act.

SECTION 2. AMENDATORY 36 O.S. 2001, Section 6532, as last amended by Section 18, Chapter 274, O.S.L. 2004 (36 O.S. Supp. 2005, 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;

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

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);

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 of this section; however, if the individual is

eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986, the requirement for exhaustion of any available COBRA or state continuation benefits is waived;

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;

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;

9. "Health insurance" means any individual or group hospital or medical expense-incurred policy or health care benefits plan or contract or excess loss, stop-loss or reinsurance policy issued by an insurer concerning a group health benefit plan. 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;

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;

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 subparagraph a of this paragraph, and

c. insurance covering medical care referred to in subparagraphs a and b of this paragraph;

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);

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

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;

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

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 3. AMENDATORY 36 O.S. 2001, Section 6539, is amended to read as follows:

Section 6539. A. 1. Each participating insurer and each participating reinsurer shall be assessed by the Board of Directors of the Health Insurance High Risk Pool ~~a portion of the operating losses of the plan; such portion being determined by multiplying the operating losses by a fraction, the numerator of which equals the insurer's total health insurance premiums or subscriber's contract charges pertaining to the direct writing of health insurance written in this state during the preceding calendar year and the denominator of which equals the total of all health insurance premiums and all subscriber contract charges written by all health insurers in this state during the preceding calendar year~~ an amount not to exceed Three Dollars ($3.00) per covered person insured or reinsured by each insurer per month, except on any insurer on policies or contracts insuring federal employees. The number of Oklahoma insureds, certificate holders, employees or their dependents insured or reinsured by all insurers shall be determined as of the end of the prior calendar year. The computation of assessments shall be made with a reasonable degree of accuracy, with the recognition that exact determinations may not always be possible.

2. The Board shall ensure that each insured, certificate holder, employee or dependent of the employee is counted only once with respect to any assessment. For such purpose, the Board shall require each insurer that obtains reinsurance for its health insurance plans to include in its count of insureds, certificate holders, employees or their dependents all insureds, certificate holders, employees or their dependents whose coverage is reinsured in whole or in part. The Board shall allow an insurer that is a reinsurer to exclude from its number of insureds, certificate holders, employees or their dependents those who have been counted

by the primary insurer or the primary reinsurer for the purpose of determining its assessment under this subsection.

B. 1. If assessments and other receipts by the Pool exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the Board to offset future losses or to reduce premiums.

2. As used in this subsection, the term "future losses" includes reserves for claims incurred but not reported.

C. 1. Each participant's proportion of participation in the plan shall be determined annually by the Board based on annual statements and other reports deemed necessary by the Board and filed with it by the insurer.

2. Any deficit incurred under the plan shall be recouped by assessments apportioned among the participants by the Board in the manner set forth in subsection A of this section, and the participants may recover the net loss, if any, in the normal course of their respective businesses without time limitation.

3. An insurer which has paid an assessment levied pursuant to this section shall not take a credit on the premium tax return for that insurer but may include the assessment amount in the insurer's claims cost calculation for the purpose of determining the insurer's rates for premiums charged for insurance policies to which the act applies. The rates shall not be deemed excessive for the sole reason of including in the calculation an amount reasonably calculated to recoup the assessment amount paid by the participating insurer or reinsurer.

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 Senate the 9th day of March, 2006.

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Presiding Officer of the Senate

Passed the House of Representatives the ____ day of _____, 2006.

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Presiding Officer of the House
of Representatives