STATE OF OKLAHOMA

1st Session of the 50th Legislature (2005)

HOUSE BILL 1484 By: Billy

AS INTRODUCED

An Act relating to health insurance; amending 74 O.S. 2001, Sections 1306, as last amended by Section 1, Chapter 405, O.S.L. 2004, and 1371, as last amended by Section 1, Chapter 414, O.S.L. 2004 (74 O.S. Supp. 2004, Sections 1306 and 1371), which relate to state and education employees; blending rates for active employees and retirees under sixty-five years of age; requiring active employees and retirees under sixty-five years of age to be rated as one group; providing an effective date; and declaring an emergency.

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

SECTION 1. AMENDATORY 74 O.S. 2001, Section 1306, as last amended by Section 1, Chapter 405, O.S.L. 2004 (74 O.S. Supp. 2004, Section 1306), is amended to read as follows:

Section 1306. The State and Education Employees Group Insurance Board shall administer and manage the group insurance plans and the flexible benefits plan and, subject to the provisions of the State and Education Employees Group Insurance Act and the State Employees Flexible Benefits Act, shall have the following powers and duties:

1. The preparation of specifications for such insurance plans as the Board may determine to be appropriate;

2. The authority and duty to request bids through the Purchasing Division of the Department of Central Services for a contract to be the claims administrator for all or any part of such insurance and benefit plans as the Board may offer;

3. The determination of the methods of claims administration under such insurance and benefit plans as the Board may offer;

4. The determination of the eligibility of employees and their dependents to participate in each of the Group Insurance Plans and

in such other insurance and benefit plans as the Board may offer and the eligibility of employees other than education employees to participate in the Life Insurance Plan provided that evidence of insurability shall not be a requirement in determining an employee's initial eligibility;

5. The determination of the amount of employee payroll deductions and the responsibility of establishing the procedure by which such deduction shall be made;

6. The establishment of a grievance procedure by which a three-member grievance panel shall act as an appeals body for complaints by insured employees regarding the allowance and payment of claims, eligibility, and other matters. Except for grievances settled to the satisfaction of both parties prior to a hearing, any person who requests in writing a hearing before the grievance panel shall receive a hearing before the panel. The grievance procedure provided by this paragraph shall be the exclusive remedy available to insured employees having complaints against the insurer. Such grievance procedure shall be subject to the Oklahoma Administrative Procedures Act, including provisions thereof for review of agency decisions by the district court. The grievance panel shall schedule a hearing regarding the allowance and payment of claims, eligibility and other matters within sixty (60) days from the date the grievance panel receives a written request for a hearing unless the panel orders a continuance for good cause shown. Upon written request by the insured employee to the grievance panel and received not less than ten (10) days before the hearing date, the grievance panel shall cause a full stenographic record of the proceedings to be made by a competent court reporter at the insured employee's expense;

7. The continuing study of the operation of such insurance and benefit plans as the Board may offer including such matters as gross and net costs, administrative costs, benefits, utilization of benefits, and claims administration;

8. The administration of the Health, Dental and Life Insurance Reserve Fund or Funds, the Flexible Benefits Revolving Fund and the Education Employees Group Insurance Reserve Fund;

9. The auditing of the claims paid pursuant to the provisions of the State and Education Employees Group Insurance Act, the State Employees Flexible Benefits Act and the State Employees Disability Program Act;

10. a. To select 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 employees as an alternative to the state self-insured health plan, and to transfer to the HMOs such funds as may be approved for an employee electing HMO alternative services. The Board may also select and contract with a vendor to offer a point-of-service plan. An HMO may offer coverage through a point-of-service plan, subject to the guidelines established by the Board. However, if the Board chooses to offer a point-of-service plan, then a vendor that offers both an HMO plan and a point-of-service plan may choose to offer only its point-of-service plan in lieu of offering its HMO plan.

b. Benefit plan contracts with the State and Education Employees Group Insurance Board, Health Maintenance Organizations, and other third-party insurance vendors shall provide for a risk adjustment factor for adverse selection that may occur, as determined by the Board, based on generally accepted actuarial principles. The risk adjustment factor shall include all members

participating in the plans offered by the State and Education Employees Group Insurance Board. The Oklahoma State Employees Benefits Council shall contract with an actuary to provide the above actuarial services, and shall be reimbursed for these contract expenses by the Board.

c. Effective for the plan year beginning ~~July 1, 1997~~ January 1, 2006, and for each plan year thereafter, in setting health insurance premiums for active employees and for retirees under sixty-five (65) years of age, HMOs, self-insured organizations and prepaid plans shall set the monthly premium for active employees ~~at a maximum of Ninety Dollars ($90.00) less than the monthly~~ to be equal to the premium for retirees under sixty-five (65) years of age. Active employees and retirees under sixty-five (65) years of age shall be rated as one group;

11. To contract for reinsurance, catastrophic insurance, or any other type of insurance deemed necessary by the Board. Provided, however, that the Board shall not offer a health plan which is owned or operated by the state and which utilizes a capitated payment plan for providers which uses a primary care physician as a gatekeeper to any specialty care provided by physician-specialists, unless specifically authorized by the Legislature;

12. The Board, pursuant to the provisions of Section 250 et seq. of Title 75 of the Oklahoma Statutes, shall adopt such rules consistent with the provisions of the State and Education Employees Group Insurance Act as it deems necessary to carry out its statutory duties and responsibilities. Emergency Rules adopted by the Board and approved by the Governor which are in effect on the first day of the Regular Session of the Oklahoma Legislature shall not become null and void until January 15 of the subsequent calendar year;

13. The Board shall contract for claims administration services with a private insurance carrier or a company experienced in claims administration of any insurance that the Board may be directed to offer. No contract for claims administration services shall be made unless such contract has been offered for bids through the Purchasing Division of the Department of Central Services. The Board shall contract with a private insurance carrier or other experienced claims administrator to process claims with software that is normally used for its customers;

14. The Board shall contract for utilization review services with a company experienced in utilization review, data base evaluation, market research, and planning and performance of the health insurance plan;

15. The Board shall approve the amount of employee premiums and dependent premiums for such insurance plans as the Board shall offer for each year no later than the bid submission date for health maintenance organizations set by the Oklahoma State Employees Benefits Council, which for plan year beginning July 1, 2001, shall be set no later than the third Friday of December of the previous fiscal year. The next plan year shall begin January 1, 2002, and on January 1 each year thereafter. For plan year beginning January 1, 2002, and for each year thereafter, the submission date shall be set no later than the third Friday of August of the previous year. Except as otherwise provided for in Section 1321 of this title, the Board shall not have the authority to adjust the premium rates after approval. The Board shall submit notice of the amount of employee premiums and dependent premiums along with an actuarial projection of the upcoming fiscal year's enrollment, employee contributions, employer contributions, investment earnings, paid claims, internal expenses, external expenses and changes in liabilities to the Director of the Office of State Finance and the Director of the

Legislative Service Bureau no later than March 1 of the previous fiscal year.

~~In~~ Effective for the plan year beginning January 1, 2006, and for each plan year thereafter, in setting health insurance premiums for active employees and retirees under sixty-five (65) years of age, the Board shall set the monthly premium for active employees ~~at a maximum of Ninety Dollars ($90.00) less than~~ to be equal to the monthly premium for retirees under sixty-five (65) years of age. Active employees and retirees under sixty-five (65) years of age shall be rated as one group;

16. Before December 1 of each year the Board shall submit to the Director of the Office of State Finance a report outlining the financial condition for the previous fiscal year of all insurance plans offered by the Board. The report shall include a complete explanation of all reserve funds and the actuarial projections on the need for such reserves. The report shall include and disclose an estimate of the future trend of medical costs, the impact from HMO enrollment, antiselection, changes in law, and other contingencies that could impact the financial status of the plan. The Director of the Office of State Finance shall make written comment on the report and shall provide such comment, along with the report submitted by the Board, to the Governor, the President Pro Tempore of the Senate, the Speaker of the House of Representatives and the Chair of the Oklahoma State Employees Benefits Council by January 15;

17. The Board shall establish a prescription drug card network;

18. The Board shall have the authority to intercept monies owing to plan participants from other state agencies, when those participants in turn, owe money to the Board. The Board shall be required to adopt rules and regulations ensuring the participants due process of law;

19. The Board is authorized to make available to eligible employees supplemental health care benefit plans to include but not be limited to long-term care, deductible reduction plans and employee co-payment reinsurance. Premiums for said plans shall be actuarially based and the cost for such supplemental plans shall be paid by the employee; and

20. There is hereby created as a joint committee of the State Legislature, the Joint Liaison Committee on State and Education Employees Group Insurance Benefits, which Joint Committee shall consist of three members of the Senate to be appointed by the President Pro Tempore thereof and three members of the House of Representatives to be appointed by the Speaker thereof. The Chair and Vice Chair of the Joint Committee shall be appointed from the membership thereof by the President Pro Tempore of the Senate and the Speaker of the House of Representatives, respectively, one of whom shall be a member of the Senate and the other shall be a member of the House of Representatives. At the beginning of the first regular session of each Legislature, starting in 1991, the Chair shall be from the Senate; thereafter the chairship shall alternate every two (2) years between the Senate and the House of Representatives.

The Joint Liaison Committee on State and Education Employees Group Insurance Benefits shall function as a committee of the State Legislature when the Legislature is in session and when the Legislature is not in session. Each appointed member of said committee shall serve until his or her successor is appointed.

The Joint Liaison Committee on State and Education Employees Group Insurance Benefits shall serve as a liaison with the State and Education Employees Group Insurance Board regarding advice, guidance, policy, management, operations, plans, programs and fiscal needs of said Board. Said Board shall not be bound by any action of the Joint Committee.

21. The State and Education Employees Group Insurance Board shall annually collect its own set of performance measures comparable to the Health Plan Employer Data and Information Set (HEDIS) for the purpose of assessing the quality of its HealthChoice plans and the other services it provides.

SECTION 2. AMENDATORY 74 O.S. 2001, Section 1371, as last amended by Section 1, Chapter 414, O.S.L. 2004 (74 O.S. Supp. 2004, Section 1371), is amended to read as follows:

Section 1371. A. All participants must purchase at least the basic plan unless the participant is a person who has retired from a branch of the United States military and has been provided with health coverage through a federal plan and that participant provides proof of that coverage. On or before January 1 of the plan year beginning July 1, 2001, and July 1 of any plan year beginning after January 1, 2002, the Oklahoma State Employees Benefits Council shall design the basic plan for the next plan year to insure that the basic plan provides adequate coverage to all participants. All benefit plans, whether offered by the State and Education Employees Group Insurance Board, a health maintenance organization or other vendors shall meet the minimum requirements set by the Council for the basic plan.

B. The Board shall offer health, disability, life and dental coverage to all participants and their dependents. For health, dental, disability and life coverage, the Board shall offer plans at the basic benefit level established by the Council, and in addition, may offer benefit plans that provide an enhanced level of benefits. The Board shall be responsible for determining the plan design and the benefit price for the plans that they offer. ~~In~~ <u>Effective for the plan year beginning January 1, 2006, and for each plan year thereafter, in</u> setting health insurance premiums for active employees and for retirees under sixty-five (65) years of age, the Board shall set the monthly premium for active employees ~~at a~~

~~maximum of Ninety Dollars ($90.00) less than~~ to be equal to the monthly premium for retirees under sixty-five (65) years of age. Active employees and retirees under sixty-five (65) years of age shall be rated as one group.

Nothing in this subsection shall be construed as prohibiting the Board from offering additional medical plans, provided that any medical plan offered to participants shall meet or exceed the benefits provided in the medical portion of the basic plan.

C. In lieu of electing any of the preceding medical benefit plans, a participant may elect medical coverage by any health maintenance organization made available to participants by the Council. The benefit price of any health maintenance organization shall be determined on a competitive bid basis. Contracts for said plans shall not be subject to the provisions of the Oklahoma Central Purchasing Act, Section 85.1 et seq. of this title. The Council shall promulgate rules establishing appropriate competitive bidding criteria and procedures for contracts awarded for flexible benefits plans. All plans offered by health maintenance organizations meeting the bid requirements as determined by the Council shall be accepted. The Council shall have the authority to reject the bid or restrict enrollment in any health maintenance organization for which the Council determines the benefit price to be excessive. The Council shall have the authority to reject any plan that does not meet the bid requirements. All bidders shall submit along with their bid a notarized, sworn statement as provided by Section 85.22 of this title. ~~In~~ Effective for the plan year beginning January 1, 2006, and for each plan year thereafter, in setting health insurance premiums for active employees and for retirees under sixty-five (65) years of age, HMOs, self-insured organizations and prepaid plans shall set the monthly premium for active employees ~~at a maximum of Ninety Dollars ($90.00) less than~~ to be equal to the monthly premium for retirees under sixty-five (65) years of age. Active employees

and retirees under sixty-five (65) years of age shall be rated as one group.

D. Nothing in this section shall be construed as prohibiting the Council from offering additional qualified benefit plans or currently taxable benefit plans.

E. Each employee of a participating employer who meets the eligibility requirements for participation in the flexible benefits plan shall make an annual election of benefits under the plan during an enrollment period to be held prior to the beginning of each plan year. The enrollment period dates will be determined annually and will be announced by the Council, providing the enrollment period shall end no later than thirty (30) days before the beginning of the plan year.

Each such employee shall make an irrevocable advance election for the plan year or the remainder thereof pursuant to such procedures as the Council shall prescribe. Any such employee who fails to make a proper election under the plan shall, nevertheless, be a participant in the plan and shall be deemed to have purchased the default benefits described in this section.

F. The Council shall prescribe the forms that participants will be required to use in making their elections, and may prescribe deadlines and other procedures for filing the elections.

G. Any participant who, in the first year for which he or she is eligible to participate in the plan, fails to make a proper election under the plan in conformance with the procedures set forth in this section or as prescribed by the Council shall be deemed automatically to have purchased the default benefits. The default benefits shall be the same as the basic plan benefits. Any participant who, after having participated in the plan during the previous plan year, fails to make a proper election under the plan in conformance with the procedures set forth in this section or prescribed by the Council, shall be deemed automatically to have

purchased the same benefits which the participant purchased in the immediately preceding plan year, except that the participant shall not be deemed to have elected coverage under the health care reimbursement account plan or the dependent care reimbursement account plan.

H. Benefit plan contracts with the Board, health maintenance organizations, and other third party insurance vendors shall provide for a risk adjustment factor for adverse selection that may occur, as determined by the Council, based on generally accepted actuarial principles.

I. 1. For the plan year ending December 31, 2004, employees covered or eligible to be covered under the State and Education Employees Group Insurance Act and the State Employees Flexible Benefits Act who are enrolled in a health maintenance organization offering a network in Oklahoma City, shall have the option of continuing care with a primary care physician for the remainder of the plan year if:

a. that primary care physician was part of a provider group that was offered to the individual at enrollment and later removed from the network of the health maintenance organization, for reasons other than for cause, and

b. the individual submits a request in writing to the health maintenance organization to continue to have access to the primary care physician.

2. The primary care physician selected by the individual shall be required to accept reimbursement for such health care services on a fee-for-service basis only. The fee-for-service shall be computed by the health maintenance organization based on the average of the other fee-for-service contracts of the health maintenance organization in the local community. The individual shall only be required to pay the primary care physician those co-payments,

coinsurance and any applicable deductibles in accordance with the terms of the agreement between the employer and the health maintenance organization and the provider shall not balance bill the patient.

3. Any network offered in Oklahoma City that is terminated prior to July 1, 2004, shall notify the health maintenance organization, Oklahoma State Employees Benefits Council and State and Education Employees Group Insurance Board by June 11, 2004, of the network's intentions to continue providing primary care services as described in paragraph 2 of this subsection offered by the health maintenance organization to state and public employees.

SECTION 3. This act shall become effective July 1, 2005.

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.

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