STATE OF OKLAHOMA

1st Session of the 50th Legislature (2005)

SENATE BILL 980 By: Pruitt

AS INTRODUCED

An Act relating to health insurance; creating the Oklahoma Equal Access to Health Insurance Act of 2005; providing short title; providing definitions; establishing the State of Oklahoma Health Benefits Program; providing for administration of Program; stating purpose; setting implementation date; authorizing amendment; providing for plan of operation; setting duties and powers of the State and Education Employees Group Insurance Board; limiting liability; requiring studies; providing duties for Administrator of the State and Education Employees Group Insurance Board; providing plan eligibility requirements; requiring certain certification; construing applicability of certain competitive bidding laws; setting term for certification; requiring certain description; authorizing Board to prescribe minimum standards; specifying plan requirements; providing for withdrawal of certification; prohibiting certification of certain plans; establishing fee schedules or methodologies; requiring approval of certain enrollment fees upon compliance; requiring certain notice; requiring hearing; providing for adjustment of enrollment fees; providing for certain adjustments; requiring Board to select certain plans; setting plan duration; limiting certain types of plans; providing exception; providing for certain commissions and payments; requiring certain reports; defining types of eligible plans; providing for participation eligibility and enrollment; requiring certain verification; providing for cessation and termination of coverage; providing certain proof of good cause; setting open season period; detailing enrollment eligibility; providing for certain preexisting conditions and surcharges; allowing member to request certain determination; setting time frame for determination; providing for certain hearing; providing enrollment outside of open season; construing certain laws; providing for continuation of coverage; prohibiting cancellation or nonrenewal under certain circumstances; providing for enrollment under certain circumstances; providing for retention of coverage after qualifying event; specifying certain qualifying events; allowing certain participating employer subsidized plan sponsors; requiring certain agreements; providing minimum provisions; requiring certain notice; providing for codification; providing an effective date; and declaring an emergency.

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 1380.1 of Title 74, unless there is created a duplication in numbering, reads as follows:

This act may be cited as the "Oklahoma Equal Access to Health Insurance Act of 2005".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1380.2 of Title 74, unless there is created a duplication in numbering, reads as follows:

For the purposes of and as used in the Oklahoma Equal Access to Health Insurance Act of 2005:

1. "Board" means the State and Education Employees Group Insurance Board;

2. "Carrier" means any person or organization subject to the authority of the Commissioner that provides one or more health benefit plans or insurance in the State of Oklahoma, and includes an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, or a multiple employer welfare arrangement; provided, however, that a Medicaid-only health maintenance organization shall not be considered a carrier for purposes of this act;

3. "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985;

4. "Commissioner" means the Insurance Commissioner of the Insurance Department;

5. "Continuous coverage" means coverage under one or more qualified health insurance plans for at least eighteen months with no gap in coverage longer than sixty-three (63) days;

6. "Covered individual" means a person who is and continues to remain eligible for coverage through the Program and is covered by one of the benefit plans offered by a participating carrier;

7. “Creditable coverage” means, continual coverage of the applicant under any of the following health plans, with no lapse in coverage of more than sixty-three (63) days:

a. a group health plan,

b. health insurance coverage,

c. Part A or Part B of Title XVIII of the Social Security Act, approved July 30, 1965 (79 Stat. 291; 42 U.S.C. § 1395c et seq. or 1395j et seq., respectively),

d. Title XIX of the Social Security Act, approved July 30, 1965 (79 Stat. 343; 42 U.S.C. § 1396 et seq.), other than coverage consisting solely of benefits under Section 1928,

e. Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.),

f. a medical care program of the Indian Health Service or of a tribal organization,

g. a state health benefits risk pool including the Health Insurance High Risk Pool,

h. a public health plan, or

i. any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996.

Creditable coverage does not include coverage consisting solely of coverage of excepted benefits;

8. “Department” means the Insurance Department;

9. “Dependent” means:

a. the spouse of the principal insured, or

b. someone who is related to the principal insured by birth, marriage, or adoption and who is also claimed as a dependent by the principal insured for purposes of filing a federal income tax return;

10. “Eligible individual” means an individual who meets one or more of the following qualifications:

a. the individual is a resident of the State of Oklahoma;

b. the individual is not a resident of the State of Oklahoma but is employed, at least twenty (20) hours a week on a regular basis in this state by a bona fide employer, and the individual's employer does not offer a group health insurance plan or the individual is not eligible to participate in any group health insurance plan offered by the individual's employer,

c. the individual is enrolled in, or eligible to enroll in, a participating employer-subsidized plan, as defined in paragraph 17 of this section,

d. the individual is self-employed in the State of Oklahoma, and if a nonresident self-employed individual, the individual's principal place of business is in this state and the individual has filed, or plans to file, a corporation franchise tax return or an unincorporated business franchise tax return for the most recent taxable period in this state,

e. the individual is a full-time student attending an institution of higher education located in this state, or

f. the individual is a dependent, as defined in paragraph 9 of this section, of an eligible individual;

11. "Employer" means any individual, partnership, association, corporation, business trust, or person or group of persons employing one or more persons, and filing payroll tax information on such person or persons;

12. "ERISA" means the Employee Retirement Income Security Act of 1974;

13. "Excepted benefits" means benefits under one or more, or any combination thereof, of the following:

a. coverage only for accident, of disability income insurance, or any combination thereof,

b. coverage issued as a supplement to liability insurance,

c. liability insurance, included general liability insurance and automobile liability insurance,

d. workers' compensation or similar insurance,

e. medical expense and loss of income benefits,

f. credit-only insurance,

g. coverage for on-site medical clinics, or other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits,

h. benefits if offered separately including:

(1) limited scope dental or vision benefits,

(2) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, or

(3) such other similar, limited benefits as are specified in rules,

i. benefits if offered as independent, noncoordinated benefits including:

(1) coverage only for a specified disease or illness, and

(2) hospital indemnity or other fixed indemnity insurance, and

j. benefits if offered as a separate insurance policy including:

(1) Medicare supplement health insurance,

(2) coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.), or

(3) similar supplemental coverage provided to coverage under a group plan;

14. "Fully-insured health benefit plan" means a health plan that an employer funds through a carrier by paying an insurance premium in exchange for payment of covered plan benefits. An employer self-funded plan is not a fully-insured benefit plan for purposes of this act;

15. "Funded welfare benefit plan" means a single employer or multiple employer plans that provide a variety of benefits to eligible employees such as life, medical, disability benefits, and others;

16. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996;

17. "Participating employer-subsidized plan" means a group health plan as defined in 29 U.S.C. 1191b sponsored by an employer and for which the plan sponsor has entered into an agreement with the Board, in accordance with the provisions of Section 12 of this act, for the Program to offer and administer health insurance benefits for enrollees in the plan;

18. "Administrator" means the Administrator of the State and Education Employees Group Insurance Board;

19. "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a medical condition based on the fact that the condition was present before the enrollment date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received. Pregnancy shall not be considered a medical condition. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of a condition related to such information;

20. "Preexisting conditions provision" means a provision in a health benefit plan that limits, denies, or excludes benefits for an enrollee for expenses or services related to a preexisting condition

for a period of time. The time period for a preexisting conditions provision begins when application for insurance is made or when an applicant is in a waiting period for coverage under any plan;

21. "Producer" means a person required to be licensed in the State of Oklahoma to sell, solicit, or negotiate insurance;

22. "Program" means the State of Oklahoma Health Benefits Program established in Section 3 of this act;

23. "Qualified health insurance" means coverage under any individual or group health insurance regulated by the State of Oklahoma or any other jurisdiction, including any employer sponsored self-funded health benefit plan, including a plan offered through the Federal Employees Health Benefits Program, TriCare, or any COBRA continuation coverage, or any other qualifying coverage required by HIPAA, as amended, or regulations under that act, but does not include any coverage consisting solely of excepted benefits;

24. "Resident" means a person who is and continues to be legally domiciled and physically residing on a permanent and full-time basis in a place of permanent habitation in the State of Oklahoma that remains the person's principal residence and from which the person is absent only for temporary or transitory purpose. A person who is a full-time student attending an institution outside of the State of Oklahoma may maintain his or her residency for purposes of this act;

25. "Self-funded health benefit plan" means a health insurance plan, not subject to regulation by the State of Oklahoma or any state, that is paid in whole or in part by the employer from its own assets or from a funded welfare benefit plan; provided that such plan does not shift any risk or liability from benefit payments to an insurer or other carrier, other than through reinsurance or stop-loss coverage; and

26. "Stop-loss insurance" means insurance purchased by self-funded buyers to protect them against the risk of large losses or

severe adverse claim experience by establishing a loss attachment point above which the insurance will be triggered.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1380.3 of Title 74, unless there is created a duplication in numbering, reads as follows:

A. There is hereby established the State of Oklahoma Health Benefits Program to be administered by the State and Education Employees Group Insurance Board and the Administrator and created to effectuate public purposes provided for in this act.

B. The general purpose of the Program is to provide choice of health insurance plans to eligible individuals. The Program shall serve as a single point of entry to determine eligibility to receive benefits for all state residents, employers located in the state and their employees, students attending institutions of higher education in the state, and all other eligible individuals seeking to obtain health insurance coverage. In the case of a state resident, the Program shall determine the individual's eligibility for the Program. However, any individual who is HIPAA-eligible and otherwise qualified may elect coverage in the Program.

C. The Program shall be administered by the Administrator and governed by the Board.

D. On of before January 1, 2006, the Board shall implement the Program.

E. Once the Program has been implemented, the Board may, in accordance with its governing procedures, thereafter on its own initiative from time to time amend the Program.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1380.4 of Title 74, unless there is created a duplication in numbering, reads as follows:

A. The Board shall create a plan of operation for the Program that shall include the following:

1. Establish procedures for the selection of health plans to be offered through the Program;

2. Establish procedures for the enrollment of eligible individuals in the Program, including an annual open-season period;

3. A plan for establishing and operating a health insurance service center to provide eligible individuals with information on the Program and manage Program enrollment;

4. Establish procedures for the handling and accounting of assets and monies of the Program including for the receipt of premium payments and the transmittal of such payments to the appropriate participating health plans;

5. A plan for publicizing the existence of the Program and the Program's eligibility requirements and enrollment procedures; and

6. Provide for other matters as may be necessary and proper for the execution of its powers, duties and obligations under the Program.

B. The Board shall do the following:

1. Develop and administer a Program that will offer all eligible individuals an opportunity to purchase a health benefit plan in accordance with the provisions of this act, and contract with carriers to offer such plans to Program enrollees;

2. Create a Program Fund, under management of the Board, to fund the operation and administration of the Program;

3. Establish a health insurance service center to provide information on the Program to eligible individuals and to enroll in the Program all qualified individuals seeking to participate in the Program;

4. Develop criteria for participation in the Program by carriers to ensure that a variety of health benefit plan options shall be made available and select plans to participate in the Program, subject to the provisions of Section 7 of this act;

5. Establish and manage a system for collecting all premium payments made by, or on behalf of, individuals obtaining health insurance coverage through the Program, including any premium payments made by enrollees, employers, unions or other organizations and transmitting such payments to the chosen plans. Such system shall include mechanisms to receive and process employer contributions and automatic payroll deductions for enrollees in the Program; and

6. Publicize the existence of the Program, and disseminate information on the Program's eligibility requirements and enrollment procedures, including preparing and distributing certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public in the State of Oklahoma.

C. The Board shall have the power to:

1. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this act, including contracts to administer enrollment and premium payments for specific groups or subpopulations;

2. Sue or be sued, including taking any legal actions necessary and proper;

3. Appoint appropriate legal, actuarial and other advisors as necessary to provide technical assistance in the operation of the Program and any other functions within the authority of the Program;

4. Establish and execute a line of credit, and establish one or more cash and investment accounts to effect the purposes of the Program;

5. Establish and maintain a Program Fund;

6. Charge and collect fees paid by carriers participating in the Program as provided for in Section 7 of this act; and

7. Promulgate any rules necessary to implement the provisions of this act and the operation of the Program.

D. The Board shall not be liable for any obligation of the Program. There is no liability on the part of any member of the Board, and no cause of action of any nature may arise against them, for any action taken or omission made by them in the performance of responsibilities relating to the Program, unless the action or omission constitutes willful or wanton misconduct.

E. No later than five (5) years after the Program begins operation, the Board shall conduct a study of the Program and the persons enrolled in the Program and they shall submit a written report to the Governor, the President Pro Tempore of the Senate and the Speaker of the House of Representatives on the status and activities of the Program based on the data collected in the study. The report shall also be available to members of the general public upon request. The study shall review:

1. The operation and administration of the Program, including surveys and reports of health benefits plans available to eligible individuals and on the experience of the plans. The experience of the plans shall include data on enrollees in the Program, expenses, claims statistics, complaints data, how the Program met its goals and other information determined to be necessary or appropriate by the Board.

2. Data regarding all complaints received about the Program including its operation and services; and

3. Any other significant observations regarding utilization of the Program.

F. After the initial report of the Program, the Board shall annually conduct a study of the Program and the persons enrolled in the Program.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1380.5 of Title 74, unless there is created a duplication in numbering, reads as follows:

A. The Administrator shall:

1. Implement the plan of operation for the Program developed by the Board;

2. Ensure that the Program provides information to eligible individuals on benefits, limitations, restrictions and costs of the plans available through the Program, through publications, a web site, and outreach programs;

3. Develop a standard application form for persons seeking to purchase health insurance through the Program to collect information necessary to determine the eligibility of the applicant and previous coverage history and to process any payments for coverage made from employer contributions, employee payroll deductions, or subsidies from public programs or private charities;

4. Determine each applicant's eligibility for the Program;

5. Administer the Program's annual open season;

6. Have authority to contract to act as the "plan administrator", as defined in 29 U.S.C. 1002 for any participating employer-subsidized plan, and undertake the obligations required of a plan administrator under federal law for all such participating employer-subsidized plans; and

7. Hire and supervise such staff, as may be determined necessary by the Board, for the administration of the Program.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1380.6 of Title 74, unless there is created a duplication in numbering, reads as follows:

A. To be eligible to offer a plan through the Program, a carrier must be licensed to issue health insurance in the State of Oklahoma and be in good standing with the Insurance Department.

B. No health insurance plan may be offered through the Program unless the Commissioner has certified that the plan and the carrier are in compliance with state health insurance laws, including those relating to mandated benefits. The certification of plans to be offered through the Program shall not be subject to any state law

requiring competitive bidding. Each certificate shall be valid for a uniform term of at least one year, but may be made automatically renewable from term to term in the absence of the notice of termination by either party.

C. Each plan certified by the Commissioner shall contain a detailed description of benefits offered, including maximums, limitations, exclusions, and other benefit limits.

D. The Board may prescribe reasonable minimum standards for health benefit plans offered by carriers through the Program.

E. Each participating health insurance plan shall offer, subject to the plan's deductibles and coinsurance schedule, major medical coverage that includes the following:

1. Hospital benefits;

2. Surgical benefits;

3. In-hospital medical benefits;

4. Ambulatory patient benefits; and

5. Prescription drug benefits.

F. Certification of a plan may be withdrawn only after notice to the carrier and opportunity for hearing. The Commissioner may, however, nonrenew the certification of any carrier at the end of a certification term.

G. No plan shall be certified that excludes an individual from coverage because of race, color, religion, national origin, sex, martial status, health status, or at the time of the first opportunity to enroll, because of age.

H. No fees may be used by the carrier until either a schedule of enrollment fees or methodology for determining enrollment fees due has been filed with and approved by the Board.

I. Either a specific schedule of fees, or a methodology for determining fees, shall be established in accordance with actuarial principles for various categories of eligible individuals; provided that the enrollment fees applicable to an eligible individual shall

not be individually determined based on the status of an eligible individual's health. However, the fees shall not be excessive, inadequate, or unfairly discriminatory. A statement by a qualified actuary or other qualified person acceptable to the Board as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

J. The Board shall approve the schedule of enrollment fees due or methodology for determining enrollment fees if the requirements of subsection B of this section are met. If the Board does not take action on the schedule or methodology within thirty (30) days of the filing, it shall be deemed approved. If the Board disapproves the filing, the Board shall notify the carrier. In the notice, the Board shall specify the reasons for disapproval. A hearing shall be held within thirty (30) days after a request in writing by the person filing.

K. The enrollment fees determined for the first plan year for which the plan is offered through the Program may be adjusted by the carrier for subsequent plan years based on experience and any later modifications to plan benefits; provided that any adjustments in enrollment fees shall be made in advance of the plan year for which they will apply and on a basis which, in the judgment of the Board, is consistent with the general practice of carriers that issue health insurance coverage to large employers.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1380.7 of Title 74, unless there is created a duplication in numbering, reads as follows:

A. The Board shall select plans to participate in the Program from only among those plans certified by the Commissioner as eligible to be offered through the Program.

B. The selection of plans to participate in the Program shall not be subject to any state law requiring competitive bidding.

C. The selection of any plan to participate in the Program shall be for a uniform term of at least one year, and may be made automatically renewable from term to term in the absence of notice of termination by either the plan or the Program.

D. The Board may not select to be offered through the Program in a single plan year more than three plans of any one plan type described in Section 8 of this act or more than ten plans total in the Program, except that for plan years in which the Board projects that total enrollment in the various health plans offered through the Program will exceed two hundred and fifty thousand (250,000) covered individuals, the number of plans the Board may select shall be not more than five plans of any one plan type described in Section 8 of this act and not more than fifteen plans total in the Program.

E. When an eligible individual or group of individuals is enrolled in the Program by a producer licensed in the State of Oklahoma, the plan chosen by each individual shall pay the producer a commission of five percent (5%) or the amount determined by the Board.

F. Any nonprofit membership organization may enroll its individual eligible members, or the individual eligible members of its member organizations, in plans offered through the Program, and shall receive a payment of five percent (5%) of premium or the amount determined by the Board from each plan for persons who are enrolled in that plan. Nothing in this section shall be deemed either to required a nonprofit membership organization that enrolls persons in plans offered through the Program to be licensed as an insurance agent or broker, or to permit such an organization to provide services requiring licensure as an agent or broker without obtaining such license.

G. Each carrier participating in the Program shall be required to furnish such reasonable reports as the Board determines to be necessary.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1380.8 of Title 74, unless there is created a duplication in numbering, reads as follows:

A. The following are types of health benefits plans to be offered through the Program and include the following:

1. Service benefit plans offering at least two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described in this title given to covered individuals, or, in the case of Blue Cross/Blue Shield or similar plans, payment is made by a carrier to the covered individual;

2. Comprehensive medical plans, such as:

a. group-practice prepayment plans which offer health benefits of the types referred to in this act, in whole or in substantial part on a prepaid basis, with professional services provided by physicians practicing as a group in a common center or centers. The group shall include at least three physicians who receive all or a substantial part of their professional income from the prepaid funds and who represent one of more medical specialties appropriate and necessary for the population proposed to be served by the plan,

b. individual-practice prepayment plans, such as preferred provider plans, which offer health services in whole or in substantial part on a prepaid basis, with professional services there under provided by individual physicians who agree to accept the payments provided by the plans as full payment for covered

services given by them including, in addition to in-hospital services, general care given in their offices and the patients' homes, out-of-hospital diagnostic procedures, and preventive care, and which plans are offered by organizations that have successfully operated similar plans before certification by the Commissioner of the plan,

c. plans that are a combination of the type of plans described in subparagraphs a and b of this paragraph,

d. consumer-directed plans that combine insured benefits with employer-paid or self-funded health care accounts,

e. employee organization plans which offer benefits of the types referred to in this act, which are sponsored or underwritten, and are administered, in whole or substantial part, by employee organizations and which are available only to individuals, and members of their families, who at the time of enrollment are members of the organization, and

f. such other types of plans as are or may become available in the United States.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1380.9 of Title 74, unless there is created a duplication in numbering, reads as follows:

A. Any eligible individual may apply to participate in the Program. An employer, labor union, professional, civic, trade, church or social organization that has eligible individuals as employees or members may apply on behalf of those eligible individuals. Any individual who is eligible for coverage under a participating employer subsidized plan shall automatically be eligible to participate in the Program. Upon determination by the Administrator that an individual is eligible to participate in the

Program, he or she may enroll, or, when applicable, be enrolled by the individual's parent or legal guardian, in a health benefits plan offered through the Program during the Program's next annual open season or at such other times as are specified in this section.

B. The Program shall require verification of eligibility, and may require any additional information or documentation, or statements under oath, when necessary to determine residency, employment, or dependent status of an applicant upon initial application and for the entire term of the individual's participation in the Program.

C. Coverage through the Program shall cease:

1. On the date an individual is no longer an eligible individual;

2. On the date an individual requests coverage to end;

3. Upon the death of the covered individual;

4. On the date state law requires cancellation of the policy; or

5. At the Program's option, thirty (30) days after the Program or the carrier makes any inquiry concerning an individual's eligibility to which the covered individual does not reply or whose reply does not satisfy the Program that the individual is an eligible individual.

D. The coverage of any covered individual who ceases to meet the eligibility requirements of this section shall be terminated at the end of the current policy period for which the necessary premiums have been paid.

E. A covered individual may provide proof to demonstrate good cause why he or she could not respond in a timely manner to the Program or the carrier.

F. From November 1 to December 1 of each year the Program shall administer a regular open season during which any eligible individual may enroll in any health benefit plan offered through the

Program without a waiting period, and may not be declined coverage, subject to the following:

1. A covered individual or covered dependent who elects to choose a different plan or plan option for the following year, shall not be subject to any preexisting condition exclusions and shall be charged the standard rate of the new plan or plan option for persons of the enrollee's age except as otherwise provided in paragraphs 3, 4 and 5 of this subsection. The same shall apply to any election by an enrollee of coverage from an eligible dependent of the enrollee, if such dependent is a covered individual;

2. An eligible individual or eligible dependent of an enrollee with eighteen (18) months or more of creditable coverage who enrolls in a plan offered through the Program shall not be subject to any preexisting condition exclusions and shall be charged the standard rate of the new plan or plan option for persons of the enrollee's age, except that if the plan which the enrollee elects provides substantially more benefits, or offers substantially lower deductibles or co-payment requirements than the enrollee's most recent creditable coverage, the carrier may charge the enrollee, for the first year only of participation in the new plan, a rate not to exceed one hundred twenty-five percent (125%) of the otherwise applicable age rate;

3. A carrier shall aggregate the periods of creditable coverage of an eligible individual or eligible dependent of an enrollee to reduce the preexisting condition exclusion period, or the carrier may charge a premium not to exceed one hundred twenty-five percent (125%) of the otherwise applicable age adjusted standard rate, or both. Any such exclusion shall not be applied during the second or subsequent years, and any such rate surcharge shall not be applied during the third or subsequent years, of participation in any plan offered through the Program;

4. An eligible individual or eligible dependent of an enrollee with no creditable coverage may enroll in a plan offered through the Program, but the enrollee may be subject to exclusion from coverage of one or more preexisting conditions, for a period not to exceed twelve (12) months, or charged a premium not to exceed one hundred and fifty percent (150%) of the otherwise applicable age adjusted standard rate, or both. Any such exclusion shall not be applied during the second or subsequent years, and any such rate surcharge shall not be applied during the third or subsequent years, of participation in any plan offered through the Program;

5. For new participants without creditable coverage, or with only limited creditable coverage, as defined in paragraphs 3 and 4 of this subsection, a carrier may elect to waive the imposition of preexisting condition exclusions and instead extend the applicable rate surcharge for an additional year beyond the time provided for in paragraphs 3 and 4 of this subsection;

6. Periods of creditable coverage with respect to an individual shall be established through presentation of certifications or in such other manner as may be specified by law; and

7. With respect to an enrollee in the Program, a preexisting condition exclusion may be imposed for medical conditions that are present not more than six (6) months prior to the date of enrollment. The preexisting condition exclusion shall extend for a period not to exceed twelve (12) months after the enrollment date. The aggregate of the periods of creditable coverage applicable to the enrollee as of the date of enrollment shall reduce the preexisting condition exclusion period.

G. In cases where a carrier, in accordance with paragraph 2, 3 or 4 of subsection F of this section, imposes a preexisting condition exclusion or a premium surcharge, and the enrollee disputes the imposition of such an exclusion or surcharge, the enrollee may request that the Board issue a determination as to the

validity or extent of such exclusion or surcharge under the provisions of this act. The Board shall issue such a determination within forty-five (45) days of the request being filed with the Board. If either the enrollee or the carrier disagrees with the outcome, he or she may submit a request for a hearing to the Board in accordance with the Administrative Procedures Act.

H. Enrollment outside of open season is subject to the following provisions:

1. The first ninety (90) days after the Program begins to accept applications for coverage under the Program shall be considered a special open season, and any eligible individual may apply to the Program during that period for coverage under a plan offered through the Program in accordance with the open season rules described in this section;

2. An eligible individual may enroll in a plan offered through the Program at a time other than the annual open season if the individual experiences a loss of eligibility for coverage under another plan as a result of one or more of the following qualifying events, provided he or she does so within sixty-three (63) days of the qualifying event:

a. the individual loses coverage in an existing health insurance plan due to the death of a spouse, parent, or legal guardian,

b. the individual, or a covered dependent, loses coverage in an existing health insurance plan, including an employer sponsored group plan, due to a change in the individual’s employment status, including termination of employment, reduction in the number of hours of employment, reduction in employer contributions toward such coverage or exhaustion of COBRA coverage,

c. the individual, or a covered dependent, loses coverage in an existing health insurance plan because of a

divorce, legal separation or other change in familial status,

d. the individual loses coverage in an existing health insurance plan because he or she achieves an age at which coverage lapses under that plan,

e. the individual, or a covered dependent, becomes newly eligible by becoming a resident of this state or because the individual's place of employment has been changed to this state,

f. the individual becomes newly eligible by becoming the spouse, or dependent, by reason of birth, adoption, placement for adoption, court order or a change in custody arrangement, of an eligible individual,

g. the individual becomes subject to a court order requiring him or her to provide health insurance coverage to certain dependents, or enters into a new arrangement for the custody of dependents that requires the providing of health insurance for those dependents, or

h. the individual loses coverage in a plan offered through the Program by reason of the plan terminating participation in the Program prior to the end of the plan year; and

3. In cases where an individual is enrolled in a plan offered through the Program as a newly eligible dependent of an enrollee, by reason of birth, adoption or placement for adoption, court order or a change in custody arrangement, either during open season or outside of open season, a carrier shall not impose any exclusion of a preexisting condition or any change in the rate charged to the enrollee, except for such differences, if any, in the plan's standard rates that reflect the addition of a new dependent to the enrollee's coverage.

I. In the case of an individual who is an eligible individual by reason of eligibility for coverage under a participating employer subsidized plan, the terms of the participating employer subsidized plan, and the applicable federal law governing such plans, shall apply and shall supersede the following provisions:

1. Paragraphs 2 through 7 of subsection F of this section;

2. Subsection G of this section; and

3. Paragraph 2 of subsection H of this section.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1380.10 of Title 74, unless there is created a duplication in numbering, reads as follows:

A. Any covered individual may continue to elect coverage under a participating plan as long as the individual remains an eligible individual and, subject to the carrier's rules regarding cancellation for nonpayment of premiums or fraud, shall not be canceled or nonrenewed because of any change in employer or employment status, marital status, health status, age, membership in any organization or other change that does not affect eligibility.

B. If any covered individual is insured under a plan offered through the Program, and that carrier offering the plan goes out of business, withdraws from the Program, discontinues the plan, or has its certification to participate in the Program withdrawn by the Commissioner, prior to the end of the plan year, the covered individual may enroll in any other plan offered through the Program in accordance with the applicable provisions of this act.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1380.11 of Title 74, unless there is created a duplication in numbering, reads as follows:

A. A covered individual who experiences a qualifying event shall be eligible to retain coverage through the Program under the individual's current plan, in accordance with the provisions of COBRA continuation of coverage, for a uniform period of thirty-six

(36) months from the date of the qualifying event as defined below, or to elect coverage under another plan participating in the Program, subject to the provisions of this act. Any such individual may further elect to change coverage at any regular open season occurring during the thirty-six (36) months continuation of coverage period.

B. In the case of an individual who is a covered individual by reason other than being enrolled in a participating employer subsidized plan, such qualifying events shall include:

1. Voluntary or involuntary termination of employment;

2. The death of a spouse, parent, or legal guardian;

3. Divorce, legal separation or other change in familial status; or

4. The individual becomes ineligible to participate in the Program by reason of no longer being a resident of the this state or because the individual is no longer employed at a location in this state.

C. In the case of a covered individual who is enrolled in a participating employer subsidized plan, such qualifying events shall include:

1. For an employee enrolled in the plan, voluntary or involuntary termination of the covered employee’s employment for reasons other than gross misconduct and reduction in the number of hours of employment;

2. For the spouse or dependent child of a covered employee enrolled in the plan, divorce or legal separation, death of the covered employee, voluntary or involuntary termination of the covered employee’s employment for reasons other than gross misconduct and reduction in the number of hours of employment, or the covered employee becomes entitled to Medicare; and

3. For a dependent child of a covered employee enrolled in the plan, the loss of dependent child status under plan rules.

D. In cases of employment related qualifying events listed in subsections B and C of this section continuation of coverage shall apply to both full-time and part-time employees.

E. The covered individual shall have sixty (60) days from the date of the qualifying event to elect continuation of coverage under the Program. The individual shall make the initial premium payment within forty-five (45) days after the date of the continuation of coverage election by the individual.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1380.12 of Title 74, unless there is created a duplication in numbering, reads as follows:

A. Any employer may apply to the Program to be the sponsor of a participating employer subsidized plan.

B. Any employer seeking to be the sponsor of a participating employer subsidized plan shall as a condition of participation in the Program, enter into a binding agreement with the Program which, at a minimum shall stipulate the following:

1. That the sponsoring employer designates the Program to be the “plan administrator”, as defined in 29 U.S.C. 1002, for the employer’s group health plan, and that the Program agrees to undertake the obligations required of a plan administrator under federal law;

2. That only the coverage and benefits offered by insurance plans participating in the Program shall constitute the coverage and benefits of the participating employer subsidized plan;

3. That the employer reserves the right to offer benefits supplemental to the benefits offered through the Program, but that any such supplemental benefits that may be offered by the employer shall constitute a separate plan or plans for which the Program shall not be the plan administrator and the Program shall not, in any manner, be responsible;

4. That the employer agrees that, for the term of the agreement, the employer will not offer to individuals eligible to participate in the Program by reason of the employer being a participating employer subsidized plan, any separate or competing group health plan offering the same, or substantially the same, benefits as provided through the Program, and as are described in this act, irrespective of whether or not any such individual is otherwise eligible to enroll in the Program on an individual basis;

5. That the employer reserves the right to determine, subject to applicable law, the criteria for eligibility, enrollment and participation in the participating employer subsidized plan and the amounts of the employer contributions to such plan; provided that, for the term of the agreement with the Program, the employer agrees not to change or amend any such criteria or contribution amounts at anytime other than during an annual period designated by the Program for participating employer subsidized plans to make such changes in conjunction with the Program's annual open season; and

6. That the employer agrees to make available, in a timely manner, for review by the Administrator, any of the employer's documents, records or information that the Program reasonably determines are necessary for the Administrator to:

a. verify that the employer's participating employer subsidized plan is in compliance with applicable federal and state laws relating to group health plans, particularly those provisions of such laws relating to nondiscrimination in coverage, and

b. verify the eligibility, under the terms of the plan, of those individuals enrolled in the employer's participating employer subsidized plan.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1380.13 of Title 74, unless there is created a duplication in numbering, reads as follows:

A carrier shall give the Board written notice, prior to notifying the members of the health benefit plan within the Program, of its intent to discontinue the offering of a health benefit plan in accordance with applicable state law.

SECTION 14. This act shall become effective July 1, 2005.

SECTION 15. 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.

50-1-1274 SJ 6/13/2015 8:59:14 AM