

1 STATE OF OKLAHOMA

2 2nd Session of the 51st Legislature (2008)

3 COMMITTEE SUBSTITUTE
4 FOR ENGROSSED
5 SENATE BILL NO. 2119

By: Sparks of the Senate

and

Peterson (Ron) of the House

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10 COMMITTEE SUBSTITUTE

11 (Insurance - Health Insurance High Risk Pool Act -
12 Health Insurance Competitive Loss Rating Act -
13 Insurance Commissioner - codification - effective
14 date -

emergency)

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19 SECTION 1. AMENDATORY 36 O.S. 2001, Section 6534, as
20 last amended by Section 19, Chapter 274, O.S.L. 2004 (36 O.S. Supp.
21 2007, Section 6534), is amended to read as follows:

22 Section 6534. A. Except as otherwise provided in this section,
23 any person who maintains a primary residence in this state for at
24 least one (1) year, or who is legally domiciled in this state on the

1 date of application and who is eligible for the credit for health
2 insurance costs under Section 35 of the Internal Revenue Code of
3 1986, or is a federally defined eligible individual shall be
4 eligible for coverage under any of the plans of the Health Insurance
5 High Risk Pool including:

6 1. The spouse of the insured; and

7 2. Any dependent unmarried child of the insured, from the
8 moment of birth. Such coverage shall terminate at the end of the
9 premium period in which the child marries, ceases to be a dependent
10 of the insured, or attains the age of nineteen (19) years, whichever
11 occurs first. However, if the child is a full-time student at an
12 accredited institution of higher learning, the coverage may continue
13 while the child remains unmarried and a full-time student, but not
14 beyond the premium period in which the child reaches the age of
15 twenty-three (23) years.

16 B. 1. No person is eligible for coverage under any of the Pool
17 plans unless such person has been rejected by at least two insurers
18 for coverage substantially similar to the primary plan coverage. As
19 used in this paragraph, rejection includes an offer of coverage with
20 a material underwriting restriction or an offer of coverage at a
21 rate equal to or greater than the primary Pool plan rates. No
22 person is eligible for coverage under any of the plans if such
23 person has, on the date of issue of coverage under any of the plans,
24 coverage equivalent to the primary plan under another health

1 insurance contract or policy. This paragraph shall not apply to
2 federally defined eligible individuals or an individual who is
3 eligible for the credit for health insurance costs under Section 35
4 of the Internal Revenue Code of 1986.

5 2. No person who is currently receiving, or is entitled to
6 receive, health care benefits under any federal or state program
7 providing financial assistance or preventive and rehabilitative
8 social services is eligible for coverage under any of the plans.

9 3. No person who is covered under any of the plans and who
10 terminates coverage is again eligible for coverage unless twelve
11 (12) months has elapsed since the coverage was terminated; provided,
12 however, this provision shall not apply to an applicant who is a
13 federally defined eligible individual. The Board of Directors of
14 the Health Insurance High Risk Pool may waive the twelve-month
15 waiting period under circumstances to be determined by the Board.

16 4. No person on whose behalf any of the plans have paid out an
17 aggregate from any or all offered plans of ~~Five Hundred Thousand~~
18 ~~Dollars (\$500,000.00)~~ One Million Dollars (\$1,000,000.00) in covered
19 benefits is eligible for coverage under any of the plans.

20 5. No inmate incarcerated in any state penal institution or
21 confined to any narcotic detention, treatment, and rehabilitation
22 facility shall be eligible for coverage under any of the plans;
23 provided, however, this provision shall not apply with respect to an
24 applicant who is a federally defined eligible individual.

1 C. The Board may establish an annual enrollment cap if the
2 Board determines it is necessary to limit costs to the plans.
3 However, federally defined eligible individuals shall be guaranteed
4 access to the Pool without regard to any enrollment caps that are
5 set for nonfederally defined eligible individuals.

6 D. The coverage of any person who ceases to meet the
7 eligibility requirements of this section may be terminated at the
8 end of the month in which an individual no longer meets the
9 eligibility requirements.

10 SECTION 2. AMENDATORY 36 O.S. 2001, Section 6537, is
11 amended to read as follows:

12 Section 6537. The Health Insurance High Risk Pool may:

13 1. Exercise powers granted to insurers under the laws of this
14 state;

15 2. Sue or be sued; ~~provided, individual members of the Board~~
16 ~~while acting in good faith within the course of their duties under~~
17 ~~the provisions of the Health Insurance High Risk Pool Act shall not~~
18 ~~be personally liable for actions taken by the Board;~~

19 3. In addition to imposing assessments under Section 6536 of
20 this title, levy interim assessments against insurers and reinsurers
21 to ensure the financial ability of the plan to cover claims,
22 expenses and administrative expenses incurred or estimated to be
23 incurred in the operation of the plan prior to the end of a calendar
24 year. Any interim assessment shall be due and payable within thirty

1 (30) days of the receipt of the assessment notice by the insurer.
2 Interim assessments shall be credited against the insurer's and
3 reinsurer's annual assessment; and

4 4. Request the Insurance Commissioner to check the reports,
5 records, books and papers of the Insurance Department to determine
6 the financial condition of an insurer for purposes of Section 6540
7 of this title.

8 SECTION 3. AMENDATORY 36 O.S. 2001, Section 6538, as
9 amended by Section 5, Chapter 439, O.S.L. 2002 (36 O.S. Supp. 2007,
10 Section 6538), is amended to read as follows:

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

18 1. The administering insurer's proven ability to handle large
19 group accident and health insurance policies and claims;

20 2. The efficiency of the administering insurer's claims-paying
21 procedures; and

22 3. An estimate of total charges for administering the plan.

23 B. The administering insurer shall serve for a period of ~~two~~
24 ~~(2)~~ up to five (5) years. At least one (1) year prior to the

1 expiration of each ~~two-year~~ contract period of service by an
2 administering insurer, the Board shall invite all reasonably
3 interested potential administering insurers, including the current
4 administering insurer, to submit bids to serve as the administering
5 insurer for the succeeding ~~two-year~~ contract period. The selection
6 of the administering insurer for the succeeding ~~two-year~~ contract
7 period shall be made at least six (6) months prior to the end of the
8 current ~~two-year~~ contract period. The Board may terminate the
9 service of the administering insurer at any time if the Board
10 determines that the administering insurer has failed to perform
11 their duties effectively according to the contract established or
12 for other good cause as determined by the Board. In this case, the
13 Board will accept bids from other potential administering insurers
14 to serve the remainder of the vacated term.

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

17 D. The administering insurer shall:

18 1. Perform all eligibility and administrative claims-payment
19 functions relating to the plan;

20 2. Pay an agent's referral fee as established by the Board to
21 each agent who refers an applicant to the plan, if the applicant is
22 accepted. The selling or marketing of the plan shall not be limited
23 to the administering insurer or its agents. The referral fees shall
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1 be paid by the administering insurer from moneys received as
2 premiums for the plan;

3 3. Establish a premium billing procedure for collection of
4 premiums from persons insured under the plan;

5 4. Perform all necessary functions to assure timely payment of
6 benefits to covered persons under the plan, including, but not
7 limited to, the following:

8 a. making available information relating to the proper
9 manner of submitting a claim for benefits under the
10 plan and distributing forms upon which submissions
11 shall be made,

12 b. evaluating the eligibility of each claim for payment
13 under the plan, and

14 c. notifying each claimant within thirty (30) days after
15 receiving a properly completed and executed proof of
16 loss, whether the claim is accepted, rejected, or
17 compromised;

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

21 6. Following the close of each calendar year, determine net
22 premiums, reinsurance premiums less administrative expenses
23 allowance, the expense of administration pertaining to the
24 reinsurance operations of the Pool, and the incurred losses for the

1 year, and report this information to the Board and to the Insurance
2 Commissioner;

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

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

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

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

21 SECTION 4. AMENDATORY Section 6, Chapter 439, O.S.L.
22 2002 (36 O.S. Supp. 2007, Section 6538.1), is amended to read as
23 follows:

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1 Section 6538.1 A. The Board of Directors of the Health
2 Insurance High Risk Pool shall select a case manager or managers
3 through a competitive bidding process, to provide case management
4 services for the Pool. The Board shall evaluate the bids submitted
5 under this subsection based on criteria established by the Board,
6 which criteria shall include, but not be limited to, the following:

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

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

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

14 B. The case manager or managers shall serve for a period of ~~two~~
15 ~~(2)~~ up to five (5) years beginning January 1, ~~2003~~ 2009. Prior to
16 the expiration of each ~~two-year~~ contract period of service by a case
17 manager, the Board shall invite all reasonably interested potential
18 case managers, including the current case manager or managers, to
19 submit bids to serve as a case manager for the succeeding ~~two-year~~
20 contract period. The selection of the case manager or managers for
21 the succeeding ~~two-year~~ contract period shall be made at least four
22 (4) months prior to the end of the current ~~two-year~~ contract period.
23 The Board may terminate the service of a case manager at any time if
24 the Board determines that the case manager has failed to perform the

1 duties effectively according to the contract established or for
2 other good cause as determined by the Board. In this case, the
3 Board will accept bids from other potential case managers to serve
4 the remainder of the vacated term.

5 C. A case manager's duties shall include:

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

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

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

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

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

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

22 2. As used in this subsection, the term "direct and indirect
23 expenses" includes the portion of the printing expenses, case
24 management expenses, management expenses, building overhead expenses

1 and other actual operating and administrative expenses of the case
2 manager which are approved by the Board as allocable to case
3 management of the plan and included in the bid specifications.

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

7 F. All information and data relating to the Pool which is
8 collected, created or received by the case manager during the course
9 of its contractual engagement with the Pool shall be the property of
10 the Pool.

11 SECTION 5. AMENDATORY 36 O.S. 2001, Section 6542, as
12 last amended by Section 20, Chapter 274, O.S.L. 2004 (36 O.S. Supp.
13 2007, Section 6542), is amended to read as follows:

14 Section 6542. A. 1. The primary plan shall offer as the basic
15 option an annually renewable policy with coverage as specified in
16 this section for each eligible person, except, that if an eligible
17 person is also eligible for Medicare coverage, the plan shall not
18 pay or reimburse any person for expenses paid by Medicare.

19 2. Any person whose health insurance is involuntarily
20 terminated for any reason other than nonpayment of premium or fraud
21 may apply for coverage under any of the plans offered by the Board
22 of Directors of the Health Insurance High Risk Pool. If such
23 coverage is applied for within sixty-three (63) days after the
24 involuntary termination and if premiums are paid for the entire

1 period of coverage, the effective date of the coverage shall be the
2 date of termination of the previous coverage.

3 3. The primary plan shall provide that, upon the death,
4 annulment of marriage or divorce of the individual in whose name the
5 contract was issued, every other person covered in the contract may
6 elect within sixty-three (63) days to continue coverage under a
7 continuation or conversion policy.

8 4. No coverage provided to a person who is eligible for
9 Medicare benefits shall be issued as a Medicare supplement policy.

10 B. The primary plan shall offer comprehensive coverage to every
11 eligible person who is not eligible for Medicare. Comprehensive
12 coverage offered under the primary plan shall pay an eligible
13 person's covered expenses, subject to the limits on the deductible
14 and coinsurance payments authorized under subsection E of this
15 section up to a lifetime limit of ~~Five Hundred Thousand Dollars~~
16 ~~(\$500,000.00)~~ One Million Dollars (\$1,000,000.00) per covered
17 individual. The maximum limit under this paragraph shall not be
18 altered by the Board of Directors of the Health Insurance High Risk
19 Pool, and no actuarially equivalent benefit may be substituted by
20 the Board.

21 C. Except for a health maintenance organization and prepaid
22 health plan or preferred provider organization utilized by the Board
23 or a covered person, the usual customary charges for the following
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1 services and articles, when prescribed by a physician, shall be
2 covered expenses in the primary plan:

3 1. Hospital services;

4 2. Professional services for the diagnosis or treatment of
5 injuries, illness, or conditions, other than dental, which are
6 rendered by a physician or by others at the direction of a
7 physician;

8 3. Drugs requiring a physician's prescription;

9 4. Services of a licensed skilled nursing facility for eligible
10 individuals, ineligible for Medicare, for not more than one hundred
11 eighty (180) calendar days during a policy year, if the services are
12 the type which would qualify as reimbursable services under
13 Medicare;

14 5. Services of a home health agency, if the services are of a
15 type which would qualify as reimbursable services under Medicare;

16 6. Use of radium or other radioactive materials;

17 7. Oxygen;

18 8. Anesthetics;

19 9. Prosthesis, other than dental prosthesis;

20 10. Rental or purchase, as appropriate, of durable medical
21 equipment, other than eyeglasses and hearing aids;

22 11. Diagnostic x-rays and laboratory tests;

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1 12. Oral surgery for partially or completely erupted, impacted
2 teeth and oral surgery with respect to the tissues of the mouth when
3 not performed in connection with the extraction or repair of teeth;

4 13. Services of a physical therapist;

5 14. Transportation provided by a licensed ambulance service to
6 the nearest facility qualified to treat the condition;

7 15. Processing of blood including, but not limited to,
8 collecting, testing, fractioning, and distributing blood; and

9 16. Services for the treatment of alcohol and drug abuse, but
10 the plan shall be required to make a fifty percent (50%) co-payment
11 and the payment of the plan shall not exceed Four Thousand Dollars
12 (\$4,000.00).

13 Usual and customary charges shall not exceed the reimbursement
14 rate for charges as set by the State and Education Employees Group
15 Insurance Board.

16 D. 1. Covered expenses in the primary plan shall not include
17 the following:

18 a. any charge for treatment for cosmetic purposes, other
19 than for repair or treatment of an injury or
20 congenital bodily defect to restore normal bodily
21 functions,

22 b. any charge for care which is primarily for custodial
23 or domiciliary purposes which do not qualify as
24 eligible services under Medicaid,

- 1 c. any charge for confinement in a private room to the
2 extent that such charge is in excess of the charge by
3 the institution for its most common semiprivate room,
4 unless a private room is prescribed as medically
5 necessary by a physician,
- 6 d. that part of any charge for services or articles
7 rendered or provided by a physician or other health
8 care personnel which exceeds the prevailing charge in
9 the locality where the service is provided, or any
10 charge for services or articles not medically
11 necessary,
- 12 e. any charge for services or articles the provision of
13 which is not within the authorized scope of practice
14 of the institution or individual providing the service
15 or articles,
- 16 f. any expense incurred prior to the effective date of
17 the coverage under the plan for the person on whose
18 behalf the expense was incurred,
- 19 g. any charge for routine physical examinations in excess
20 of one every twenty-four (24) months,
- 21 h. any charge for the services of blood donors and any
22 fee for the failure to replace the first three (3)
23 pints of blood provided to an eligible person
24 annually, and

1 i. any charge for personal services or supplies provided
2 by a hospital or nursing home, or any other nonmedical
3 or nonprescribed services or supplies.

4 2. The primary plan may provide an option for a person to have
5 coverage for the expenses set out in paragraph 1 of this subsection
6 or any benefits payable under any other health insurance policy or
7 plan, commensurate with the deductible and coinsurance selected.

8 E. 1. The primary plan shall provide for a choice of annual
9 deductibles per person covered for major medical expenses in the
10 amounts of Five Hundred Dollars (\$500.00), One Thousand Dollars
11 (\$1,000.00), One Thousand Five Hundred Dollars (\$1,500.00), Two
12 Thousand Dollars (\$2,000.00), Five Thousand Dollars (\$5,000.00) and
13 Seven Thousand Five Hundred Dollars (\$7,500.00), plus the additional
14 benefits payable at each level of deductible; provided, if two
15 individual members of a family satisfy the applicable deductible, no
16 other members of the family shall be required to meet deductibles
17 for the remainder of that calendar year.

18 2. The schedule of premiums and deductibles shall be
19 established by the Board.

20 3. Rates for coverage issued by the Pool may not be
21 unreasonable in relation to the benefits provided, the risk
22 experience and the reasonable expenses of providing coverage.

23 4. Separate schedules of premium rates based on age may apply
24 for individual risks.

1 5. Rates are subject to approval by the Insurance Commissioner.

2 6. Standard risk rates for coverages issued by the Pool shall
3 be established by the Board, subject to the approval of the
4 Insurance Commissioner, using reasonable actuarial techniques, and
5 shall reflect anticipated experiences and expenses of such coverage
6 for standard risks.

7 7. a. The rating plan established by the Board shall
8 initially provide for rates equal to one hundred
9 twenty-five percent (125%) of the average standard
10 risk rates of the five largest insurers doing business
11 in the state.

12 b. Any change to the initial rates shall be based on
13 experience of the plans and shall reflect reasonably
14 anticipated losses and expenses. The rates shall not
15 increase more than five percent (5%) annually with a
16 maximum rate not to exceed one hundred fifty percent
17 (150%) of the average standard risk rates.

18 8. a. A Pool policy may contain provisions under which
19 coverage is excluded during a period of twelve (12)
20 months following the effective date of coverage with
21 respect to a given covered person's preexisting
22 condition, as long as:

1 (1) the condition manifested itself within a period
2 of six (6) months before the effective date of
3 coverage, or

4 (2) medical advice or treatment for the condition was
5 recommended or received within a period of six
6 (6) months before the effective date of coverage.
7 The provisions of this paragraph shall not apply
8 to a person who is a federally defined eligible
9 individual.

10 b. The Board shall waive the twelve-month period if the
11 person had continuous coverage under another policy
12 with respect to the given condition within a period of
13 six (6) months before the effective date of coverage
14 under the Pool plan. The Board shall also waive any
15 preexisting waiting periods for an applicant who is a
16 federally defined eligible individual.

17 c. In the case of an individual who is eligible for the
18 credit for health insurance costs under Section 35 of
19 the Internal Revenue Code of 1986, the preexisting
20 conditions limitation will not apply if the individual
21 maintained creditable health insurance coverage for an
22 aggregate period of three (3) months as of the date on
23 which the individual seeks to enroll in coverage under
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1 the Pool plan, not counting any period prior to a
2 sixty-three-day break in coverage.

3 9. a. No amounts paid or payable by Medicare or any other
4 governmental program or any other insurance, or self-
5 insurance maintained in lieu of otherwise statutorily
6 required insurance, may be made or recognized as
7 claims under such policy, or be recognized as or
8 towards satisfaction of applicable deductibles or out-
9 of-pocket maximums, or to reduce the limits of
10 benefits available.

11 b. The Board shall have a cause of action against a
12 covered person for any benefits paid to a covered
13 person which should not have been claimed or
14 recognized as claims because of the provisions of this
15 paragraph, or because otherwise not covered.

16 SECTION 6. NEW LAW A new section of law to be codified
17 in the Oklahoma Statutes as Section 6545 of Title 36, unless there
18 is created a duplication in numbering, reads as follows:

19 A. No applicant or participant in any plan adopted by the Board
20 of Directors of the Health Insurance High Risk Pool may file a civil
21 action against the Health Insurance High Risk Pool unless the party
22 commencing the action has first filed a grievance and received a
23 final decision thereon in accordance with the procedures authorized
24 under Section 6536 of Title 36 of the Oklahoma Statutes. Any such

1 civil action shall be commenced within six (6) months of the Board's
2 final decision. Venue of any such action shall be in Oklahoma
3 County.

4 B. The Board, the individual members of the Board, and any
5 employee, agent or independent contractor acting on behalf of the
6 Pool shall not be liable for any obligations of the Pool.

7 C. No action taken in the administration of the Pool
8 established under the Health Insurance High Risk Pool Act shall be
9 the basis of any legal action, civil or criminal liability or
10 penalty against the Board, against any individual member of the
11 Board, against any agent, employee or independent contractor of the
12 Pool or the Board, or against any member insurer of the Pool, either
13 jointly or severally.

14 SECTION 7. This act shall become effective July 1, 2008.

15 SECTION 8. It being immediately necessary for the preservation
16 of the public peace, health and safety, an emergency is hereby
17 declared to exist, by reason whereof this act shall take effect and
18 be in full force from and after its passage and approval.

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