

ENROLLED HOUSE  
BILL NO. 1928

By: Steele, Terrill, Kern,  
Inman, Wright, McDaniel  
(Randy) and McDaniel  
(Jeannie) of the House

and

Adelson of the Senate

An Act relating to insurance; amending Sections 2, 3, 4 and 5, Chapter 306, O.S.L. 2005 (36 O.S. Supp. 2006, Sections 6060.15, 6060.16, 6060.17 and 6060.18), which relate to the Health Savings Account Act; modifying definitions; modifying provisions related to maximum deposits in health savings accounts; modifying restriction on eligible expenditures; modifying provisions governing treatment of interest for purposes of Oklahoma Income Tax Act; amending 74 O.S. 2001, Section 1370, as last amended by Section 3, Chapter 450, O.S.L. 2005 (74 O.S. Supp. 2006, Section 1370), which relates to flexible benefit allowance; providing for condition on certain military health plans; amending 74 O.S. 2001, Section 1371, as last amended by Section 8, Chapter 231, O.S.L. 2006 (74 O.S. Supp. 2006, Section 1371), which relates to default benefits for plans offered by health maintenance organizations; providing condition for military exemption; requiring the State and Education Employees Group Insurance Board to make the health savings account available to eligible employees; specifying time in which certain plan is offered; requiring confirmation of health savings account to certain Board by employees; providing for codification; and declaring an emergency.

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

SECTION 1. AMENDATORY Section 2, Chapter 306, O.S.L. 2005 (36 O.S. Supp. 2006, Section 6060.15), is amended to read as follows:

Section 6060.15 As used in this act:

1. "Deductible" means the total deductible for an eligible individual and all the dependents of that eligible individual for a calendar year;

2. "Dependent" means the spouse or child of the eligible individual as defined in Section 152 of the Internal Revenue Code;

3. "Eligible individual" means the individual taxpayer, including employees of an employer who contributes to health savings accounts on the employees' behalf, who:

- a. must be covered by a "high deductible health plan" individually or with dependent,
- b. may not be covered under any health plan that is not a high deductible health plan, except for:
  - (1) coverage for accidents,
  - (2) workers' compensation insurance,
  - (3) insurance for a specified disease or illness,
  - (4) insurance paying a fixed amount per day per hospitalization, and
  - (5) tort liabilities, and
- c. establishes the health savings account, or on whose behalf the health savings account is established;

4. "Health savings account" or "account" means a trust or custodian established in this state pursuant to a health savings account program exclusively to pay the qualified medical expenses of an eligible individual or their dependents, but only if the written

governing instrument creating the account meets the following requirements:

- a. except in the case of a rollover contribution, no contribution will be accepted:
  - (1) unless it is in cash, or
  - (2) to the extent the contribution, when added to the previous contributions to the account for the calendar year, exceeds ~~one hundred percent (100%) of the eligible individual's deductible or Two Thousand Six Hundred Dollars (\$2,600.00) for an individual or Five Thousand One Hundred Fifty Dollars (\$5,150.00) per family, whichever is lower~~ the maximum contribution amount pursuant to Section 223 of the Internal Revenue Code,
- b. the trustee or custodian is a bank, a credit union, an insurance company, or another person approved by the United States Secretary of Health and Human Services,
- c. no part of the trust assets will be invested in life insurance contracts,
- d. the assets of the account will not be commingled with other property except as allowed for under Individual Retirement Accounts, and
- e. eligible individual's interest in the account is nonforfeitable;

5. "Health savings account program" or "program" means a program that includes all of the following:

- a. the purchase by an eligible individual or by an employer of a high deductible health plan, and
- b. the contribution into a health savings account by an eligible individual or on behalf of an employee or by their employer. The total annual contribution may not exceed ~~the amount of the plan's higher deductible or the amounts listed in paragraph 8 of this section~~ maximum contribution amount pursuant to Section 223 of the Internal Revenue Code;

6. "High deductible health plan" means a health coverage policy, certificate, or contract that provides for payments for covered benefits that exceed the higher deductible;

7. "Qualified medical expense" means an expense paid by the taxpayer for medical care described in paragraph d of Section 213 of the Internal Revenue Code, but only to the extent such amounts are not compensated for by insurance or otherwise; and

8. "High deductible" means:

- a. in the case of self-only coverage, an annual deductible which is not less than One Thousand Dollars (\$1,000.00) and the sum of the annual deductible and other annual out-of-pocket expenses required to be paid under the plan for covered benefits does not exceed Five Thousand Dollars (\$5,000.00), or
- b. in the case of family coverage, an annual deductible of not less than Two Thousand Dollars (\$2,000.00) and the sum of the annual deductible and other annual out-of-pocket expenses required to be paid under the plan for covered benefits does not exceed Ten Thousand Dollars (\$10,000.00).

A plan shall not fail to be treated as a high deductible plan by reason of failing to have a deductible for preventive care or, in the case of network plans, for having out-of-pocket expenses which exceed these limits on an annual deductible for services provided outside the network.

SECTION 2. AMENDATORY Section 3, Chapter 306, O.S.L. 2005 (36 O.S. Supp. 2006, Section 6060.16), is amended to read as follows:

Section 6060.16 A. The provisions of this act shall also apply to taxpayers who are not receiving preferred federal tax treatment for a health savings account pursuant to Section 223 of the Internal Revenue Code.

B. For taxable years beginning after 2005, a resident of Oklahoma or an employer shall be allowed to deposit contributions to a health savings account. The amount of deposit for each year shall not exceed ~~one of the following:~~

~~1. The amount of the plan's high deductible; or~~

~~2. Two Thousand Six Hundred Dollars (\$2,600.00) for an individual policy; or~~

~~3. Five Thousand One Hundred Fifty Dollars (\$5,150.00) for a family policy~~ the maximum contribution amount pursuant to Section 223 of the Internal Revenue Code.

C. Except as provided in Section ~~5~~ 6060.18 of this ~~act~~ title, the following are exempt from taxation under the Oklahoma Income Tax Act:

1. Principal contributed to and interest earned on a health savings account ~~up to the amount of the high deductible~~; and

2. Money reimbursed to an eligible individual or an employee for qualified medical expenses.

SECTION 3. AMENDATORY Section 4, Chapter 306, O.S.L. 2005 (36 O.S. Supp. 2006, Section 6060.17), is amended to read as follows:

Section 6060.17 ~~A.~~ The trustee or custodian shall utilize the funds held in a health savings account solely for the following purposes:

1. To pay the qualified medical expenses of the eligible individual or their dependents; or

2. To purchase a health coverage policy certificate, or contract, if the eligible individual:

a. is receiving unemployment compensation,

b. is exercising continuation privileges under federal law, or

c. is purchasing a long-term care insurance contract; or

3. To pay for health insurance other than a Medicare supplemental policy for those who are Medicare eligible.

~~B. Funds held in a health savings account shall not be used to cover expenses of the eligible individual or their dependents that are otherwise covered, including, but not limited to, medical expenses covered by the following:~~

~~1. An automobile insurance policy;~~

~~2. Workers' compensation insurance policy or self-insured plan;~~  
~~or~~

~~3. Another employer funded health coverage policy, certificate or contract.~~

SECTION 4. AMENDATORY Section 5, Chapter 306, O.S.L. 2005 (36 O.S. Supp. 2006, Section 6060.18), is amended to read as follows:

Section 6060.18 A. Notwithstanding paragraphs C, D, E, and F of this section, an eligible individual may withdraw money from their health savings account for any purpose other than a purpose described in ~~subsection A of~~ Section 4 6060.17 of this ~~act~~ title.

B. If the eligible individual withdraws money for any purpose other than a purpose described in ~~subsection A of~~ Section 4 6060.17 of this ~~act~~ title, at any other time, all of the following shall apply:

1. The amount of the withdrawal is income for the purposes ~~in~~ of the Oklahoma Income Tax Act in the tax year of the withdrawal; and

2. ~~Interest earned on the account during the tax year in which a withdrawal under this subsection is made is income for the purposes of the Oklahoma Income Tax Act~~ The tax imposed on the withdrawal which is includable in income shall be increased by ten percent (10%) of the amount which is so includable.

C. The amount of disbursement of any assets of a health savings account pursuant to a filing for protection under Section 101 of Title 11 of the United States Code by an eligible individual or person for whose benefit the account was established is not considered a withdrawal for purposes of this section. The amount of a disbursement is not subject to taxation under the Oklahoma Income Tax Act and subsection B of this section does not apply.

D. The transfer of an eligible individual's interest in a health savings account to an eligible individual's spouse or former spouse under a divorce or separation instrument shall not be considered a taxable transfer made by such eligible individual, notwithstanding any other provision of this title, and the interest shall, after the transfer, be treated as a health savings account with respect to which the spouse is the eligible individual.

E. Upon the death of the eligible individual, the trustee or custodian shall distribute the principal and accumulated interest of the health savings account to the estate of the deceased.

F. If an employee becomes employed with a different employer that participates in a health savings account program, the employee may transfer their health savings account to that new employer's trustee or custodian, or to an individually purchased account program.

SECTION 5. AMENDATORY 74 O.S. 2001, Section 1370, as last amended by Section 3, Chapter 450, O.S.L. 2005 (74 O.S. Supp. 2006, Section 1370), is amended to read as follows:

Section 1370. A. Subject to the requirement that a participant must elect the default benefits, the basic plan, or is a person who has retired from a branch of the United States military and has been provided with health care through a federal plan, to the extent that it is consistent with federal law, and provides proof of this coverage, flexible benefit dollars may be used to purchase any of the benefits offered by the Oklahoma State Employees Benefits Council under the flexible benefits plan. A participant who has provided proof of other coverage as described in this subsection shall not receive flexible benefit dollars if the person elects not to purchase any benefits. A participant's flexible benefit dollars for a plan year shall consist of the sum of (1) flexible benefit allowance credited to a participant by the participating employer, and (2) pay conversion dollars elected by a participant.

B. Each participant shall be credited annually with a specified amount as a flexible benefit allowance which shall be available for the purchase of benefits. The amount of the flexible benefit allowance credited to each participant shall be communicated to him or her prior to the enrollment period for each plan year.

C. Except as provided in subsection D of this section, for the plan year ending December 31, 2001, and each plan year thereafter,

the amount of a participant's benefit allowance, which shall be the total amount the employer contributes for the payment of insurance premiums or other benefits, shall be:

1. The greater of Two Hundred Sixty-two Dollars and nineteen cents (\$262.19) per month or an amount equal to the sum of the average monthly premiums of all high option health insurance plans, excluding the point-of-service plans, the average monthly premiums of the dental plans, the monthly premium of the disability plan, and the monthly premium of the basic life insurance plan offered to state employees or the amount determined by the Council based on a formula for determining a participant's benefit credits consistent with the requirements of 26 U.S.C., Section 125(g)(2) and regulations thereunder; or

2. The greater of Two Hundred Twenty-four Dollars and sixty-nine cents (\$224.69) per month or an amount equal to the sum of the average monthly premiums of all high option health insurance plans, excluding the point-of-service plans, the average monthly premiums of the dental plans, the monthly premium of the disability plan, and the monthly premium of the basic life insurance plan offered to state employees plus one of the additional amounts as follows for participants who elect to include one or more dependents:

- a. for a spouse, seventy-five percent (75%) of the average price of all high option benefit plans, excluding the point-of-service plans, available for coverage of a spouse,
- b. for one child, seventy-five percent (75%) of the average price of all high option benefit plans available, excluding the point-of-service plans, for coverage of one child,
- c. for two or more children, seventy-five percent (75%) of the average price of all high option benefit plans available, excluding the point-of-service plans, for coverage of two or more children,
- d. for a spouse and one child, seventy-five percent (75%) of the average price of all high option benefit plans available, excluding the point-of-service plans, for coverage of a spouse and one child, or



- e. for a spouse and two or more children, seventy-five percent (75%) of the average price of all high option benefit plans available, excluding the point-of-service plans, for coverage of a spouse and two or more children.

D. ~~For the plan year beginning January 1, 2006, and each plan year thereafter~~ To the extent that it is consistent with federal law, for an employee who is an eligible TRICARE beneficiary and has opted not to purchase health care coverage and who purchases a group TRICARE Supplemental product, the amount of the participant's benefit allowance shall be equal to the sum of the monthly premium of the group TRICARE Supplemental product purchased by the participant, if any, the average monthly premiums of the dental plans, the monthly premium of the disability plan, and the monthly premium of the basic life insurance plan offered to state employees or the amount determined by the Council based on a formula for determining a participant's benefit credits consistent with the requirements of 26 U.S.C., Section 125(g)(2) and regulations thereunder. ~~For the plan year beginning January 1, 2006, and each plan year thereafter~~ To the extent that it is consistent with federal law, for each eligible dependent of an employee who is an eligible TRICARE beneficiary and has opted not to purchase health care coverage, if the employee purchases a group TRICARE Supplemental product on behalf of the dependent, the benefit allowance shall be equal to seventy-five percent (75%) of the monthly premium of the group TRICARE Supplemental product purchased by the participant on behalf of the dependent.

E. This section shall not prohibit payments for supplemental health insurance coverage made pursuant to Section 1314.4 of this title or payments for the cost of providing health insurance coverage for dependents of employees of the Grand River Dam Authority.

F. If a participant desires to buy benefits whose sum total of benefit prices is in excess of his or her flexible benefit allowance, the participant may elect to use pay conversion dollars to purchase such excess benefits. Pay conversion dollars may be elected through a salary reduction agreement made pursuant to the election procedures of Section 1371 of this title. The elected amount shall be deducted from the participant's compensation in equal amounts each pay period over the plan year. On termination of employment during a plan year, a participant shall have no obligation to pay the participating employer any pay conversion

dollars allocated to the portion of the plan year after the participant's termination of employment.

G. If a participant elects benefits whose sum total of benefit prices is less than his or her flexible benefit allowance, he or she shall receive any excess flexible benefit allowance as taxable compensation. Such taxable compensation will be paid in substantially equal amounts each pay period over the plan year. On termination during a plan year, a participant shall have no right to receive any such taxable cash compensation allocated to the portion of the plan year after the participant's termination. Nothing herein shall affect a participant's obligation to elect the minimum benefits or to accept the default benefits of the plan with corresponding reduction in the sum of his or her flexible benefit allowance equal to the sum total benefit price of such minimum benefits or default benefits.

SECTION 6. AMENDATORY 74 O.S. 2001, Section 1371, as last amended by Section 8, Chapter 231, O.S.L. 2006 (74 O.S. Supp. 2006, Section 1371), is amended to read as follows:

Section 1371. A. All participants must purchase at least the basic plan unless, to the extent that it is consistent with federal law, 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. Effective for the plan year beginning January 1, 2007, and for each plan year thereafter, in 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 to be equal

to the monthly premium for retirees under sixty-five (65) years of age.

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. Effective for the plan year beginning January 1, 2007, 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 to be equal to the monthly premium for retirees under sixty-five (65) years of age.

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 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1375 of Title 74, unless there is created a duplication in numbering, reads as follows:

The State and Education Employees Group Insurance Board shall make the health savings account authorized by the provisions of the Health Savings Account Act established in Section 6060.14 of Title 36 of the Oklahoma Statutes available by offering a high deductible health plan to all persons who are eligible employees for purposes of any health care insurance offered through or under the supervision of the Board. The high deductible health plan shall be offered no later than January 1, 2009. Any employee who elects to participate in a high deductible health plan offered through the State and Education Employees Group Insurance Board shall establish a health savings account (HSA) as defined in Section 223 of the Internal Revenue Code. The employee shall provide confirmation of such account to the State and Education Employees Group Insurance Board prior to the effective date of coverage.

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

Passed the House of Representatives the 23rd day of May, 2007.

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Presiding Officer of the House of  
Representatives

Passed the Senate the 24th day of May, 2007.

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Presiding Officer of the Senate