

ENROLLED SENATE
BILL NO. 2119

By: Sparks and Adelson of the
Senate

and

Peterson (Ron) of the House

An Act relating to insurance; amending 36 O.S. 2001, Sections 6531, 6534, as last amended by Section 19, Chapter 274, O.S.L. 2004, 6537, 6538, as amended by Section 5, Chapter 439, O.S.L. 2002, Section 6, Chapter 439, O.S.L. 2002, and 6542, as last amended by Section 20, Chapter 274, O.S.L. 2004 (36 O.S. Supp. 2007, Sections 6534, 6538, 6538.1 and 6542), which relate to the Health Insurance High Risk Pool Act; updating and modifying short title; modifying amount of lifetime limit of covered expenses; modifying powers; modifying term of the administering insurer and case managers; allowing the Board to terminate the service of the administering insurer or case managers for good cause as determined by the Board; specifying that certain information relating to the Health Insurance High Risk Pool shall be the property of the Pool; requiring grievance to be filed before civil action may be commenced against the Pool; providing that individual members of the Board shall not be liable under certain conditions; requiring the Board to conduct certain study and to issue a report; providing for codification; providing for noncodification; providing an effective date; and declaring an emergency.

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

SECTION 1. AMENDATORY 36 O.S. 2001, Section 6531, is amended to read as follows:

Section 6531. Sections ~~1~~ 6531 through ~~14~~ 6544 of this ~~act~~ title and Section 8 of this act shall be known and may be cited as the "Health Insurance High Risk Pool Act".

SECTION 2. AMENDATORY 36 O.S. 2001, Section 6534, as last amended by Section 19, Chapter 274, O.S.L. 2004 (36 O.S. Supp. 2007, Section 6534), is amended to read as follows:

Section 6534. A. Except as otherwise provided in this section, any person who maintains a primary residence in this state for at least one (1) year, or who is legally domiciled in this state on the date of application and who is eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986, or is a federally defined eligible individual shall be eligible for coverage under any of the plans of the Health Insurance High Risk Pool including:

1. The spouse of the insured; and

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

B. 1. No person is eligible for coverage under any of the Pool plans unless such person has been rejected by at least two insurers for coverage substantially similar to the primary plan coverage. As used in this paragraph, rejection includes an offer of coverage with a material underwriting restriction or an offer of coverage at a rate equal to or greater than the primary Pool plan rates. No person is eligible for coverage under any of the plans if such person has, on the date of issue of coverage under any of the plans, coverage equivalent to the primary plan under another health insurance contract or policy. This paragraph shall not apply to

federally defined eligible individuals or an individual who is eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986.

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

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

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

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

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

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

SECTION 3. AMENDATORY 36 O.S. 2001, Section 6537, is amended to read as follows:

Section 6537. The Health Insurance High Risk Pool may:

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

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

3. In addition to imposing assessments under Section 6536 of this title, levy interim assessments against insurers and reinsurers to ensure the financial ability of the plan to cover claims, expenses and administrative expenses incurred or estimated to be incurred in the operation of the plan prior to the end of a calendar year. Any interim assessment shall be due and payable within thirty (30) days of the receipt of the assessment notice by the insurer. Interim assessments shall be credited against the insurer's and reinsurer's annual assessment; and

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

SECTION 4. AMENDATORY 36 O.S. 2001, Section 6538, as amended by Section 5, Chapter 439, O.S.L. 2002 (36 O.S. Supp. 2007, Section 6538), is amended to read as follows:

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

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

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

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

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

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

D. The administering insurer shall:

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

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

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

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

- a. making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made,
- b. evaluating the eligibility of each claim for payment under the plan, and
- c. notifying each claimant within thirty (30) days after receiving a properly completed and executed proof of loss, whether the claim is accepted, rejected, or compromised;

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

6. Following the close of each calendar year, determine net premiums, reinsurance premiums less administrative expenses allowance, the expense of administration pertaining to the reinsurance operations of the Pool, and the incurred losses for the year, and report this information to the Board and to the Insurance Commissioner;

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

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

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

2. As used in this subsection, the term "direct and indirect expenses" includes the portion of the audited administrative costs, printing expenses, claims administration expenses, management expenses, building overhead expenses and other actual operating and

administrative expenses of the administering insurer which are approved by the Board as allocable to the administration of the plan and included in the bid specifications.

SECTION 5. AMENDATORY Section 6, Chapter 439, O.S.L. 2002 (36 O.S. Supp. 2007, Section 6538.1), is amended to read as follows:

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

1. The case manager or managers' proven ability to handle large group accident and health insurance case management and its understanding of health care delivery systems;
2. The cost savings attributed to the case manager or managers' services; and
3. An estimate of total charges for providing case management services to the Pool.

B. The case manager or managers shall serve for a period of ~~two~~ (2) up to five (5) years beginning January 1, ~~2003~~ 2009. Prior to the expiration of each ~~two-year~~ contract period of service by a case manager, the Board shall invite all reasonably interested potential case managers, including the current case manager or managers, to submit bids to serve as a case manager for the succeeding ~~two-year~~ contract period. The selection of the case manager or managers for the succeeding ~~two-year~~ contract period shall be made at least four (4) months prior to the end of the current ~~two-year~~ contract period. The Board may terminate the service of a case manager at any time if the Board determines that the case manager has failed to perform the duties effectively according to the contract established or for other good cause as determined by the Board. In this case, the Board will accept bids from other potential case managers to serve the remainder of the vacated term.

C. A case manager's duties shall include:

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

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

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

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

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

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

2. As used in this subsection, the term "direct and indirect expenses" includes the portion of the printing expenses, case management expenses, management expenses, building overhead expenses and other actual operating and administrative expenses of the case manager which are approved by the Board as allocable to case management of the plan and included in the bid specifications.

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

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

SECTION 6. AMENDATORY 36 O.S. 2001, Section 6542, as last amended by Section 20, Chapter 274, O.S.L. 2004 (36 O.S. Supp. 2007, Section 6542), is amended to read as follows:

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

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

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

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

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

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

1. Hospital services;
2. Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental, which are rendered by a physician or by others at the direction of a physician;
3. Drugs requiring a physician's prescription;
4. Services of a licensed skilled nursing facility for eligible individuals, ineligible for Medicare, for not more than one hundred eighty (180) calendar days during a policy year, if the services are the type which would qualify as reimbursable services under Medicare;
5. Services of a home health agency, if the services are of a type which would qualify as reimbursable services under Medicare;
6. Use of radium or other radioactive materials;
7. Oxygen;
8. Anesthetics;
9. Prosthesis, other than dental prosthesis;
10. Rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;
11. Diagnostic x-rays and laboratory tests;
12. Oral surgery for partially or completely erupted, impacted teeth and oral surgery with respect to the tissues of the mouth when not performed in connection with the extraction or repair of teeth;
13. Services of a physical therapist;
14. Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

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

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

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

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

- a. any charge for treatment for cosmetic purposes, other than for repair or treatment of an injury or congenital bodily defect to restore normal bodily functions,
- b. any charge for care which is primarily for custodial or domiciliary purposes which do not qualify as eligible services under Medicaid,
- c. any charge for confinement in a private room to the extent that such charge is in excess of the charge by the institution for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician,
- d. that part of any charge for services or articles rendered or provided by a physician or other health care personnel which exceeds the prevailing charge in the locality where the service is provided, or any charge for services or articles not medically necessary,
- e. any charge for services or articles the provision of which is not within the authorized scope of practice of the institution or individual providing the service or articles,

- f. any expense incurred prior to the effective date of the coverage under the plan for the person on whose behalf the expense was incurred,
- g. any charge for routine physical examinations in excess of one every twenty-four (24) months,
- h. any charge for the services of blood donors and any fee for the failure to replace the first three (3) pints of blood provided to an eligible person annually, and
- i. any charge for personal services or supplies provided by a hospital or nursing home, or any other nonmedical or nonprescribed services or supplies.

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

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

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

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

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

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

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

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

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

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

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

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

b. The Board shall waive the twelve-month period if the person had continuous coverage under another policy with respect to the given condition within a period of six (6) months before the effective date of coverage

under the Pool plan. The Board shall also waive any preexisting waiting periods for an applicant who is a federally defined eligible individual.

- c. In the case of an individual who is eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986, the preexisting conditions limitation will not apply if the individual maintained creditable health insurance coverage for an aggregate period of three (3) months as of the date on which the individual seeks to enroll in coverage under the Pool plan, not counting any period prior to a sixty-three-day break in coverage.
9. a. No amounts paid or payable by Medicare or any other governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may be made or recognized as claims under such policy, or be recognized as or towards satisfaction of applicable deductibles or out-of-pocket maximums, or to reduce the limits of benefits available.
- b. The Board shall have a cause of action against a covered person for any benefits paid to a covered person which should not have been claimed or recognized as claims because of the provisions of this paragraph, or because otherwise not covered.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6545 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. No applicant or participant in any plan adopted by the Board of Directors of the Health Insurance High Risk Pool may file a civil action against the Health Insurance High Risk Pool unless the party commencing the action has first filed a grievance and received a final decision thereon in accordance with the procedures authorized under Section 6536 of Title 36 of the Oklahoma Statutes. Any such civil action shall be commenced within one (1) year of the Board's final decision. Venue of any such action shall be in Oklahoma County.

B. Individual members of the Board, including the ex officio nonvoting members, while acting in good faith within the course of their duties under the provisions of the Health Insurance High Risk Pool Act shall not be personally liable for actions taken by the Board.

SECTION 8. NEW LAW A new section of law not to be codified in the Oklahoma Statutes reads as follows:

The Board of Directors of the Health Insurance High Risk Pool shall conduct a comprehensive study on the effectiveness of the Health Insurance High Risk Pool Act and shall issue a report to the Insurance Commissioner, Governor, President Pro Tempore of the Senate and the Speaker of the House of Representatives before March 1, 2009. The study shall include, but not be limited to, a nationwide analysis of states operating similar high risk pools relating to coverage, lifetime caps, premiums, assessments on insurers and reinsurers, risk banding and coverage affordability for such High Risk Pool members. The report shall contain recommendations as to actions necessary to improve the overall effectiveness, efficiency and fairness to members, insurers and reinsurers while ensuring the Pool's long-term fiscal viability.

SECTION 9. Sections 2 and 6 of this act shall become effective July 1, 2009.

SECTION 10. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

Passed the Senate the 22nd day of May, 2008.

Presiding Officer of the Senate

Passed the House of Representatives the 23rd day of May, 2008.

Presiding Officer of the House
of Representatives