

SB 2119

THE STATE SENATE
Monday, February 25, 2008

Senate Bill No. 2119
As Amended

SENATE BILL NO. 2119 - By: SPARKS of the Senate and PETERSON (Ron) of the House.

[insurance - Health Insurance High Risk Pool Act -
effective date -
emergency]

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

SECTION 1. 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

1 of the insured, or attains the age of nineteen (19) years, whichever
2 occurs first. However, if the child is a full-time student at an
3 accredited institution of higher learning, the coverage may continue
4 while the child remains unmarried and a full-time student, but not
5 beyond the premium period in which the child reaches the age of
6 twenty-three (23) years.

7 B. 1. No person is eligible for coverage under any of the Pool
8 plans unless such person has been rejected by at least two insurers
9 for coverage substantially similar to the primary plan coverage. As
10 used in this paragraph, rejection includes an offer of coverage with
11 a material underwriting restriction or an offer of coverage at a
12 rate equal to or greater than the primary Pool plan rates. No
13 person is eligible for coverage under any of the plans if such
14 person has, on the date of issue of coverage under any of the plans,
15 coverage equivalent to the primary plan under another health
16 insurance contract or policy. This paragraph shall not apply to
17 federally defined eligible individuals or an individual who is
18 eligible for the credit for health insurance costs under Section 35
19 of the Internal Revenue Code of 1986.

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

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

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

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

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

22 D. The coverage of any person who ceases to meet the
23 eligibility requirements of this section may be terminated at the

1 end of the month in which an individual no longer meets the
2 eligibility requirements.

3 SECTION 2. AMENDATORY 36 O.S. 2001, Section 6542, as
4 last amended by Section 20, Chapter 274, O.S.L. 2004 (36 O.S. Supp.
5 2007, Section 6542), is amended to read as follows:

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

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

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

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

3 B. The primary plan shall offer comprehensive coverage to every
4 eligible person who is not eligible for Medicare. Comprehensive
5 coverage offered under the primary plan shall pay an eligible
6 person's covered expenses, subject to the limits on the deductible
7 and coinsurance payments authorized under subsection E of this
8 section up to a lifetime limit of ~~Five Hundred Thousand Dollars~~
9 ~~(\$500,000.00)~~ One Million Dollars (\$1,000,000.00) per covered
10 individual. The maximum limit under this paragraph shall not be
11 altered by the Board of Directors of the Health Insurance High Risk
12 Pool, and no actuarially equivalent benefit may be substituted by
13 the Board.

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

19 1. Hospital services;

20 2. Professional services for the diagnosis or treatment of
21 injuries, illness, or conditions, other than dental, which are
22 rendered by a physician or by others at the direction of a
23 physician;

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

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

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

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

- 10 a. any charge for treatment for cosmetic purposes, other
11 than for repair or treatment of an injury or
12 congenital bodily defect to restore normal bodily
13 functions,
- 14 b. any charge for care which is primarily for custodial
15 or domiciliary purposes which do not qualify as
16 eligible services under Medicaid,
- 17 c. any charge for confinement in a private room to the
18 extent that such charge is in excess of the charge by
19 the institution for its most common semiprivate room,
20 unless a private room is prescribed as medically
21 necessary by a physician,
- 22 d. that part of any charge for services or articles
23 rendered or provided by a physician or other health

- 1 care personnel which exceeds the prevailing charge in
2 the locality where the service is provided, or any
3 charge for services or articles not medically
4 necessary,
- 5 e. any charge for services or articles the provision of
6 which is not within the authorized scope of practice
7 of the institution or individual providing the service
8 or articles,
- 9 f. any expense incurred prior to the effective date of
10 the coverage under the plan for the person on whose
11 behalf the expense was incurred,
- 12 g. any charge for routine physical examinations in excess
13 of one every twenty-four (24) months,
- 14 h. any charge for the services of blood donors and any
15 fee for the failure to replace the first three (3)
16 pints of blood provided to an eligible person
17 annually, and
- 18 i. any charge for personal services or supplies provided
19 by a hospital or nursing home, or any other nonmedical
20 or nonprescribed services or supplies.

21 2. The primary plan may provide an option for a person to have
22 coverage for the expenses set out in paragraph 1 of this subsection

1 or any benefits payable under any other health insurance policy or
2 plan, commensurate with the deductible and coinsurance selected.

3 E. 1. The primary plan shall provide for a choice of annual
4 deductibles per person covered for major medical expenses in the
5 amounts of Five Hundred Dollars (\$500.00), One Thousand Dollars
6 (\$1,000.00), One Thousand Five Hundred Dollars (\$1,500.00), Two
7 Thousand Dollars (\$2,000.00), Five Thousand Dollars (\$5,000.00) and
8 Seven Thousand Five Hundred Dollars (\$7,500.00), plus the additional
9 benefits payable at each level of deductible; provided, if two
10 individual members of a family satisfy the applicable deductible, no
11 other members of the family shall be required to meet deductibles
12 for the remainder of that calendar year.

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

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

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

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

21 6. Standard risk rates for coverages issued by the Pool shall
22 be established by the Board, subject to the approval of the
23 Insurance Commissioner, using reasonable actuarial techniques, and

1 shall reflect anticipated experiences and expenses of such coverage
2 for standard risks.

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

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

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

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

22 (2) medical advice or treatment for the condition was
23 recommended or received within a period of six

1 (6) months before the effective date of coverage.
2 The provisions of this paragraph shall not apply
3 to a person who is a federally defined eligible
4 individual.

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

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

21 9. a. No amounts paid or payable by Medicare or any other
22 governmental program or any other insurance, or self-
23 insurance maintained in lieu of otherwise statutorily

1 required insurance, may be made or recognized as
2 claims under such policy, or be recognized as or
3 towards satisfaction of applicable deductibles or out-
4 of-pocket maximums, or to reduce the limits of
5 benefits available.

6 b. The Board shall have a cause of action against a
7 covered person for any benefits paid to a covered
8 person which should not have been claimed or
9 recognized as claims because of the provisions of this
10 paragraph, or because otherwise not covered.

11 SECTION 3. This act shall become effective July 1, 2008.

12 SECTION 4. It being immediately necessary for the preservation
13 of the public peace, health and safety, an emergency is hereby
14 declared to exist, by reason whereof this act shall take effect and
15 be in full force from and after its passage and approval.

16 COMMITTEE REPORT BY: COMMITTEE ON RETIREMENT & INSURANCE, dated
17 2-21-08 - DO PASS, As Amended and Coauthored.