

ENROLLED HOUSE
BILL NO. 2026

By: Steele, McAffrey, Walker,
Faught, Shumate, Cox,
Pittman and Wright (John)
of the House

and

Crain of the Senate

An Act relating to public health; creating the Health Care for Oklahomans Act; directing the Insurance Commissioner to advise and aid certain board; authorizing the Commissioner to promulgate certain rules; providing for duties of certain board; providing for certain duties of the Commissioner; directing the Commissioner to initiate certain program; requiring certain referral; defining terms; permitting health carriers to offer certain plans to specified persons; requiring certain statement; providing for certain disclosure; requiring certain insurers to offer specified policies; directing health carriers to file certain rates; providing for the adoption of certain rules; amending 56 O.S. 2001, Section 1010.1, as last amended by Section 1, Chapter 412, O.S.L. 2008 (56 O.S. Supp. 2008, Section 1010.1), which relates to the premium assistant program; authorizing the purchase of certain high-deductible plan; providing for codification; and providing an effective date.

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

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4601 of Title 36, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Health Care for Oklahomans Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4602 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner in collaboration with the Oklahoma Health Care Authority shall advise and aid the Health Care for the Uninsured Board (HUB) in its duties. The Insurance Commissioner is hereby authorized to promulgate such reasonable rules as are necessary to implement the purposes of this act.

B. The State Board of Health shall direct the implementation and duties of the HUB to assist the Insurance Commissioner. The duties of the HUB shall be to:

1. Advise, consult with, and make recommendations to the Commissioner as to the matters addressed in subsection C of this section; and

2. Assist and advise the Commissioner on such other matters as the Commissioner may submit for recommendations to the State Board of Health.

C. The Commissioner shall:

1. Establish a system of certification for insurance programs offered in this state to be recommended by the HUB;

2. Establish a system for the credentialing of insurance producers who intend to market insurance programs certified by the state in accordance with this section.

3. Establish a system of counseling, including a website, for those individuals who are without health insurance and are not covered by Medicaid, that includes but is not limited to:

- a. educating consumers about insurance programs certified by the state in accordance with this section,
- b. aiding consumers in choosing policies that cover medically necessary services for that consumer, and
- c. educating consumers on how to utilize primary and preventative care in order to reduce the unnecessary utilization of services by the consumer; and

4. Establish a system whereby if an individual qualifies for a subsidy under the premium assistance program, established in Section 1010.1 of Title 56 of the Oklahoma Statutes, that person is able to become enrolled through the HUB in conjunction with local, qualified insurance producers.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4603 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner in collaboration with the Oklahoma Health Care Authority shall initiate a program to encourage enrollment of individuals, not covered by insurance or Medicaid in health insurance programs.

B. Upon treatment of an uninsured individual or an individual not covered by Medicaid, a health care provider shall refer the individual to the HUB established in Section 2 of this act to begin the enrollment process in a certified insurance plan or the premium assistance program established in Section 1010.1 of Title 56 of the Oklahoma Statutes, if eligible.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4415 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in this section:

1. "Health carrier" means any entity or insurer authorized under Title 36 of the Oklahoma Statutes to provide accident or health insurance or health benefits in this state and any entity or person engaged in the business of making contracts of accident or health insurance;

2. "Standard health benefit plan" means an accident or health insurance policy that does not offer or provide state-mandated health benefits but that provides creditable coverage and is issued to an individual under forty (40) years of age; and

3. a. "State-mandated health benefits" means coverage for health care services or benefits, required by state law or state regulations, requiring the reimbursement or utilization related to a specific illness, injury, or condition of the covered person, including those

provisions listed in Sections 6060 through 6060.11 of Title 36 of the Oklahoma Statutes.

- b. "State-mandated health benefits" does not mean those benefits found in Sections 4401 through 4411 and 4501 through 4513 of Title 36 of the Oklahoma Statutes.

B. 1. A health carrier may offer one or more standard health benefit plans to individuals under forty (40) years of age.

2. Each application and health benefit plan issued pursuant to this section shall contain the following language at the beginning of the document in bold type:

"This standard health benefit plan does not provide state-mandated health benefits normally required in accident and health insurance policies in the State of Oklahoma. This standard health benefit plan may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in the State of Oklahoma."

C. An insurer providing a standard health benefit plan shall provide a proposed policyholder or policyholder with a written disclosure statement that:

1. Lists those state-mandated health benefits not included under the standard health benefit plan and acknowledges that the plan being purchased does not provide those benefits; and

2. Provides a notice that purchase of the plan may limit the future coverage options of the policyholder in the event the health of the policyholder changes and needed benefits are not available under the standard health benefit plan.

D. Each applicant for initial coverage and each policyholder on renewal of coverage shall sign the disclosure statement provided by the insurer under subsection C of this section and return the statement to the insurer. An insurer shall:

1. Retain the signed disclosure statement in the records of the insurer; and

2. Upon request of the Insurance Commissioner, provide the signed disclosure statement to the Oklahoma Insurance Department.

E. An insurer that offers one or more standard health benefit plans as provided in this section shall also offer at least one accident or health insurance policy with state-mandated health benefits that is otherwise authorized by Title 36 of the Oklahoma Statutes.

F. A health carrier shall file, for informational purposes only, with the Oklahoma Insurance Department the rates to be used with a standard health benefit plan.

G. The Insurance Commissioner shall adopt rules necessary to implement the provisions of this section.

SECTION 5. AMENDATORY 56 O.S. 2001, Section 1010.1, as last amended by Section 1, Chapter 412, O.S.L. 2008 (56 O.S. Supp. 2008, Section 1010.1), is amended to read as follows:

Section 1010.1 A. ~~Sections~~ Section 1010.1 et seq. of this title shall be known and may be cited as the "Oklahoma Medicaid Program Reform Act of 2003".

B. Recognizing that many Oklahomans do not have health care benefits or health care coverage, that many small businesses cannot afford to provide health care benefits to their employees, and that, under federal law, barriers exist to providing Medicaid benefits to the uninsured, the Oklahoma Legislature hereby establishes provisions to lower the number of uninsured, assist businesses in their ability to afford health care benefits and coverage for their employees, and eliminate barriers to providing health coverage to eligible enrollees under federal law.

C. Unless otherwise provided by law, the Oklahoma Health Care Authority shall provide coverage under the state Medicaid program to children under the age of eighteen (18) years whose family incomes do not exceed one hundred eighty-five percent (185%) of the federal poverty level.

D. 1. The Authority is directed to apply for a waiver or waivers to the Centers for Medicaid and Medicare Services (CMS) that will accomplish the purposes outlined in subsection B of this section. The Authority is further directed to negotiate with CMS to include in the waiver authority provisions to:

a. increase access to health care for Oklahomans,

- b. reform the Oklahoma Medicaid Program to promote personal responsibility for health care services and appropriate utilization of health care benefits through the use of public-private cost sharing,
- c. enable small employers, and/or employed, uninsured adults with or without children to purchase employer-sponsored, state-approved private, or state-sponsored health care coverage through a state premium assistance payment plan. If by January 1, 2012, the Employer/Employee Partnership for Insurance Coverage Premium Assistance Program is not consuming more than seventy-five percent (75%) of its dedicated source of funding, then the program will be expanded to include parents of children eligible for Medicaid, and
- d. develop flexible health care benefit packages based upon patient need and cost.

2. The Authority may phase in any waiver or waivers it receives based upon available funding.

3. The Authority is authorized to develop and implement a premium assistance plan to assist small businesses and/or their eligible employees to purchase employer-sponsored insurance or "buy-in" to a state-sponsored benefit plan.

- 4. a. The Authority is authorized to seek from the Centers for Medicare and Medicaid Services any waivers or amendments to existing waivers necessary to accomplish an expansion of the premium assistance program to:
 - (1) include for-profit employers with two hundred fifty employees or less up to any level supported by existing funding resources⁷ and
 - (2) include not-for-profit employers with five hundred employees or less up to any level supported by existing funding resources.
- b. Foster parents employed by employers with greater than two hundred fifty employees shall be exempt from the qualifying employer requirement provided for in this paragraph and shall be eligible to qualify for the

premium assistance program provided for in this section if supported by existing funding.

E. For purposes of this paragraph, "for-profit employer" shall mean an entity which is not exempt from taxation pursuant to the provisions of Section 501(c)(3) of the Internal Revenue Code and "not-for-profit employer" shall mean an entity which is exempt from taxation pursuant to the provisions of Section 501(c)(3) of the Internal Revenue Code.

F. The Authority is authorized to seek from the Centers for Medicare and Medicaid Services any waivers or amendments to existing waivers necessary to accomplish an extension of the premium assistance program to include qualified employees whose family income does not exceed two hundred fifty percent (250%) of the federal poverty level, subject to the limit of federal financial participation.

G. The Authority is authorized to create as part of the premium assistance program an option to purchase a high-deductible health insurance plan that is compatible with a health savings account.

H. 1. There is hereby created in the State Treasury a revolving fund to be designated the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund".

2. The fund shall be a continuing fund, not subject to fiscal year limitations, and shall consist of:

- a. all monies received by the Authority pursuant to this section and otherwise specified or authorized by law,
- b. monies received by the Authority due to federal financial participation pursuant to Title XIX of the Social Security Act, and
- c. interest attributable to investment of money in the fund.

3. All monies accruing to the credit of the fund are hereby appropriated and shall be budgeted and expended by the Authority to implement a premium assistance plan, unless otherwise provided by law.

SECTION 6. This act shall become effective November 1, 2009.

Passed the House of Representatives the 29th day of April, 2009.

Presiding Officer of the House
of Representatives

Passed the Senate the 16th day of April, 2009.

Presiding Officer of the Senate