

ENROLLED SENATE
BILL NO. 553

By: Justice of the Senate
and
Osborn of the House

An Act relating to insurance; amending 36 O.S. 2001, Section 4509, which relates to extension and termination of group accident and health coverage; providing that certain provisions are inapplicable in certain circumstances; modifying and expanding scope of coverage; expanding coverage period; providing for premiums; providing for continuation of coverage in certain circumstances; amending 36 O.S. 2001, Sections 6532, as last amended by Section 18, Chapter 274, O.S.L. 2004 and 6534, as last amended by Section 2, Chapter 404, O.S.L. 2008 (36 O.S. Supp. 2008, Sections 6532 and 6534), which relate to the Health Insurance High Risk Pool Act; modifying definitions; providing certain exception; construing act; and declaring an emergency.

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

SECTION 1. AMENDATORY 36 O.S. 2001, Section 4509, is amended to read as follows:

Section 4509. A. When an insured employee or a dependent whose group insurance coverage is terminated and the coverage is subject to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272, April 7, 1986, 100 Stat. 82, neither subsection B, C, or D of this section applies.

B. In the case of an employee whose insurance is terminated under a group policy providing hospital, medical or surgical, or Christian Science care and treatment expense benefits, or contract of hospital or medical service or indemnity; or prepaid health plan or health maintenance organization subscriber contract, such employee and ~~his~~ the dependents of the employee shall remain insured under the policy or contract for a period of at least ~~thirty (30)~~ sixty-three (63) days after such termination, unless during such period the employee and his dependents shall otherwise become entitled to similar insurance from some other source. Premiums may be charged for this period. The premiums charged shall be the premiums which would have been charged for the coverage provided under the group policy or contract had termination not occurred.

~~B.~~ C. If an employee has been covered for at least six (6) months under any group accident and health insurance policy delivered in this state, providing hospital, medical or surgical, or Christian Science care and treatment expense benefits, or under a contract of hospital or medical service or indemnity, and the individual employee has had his employment terminated or the group itself is terminated, then the termination shall not affect coverage of the insured or his dependents for any continuous loss which commenced while the insurance was in force. The extension of benefits beyond the period the insurance was in force may be predicated upon the continuous total disability of the person insured or his or her dependents or the expenses incurred in connection with a plan of surgical treatment, which shall include maternity care and delivery expenses, which commenced prior to the termination. The coverage for the extension of benefits shall be for the maximum benefits under the terminated policy or for a time period of not less than three (3) months in the case of basic coverage or six (6) months in the case of major medical coverage. Premium monies may be charged for the period of the extension of benefits. The premiums charged shall be the premiums which would have been charged for the coverage provided under the group policy or contract had termination not occurred.

D. When an insured employee or a dependent whose group health insurance coverage is terminated due to the employee's involuntary termination from employment, the employee or his or her dependents shall have a right to continue the group health insurance coverage

for four (4) months following the employee's termination from employment subject to all of the following conditions:

1. The group health insurance is provided pursuant to a group policy providing hospital, medical or surgical, or Christian Science care and treatment expense benefits; or contract of hospital or medical service or indemnity; or prepaid health plan or health maintenance organization subscriber contract; or a self-insured employer plan;

2. The coverage shall be the same coverage as was provided prior to the employee's termination;

3. Premiums shall be paid for the period of coverage. The premiums charged shall be the premiums which would have been charged for the coverage provided under the group policy or contract had termination not occurred;

4. The employee was not terminated for misconduct; and

5. This subsection shall remain in force only until the end of the period for which a premium subsidy is available pursuant to the American Recovery and Reinvestment Act of 2009 (ARRA) or its successor.

SECTION 2. AMENDATORY 36 O.S. 2001, Section 6532, as last amended by Section 18, Chapter 274, O.S.L. 2004 (36 O.S. Supp. 2008, Section 6532), is amended to read as follows:

Section 6532. As used in the Health Insurance High Risk Pool Act:

1. "Agent" means any person who is licensed to sell health insurance in this state;

2. "Primary plan" means the comprehensive health insurance benefit plan adopted by the Board of Directors of the Health Insurance High Risk Pool which meets all requirements of federal law as a plan required to be offered by the Pool;

3. "Board" means the Board of Directors of the Health Insurance High Risk Pool;

4. "Church plan" has the meaning given such term under Section 3(33) of the Employee Retirement Income Security Act of 1974;

5. "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

- a. a group health plan,
- b. health insurance coverage,
- c. Part A or B of Title XVIII of the Social Security Act,
- d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 of such act,
- e. Chapter 55 of Title 10, U.S. Code,
- f. a medical care program of the Indian Health Service or of a tribal organization,
- g. a state health benefits risk pool,
- h. a health plan offered under Chapter 89 of Title 5, U.S. Code,
- i. a public health plan as defined in federal regulations, or
- j. a health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);

6. "Federally defined eligible individual" means an individual:

- a. for whom, as of the date on which the individual seeks coverage under the Health Insurance High Risk Pool Act, the aggregate of the periods of creditable coverage, as defined in Section 1D of the Employee Retirement Income Security Act of 1974, is eighteen (18) or more months,

- b. whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in conjunction with any such plan, and
- c. who is not eligible for coverage under a group health plan, part A or B of Title XVIII of the Social Security Act, or a state plan under Title XIX of such Act or any successor program and who does not have other health insurance coverage, except that a person who has exhausted COBRA coverage shall be, for the purposes of the Health Insurance High Risk Pool Act, a federally defined individual
- ~~d. with respect to whom the most recent coverage under a COBRA continuation provision or under a similar state program, elected such coverage, and~~
- ~~e. who has exhausted such continuation coverage under such provision or program, if the individual elected the continuation coverage described in this paragraph of this section; however, if the individual is eligible for the credit for health insurance costs under Section 35 of the Internal Revenue Code of 1986, the requirement for exhaustion of any available COBRA or state continuation benefits is waived;~~

7. "Governmental plan" has the same meaning given such term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan;

8. "Group health benefit plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care as defined in Section 3N of the Employee Retirement Income Security Act of 1974 and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise;

9. "Health insurance" means any individual or group hospital or medical expense-incurred policy or health care benefits plan or

contract. The term does not include any policy governing short-term accidents only, a fixed-indemnity policy, a limited benefit policy, a specified accident policy, a specified disease policy, a Medicare supplement policy, a long-term care policy, medical payment or personal injury coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance, a disability policy, or workers' compensation;

10. "Insurer" means any individual, corporation, association, partnership, fraternal benefit society, or any other entity engaged in the health insurance business, except insurance agents and brokers. This term shall also include not-for-profit hospital service and medical indemnity plans, health maintenance organizations, preferred provider organizations, prepaid health plans, the State and Education Employees Group Health Insurance Plan, and any reinsurer reinsuring health insurance in this state, which shall be designated as engaged in the business of insurance for the purposes of Section 6531 et seq. of this title;

11. "Medical care" means amounts paid for:

- a. the diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,
- b. transportation primarily for and essential to medical care referred to in subparagraph a of this paragraph, and
- c. insurance covering medical care referred to in subparagraphs a and b of this paragraph;

12. "Medicare" means coverage under Parts A and B of Title XVIII of the Social Security Act (Public Law 74-271, 42 U.S.C., Section 1395 et seq., as amended);

13. "Pool" means the Health Insurance High Risk Pool;

14. "Physician" means a doctor of medicine and surgery, doctor of osteopathic medicine, doctor of chiropractic, doctor of podiatric medicine, doctor of optometry, and, for purposes of oral and

maxillofacial surgery only, a doctor of dentistry, each duly licensed by this state;

15. "Plan" means any of the comprehensive health insurance benefit plans as adopted by the Board of Directors of the Health Insurance High Risk Pool, or by rule;

16. "Alternative plan" means any of the comprehensive health insurance benefit plans adopted by the Board of Directors of the Health Insurance High Risk Pool other than the primary plan; and

17. "Reinsurer" means any insurer as defined in Section 103 of this title from whom any person providing health insurance to Oklahoma insureds procures insurance for itself as the insurer, with respect to all or part of the health insurance risk of the person.

SECTION 3. AMENDATORY 36 O.S. 2001, Section 6534, as last amended by Section 2, Chapter 404, O.S.L. 2008 (36 O.S. Supp. 2008, 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~~ Except as provided in this paragraph, 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 except for a person who has exhausted COBRA coverage as provided for in subparagraph c of paragraph 6 of Section 6532 of this title.

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 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.

E. Nothing in this section shall be construed to deny eligibility to a person who has exhausted COBRA coverage. Any person who has exhausted COBRA coverage must apply for coverage under any of the Pool plans within sixty-three (63) days after exhausting such COBRA coverage in order to have a preexisting condition covered.

SECTION 4. 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 6th day of May, 2009.

Presiding Officer of the Senate

Passed the House of Representatives the 6th day of April, 2009.

Presiding Officer of the House
of Representatives