

1 STATE OF OKLAHOMA

2 1st Session of the 52nd Legislature (2009)

3 HOUSE BILL 2026

By: Steele

4
5 AS INTRODUCED

6
7 An Act relating to public health; creating the Health
8 Care for Oklahomans Act; directing the establishment
9 of certain board; specifying duties; providing for
10 certain fee; providing for certain point-of-service
11 enrollment; providing certain coverage of
12 uncompensated care in certain circumstance; directing
13 the establishment of a program to develop the health
14 care workforce; specifying scholarships and grants;
15 requiring certain condition; defining terms;
16 authorizing a health carrier to offer certain plan;
17 requiring certain statement on application and plan;
18 providing for disclosure statement; specifying
19 content and procedures; requiring health carrier to
20 offer certain additional plan; requiring the filing
21 of certain rates with the Oklahoma Insurance
22 Department; providing for the promulgation of rules;
23 amending 36 O.S. 2001, Section 6542, as last amended
24 by Section 6, Chapter 404, O.S.L. 2008 (36 O.S. Supp.
2008, Section 6542), which relates to the high risk
pool; clarifying language; 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 Medicaid; authorizing the
purchase of certain high-deductible plan; defining
term; providing for certain tax credit; specifying
limitations; providing for carryover; providing for
the promulgation of rules; providing for
codification; and providing effective dates.

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

1 SECTION 1. NEW LAW A new section of law to be codified
2 in the Oklahoma Statutes as Section 4901 of Title 63, unless there
3 is created a duplication in numbering, reads as follows:

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

6 SECTION 2. NEW LAW A new section of law to be codified
7 in the Oklahoma Statutes as Section 4902 of Title 63, unless there
8 is created a duplication in numbering, reads as follows:

9 A. The Oklahoma Health Care Authority in collaboration with the
10 Insurance Department shall establish the Health Care for the
11 Uninsured Board (HUB). The HUB shall:

12 1. Review and establish a system of certification for insurance
13 programs offered in this state to be recommended by the HUB;

14 2. Establish a system of counseling, for those individuals who
15 are without health insurance and are not on Medicaid, that includes
16 but is not limited to:

17 a. educating consumers about insurance programs certified
18 by the state in accordance with this section,

19 b. aiding consumers in choosing policies that cover
20 medically necessary services for that consumer, and

21 c. educating consumers on how to utilize primary and
22 preventative care in order to reduce the unnecessary
23 utilization of services by the consumer; and
24

1 3. Establish a system whereby if an individual qualifies for a
2 subsidy under the premium assistance program, established in Section
3 1010.1 of Title 56 of the Oklahoma Statutes, that person is able to
4 become enrolled through the HUB.

5 B. The HUB shall charge an administrative fee, not to exceed
6 five percent (5%) of the monthly cost of the plan, for services
7 provided to those persons that do not qualify for a subsidy.

8 SECTION 3. NEW LAW A new section of law to be codified
9 in the Oklahoma Statutes as Section 4903 of Title 63, unless there
10 is created a duplication in numbering, reads as follows:

11 A. The Oklahoma Health Care Authority shall initiate a program
12 with Oklahoma hospitals and health care providers to enroll
13 patients, not covered by insurance or Medicaid and not otherwise
14 able to pay for the treatment, in health insurance programs at the
15 point of service.

16 B. Upon treatment of an uninsured individual or an individual
17 not covered by Medicaid, a provider shall refer the individual to
18 the HUB established in Section 2 of this act for either enrollment
19 in a certified insurance plan or the premium assistance program
20 established in Section 1010.1 of Title 56 of the Oklahoma Statutes,
21 if eligible. Once an individual is enrolled in a plan, the provider
22 shall receive a one-time reimbursement for the cost of the
23 uncompensated care received by the patient. The patient shall be
24 held financially responsible for all care thereafter.

1 SECTION 4. NEW LAW A new section of law to be codified
2 in the Oklahoma Statutes as Section 4904 of Title 63, unless there
3 is created a duplication in numbering, reads as follows:

4 A. The Oklahoma Health Care Workforce Center shall establish a
5 program to develop the health care workforce. The program shall
6 consist of:

7 1. Scholarships for those individuals enrolled in primary care
8 physician and nursing education and certification programs;

9 2. Scholarships for individuals to cover the costs of gaining
10 advanced degrees necessary to serve as faculty members for nursing
11 or allied health programs; and

12 3. Grants to nursing and allied health education institutions
13 to increase clinical opportunities and to better utilize online and
14 distance learning, simulations, and other innovative methods to
15 provide education and training.

16 B. Scholarships shall have a condition requiring the recipient
17 of funds to agree to practice in this state for a specified time
18 period. If a recipient breaches the agreement then the funds
19 provided shall become a debt owed by the recipient to the state.

20 SECTION 5. NEW LAW A new section of law to be codified
21 in the Oklahoma Statutes as Section 4415 of Title 36, unless there
22 is created a duplication in numbering, reads as follows:

23 A. As used in this section:
24

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

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

10 3. a. "State-mandated health benefits" means coverage for
11 health care services or benefits, required by state
12 law or state regulations, requiring the reimbursement
13 or utilization related to a specific illness, injury,
14 or condition of the covered person, including those
15 provisions listed in Sections 6060 through 6060.11 of
16 Title 36 of the Oklahoma Statutes.

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

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

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

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

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

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

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

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

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

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

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

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

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

13 SECTION 6. AMENDATORY 36 O.S. 2001, Section 6542, as
14 last amended by Section 6, Chapter 404, O.S.L. 2008 (36 O.S. Supp.
15 2008, Section 6542), is amended to read as follows:

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

21 2. Any person whose health insurance is involuntarily
22 terminated for any reason other than nonpayment of premium or fraud
23 may apply for coverage under any of the plans offered by the Board
24 of Directors of the Health Insurance High Risk Pool. If such

1 coverage is applied for within sixty-three (63) days after the
2 involuntary termination and if premiums are paid for the entire
3 period of coverage, the effective date of the coverage shall be the
4 date of termination of the previous coverage.

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

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

12 B. The primary plan shall offer comprehensive coverage to every
13 eligible person who is not eligible for Medicare. Comprehensive
14 coverage offered under the primary plan shall pay an eligible
15 person's covered expenses, subject to the limits on the deductible
16 and coinsurance payments authorized under subsection E of this
17 section up to a lifetime limit of One Million Dollars
18 (\$1,000,000.00) per covered individual. The maximum limit under
19 this paragraph shall not be altered by the Board of Directors of the
20 Health Insurance High Risk Pool, and no actuarially equivalent
21 benefit may be substituted by the Board.

22 C. Except for a health maintenance organization and prepaid
23 health plan or preferred provider organization utilized by the Board
24 or a covered person, the usual customary charges for the following

1 services and articles, when prescribed by a physician, shall be
2 covered expenses in the primary plan:

3 1. Hospital services;

4 2. Professional services for the diagnosis or treatment of
5 injuries, illness, or conditions, other than dental, which are
6 rendered by a physician or by others at the direction of a
7 physician;

8 3. Drugs requiring a physician's prescription;

9 4. Services of a licensed skilled nursing facility for eligible
10 individuals, ineligible for Medicare, for not more than one hundred
11 eighty (180) calendar days during a policy year, if the services are
12 the type which would qualify as reimbursable services under
13 Medicare;

14 5. Services of a home health agency, if the services are of a
15 type which would qualify as reimbursable services under Medicare;

16 6. Use of radium or other radioactive materials;

17 7. Oxygen;

18 8. Anesthetics;

19 9. Prosthesis, other than dental prosthesis;

20 10. Rental or purchase, as appropriate, of durable medical
21 equipment, other than eyeglasses and hearing aids;

22 11. Diagnostic ~~x-rays~~ X-rays and laboratory tests;

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1 12. Oral surgery for partially or completely erupted, impacted
2 teeth and oral surgery with respect to the tissues of the mouth when
3 not performed in connection with the extraction or repair of teeth;

4 13. Services of a physical therapist;

5 14. Transportation provided by a licensed ambulance service to
6 the nearest facility qualified to treat the condition;

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

9 16. Services for the treatment of alcohol and drug abuse, but
10 the plan shall be required to make a fifty percent (50%) co-payment
11 and the payment of the plan shall not exceed Four Thousand Dollars
12 (\$4,000.00).

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

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

18 a. any charge for treatment for cosmetic purposes, other
19 than for repair or treatment of an injury or
20 congenital bodily defect to restore normal bodily
21 functions,

22 b. any charge for care which is primarily for custodial
23 or domiciliary purposes which do not qualify as
24 eligible services under Medicaid,

- 1 c. any charge for confinement in a private room to the
2 extent that such charge is in excess of the charge by
3 the institution for its most common semiprivate room,
4 unless a private room is prescribed as medically
5 necessary by a physician,
- 6 d. that part of any charge for services or articles
7 rendered or provided by a physician or other health
8 care personnel which exceeds the prevailing charge in
9 the locality where the service is provided, or any
10 charge for services or articles not medically
11 necessary,
- 12 e. any charge for services or articles the provision of
13 which is not within the authorized scope of practice
14 of the institution or individual providing the service
15 or articles,
- 16 f. any expense incurred prior to the effective date of
17 the coverage under the plan for the person on whose
18 behalf the expense was incurred,
- 19 g. any charge for routine physical examinations in excess
20 of one every twenty-four (24) months,
- 21 h. any charge for the services of blood donors and any
22 fee for the failure to replace the first three (3)
23 pints of blood provided to an eligible person
24 annually, and

1 i. any charge for personal services or supplies provided
2 by a hospital or nursing home, or any other nonmedical
3 or nonprescribed services or supplies.

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

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

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

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

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

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

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

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

12 b. Any change to the initial rates shall be based on
13 experience of the plans and shall reflect reasonably
14 anticipated losses and expenses. The rates shall not
15 increase more than five percent (5%) annually with a
16 maximum rate not to exceed one hundred fifty percent
17 (150%) of the average standard risk rates.

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

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

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

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

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

3 9. a. No amounts paid or payable by Medicare or any other
4 governmental program or any other insurance, or self-
5 insurance maintained in lieu of otherwise statutorily
6 required insurance, may be made or recognized as
7 claims under such policy, or be recognized as or
8 towards satisfaction of applicable deductibles or out-
9 of-pocket maximums, or to reduce the limits of
10 benefits available.

11 b. The Board shall have a cause of action against a
12 covered person for any benefits paid to a covered
13 person which should not have been claimed or
14 recognized as claims because of the provisions of this
15 paragraph, or because otherwise not covered.

16 SECTION 7. AMENDATORY 56 O.S. 2001, Section 1010.1, as
17 last amended by Section 1, Chapter 412, O.S.L. 2008 (56 O.S. Supp.
18 2008, Section 1010.1), is amended to read as follows:

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

22 B. Recognizing that many Oklahomans do not have health care
23 benefits or health care coverage, that many small businesses cannot
24 afford to provide health care benefits to their employees, and that,

1 under federal law, barriers exist to providing Medicaid benefits to
2 the uninsured, the Oklahoma Legislature hereby establishes
3 provisions to lower the number of uninsured, assist businesses in
4 their ability to afford health care benefits and coverage for their
5 employees, and eliminate barriers to providing health coverage to
6 eligible enrollees under federal law.

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

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

- 17 a. increase access to health care for Oklahomans,
- 18 b. reform the Oklahoma Medicaid Program to promote
19 personal responsibility for health care services and
20 appropriate utilization of health care benefits
21 through the use of public-private cost sharing,
- 22 c. enable small employers, and/or employed, uninsured
23 adults with or without children to purchase employer-
24 sponsored, state-approved private, or state-sponsored

1 health care coverage through a state premium
2 assistance payment plan. If by January 1, 2012, the
3 Employer/Employee Partnership for Insurance Coverage
4 Premium Assistance Program is not consuming more than
5 seventy-five percent (75%) of its dedicated source of
6 funding, then the program will be expanded to include
7 parents of children eligible for Medicaid, and

- 8 d. develop flexible health care benefit packages based
9 upon patient need and cost.

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

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

16 4. a. The Authority is authorized to seek from the Centers for
17 Medicare and Medicaid Services any waivers or amendments
18 to existing waivers necessary to accomplish an expansion
19 of the premium assistance program to:

- 20 (1) include for-profit employers with two hundred fifty
21 employees or less up to any level supported by
22 existing funding resources⁷ and
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1 (2) include not-for-profit employers with five hundred
2 employees or less up to any level supported by
3 existing funding resources.

4 b. Foster parents employed by employers with greater than
5 two hundred fifty employees shall be exempt from the
6 qualifying employer requirement provided for in this
7 paragraph and shall be eligible to qualify for the
8 premium assistance program provided for in this section
9 if supported by existing funding.

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

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

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

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

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

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

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

20 SECTION 8. NEW LAW A new section of law to be codified
21 in the Oklahoma Statutes as Section 2358.8 of Title 68, unless there
22 is created a duplication in numbering, reads as follows:

23 A. As used in this section, "Section 125 plan" means a separate
24 written plan, maintained by an employer for employees, that meets

1 the specific requirements and regulations of Section 125 of the
2 Internal Revenue Code.

3 B. For tax years beginning after December 31, 2009, there shall
4 be allowed against the tax imposed by Section 2355 of Title 68 of
5 the Oklahoma Statutes, a credit for employers that participate in
6 the Section 125 plan. The credit shall be equal to Five Hundred
7 Dollars (\$500.00) annually.

8 C. In no event shall the amount of the credit exceed the amount
9 of any tax liability of the taxpayer.

10 D. Any credits allowed but not used in any tax year may be
11 carried over in order to each of the four (4) tax years following
12 the year of qualification.

13 E. An employer shall claim the tax credit provided by this
14 section for no more than four (4) taxable years.

15 F. The Oklahoma Tax Commission may promulgate such rules as may
16 be necessary to implement the provisions of this section.

17 SECTION 9. Sections 1 through 7 of this act shall become
18 effective November 1, 2009.

19 SECTION 10. Section 8 of this act shall become effective
20 January 1, 2010.

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