SENATE FLOOR VERSION
February 28, 2011

SENATE BILL NO. 563 By: Brown of the Senate

and

Mulready of the House

An Act relating to health insurance high risk pool plans; amending 36 O.S. 2001, Sections 6532, as last amended by Section 2, Chapter 207, O.S.L. 2009 and 6542, as last amended by Section 6, Chapter 404, O.S.L. 2008 (36 O.S. Supp. 2010, Sections 6532 and 6542), which relate to the Health Insurance High Risk Pool Act; modifying definitions; modifying determination of certain rates; and declaring an emergency.

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

SECTION 1. AMENDATORY 36 O.S. 2001, Section 6532, as last amended by Section 2, Chapter 207, O.S.L. 2009 (36 O.S. Supp. 2010, 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)<u>, or</u>

k. a temporary high risk pool referred to as the Pre-Existing Condition Insurance Plan or PCIP program, offered pursuant to Section 1101(b) of the Patient Protection and Affordable Care Act ("Affordable Care Act", Public Law 111-148);

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. The eighteen-month period required in this paragraph shall not apply to an individual whose most recent creditable coverage was under a plan defined in paragraph k of subsection 5 of this section,

b. whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, a temporary high risk health insurance pool referred to as the Pre-Existing Condition Insurance Plan or PCIP program, offered pursuant to Section 1101(b) of the Patient Protection and Affordable Care Act ("Affordable Care Act", Public Law 111-148) which has

ceased to be available 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;

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~~ the Health Insurance High Risk Pool Act;

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 2. AMENDATORY 36 O.S. 2001, Section 6542, as last amended by Section 6, Chapter 404, O.S.L. 2008 (36 O.S. Supp. 2010, 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 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 weighted 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 3. 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.

COMMITTEE REPORT BY: COMMITTEE ON RETIREMENT & INSURANCE, dated 2-24-11 - DO PASS, As Coauthored.