

1 STATE OF OKLAHOMA

2 1st Session of the 53rd Legislature (2011)

3 SENATE BILL 50

By: Wilson

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5
6 AS INTRODUCED

7 An Act relating to accident and health insurance
8 policies; amending 36 O.S. 2001, Section 4502, which
9 relates to group accident and health policies;
10 requiring the Insurance Commissioner to approve the
11 discontinuance of certain coverages; requiring the
12 Commissioner to make certain determinations;
13 requiring the Commissioner to take certain
14 information into consideration when making certain
15 determinations; requiring the issuer to provide
16 certain notice; providing for damages under certain
17 circumstances; directing the Commissioner to order an
18 extended benefit to be provided during certain total
19 disability; authorizing the Commissioner to
20 promulgate rules; and providing an effective date.

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1 reduce benefits unless contained in a written instrument signed by
2 the policyholder or the insured person, a copy of which has been
3 furnished to such policyholder or to such person or ~~his~~ the
4 beneficiary-;

5 2. A provision that the insurer will furnish to the
6 policyholder, for delivery to each employee or member of the insured
7 group, an individual certificate setting forth in summary form a
8 statement of the essential features of the insurance coverage of
9 such employee or member and to whom benefits are payable. If
10 dependents or family members are included in the coverage additional
11 certificates need not be issued for delivery to such dependents or
12 family members-; and

13 3. A provision that to the group originally insured may be
14 added from time to time eligible new employees or members or
15 dependents, as the case may be, in accordance with the terms of the
16 policy.

17 B. Each group health policy certificate subject to the
18 provisions of the Federal Health Insurance Portability and
19 Accountability Act, Public Law 104-191, (HIPAA) laws shall contain
20 in substance the following provisions, which shall be in addition to
21 the provisions required by subsection A of this section.

22 1. A provision that a health benefit plan shall not deny,
23 exclude or limit benefits for a covered individual for losses
24

1 incurred more than twelve (12) months following the effective date
2 of the individual's coverage due to a preexisting condition;

3 2. A provision that a health benefit plan shall not define a
4 preexisting condition more restrictively than:

5 a. a condition for which medical advice, diagnosis, care
6 or treatment was recommended or received during the
7 six (6) months immediately preceding the effective
8 date of coverage,

9 b. pregnancy and genetic information shall not be
10 considered preexisting conditions,

11 c. a health benefit plan may exclude a preexisting
12 condition for late enrollees for a period not to
13 exceed eighteen (18) months from the date the
14 individual enrolls for coverage,

15 d. the period of any such preexisting condition exclusion
16 shall be reduced by the aggregate of the periods of
17 creditable coverage as defined in the Federal HIPAA
18 laws,

19 e. a period of creditable coverage shall not be counted
20 if after such period and before the enrollment date,
21 there was a sixty-three-day period during all of which
22 the individual was not covered under any creditable
23 coverage,

24

1 f. "enrollment date" means the date of enrollment of the
2 individual in the plan or coverage or, if earlier, the
3 first day of the waiting period for such enrollment,
4 and

5 g. "late enrollee" means a participant or beneficiary who
6 enrolls under the plan other than during the first
7 period in which the individual is eligible to enroll
8 under the plan or a special enrollment period;

9 3. A provision that individuals losing other coverage shall be
10 permitted to enroll for coverage under the terms of the plan if each
11 of the following conditions is met:

12 a. the employee or dependent was covered under a group
13 health plan or had health insurance coverage at the
14 time coverage was previously offered to the employee
15 or dependent,

16 b. the employee stated in writing at such time that
17 coverage under a group health plan or health insurance
18 coverage was the reason for declining enrollment, but
19 only if the plan sponsor or issuer required such a
20 statement at such time and provided the employee with
21 notice of such requirement, and the consequences of
22 such requirement, at such time,

23 c. the employee's or dependent's coverage was under a
24 COBRA continuation provision and the coverage under

1 such provision was exhausted; or was not under such a
2 provision and either the coverage was terminated as a
3 result of loss of eligibility for the coverage,
4 including as a result of legal separation, divorce,
5 death, termination of employment, or reduction in the
6 number of hours of employment, or employer
7 contributions toward such coverage were terminated,
8 and

9 d. under the terms of the plan, the employee requests
10 such enrollment not later than thirty (30) days after
11 the date of exhaustion of coverage;

12 4. A provision that for any period that an individual is in a
13 waiting period for any coverage under a group health plan or for
14 group health insurance coverage or is in an affiliation period, that
15 period shall not be taken into account in determining the continuous
16 period of creditable coverage. "Affiliation period" means a period
17 which, under the terms of the health insurance coverage offered by a
18 health maintenance organization, must expire before the health
19 insurance coverage becomes effective. The organization is not
20 required to provide health care services or benefits during such
21 period and no premium shall be charged to the participant or
22 beneficiary for any coverage during the period;

23 5. A provision that preexisting condition exclusions will not
24 apply to newborns, who, as of the last day of the thirty-day period

1 beginning with the date of birth, are covered under creditable
2 coverage;

3 6. A provision that preexisting condition exclusions will not
4 apply to a child who is adopted or placed for adoption before
5 attaining eighteen (18) years of age;

6 7. A provision that dependents are eligible for a special
7 enrollment period if the group health plan makes coverage available
8 with respect to a dependent of an individual, and the individual is
9 a participant under the plan, or has met any waiting period
10 applicable to becoming a participant under the plan and is eligible
11 to be enrolled under the plan but for a failure to enroll during a
12 previous enrollment period, and a person becomes such a dependent of
13 the individual through marriage, birth or adoption or placement for
14 adoption. The special enrollment period shall apply to that person
15 or, if not otherwise enrolled, the individual, the dependent of the
16 individual, and in the case of the birth or adoption of a child, the
17 spouse of the individual may be enrolled as a dependent of the
18 individual if such spouse is otherwise eligible for coverage.

19 a. The dependent special enrollment period shall be a
20 period of not less than thirty (30) days and shall
21 begin on the later of the date dependent coverage is
22 made available, or the date of the marriage, birth, or
23 adoption or placement for adoption.

24

1 b. There is no waiting period if an individual seeks to
2 enroll a dependent during the first thirty (30) days
3 of such a dependent special enrollment period.

4 c. The coverage for the dependent shall become effective
5 in the case of marriage, not later than the first day
6 of the first month beginning after the date the
7 completed request for enrollment is received, in the
8 case of a dependent's birth, as of the date of such
9 birth, in the case of a dependent's adoption or
10 placement for adoption, the date of such adoption or
11 placement for adoption;

12 8. A provision that eligibility or continued eligibility of any
13 individual will not be based on any of the following health-status-
14 related factors in relation to the individual or a dependent of the
15 individual: health status, medical condition, including both
16 physical and mental illnesses, claims experience, receipt of health
17 care, medical history, genetic information, evidence of
18 insurability, including conditions arising out of acts of domestic
19 violence or disability.

20 a. Carriers are not required to provide particular
21 benefits other than those provided under the terms of
22 the plan or coverage.

23 b. Carriers may establish limitations or restrictions on
24 the amount, level, extent, and nature of the benefits

1 or coverage for similarly situated individuals
2 enrolled in the plan or coverage;

3 9. A provision that the group health plan is guaranteed
4 renewable, except as provided pursuant to the federal provisions
5 found in HIPAA, which are as follows:

- 6 a. nonpayment of premium,
- 7 b. fraud,
- 8 c. violation of participation and/or contribution rules,
- 9 d. termination of coverage:

10 (1) in any case in which an issuer decides to
11 discontinue offering a particular type of group
12 health insurance coverage offered in the large or
13 small group market, coverage of such type may be
14 discontinued by the issuer only if:

15 (a) the issuer requests that the Insurance
16 Commissioner approve such discontinuance, in
17 such form as designated by the Commissioner,
18 and receives such approval,

19 (b) the Commissioner shall, no later than sixty
20 (60) days after receipt of such request,
21 grant such approval only if the Commissioner
22 determines that the discontinuance of the
23 coverage of this class in such market by the
24 issuer is neither with the intent nor as a

1 pretext to discontinuing the coverage of any
2 policyholder or any insured due to the claim
3 experience of any health status-related
4 factor relating to any policyholder or
5 insured covered by any such policy,

6 (c) the Commissioner shall make such
7 determination only after examining and
8 taking into consideration the claim
9 histories and premium rates for each policy
10 in the class, the historical profits and
11 losses for the class of policies, comments
12 from policyholders or others submitted to
13 the Commissioner within thirty (30) days
14 after receipt of any such request, and other
15 information the Commissioner deems relevant,

16 (d) the issuer, no later than the date any such
17 request to the Commissioner is made, shall
18 provide written notice to each policyholder
19 provided coverage of this class in such
20 market and to all participants and
21 beneficiaries covered under such coverage of
22 such request, along with notice of the
23 earliest possible date that the Commissioner
24 might approve such request, the earliest

1 possible date that such coverage could be
2 discontinued, and a statement written in
3 plain English of the obligations of the
4 issuer and the rights of the policyholder
5 pursuant to this subdivision and
6 subdivisions (f) and (g) of this division,
7 (e) the issuer, upon approval by the
8 Commissioner of any such request:

9 i. provides notice to each plan sponsor
10 provided coverage of this type in such
11 market, and participants and
12 beneficiaries covered under such
13 coverage, of such discontinuation at
14 least ninety (90) days prior to the
15 date of the discontinuation of such
16 coverage, ~~and~~

17 ii. makes available the option to purchase
18 all or, in the case of the large group
19 market, any other health insurance
20 coverage currently being offered by the
21 issuer to a group health plan in such
22 market, ~~and~~

23 iii. in exercising the option to discontinue
24 coverage of this type and in offering

1 the option of coverage pursuant to this
2 provision, the issuer acts uniformly
3 without regard to the claims experience
4 of those sponsors or any health-status-
5 related factor relating to any
6 participants or beneficiaries covered
7 or new participants or beneficiaries
8 who may become eligible for such
9 coverage,

10 (f) where an issuer discontinues a particular
11 class of group or blanket policy of
12 hospital, surgical or medical expense
13 insurance offered in the small or large
14 group market, other than where the
15 Commissioner authorizes such discontinuance
16 pursuant to subdivision (c) of this
17 division, such issuer shall be liable to the
18 former holder or beneficiary of such policy,
19 or to his or her estate, for compensatory
20 damages arising from such unlawful
21 discontinuance, plus costs and reasonable
22 attorney fees, in an action commenced no
23 later than five (5) years after the date of
24 such discontinuance. In any such action,

1 the court may grant such injunctive relief
2 as the court may deem proper. Any
3 determination by the Commissioner, pursuant
4 to subdivision (c) of this division, shall
5 be reviewable in the manner specified by
6 law,

7 (g) the Commissioner shall, where major medical
8 insurance or insurance providing major
9 medical type benefits is discontinued
10 pursuant to subdivision (c) of this
11 division, order that an extended benefit
12 shall be provided during total disability,
13 with respect to the sickness, injury or
14 pregnancy which caused the disability of at
15 least eighteen (18) months subsequent to
16 discontinuance of insurance unless similar
17 coverage is afforded for the total
18 disability under another group plan, and
19 (h) the Commissioner is authorized to promulgate
20 such rules as the Commissioner deems
21 necessary to implement the provisions of
22 this subparagraph,

23 (2) in any case in which an issuer decides to
24 discontinue offering a particular type of group

1 health insurance coverage offered in the large or
2 small group market, coverage of such type may be
3 discontinued by the issuer only if: the issuer
4 provides notice to the Oklahoma Insurance
5 Department and to each plan sponsor and
6 participants and beneficiaries covered under such
7 coverage of such discontinuation at least one
8 hundred eighty (180) days prior to the date of
9 the discontinuation of such coverage; and all
10 health insurance issued or delivered for issuance
11 in the state in such market or markets are
12 discontinued and coverage under such health
13 insurance coverage in such market or markets is
14 not renewed, and

15 (3) in the case of a discontinuation under division
16 (2) of this subparagraph in a market, the issuer
17 shall not provide for the issuance of any health
18 insurance coverage in the market and in this
19 state during the five-year period beginning on
20 the date of the discontinuation of the last
21 health insurance coverage not so renewed,

22 e. movement outside the service area, and

23 f. association membership ceases; and

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1 10. A provision that certification of creditable coverage will
2 be issued individuals covered:

- 3 a. at the time an individual ceases to be covered under
4 the plan or otherwise becomes covered under a COBRA
5 continuation provision,
6 b. in the case of an individual becoming covered under
7 such a provision, at the time the individual ceases to
8 be covered under such provision, and
9 c. on the request on behalf of an individual made not
10 later than twenty-four (24) months after the date of
11 cessation of the coverage described in subparagraph a
12 or b of this paragraph, whichever is later.

13 The certification described in this paragraph is a written
14 certification of the period of creditable coverage of the individual
15 under such plan and the coverage, if any, under such COBRA
16 continuation provision, and the waiting period, if any, and
17 affiliation period, if applicable, imposed with respect to the
18 individual for any coverage under such plan.

19 SECTION 2. This act shall become effective November 1, 2011.
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