STATE OF OKLAHOMA

1st Session of the 54th Legislature (2013)

HOUSE BILL 1342 By: Mulready

AS INTRODUCED

An Act relating to insurance; enacting the Individual Market Health Insurance Coverage Act; stating purpose; defining terms; providing applicability of the act; providing premium rate restrictions; requiring certain health coverage be available to certain eligible persons; requiring a health carrier to renew and continue coverage except in certain instances; requiring certain health carriers to make dependent coverage of children available until a certain age; prohibiting certain preexisting condition exclusions; requiring a health carrier to provide for certain special enrollment periods; prohibiting a health carrier from discriminating against individuals based on health status or genetic information; prohibiting certain genetic tests; prohibiting health carriers from establishing lifetime and annual limits on certain health benefits; prohibiting health carriers from rescinding coverage except in certain instances and when notice is provided; requiring health benefit plans to include certain levels of coverage; requiring health benefit plans to provide coverage for certain preventive health services; requiring health benefit plans to provide coverage for participation in certain approved clinical trials; requiring certain health benefit plans to permit choice of health care professional; providing access to pediatric, obstetrical and gynecological care requirements; requiring summary of benefits and coverage explanation; requiring certification of creditable coverage; providing fair marketing standards; providing quality-of-care reporting requirements; 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 8001 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 "Individual Market Health Insurance Coverage Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8002 of Title 36, unless there is created a duplication in numbering, reads as follows:

The purpose and intent of this act is to set out the requirements for guaranteed availability, guaranteed renewability and premium rating in the individual market and provide for the establishment of coverage and other benefit requirements in the individual market.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8003 of Title 36, unless there is created a duplication in numbering, reads as follows:

For purposes of this act:

1. "Bona fide association" means an association that meets all of the following criteria:

a. serves a single profession that requires a significant amount of education, training or experience, or a license or certificate from a state authority to practice that profession,

b. has been actively in existence for five (5) years,

c. has a constitution and by-laws or other analogous governing documents,

d. has been formed and maintained in good faith for purposes other than obtaining insurance,

e. is not owned or controlled by a carrier or affiliated with a carrier,

f. does not condition membership in the association on any health-status-related factor,

g. has at least one thousand members if it is a national association, five hundred members if it is a state association, or two hundred members if it is a local association,

h. all members and dependents of members are eligible for coverage regardless of any health-status-related factor,

i. does not make a health benefit plan offered through the association available other than in connection with a member of the association,

j. is governed by a board of directors and sponsors annual meetings of its members, and

k. producers only market association memberships, accept applications for membership, or sign up members in the professional association where the subject individuals

are actively engaged in, or directly related to, the profession represented by the association;

2. "Carrier" or "health carrier" shall be defined in the same manner as paragraph 27 of Section 6475.3 of Title 36 of the Oklahoma Statutes;

3. "Commissioner" means the Insurance Commissioner;

4. "Converted policy" means a policy of insurance providing benefits substantially equivalent to those provided under the policy from which conversion is made;

5. "Covered benefits" or "benefits" means those health care services to which an individual is entitled under the terms of a health benefit plan;

6. "Covered person" means a policyholder or enrollee participating in a health benefit plan;

7. "Creditable coverage" means, with respect to an individual, health benefits or coverage provided under any of the following:

a. a group health plan,

b. a health benefit plan,

c. Part A or Part B of Title XVIII of the Social Security Act (Medicare),

d. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 (the program for distribution of pediatric vaccines),

e. Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents. For purposes of Title 10, U.S.C. Chapter 55, "uniformed services" means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service),

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, United States Code (Federal Employees Health Benefits Program (FEHBP)),

i. a public health plan which, for purposes of this act, means a plan established or maintained by a state, the United States government or a foreign country or any political subdivision of a state, the United States government or a foreign country that provides health insurance coverage to individuals enrolled in the plan,

j. a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)), or

k. Title XXI of the Social Security Act (State Children's Health Insurance Program);

8. Except as otherwise may be defined for purposes of Section 8 of this act, "dependent" shall be defined in the same manner as in paragraph 13 of Section 6512 of Title 36 of the Oklahoma Statutes;

9. "Employee" has the meaning given such term under Section 3(6) of ERISA;

10. "Enrollee" means an individual who is covered by a health benefit plan providing individual health insurance coverage;

11. a. "Essential health benefits" has the meaning under Section 1302(b) of the Federal Act and applicable regulations.

b. Essential health benefits include:

(1) ambulatory patient services,

(2) emergency services,

(3) hospitalization,

(4) laboratory services,

(5) maternity and newborn care,

(6) mental health and substance abuse disorder services, including behavioral health treatment,

(7) pediatric services, including oral and vision care,

(8) prescription drugs,

(9) preventive and wellness services and chronic disease management, and

(10) rehabilitative and habilitative services and devices;

12. "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

13. "Family member" means with respect to an individual:

a. a dependent of the individual, and

b. any other individual who is a first-degree, second-degree, third-degree or fourth-degree relative of the individual or an individual described in subparagraph a of this paragraph;

14. a. "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 11 I-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (ACA), and any amendments thereto, or regulations or guidance issued under those acts.

b. "Federal Act" includes Title XXVII of the PHSA, as amended by the ACA;

15. a. "Genetic information" means, with respect to any individual, information about:

(1) the individual's genetic tests,

(2) the genetic tests of the individual's family members, and

(3) the manifestation of a disease or disorder in family members of the individual.

b. ”Genetic information" includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by the individual or any family member of the individual.

c. "Genetic information" does not include information about the sex or age of any individual;

16. "Genetic services" means:

a. a genetic test,

b. genetic counseling, including obtaining, interpreting or assessing genetic information, or

c. genetic education;

17. a. “Genetic test” means an analysis of human DNA, RNA, chromosomes, proteins or metabolites that detects genotypes, mutations or chromosomal changes.

b. “Genetic test” does not mean:

(1) an analysis of proteins or metabolites that does not detect genotypes, mutations or chromosomal changes, or

(2) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved;

18. "Geographic rating area" is an area established in accordance with Section 2701(a)(2) of the PHSA, or any federal regulation adopted thereunder, for purposes of adjusting the rates for a health benefit plan;

19. "Grandfathered health plan coverage" means coverage provided by a health carrier in which an individual was enrolled on March 23, 2010, for as long as it maintains that status in accordance with federal regulations, and includes any extension of coverage to individuals who become dependents of grandfathered enrollees after March 23, 2010;

20. "Group health insurance plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to an employer or group of employers to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services;

21. "Group health plan" has the meaning given such term under Section 2791(a) of the PHSA;

22. a. "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

b. "Health benefit plan" does not include:

(1) coverage only for accident, or disability income insurance, or any combination thereof,

(2) coverage issued as a supplement to liability insurance,

(3) liability insurance, including general liability insurance and automobile liability insurance,

(4) workers' compensation or similar insurance,

(5) automobile medical payment insurance,

(6) credit-only insurance,

(7) coverage for on-site medical clinics, or

(8) other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

c. "Health benefit plan" does not include the following benefits if they are provided under a separate policy,

certificate or contract of insurance or are otherwise not an integral part of the plan:

(1) limited scope dental or vision benefits,

(2) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, or

(3) other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

d. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(1) coverage only for a specified disease or illness, or

(2) hospital indemnity or other fixed indemnity insurance.

e. "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(1) Medicare supplemental health insurance as defined under Section 1882(g)(I) of the Social Security Act,

(2) coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)), or

(3) similar supplemental coverage provided to coverage under a group health insurance plan;

23. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law;

24. "Health care provider" or "provider" means a health care professional or facility;

25. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a medical condition, illness, injury or disease;

26. "Health maintenance organization" means a person that undertakes to provide or arrange for the delivery of health care services to covered persons on a prepaid basis, except for a covered person's responsibility for copayments, coinsurance or deductibles;

27. "Health-status-related factor" means any of the following factors:

a. health status,

b. medical condition, including both physical and mental illnesses,

c. claims experience,

d. receipt of health care services,

e. medical history,

f. genetic information,

g. evidence of insurability, including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities,

h. disability, or

i. any other health-status-related factor determined appropriate by the Secretary;

28. a. “Individual market health insurance coverage” means health insurance coverage, other than a converted policy, offered to individuals in the individual market, but does not include short-term limited duration insurance.

b. For purposes of this act, “student health insurance coverage”, as defined in paragraph 39 of this section,

shall be considered a type of individual health insurance coverage;

29. "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan;

30. "Network plan" means a health benefit plan issued by a health carrier under which the financing and delivery of health care services, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier;

31. "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing;

32. a. "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the enrollment date of the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

b. Genetic information shall not be treated as a condition under subparagraph a of this paragraph for which a preexisting condition exclusion may be imposed

in the absence of a diagnosis of the condition related to the information;

33. "Policyholder" means an individual who has paid premium for himself or herself and his or her dependents, if any, who are also covered under a health benefit plan providing individual health insurance coverage, and is responsible for continued premium payments under the terms of the health benefit plan;

34. "Premium" means all monies paid by a policyholder as a condition of receiving individual health insurance coverage from a health carrier, including any fees or other contributions associated with the health benefit plan and includes any portion of premium paid on behalf of a policyholder;

35. "Producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance;

36. a. "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.

b. "Rescission" does not include a cancellation or discontinuance of coverage under a health benefit plan if:

(1) the cancellation or discontinuance of coverage has only a prospective effect, or

(2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is

attributable to a failure to timely pay required premiums or contributions towards the cost of coverage;

37. "Secretary" means the Secretary of the federal Department of Health and Human Services;

38. "Student administrative health fee" means a fee charged by an institution of higher education on a periodic basis to students of the institution of higher education to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health insurance coverage;

39. "Student health insurance coverage" means a type of individual health insurance coverage that is provided pursuant to a written agreement between an institution of higher education (as defined in the Higher Education Act of 1965) and a health carrier and provided to students enrolled in that institution of higher education and their dependents, that meets the following:

a. does not make health insurance coverage available other than in connection with enrollment as student (or as a dependent of a student) in the institution of higher education,

b. does not condition eligibility for health insurance coverage on any health-status-related factor related to a student (or a dependent of a student), and

c. meets any additional requirement that may be imposed under state law;

40. "Underwriting purposes" means:

a. rules for, or determination of, eligibility including enrollment and continued eligibility for benefits under the health benefit plan,

b. the computation of premium or contribution amounts under the health benefit plan, and

c. other activities related to the creation, renewal or replacement of a contract of individual health insurance coverage; and

41. "Waiting period" means the period of time that must pass before coverage for a covered person who is otherwise eligible to enroll under the terms of a health benefit plan can become effective.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8004 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Subject to subsection B of this section, this act shall apply to health carriers offering health benefit plans providing individual health insurance coverage in this state.

B. Except for Sections 7 and 8, subsection C of Section 10, paragraph 1 of subsection A of Section 11, and Sections 12, 17, 18 and 19 of this act and to the extent provisions of other sections in

this act were in effect pursuant to Pub. L. No. 104-191 (HIPAA) and Pub. L. No. 110-233 (GINA) prior to the effective date of the Federal Act, this act does not apply to any grandfathered health plan coverage.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8005 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. With respect to the premium rates charged by a health carrier offering a health benefit plan providing individual market health insurance coverage subject to this act, the carrier shall develop its premium rates based on the following and vary the premium rates with respect to the particular plan or coverage only by:

a. whether the plan or coverage covers an individual or family,

b. geographic rating area, established in accordance with Section 2701(a)(2) of the Public Health Service Act (PHSA),

c. age, except that the rate shall not vary by more than three to one for adults, and

d. tobacco use, except that the rate shall not vary by more than one and one-half to one.

2. A premium rate shall not vary with respect to any particular health benefit plan or individual market health insurance coverage by any other factor not described in paragraph 1 of this subsection.

3. With respect to family coverage under a health benefit plan providing individual market health insurance coverage, the rating variations permitted under subparagraphs c and d of paragraph 1 of this subsection shall be applied based on the portion of the premium that is attributable to each family member covered under the plan.

B. The premium charged with respect to any particular health benefit plan or individual market health insurance coverage shall not be adjusted more frequently than annually except that the premium rates may be changed to reflect:

1. Changes to the family composition of the policyholder;

2. Changes in geographic rating area of the policyholder, as provided in subparagraph b of paragraph 1 of subsection A of this section;

3. Changes in tobacco use, as provided in subparagraph d of paragraph 1 of subsection A of this section;

4. Changes to the health benefit plan requested by the policyholder; or

5. Other changes required by federal law or regulations or otherwise expressly permitted by state law.

C. A health carrier shall consider all enrollees in all health benefit plans (other than grandfathered health plan coverage)

offered by the carrier in the individual market, including those enrollees who do not enroll in such plans through an exchange, as established under Section 1311 of the Federal Act, to be members of a single risk pool.

D. The Commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by health carriers are consistent with the purposes of this act.

E. In connection with the offering for sale of individual market health insurance coverage under this act, a health carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

1. The provisions of the coverage concerning the carrier's right to change premium rates and the factors that may affect changes in premium rates; and

2. A listing of and descriptive information, including benefits and premiums, about all health benefit plans offered by the carrier that provide individual market health insurance coverage and the availability of the plans for which the individual is qualified.

F. 1. Each health carrier shall maintain at its principal place of business a complete and detailed description of its rating practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

2. Each health carrier shall file with the Commissioner annually, on or before March 15, an actuarial certification certifying that the carrier is in compliance with this act and that the rating methods of the carrier are actuarially sound. The certification shall be in a form and manner, and shall contain such information, as specified by the Commissioner. A copy of the certification shall be retained by the carrier at its principal place of business.

3. a. A health carrier shall make the information and documentation described in paragraph 1 of this subsection available to the Commissioner upon request.

b. Except in cases of violations of this act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the Commissioner to persons outside of the Insurance Department except as agreed to by the health carrier or as ordered by a court of competent jurisdiction.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8006 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Subject to subsections B through E of this section, each health carrier that offers a health benefit plan providing individual market health insurance coverage in this state shall

issue any applicable health benefit plan to any eligible individual who applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this act.

B. 1. A health carrier described under subsection A of this section may restrict enrollment in coverage described in subsection A of this section to open or special enrollment periods.

2. A health carrier described under subsection A of this section shall, in accordance with regulations established by the Secretary, establish special enrollment periods for qualifying events and as provided in subsection B of Section 9 of this act.

C. 1. Subject to paragraph 3 of this subsection, a health carrier with respect to coverage offered through a network plan shall not be required to offer coverage under that plan or accept applications for that plan pursuant to subsection A of this section in the case of the following:

a. to an individual, when the individual does not live or reside within the carrier's established geographic service area for such network plan, or

b. within the geographic service area for such network plan where the carrier reasonably anticipates, and demonstrates to the satisfaction of the Commissioner, that it will not have the capacity within its established geographic service area to deliver service

adequately to any additional individuals because of its obligations to existing enrollees.

2. A health carrier that cannot offer coverage pursuant to subparagraph b of paragraph 1 of this subsection may not offer coverage in the individual market in the applicable geographic service area to new individuals or to any enrollees until the later of one hundred eighty (180) days following each such refusal or the date on which the carrier notifies the Commissioner that it has regained capacity to deliver services.

3. A health carrier shall apply the provisions of this subsection uniformly to all individuals without regard to the claims experience of those individuals and their dependents or any health-status-related factor relating to such individuals and their dependents.

D. 1. A health carrier described under subsection A of this section shall not be required to provide coverage if:

a. for any period of time the carrier demonstrates, and the Commissioner determines, the carrier does not have the financial reserves necessary to underwrite additional coverage, and

b. the carrier is applying this subsection uniformly to all individuals in the individual market in this state consistent with applicable state law and without regard to the claims experience of an individual and

the dependents of the individual or any health-status-related factor relating to such individual and the dependents of the individual.

2. A health carrier that denies coverage in accordance with paragraph 1 of this subsection may not offer coverage in the individual market in this state for the later of:

a. a period of one hundred eighty (180) days after the date the coverage is denied, or

b. until the carrier has demonstrated to the Commissioner that it has sufficient financial reserves to underwrite additional coverage.

E. 1. This section shall not be construed to require a health carrier offering health benefit plans only in connection with group health plans to offer coverage in the individual market.

2. This section shall not be construed to require that a health carrier offering health benefits plans only through one or more bona fide associations offer coverage in the individual market. However, if the health carrier offers health benefit plan bona fide association coverage in the individual market, the health carrier shall offer such coverage to eligible individuals in the individual market as required under subsection A of this section and consistent with the provisions of paragraph 1 of Section 3 of this act.

F. This section shall not be construed to require a health carrier offering only student health insurance coverage to otherwise

offer coverage in the individual market so long as the carrier is offering student health insurance coverage consistent with the provisions of paragraph 39 of Section 3 of this act.

G. At the time of renewal, a health carrier may modify coverage under a health benefit plan offering individual market health insurance coverage so long as such modification is consistent with state law and effective on a uniform basis among all individuals with the health benefit plan.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8007 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as provided in this section, a health carrier offering health benefit plans providing individual market health insurance coverage in this state subject to this act shall renew or continue in force the coverage, at the option of the policyholder.

B. A health carrier may nonrenew or discontinue coverage under a health benefit plan subject to this act if:

1. The policyholder has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the carrier has not received timely premium payments;

2. The policyholder or the policyholder's representative has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage;

3. The carrier elects to cease offering individual market health insurance coverage in this state in accordance with subsection D of this section and other applicable state law;

4. In the case of a health carrier that offers coverage through a network plan, the policyholder no longer lives or resides within the carrier's established geographic service area and the carrier would deny enrollment in the plan pursuant to subparagraph (b) of paragraph 1 of subsection C of Section 6 of this act;

5. The Commissioner:

a. finds that the continuation of the coverage would not be in the best interests of the covered persons or would impair the carrier's ability to meet its contractual obligations, and

b. assists affected covered persons in finding replacement coverage;

6. In the case of health benefit plans that are made available in the individual market only through one or more bona fide associations, the membership of a policyholder in the association on the basis of which the coverage is provided ceases, provided the coverage is terminated under this paragraph uniformly without regard to any health-status-related factor relating to any covered person;

7. In the case of health benefit plans that are made available in the individual market as student health insurance coverage, the student policyholder covered under the coverage ceases to be a

student at the institution of higher education through which the student health insurance coverage is offered, provided the coverage is terminated under this paragraph uniformly without regard to any health-status-related factor related to any covered person; or

8. The Commissioner finds that the product form is obsolete and is being replaced with comparable coverage and the carrier decides to discontinue offering that particular type of health benefit plan (obsolete product form) in this state's individual market if the carrier:

a. provides advance notice of its decision under this paragraph to the Commissioner in each state in which it is licensed,

b. provides notice of the decision not to renew coverage at least one hundred eighty (180) days prior to the nonrenewal of any health benefit plans to:

(1) all affected policyholders, and

(2) the Commissioner in each state in which an affected policyholder is known to reside,

provided the notice sent to the Commissioner under this division is sent at least three (3) working days prior to the date the notice is sent to the affected policyholders,

c. provides notice to each enrollee issued that particular type of health benefit plan (obsolete

product form) that the policyholder has the option to purchase all other health benefit plans currently being offered by the carrier in the individual market in this state, and

d. in exercising this option to discontinue that particular type of health benefit plan (obsolete product form) and in offering the option of coverage pursuant to subparagraph c of this paragraph acts uniformly without regard to the claims experience of those covered persons or any other health-status-related factor relating to any covered person who may become eligible for coverage.

C. In any case in which a health carrier decides to discontinue offering a particular type of health benefit plan of individual market health insurance coverage, the health carrier may discontinue coverage in accordance with applicable state law only if the carrier:

1. Provides advance notice of its decision under this subsection to the Commissioner in each state in which it is licensed;

2. Provides notice of the decision not to renew coverage at least ninety (90) days prior to the nonrenewal of the health benefit plan to:

a. all affected policyholders, and

b. the Commissioner in each state in which an affected policyholder is known to reside, provided the notice to the Commissioner under this subparagraph is sent at least three (3) working days prior to the date the notice is sent to the affected policyholders;

3. Provides notice to each enrollee issued that particular type of health benefit plan that the policyholder has the option to purchase all other health benefit plans providing individual market health insurance coverage currently being offered by the carrier in this state; and

4. In exercising this option to discontinue that particular type of health benefit plan and in offering the option of coverage pursuant to paragraph 3 of this subsection, acts uniformly without regard to the claims experience of those policyholders or any health-status-related factor relating to any policyholder or dependent of a policyholder or new policyholders and their dependents who may become eligible for coverage.

D. 1. In any case in which a health carrier elects to discontinue offering health insurance coverage under health benefit plans in the individual market, or all markets, in this state, the carrier may discontinue such coverage only in accordance with applicable state law and if:

a. the carrier provides advance notice of its decision under this paragraph to the Commissioner in each state in which it is licensed, and

b. provides notice of the decision not to renew coverage at least one hundred eighty (180) days prior to the nonrenewal of any health benefit plans to:

(1) all affected policyholders, and

(2) the Commissioner in each state in which an affected policyholder is known to reside, provided the notice sent to the Commissioner under this division is sent at least three (3) working days prior to the date the notice is sent to the affected policyholders.

2. In the case of a discontinuance under paragraph 1 of this subsection, the health carrier shall be prohibited from writing new business in the market in this state for a period of five (5) years beginning on the date the carrier ceased offering new coverage in this state.

3. In the case of a discontinuance under paragraph 1 of this subsection, the health carrier, as determined by the Commissioner, may renew its existing business in the market in this state or may be required to nonrenew all of its existing business in the market in this state.

E. In the case of a health carrier doing business in one established geographic service area of the state, the provisions of this section shall apply only to the carrier's operations in that service area.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8008 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health carrier offering health benefit plans providing individual market health insurance coverage that makes available dependent coverage of children shall make that coverage available for children until attainment of twenty-six (26) years of age.

B. 1. With respect to a child who has not attained twenty-six (26) years of age, a health carrier shall not define "dependent" for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and the policyholder.

2. a. A health carrier shall not deny or restrict coverage for a child who has not attained twenty-six (26) years of age based on a factor, such as the presence or absence of the child's financial dependency upon the policyholder or any other person, residency with the policyholder or with any other person, marital status, student status, employment or any combination of those factors.

b. In addition to subparagraph a of this paragraph, a health carrier shall not deny or restrict coverage of a child based on eligibility for other coverage.

C. Nothing in this section shall be construed to require a health carrier to make coverage available for the child of a child receiving dependent coverage, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild.

D. The terms of coverage in a health benefit plan offered by a health carrier providing dependent coverage of children cannot vary based on age except for children who are twenty-six (26) years of age or older.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8009 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Health carriers offering health benefit plans providing individual market health insurance coverage shall not impose any preexisting condition exclusion with respect to such coverage.

B. 1. A health carrier described in subsection A of this section that makes coverage available under a health benefit plan with respect to a dependent of an individual shall provide for a dependent special enrollment period described in paragraph 2 of this subsection during which the dependent in the case of the birth or adoption (or placement for adoption) of a child or the spouse of the

individual, if the spouse is otherwise eligible for coverage, may be enrolled as a dependent of the individual.

2. The special enrollment period for individuals that meet the provisions of paragraph 1 of this subsection shall be a period of not less than thirty (30) days and begins on the later of:

a. the date dependent coverage is made available, or

b. the date of the marriage, birth or adoption or placement for adoption described in paragraph 1 of this subsection.

3. If an individual seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period described under paragraph 2 of this subsection, the coverage of the dependent shall be effective:

a. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received,

b. in the case of a dependent's birth, as of the date of birth, and

c. in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8010 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A health carrier offering health benefit plans providing individual market health insurance coverage in this state shall not establish rules for eligibility, including continuing eligibility, of any individual to enroll under the terms of coverage based on any health-status-related factor in relation to the individual or dependent of the individual.

B. 1. A health carrier described in subsection A of this section shall not require any individual as a condition of enrollment or continued enrollment under a health benefit plan to pay a premium or contribution that is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health-status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

2. Nothing in paragraph 1 of this subsection may be construed to restrict the amount that an individual may be charged for individual market health insurance coverage.

C. A health carrier offering health benefit plans providing individual market health insurance coverage in this state shall not establish rules for the eligibility, including continued eligibility, of any individual to enroll for coverage under an individual health benefit plan based on genetic information.

D. A health carrier offering health benefit plans providing individual market health insurance coverage shall not adjust premium

or contribution amounts for an individual on the basis of genetic information concerning the individual or a family member of the individual.

E. A health carrier offering health benefit plans providing individual market health insurance coverage shall not on the basis of genetic information impose any preexisting condition exclusion with respect to coverage under the plan.

F. 1. A health carrier offering health benefit plans providing individual market health insurance coverage shall not request or require an individual or a family member of an individual to undergo a genetic test.

2. Paragraph 1 of this subsection shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that the individual undergo a genetic test.

3. a. Nothing in paragraph 1 of this subsection shall be construed to preclude the health carrier from obtaining and using the results of a genetic test in making a determination regarding payment (as that term is defined for purposes of applying the regulations promulgated by the Secretary under part C of Title XI of the Social Security Act and Section 264 of HIPAA, as may be revised from time to time) consistent with subsections C and E of this section.

b. For purposes of subparagraph a of this paragraph, the health carrier may request only the minimum amount of information necessary to accomplish the intended purpose.

4. Notwithstanding paragraph 1 of this subsection, the health carrier may request, but not require, that an individual or a family member of the individual undergo a genetic test if each of the following conditions is met:

a. the request is made pursuant to research that complies with Part 46 of Title 45, Code of Federal Regulations or equivalent federal regulations and any applicable state or local law or regulations for the protection of human subjects in research,

b. the carrier clearly indicates to each individual or, in the case of a minor child, to the legal guardian of the child to whom the request is made that:

(1) compliance with the request is voluntary, and

(2) noncompliance will have no effect on enrollment status or premium or contribution amounts,

c. no genetic information collected or acquired under this paragraph shall be used for underwriting purposes,

d. the carrier notifies the Secretary in writing that the carrier is conducting activities pursuant to the

exception provided in this paragraph, including a description of the activities conducted, and

e. the carrier complies with such other conditions as the Secretary may by regulation require for activities conducted under this paragraph.

G. 1. A health carrier offering health benefit plans providing individual market health insurance coverage shall not request, require or purchase genetic information for underwriting purposes.

2. A health carrier offering health benefit plans providing individual market health insurance coverage shall not request, require or purchase genetic information with respect to any individual prior to the individual's enrollment under the plan in connection with such enrollment.

3. If the health carrier obtains genetic information incidental to the requesting, requiring or purchasing of other information concerning any individual, such request, requirement or purchase shall not be considered a violation of paragraph 2 of this subsection if such request, requirement or purchase is not in violation of paragraph 1 of this subsection.

H. Any reference in this section to genetic information concerning an individual or family member of an individual shall:

1. With respect to the individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by the pregnant woman; and

2. With respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8011 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. Except as provided in subsection B of this section, health carriers offering health benefit plans providing individual market health insurance coverage shall not establish a lifetime limit on the dollar amount of essential health benefits for any individual.

2. a. Except as provided in subparagraph b of this paragraph and subsections B and C of this section, a health carrier shall not establish any annual limit on the dollar amount of essential health benefits for any individual.

b. A health flexible spending arrangement (FSA), as defined in Section 106(c)(2) of the Internal Revenue Code, a medical savings account (MSA), as defined in Section 220 of the Internal Revenue Code, and a health savings account (HSA), as defined in Section 223 of the Internal Revenue Code are not subject to the requirements of subparagraph a of this paragraph.

B. The provisions of subsection A of this section shall not prevent a health carrier from placing annual or lifetime dollar limits for any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable federal or state law.

C. Nothing in this section prohibits a health carrier from excluding all benefits for a given condition, as otherwise permitted under federal or state law.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8012 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. A health carrier shall not rescind coverage under a health benefit plan with respect to an individual, including family coverage in which the individual is included, after the individual is covered under the plan, unless:

a. the individual or a person seeking coverage on behalf of the individual, performs an act, practice or omission that constitutes fraud, or

b. the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

2. For purposes of subparagraph a of paragraph 1 of this subsection, a person seeking coverage on behalf of an individual

does not include a producer or employee or authorized representative of the health carrier.

B. A health carrier shall provide at least thirty (30) days advance written notice to each individual who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with subsection A of this section regardless of whether the rescission applies to the entire group in the case of family coverage or only to the policyholder.

C. The provisions of this section apply regardless of any applicable contestability period.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8013 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. Health carriers offering health benefit plans providing individual market health insurance coverage shall ensure that such coverage includes the essential health benefits package required under Section 1302(a) of the Federal Act, as described in paragraph 2 of this subsection.

2. For purposes of this subsection, "essential health benefits package" means coverage that:

a. provides for the essential health benefits, as defined in paragraph 11 of Section 3 of this act,

b. limits cost-sharing for such coverage in accordance with Section 13029(c) of the Federal Act, as described in subsection B of this section; and

c. subject to subsection C of this section, provides bronze, silver, gold or platinum levels of coverage described in Section 1302(d) of the Federal Act as follows:

(1) bronze level. A health benefit plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to sixty percent (60%) of the full actuarial value of the benefits provided under the plan,

(2) silver level. A health benefit plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to seventy percent (70%) of the full actuarial value of the benefits provided under the plan,

(3) gold level. A health benefit plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to eighty percent (80%) of the full

actuarial value of the benefits provided under the plan, and

(4) platinum level. A health benefit plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to ninety percent (90%) of the full actuarial value of the benefits provided under the plan.

B. If a health carrier offers health insurance coverage in any level of coverage specified under Section 1302(d) of the Federal Act, as described in subparagraph c of paragraph 2 of subsection A of this section, the carrier shall also offer such coverage in that level as a health benefit plan in which the only enrollees are individuals who, as of the beginning of a policy year, have not attained the age of twenty-one (21) years.

C. A health benefit plan not providing a bronze, silver, gold or platinum level of coverage, as described in subparagraph c of paragraph 2 of subsection A of this section, shall be treated as meeting the requirements of Section 1302(d) of the Federal Act with respect to any policy year if it provides a catastrophic plan that meets the requirements of Section 1302(e) of the Federal Act.

D. This section shall not apply to a dental plan described in Section 1311(d)(2)(B)(ii) of the Federal Act.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8014 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. A health carrier offering health benefit plans providing individual market health insurance coverage shall provide coverage for all of the following items and services, and shall not impose any cost-sharing requirements, such as a copayment, coinsurance or deductible, with respect to the following items and services:

a. except as otherwise provided in subsection B of this section, evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved,

b. immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this paragraph, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a

recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention,

c. with respect to infants, children and adolescents, evidence-informed preventive care, and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration, and

d. with respect to women, to the extent not described in this paragraph, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

2. a. (1) A health carrier is not required to provide coverage for any items or services specified in any recommendation or guideline described in paragraph 1 of this subsection after the recommendation or guideline is no longer described in paragraph 1 of this subsection.

(2) Other provisions of state or federal law may apply in connection with a health carrier's ceasing to provide coverage for any such items or services including Section 2715(d)(4) of the Public Health Services Act, which requires a health carrier to give sixty (60) days advance

notice to an enrollee before any material modification will become effective.

b. For purposes of paragraph 1 of this subsection and for purposes of any other provision of law, the United States Preventive Services Task Force recommendations regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current.

c. A health carrier shall, for policy years that begin on or after the date that is one (1) year after the recommendation or guideline is issued, revise the preventive services covered under its health benefit plans pursuant to this section consistent with the recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the guidelines with respect to infants, children, adolescents and women evidence-based preventive care and screenings by the health Resources and Services Administration in effect at the time.

B. 1. A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in

subsection A of this section is billed separately or is tracked as individual encounter data separately from the office visit.

2. A health carrier shall not impose cost-sharing requirements with respect to an office visit if an item or service described in subsection A of this section is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or service.

3. A health carrier may impose cost-sharing requirements with respect to an office visit if an item or service described in subsection A of this section is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the item or service.

4. Notwithstanding the requirements of this section, student administrative health fees are not considered cost-sharing requirements with respect to specified recommended preventive services.

C. 1. Nothing in this section requires a health carrier that has a network of providers to provide benefits for items and services described in subsection A of this section that are delivered by an out-of-network provider.

2. Nothing in subsection A of this section precludes a health carrier that has a network of providers from imposing cost-sharing

requirements for items or services described in subsection A of this section that are delivered by an out-of-network provider.

D. Nothing prevents a health carrier from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described in subsection A to the extent not specified in the recommendation or guideline.

E. Nothing in this section prohibits a health carrier from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that Task Force or that Advisory Committee, or under those guidelines. A health carrier may impose cost-sharing requirements for a treatment not described in subsection A of this section even if the treatment results from an item or service described in subsection A of this section.

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8015 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. As used in this section, the following definitions apply:

1. "Approved clinical trial" means a phase I, a phase II, a phase III or a phase IV clinical trial that is conducted in relation

to the prevention, detection or treatment of cancer or a life-threatening condition and is not designed exclusively to test toxicity or disease pathophysiology and the trial must be:

a. conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA),

b. exempt from obtaining an investigational new drug application, or

c. approved or funded by:

(1) the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services or a cooperative group or center of any of the entities described in this item,

(2) a cooperative group or center of the U.S. Department of Defense or the U.S. Department of Veterans Affairs,

(3) a qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or

(4) the U.S. Departments of Veterans Affairs, Defense or Energy if the trial has been reviewed or

approved through a system of peer review determined by the Secretary to:

(a) be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

(b) provide an unbiased scientific review by qualified individuals who have no interest in the outcome of the review;

2. "Life-threatening condition" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted;

3. "Qualified individual" means an individual with individual market health insurance coverage who is eligible to participate in an approved clinical trial according to the trial protocol for the treatment of cancer or a life-threatening condition because:

a. the referring health care professional is participating in the trial and has concluded that the individual's participation in the trial would be appropriate, or

b. the individual provides medical and scientific information establishing that the individual's participation in the trial is appropriate because the individual meets the conditions described in the trial protocol; and

4. a. "Routine patient costs" include all items and services covered by the health benefit plan of individual market health insurance coverage when the items or services are typically covered for an enrollee who is not a qualified individual enrolled in an approved clinical trial.

b. "Routine patient costs" does not include:

(1) an investigational item, device or service that is part of the trial,

(2) an item or service provided solely to satisfy data collection and analysis needs for the trial if the item or services are not used in the direct clinical management of the patient,

(3) a service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis, or

(4) an item or service customarily provided and paid for by the sponsor of a trial.

B. A health carrier that offers a health benefit plan providing individual market health insurance coverage in this state may not:

1. Deny participation by a qualified individual in an approved clinical trial;

2. Deny, limit or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in the trial; or

3. Discriminate against an individual on the basis of the individual's participation in an approved clinical trial.

C. A network plan may require a qualified individual who wishes to participate in an approved clinical trial to participate in a trial that is offered through a health care provider who is part of the network plan if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.

D. This section applies to a qualified individual residing in this state who participates in an approved clinical trial that is conducted outside of this state.

E. This section shall not be construed to require a health carrier offering individual market health insurance coverage through a network plan to provide benefits for routine patient costs if the services are provided outside of the plan's network unless the out-of-network benefits are otherwise provided under the coverage.

F. Nothing in this section shall be construed to limit a health carrier's coverage with respect to clinical trials.

SECTION 16. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8016 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. a. If a health carrier offering individual market health insurance coverage under a health benefit plan requires or provides for the designation by a covered person of a participating primary care health care professional, the health carrier shall permit each covered person to:

(1) designate any participating primary care health care professional who is available to accept the covered person, and

(2) for a child, designate any participating physician who specializes in pediatrics as the child's primary care health care professional and is available to accept the child.

b. The provisions of division (2) of subparagraph a of this paragraph shall not be construed to waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of pediatric care.

2. a. If a health carrier provides coverage for obstetrical or gynecological care and requires the designation by a covered person of a participating primary care health care professional, the health carrier:

(1) shall not require any covered person's, including a primary care health care professional's,

authorization or referral in the case of a female covered person who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology, and

(2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to division (1) of this subparagraph, by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care health care professional.

b. (1) The health carrier may require the health care professional to agree to otherwise adhere to the health carrier's policies and procedures, including procedures for obtaining prior authorization and provider services in accordance with a treatment plan, if any, approved by the health carrier.

(2) For purposes of division (1) of this subparagraph, a "health care professional, who specializes in obstetrics or gynecology" means any individual, including an individual other

than a physician, who is authorized under state law to provide obstetrical or gynecological care.

c. The provisions of division (1) of subparagraph a of this paragraph shall not be construed to:

(1) waive any exclusions of coverage under the terms and conditions of the health benefit plan with respect to coverage of obstetrical or gynecological care, or

(2) preclude the health carrier involved from requiring that the participating health care professional providing obstetrical or gynecological care notify the primary care health care professional or the health carrier of treatment decisions.

B. 1. A health carrier shall provide notice to covered persons of the terms and conditions of the health benefit plan related to the designation of a participating health care professional provided in subsection A of this section and of a covered person's rights with respect to those provisions.

2. The notice described in paragraph 1 of this subsection shall be included whenever the health carrier provides a policyholder with a summary plan description or other similar description of benefits under the health benefit plan.

SECTION 17. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8017 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Health carriers offering health benefit plans providing individual market health insurance coverage shall provide a summary of benefits and coverage explanation pursuant to the standards adopted by the Secretary under Section 2715(a) of the PHSA to:

1. An applicant at the time of application;

2. An enrollee prior to the time of enrollment or reenrollment, as applicable; and

3. A policyholder at the time of issuance of the policy.

B. A health carrier described in subsection A of this subsection shall be deemed to have complied with subsection A of this subsection if the summary of benefits and coverage described in Section 2715(a) of the PHSA is provided in paper or electronic form, in accordance with the standards adopted by the Secretary under Section 2715(d) of the PHSA.

C. Except in connection with a policy renewal or reissuance, if a health carrier makes any material modifications in any of the terms of the coverage, as defined for purposes of Section 102 of ERISA, that is not reflected in the most recently provided summary of benefits and coverage, the carrier shall provide notice of the modification to covered persons not later than sixty (60) days prior to the date on which the modification will become effective.

SECTION 18. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8018 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Health carriers offering health benefit plans providing individual market health insurance coverage shall provide written certification of creditable coverage to individuals in accordance with subsection B of this section.

B. The certification of creditable coverage shall be provided:

1. At the time an individual ceases to be covered under the health benefit plan; and

2. At the time a request is made on behalf of an individual if the request is made not later than twenty-four (24) months after the date of cessation of coverage, whichever is later.

C. The certification described in this section is a written certification of:

1. The period of creditable coverage of the individual under the health benefit plan; and

2. The waiting period, if any, and affiliation period, if applicable, imposed on the individual for any coverage under the health benefit plan.

SECTION 19. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8019 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Subject to subsection A of Section 6 of this act, each health carrier providing individual market health insurance coverage shall actively market all health benefit plans sold by the carrier to eligible individuals in this state.

B. 1. Except as provided in paragraph 2 of this subsection, a health carrier or a producer shall not, directly or indirectly, engage in the following activities:

a. encourage or direct individuals to refrain from filing an application for coverage with the carrier because of any health-status-related factor or because of the industry, occupation or geographic location of the individual, or

b. encourage or direct individuals to seek coverage from another carrier because of any health-status-related factor or because of the industry, occupation or geographic location of the individual.

2. The provisions of paragraph 1 of this subsection shall not apply with respect to information provided by a health carrier or producer to an individual regarding the established geographic service area or a restricted network provision of a health carrier.

C. 1. Except as provided in paragraph 2 of this subsection, a health carrier shall not, directly or indirectly, enter into any contract, agreement or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a

health benefit plan to be varied because of any initial or renewal health-status-related factor, industry, occupation or geographic location of the individual or the individual’s dependents.

2. Paragraph 1 of this subsection shall not apply with respect to a compensation arrangement that provides compensation to a producer that does not vary because of any health-status-related factor, industry, occupation or geographic area of the individual or the individual’s dependents.

D. A health carrier shall not terminate, fail to renew or limit its contract or agreement of representation with a producer for any reason related to any initial or renewal health-status-related factor, occupation or geographic location of any individual or the individual's dependents placed by the producer with the carrier.

E. Denial by a health carrier of an application for coverage from an individual shall be in writing or electronically provided and shall state the reason or reasons for the denial. Nothing in this subsection allows any denial by a health carrier that is not in compliance with Sections 6 and 7 of this act.

F. The Commissioner may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans providing individual market health insurance coverage to individuals in this state.

G. 1. A violation of this section by a health carrier or a producer shall be an unfair trade practice under Article 12 of Title 36 of the Oklahoma Statutes.

2. If a health carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans providing individual market health insurance coverage in this state, the third-party administrator shall be subject to this section as if it were a health carrier.

SECTION 20. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8020 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. Health carriers offering health benefit plans providing individual market health insurance coverage in this state shall annually submit to the Secretary and the Commissioner in each state the carrier is licensed, and to policyholders under the coverage, a report on whether the benefits under the coverage satisfy the elements described in subsection B of this section.

2. The report required under paragraph 1 of this subsection shall be made available to each policyholder under the coverage during each open enrollment period.

B. 1. For purposes of subsection A of this section, using the reporting requirements developed by the Secretary, a health carrier

shall report on coverage benefits and health care provider reimbursement structures that:

a. improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model, as defined for purposes of Section 3602 of the Federal Act, for treatment or services under the coverage,

b. implement activities that prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning and post-discharge reinforcement by an appropriate health care professional,

c. implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine and health information technology under the coverage, and

d. implement wellness and health promotion activities.

2. For purposes of subparagraph d of paragraph 1 of this subsection, wellness and health promotion activities may include personalized wellness and prevention services, which are

coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program's participants, and which may include the following wellness and prevention efforts:

a. smoking cessation,

b. weight management,

c. stress management,

d. physical fitness,

e. nutrition,

f. heart disease prevention,

g. healthy lifestyle support, and

h. diabetes prevention.

SECTION 21. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8021 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Commissioner may establish an assessment and payment mechanism for health carriers providing individual market health insurance coverage to adjust for actuarial risk that is consistent with the criteria and methods developed by the Secretary in accordance with Section 1343(b) of the Federal Act.

SECTION 22. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 8022 of Title 36, unless there is created a duplication in numbering, reads as follows:

The Commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this act.

SECTION 23. This act shall become effective November 1, 2013.

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