STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 1310 By: McCortney

COMMITTEE SUBSTITUTE

An Act relating to state-sponsored employee benefits; amending 63 O.S. 2021, Section 5003, which relates to powers and duties of the Oklahoma Health Care Authority; directing the Authority to administer state-sponsored benefits; amending 74 O.S. 2021, Sections 1306.2, 1306.5, 1318, 1321, and 1371, which relate to the administration of state-sponsored plans; conforming language; removing requirement for certain bid acceptance; updating statutory language; providing an effective date; and declaring an emergency.

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

SECTION 1. AMENDATORY 63 O.S. 2021, Section 5003, is amended to read as follows:

Section 5003. A. The Legislature recognizes that the state is a major purchaser of health care services, and the increasing costs of such health care services are posing and will continue to pose a great financial burden on the state. It is the policy of the state to provide comprehensive health care as an employer to state employees and officials and their dependents and to those who are dependent on the state for necessary medical care. It is imperative

that the state develop effective and efficient health care delivery systems and strategies for procuring health care services in order for the state to continue to purchase the most comprehensive health care possible.

B. It is therefore incumbent upon the Legislature to establish the Oklahoma Health Care Authority whose purpose shall be to:

1. Purchase ~~state and education employees' health care benefits and~~ Medicaid benefits;

2. Study all state-purchased and state-subsidized health care, alternative health care delivery systems and strategies for the procurement of health care services in order to maximize cost containment in these programs while ensuring access to quality health care; ~~and~~

3. Make recommendations aimed at minimizing the financial burden which health care poses for the state, its employees and its charges, while at the same time allowing the state to provide the most comprehensive health care possible; and

4. Administer the state-sponsored health and dental benefits plans known as HealthChoice and life insurance plans in accordance with the Oklahoma Employees Insurance and Benefits Act and the State Employees Flexible Benefits Act. The Office of Management and Enterprise Services shall cause the transfer of all necessary assets, data, records, and personnel necessary for the

administration of HealthChoice not later than the effective date of this act.

SECTION 2. AMENDATORY 74 O.S. 2021, Section 1306.2, is amended to read as follows:

Section 1306.2. A. The ~~Director of the Office of Management and Enterprise Services~~ Oklahoma Health Care Authority shall submit to the Insurance Commissioner the following information regarding utilization review performed by employees of the ~~Office~~ Authority:

1. A utilization review plan that includes:

   a. an adequate summary description of review standards, protocol and procedures to be used in evaluating proposed or delivered hospital and medical care,

   b. assurances that the standards and criteria to be applied in review determinations are established with input from health care providers representing major areas of specialty and certified by the boards of the various American medical specialties, and

   c. the provisions by which patients or health care providers may seek reconsideration or appeal of adverse decisions concerning requests for medical evaluation, treatment or procedures;

2. The type and qualifications of the personnel either employed or under contract to perform the utilization review;

3. The procedures and policies to ensure that an employee of the ~~Office~~ Authority is reasonably accessible to patients and health care providers five (5) days a week during normal business hours, such procedures and policies to include as a requirement a toll-free telephone number to be available during ~~said~~ such business hours;

4. The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

5. The policies and procedures to verify the identity and authority of personnel performing utilization review by telephone;

6. A copy of the materials designed to inform applicable patients and health care providers of the requirements of the utilization review plan;

7. The procedures for receiving and handling complaints by patients, hospitals and health care providers concerning utilization review; and

8. Procedures to ensure that after a request for medical evaluation, treatment, or procedures has been rejected in whole or in part and in the event a copy of the report on ~~said~~ such rejection is requested, a copy of the report of the personnel performing utilization review concerning the rejection shall be mailed by the insurer, postage prepaid, to the ill or injured person, the treating health care provider, hospital or to the person financially

responsible for the patient's bill within fifteen (15) days after receipt of the request for the report.

B. The ~~Office~~ Authority shall pay an annual fee to the Insurance Commissioner of Five Hundred Dollars ($500.00).

SECTION 3. AMENDATORY 74 O.S. 2021, Section 1306.5, is amended to read as follows:

Section 1306.5. A network provider facility or physician contract, or any part or section of it, may be amended at any time during the term of the contract only by mutual written consent of duly authorized representatives of the ~~Office of Management and Enterprise Services~~ Oklahoma Health Care Authority and the facility or physician.

SECTION 4. AMENDATORY 74 O.S. 2021, Section 1318, is amended to read as follows:

Section 1318. No former employee who is reemployed by a participating entity within twenty-four (24) months after the date of termination of previous employment shall be enrolled in the Oklahoma Employees Insurance and Benefits Plan authorized by Sections 1301 through 1329.1 of this title, for a greater amount of life insurance or life benefit than the amount for which the life of the former employee was insured under the plan at the date of termination of employment, except upon the former employee furnishing evidence of insurability, satisfactory to the ~~Office of Management and Enterprise Services~~ Oklahoma Health Care Authority,

and any greater amount of benefit or insurance provided the employee shall be at the former employee's cost.

SECTION 5. AMENDATORY 74 O.S. 2021, Section 1321, is amended to read as follows:

Section 1321. A. The ~~Office of Management and Enterprise Services~~ Oklahoma Health Care Authority shall have the authority to determine all rates and life, dental and health benefits for state-sponsored plans. All rates shall be compiled in a comprehensive Schedule of Benefits. The Schedule of Benefits shall be available for inspection during regular business hours at the ~~Office of Management and Enterprise Services~~ Authority. The ~~Office~~ Authority shall have the authority to annually adjust the rates and benefits based on claim experience.

B. The premiums for such insurance plans offered for the next plan year shall be established as follows:

1. For active employees and their dependents, the ~~Office's~~ Authority's premium determination shall be made no later than the bid submission date for health maintenance organizations set by the ~~Oklahoma State Employees Benefits Council~~ Oklahoma Employees Insurance and Benefits Board, which shall be set in August no later than the third Friday of that month; and

2. For all other covered members and dependents, the ~~Office's~~ Authority's and the health maintenance organizations' premium

determinations shall be no later than the fourth Friday of September.

C. The Office may approve a mid-year adjustment requested by the Authority provided the need for an adjustment is substantiated by an actuarial determination or more current experience rating. The only publication or notice requirements that shall apply to the Schedule of Benefits shall be those requirements provided in the Oklahoma Open Meeting Act and within this section. It is the intent of the Legislature that the benefits provided not include cosmetic dental procedures except for certain orthodontic procedures as adopted by the ~~Director~~ Chief Executive Officer of the Authority.

SECTION 6. AMENDATORY 74 O.S. 2021, Section 1371, is amended to read as follows:

Section 1371. A. All participants must purchase at least the basic plan unless, to the extent that it is consistent with federal law, the participant is a person who has retired from a branch of the United States military and has been provided with health coverage through a federal plan and that participant provides proof of that coverage, or the participant has opted out of the state's basic plan according to the provisions in Section 1308.3 of this title. On or before January 1 of the plan year beginning July 1, 2001, and July 1 of any plan year beginning after January 1, 2002, the Oklahoma Employees Insurance and Benefits Board shall design the basic plan for the next plan year to ensure that the basic plan

provides adequate coverage to all participants. All benefit plans, whether offered by the ~~State and Education Employees Group Insurance~~ Board, a health maintenance organization (HMO) or other vendors, shall meet the minimum requirements set by the Board for the basic plan.

B. The Board shall offer health, disability, life and dental coverage to all participants and their dependents. For health, dental, disability and life coverage, the Board shall offer plans at the basic benefit level established by the Board, and in addition, may offer benefit plans that provide an enhanced level of benefits. The Board shall be responsible for determining the plan design and the benefit price for the plans that ~~they offer~~ it offers. Effective for the plan year beginning January 1, 2017, and for each plan year thereafter, in setting health insurance premiums for active employees and for retirees under sixty-five (65) years of age, the Board shall set the monthly premium for active employees to be equal to the monthly premium for retirees under sixty-five (65) years of age; except that the Board may offer retirees under sixty-five (65) years of age the opportunity to voluntarily enroll in an alternative plan of insurance at a rate that is between One Hundred Dollars ($100.00) less than the monthly premium for active employees and up to One Hundred Dollars ($100.00) more than the monthly premium for active employees. Retirees under the age of sixty-five (65) who enroll in an alternative plan of insurance shall retain the

right to enroll in any other health insurance plan offered by the Board for which they might be qualified during a subsequent open enrollment period.

Nothing in this subsection shall be construed as prohibiting the Board from offering additional medical plans, provided that any medical plan offered to participants shall meet or exceed the benefits provided in the medical portion of the basic plan.

C. In lieu of electing any of the preceding medical benefit plans, a participant may elect medical coverage by any health maintenance organization made available to participants by the Board. The benefit price of any health maintenance organization shall be determined on a competitive bid basis. Contracts for ~~said~~ such plans shall not be subject to the provisions of ~~The~~ the Oklahoma Central Purchasing Act. The Board shall promulgate rules establishing appropriate competitive bidding criteria and procedures for contracts awarded for flexible benefits plans. ~~All plans offered by health maintenance organizations meeting the bid requirements as determined by the Board shall be accepted.~~ The Board shall have the authority to reject the bid or restrict enrollment in any health maintenance organization for which the Board determines the benefit price to be excessive. The Board shall have the authority to reject any plan that does not meet the bid requirements. All bidders shall submit along with their bid a notarized, sworn statement as provided by Section 85.22 of this

title. Effective for the plan year beginning January 1, 2007, and for each plan year thereafter, in setting health insurance premiums for active employees and for retirees under sixty-five (65) years of age, HMOs, self-insured organizations and prepaid plans shall set the monthly premium for active employees to be equal to the monthly premium for retirees under sixty-five (65) years of age.

D. Nothing in this section shall be construed as prohibiting the Board from offering additional qualified benefit plans or currently taxable benefit plans.

E. Each employee of a participating employer who meets the eligibility requirements for participation in the flexible benefits plan shall make an annual election of benefits under the plan during an enrollment period to be held prior to the beginning of each plan year. The enrollment period dates will be determined annually and will be announced by the Board~~, providing~~; provided, the enrollment period shall end no later than thirty (30) days before the beginning of the plan year.

Each such employee shall make an irrevocable advance election for the plan year or the remainder thereof pursuant to such procedures as the Board shall prescribe. Any such employee who fails to make a proper election under the plan shall, nevertheless, be a participant in the plan and shall be deemed to have purchased the default benefits described in this section.

F. The Board shall prescribe the forms that participants will be required to use in making their elections, and may prescribe deadlines and other procedures for filing the elections.

G. Any participant who, in the first year for which he or she is eligible to participate in the plan, fails to make a proper election under the plan in conformance with the procedures set forth in this section or as prescribed by the Board shall be deemed automatically to have purchased the default benefits. The default benefits shall be the same as the basic plan benefits. Any participant who, after having participated in the plan during the previous plan year, fails to make a proper election under the plan in conformance with the procedures set forth in this section or prescribed by the Board, shall be deemed automatically to have purchased the same benefits which the participant purchased in the immediately preceding plan year, except that the participant shall not be deemed to have elected coverage under the health care reimbursement account plan or the dependent care reimbursement account plan.

H. Benefit plan contracts with the Board, health maintenance organizations, and other ~~third party~~ third-party insurance vendors shall provide for a risk adjustment factor for adverse selection that may occur, as determined by the Board, based on generally accepted actuarial principles.

I. 1. For the plan year ending December 31, 2004, employees covered or eligible to be covered under the State and Education Employees Group Insurance Act and the State Employees Flexible Benefits Act who are enrolled in a health maintenance organization offering a network in Oklahoma City, shall have the option of continuing care with a primary care physician for the remainder of the plan year if:

a. that primary care physician was part of a provider group that was offered to the individual at enrollment and later removed from the network of the health maintenance organization, for reasons other than for cause, and

b. the individual submits a request in writing to the health maintenance organization to continue to have access to the primary care physician.

2. The primary care physician selected by the individual shall be required to accept reimbursement for such health care services on a fee-for-service basis only. The fee-for-service shall be computed by the health maintenance organization based on the average of the other fee-for-service contracts of the health maintenance organization in the local community. The individual shall only be required to pay the primary care physician those co-payments, coinsurance and any applicable deductibles in accordance with the terms of the agreement between the employer and the health

maintenance organization and the provider shall not balance bill the patient.

3. Any network offered in Oklahoma City that is terminated prior to July 1, 2004, shall notify the health maintenance organization, and Oklahoma Employees Insurance and Benefits Board by June 11, 2004, of the network's intentions to continue providing primary care services as described in paragraph 2 of this subsection offered by the health maintenance organization to state and public employees.

SECTION 7. This act shall become effective July 1, 2024.

SECTION 8. It being immediately necessary for the preservation of the public peace, health or 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.

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