STATE OF OKLAHOMA

1st Session of the 56th Legislature (2017)

HOUSE BILL 1630 By: Rogers

AS INTRODUCED

An Act relating to state government; amending 74 O.S. 2011, Section 1371, as last amended by Section 1, Chapter 178, O.S.L. 2016 (74 O.S. Supp. 2016, Section 1371), which relates to the Oklahoma State Employees Benefits Act; modifying benefit plans offered by the Oklahoma Employees Insurance and Benefits Board; prohibiting assessment of risk adjustment factors on certain contracts; and providing an effective date.

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

SECTION 1. AMENDATORY 74 O.S. 2011, Section 1371, as last amended by Section 1, Chapter 178, O.S.L. 2016 (74 O.S. Supp. 2016, 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 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. 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 Board shall offer health maintenance organization plans with the same actuarial value as Healthchoice High (Hi). The benefit price of any health maintenance organization shall be determined on a competitive bid basis. Contracts for said plans shall not be subject to the provisions of 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 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 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~~ No risk adjustment factor shall be assessed on benefit plan contracts with the Board, health maintenance organizations or other third-party insurance vendors.

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 2. This act shall become effective November 1, 2017.

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