An Act

ENROLLED SENATE
BILL NO. 943

By: Treat of the Senate

and

McCall of the House

An Act relating to health insurance; amending 36 O.S. 2011, Sections 6512, as amended by Section 1, Chapter 151, O.S.L. 2012 and 6513, as amended by Section 2, Chapter 151, O.S.L. 2012 (36 O.S. Supp. 2018, Sections 6512 and 6513), which relate to definitions and application of the Small Employer Health Insurance Reform Act to certain group health benefit plans; deleting definitions; eliminating certain exceptions to Act; eliminating timeframe for correcting certain retention level; eliminating prohibition against requirement of certain contract; removing requirement that certain health plans be sold at certain rate; defining terms; creating exception to applicability of Act; establishing requirements for certain health plans; requiring that certain health plans be sold at certain rate; providing for codification; and providing an effective date.

SUBJECT: Health insurance

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

SECTION 1. AMENDATORY 36 O.S. 2011, Section 6512, as amended by Section 1, Chapter 151, O.S.L. 2012 (36 O.S. Supp. 2018, Section 6512), is amended to read as follows:

Section 6512. As used in the Small Employer Health Insurance Reform Act:

1. "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Insurance Commissioner that a small employer carrier is in compliance with the provisions of Section 6515 of this title, based upon the examination of the person, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans;

2. "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person;

3. "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

4. "Basic health benefit plan" means a lower cost health benefit plan adopted by the state for small employer groups;

5. "Board" means the board of directors of the program established pursuant to Section 6522 of this title;

6. ~~Bona fide association" means an association that:~~

~~a. has been actively in existence for at least five (5) years,~~

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

~~c. does not condition membership in the association on any health-status related factor relating to any individual including an employee of an employer or a dependent of an individual,~~

~~d. makes health insurance coverage offered through the bona fide association available to all members regardless of any health status related factor relating to the members or individuals eligible for coverage through the member, and~~

~~e. does not make health insurance offered through the bona fide association available other than in connection with a member of the bona fide association;~~

~~7.~~ "Carrier" means any entity which provides health insurance in this state. For the purposes of the Small Employer Health Insurance Reform Act, carrier includes a licensed insurance company, not-for-profit hospital service or medical indemnity corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

~~8.~~ 7. "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage shall not be case characteristics for the purposes of the Small Employer Health Insurance Reform Act. A small employer carrier shall not use case characteristics, other than age, gender, industry, geographic area and family composition, without prior approval of the Insurance Commissioner. Group size shall not be used as a case characteristic;

~~9.~~ 8. "Class of business" means all or a separate grouping of small employers established pursuant to Section 6514 of this title. Group size shall not be used as a class of business;

~~10.~~ 9. "Commissioner" means the Insurance Commissioner;

~~11.~~ 10. "Control", "controlling", "controlled by" or "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract or otherwise, unless the power is the result of an official position with or corporate office held by the person.

Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact in the manner provided in Section 1654 of this title. The Commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect;

~~12.~~ 11. "Department" means the Insurance Department;

~~13.~~ 12. "Dependent" means a spouse, an unmarried child under the age of eighteen (18), an unmarried child who is a full-time student under the age of twenty-three (23) and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent;

~~14.~~ 13. "Eligible employee" means an employee who works on a full-time basis or, at the option of the employer, an employee who works on a part-time basis with a normal work week of twenty-four (24) or more hours. The term includes a sole proprietor, a partner of a partnership, and associates of a limited liability company, if the sole proprietor, partner or associate is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis;

~~15.~~ 14. "Established geographic service area" means a geographic area, as approved by the Commissioner and based on the certificate of authority of the carrier to transact insurance in this state, within which the carrier is authorized to provide coverage;

~~16.~~ 15. a. "Health benefit plan" means any hospital or medical policy or certificate; contract of insurance provided by a not-for-profit hospital service or medical indemnity plan; or prepaid health plan or health maintenance organization subscriber contract.

b. Health benefit plan does not include accident-only, credit, dental, vision, Medicare supplement, long-term

care, or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

c. "Health benefit plan" shall not include policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance, provided that the carrier offering those policies or certificates complies with the following:

(1) the carrier files on or before March 1 of each year a certification with the Commissioner that contains the statement and information described in division (2) of this subparagraph,

(2) the certification required in division (1) of this subparagraph shall contain the following:

(a) a statement from the carrier certifying that policies or certificates described in this subparagraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance, and

(b) a summary description of each policy or certificate described in this subparagraph, including the average annual premium rates or range of premium rates in cases where premiums vary by age, gender or other factors charged for such policies and certificates in this state, and

(3) in the case of a policy or certificate that is described in this subparagraph and that is offered for the first time in this state on or after May 20, 1994, the carrier files with the Commissioner the information and statement required in division (2) of this subparagraph at least thirty (30) days prior to the date a policy

or certificate is issued or delivered in this state;

~~17.~~ 16. "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

~~18.~~ 17. "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period is a period of at least thirty-one (31) days. However, an eligible employee or dependent shall not be considered a late enrollee if:

a. the individual meets each of the following:

(1) the individual was covered under qualifying previous coverage at the time of the initial enrollment,

(2) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse or divorce, and

(3) the individual requests enrollment within thirty (30) days after termination of the qualifying previous coverage,

b. the individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period, or

c. a court has ordered coverage be provided for a spouse or minor or dependent child under a health benefit plan of a covered employee and request for enrollment is made within thirty (30) days after issuance of the court order;

~~19.~~ 18. "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

~~20.~~ 19. "Premium" means all monies paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan;

~~21.~~ 20. "Program" means the Oklahoma Small Employer Health Reinsurance Program created pursuant to Section 6522 of this title;

~~22.~~ 21. "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

a. Medicare or Medicaid,

b. an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan, or

c. an individual health insurance policy, including coverage issued by a health maintenance organization, fraternal benefit society and those entities set forth in Sections 6901 through 6936 of this title, that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the policy has been in effect for a period of at least one (1) year;

~~23.~~ 22. "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect;

~~24.~~ 23. "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to Section 6522 of this title;

~~25.~~ 24. "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Sections 6901 through 6963 of this title to provide health care services to covered individuals;

~~26.~~ 25. "Small employer" means any person, firm, corporation, partnership, limited liability company or association that is actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed no more than fifty (50) eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state income taxation, shall be considered one employer; and

~~27.~~ 26. "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

SECTION 2. AMENDATORY 36 O.S. 2011, Section 6513, as amended by Section 2, Chapter 151, O.S.L. 2012 (36 O.S. Supp. 2018, Section 6513), is amended to read as follows:

Section 6513. A. Except as otherwise provided in this section and in Section 3 of this act, the Small Employer Health Insurance Reform Act shall apply to any group health benefit plan that provides coverage to two (2) or more eligible employees of a small employer in this state and to individual health benefits plans providing coverage for the eligible employees of a small employer which may include the employer when three (3) or more of such individual plans are sold to a small employer if any of the following conditions are met:

1. Any portion of the premium or benefits is paid by or on behalf of the small employer;

2. An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

3. The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162 or Section 106 of the United States Internal Revenue Code.

B. 1. Except as provided in paragraph 2 of this subsection, for the purposes of the Small Employer Health Insurance Reform Act, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by the Small Employer Health Insurance Reform Act shall apply as if all health benefit plans issued to small employers in this state by such affiliated carriers were issued by one carrier, unless on or before July 1, 1992, the respective affiliate carriers operated with separate books of business as insurers of health benefit plans in which event each such affiliate carrier shall be treated as a separate carrier.

2. An affiliated carrier that is a health maintenance organization granted a certificate of authority by the Insurance Commissioner pursuant to the provisions of Sections 6901 through 6951 of Title 36 of the Oklahoma Statutes may be considered to be a separate carrier for the purposes of the Small Employer Health Insurance Reform Act.

~~C. 1. Except as otherwise expressly set forth in this subsection, the provisions of the Small Employer Health Insurance Reform Act shall not apply to a health benefit plan issued to a small employer group through a bona fide association health plan. Each bona fide association health plan that meets the requirements of this section shall be considered a large group for purposes of application of the Oklahoma Insurance Code. For purposes of this subsection, a "bona fide association health plan" means a health benefit plan that:~~

~~a. is sponsored by a bona fide association as defined in Section 6512 of this title,~~

~~b. is delivered or issued for delivery to a bona fide association in a form that meets the requirements of Section 4502 of this title, and~~

c. satisfies all of the following:

(1) the initial premium rate for small employers in the bona fide association health plan shall be subject to the restrictions regarding premium rates contained in Section 6515 of this title,

(2) the association shall not discriminate in membership requirements based on actual or expected health status of individual enrollees or prospective enrollees,

(3) small employer groups that have two (2) or more eligible employees and that meet the membership requirements for the association are not excluded from the association health plan, and

(4) except as provided in paragraph 2 of this subsection, the association health plan maintains an eighty percent (80%) retention rate.

2. The eighty percent (80%) retention rate specified in division (4) of subparagraph c of paragraph 1 of this subsection shall not include employer groups that:

a. go out of business, whether through merger, acquisition or any other reason,

b. no longer meet eligibility requirements for membership in the association,

c. no longer meet participation requirements for employers that are set forth in the plan documents, or

d. fail to pay premiums.

3. A bona fide association health plan that fails to maintain the eighty percent (80%) retention rate during any year may have twelve months to correct the retention level before being required to become subject to the requirements of the Small Employer Health Insurance Reform Act.

~~4. A bona fide association health plan may not require a contract under this subsection between the bona fide association health plan and the member to be effective for a period of longer than two (2) years. This provision shall not be construed to prevent a contract from being extended for additional two-year periods or preventing the member from voluntarily electing a contract period of longer than two (2) years.~~

~~5. Each bona fide association health plan shall be available to be marketed and sold by all licensed agents and brokers of the health carrier, at the health carrier's standard commission and/or fee schedule for the calendar year.~~

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6530 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. "Bona fide association" means any association that has a current form M-1 filed with and accepted by the United States Department of Labor showing Oklahoma as the state of operation and:

1. Is formed under a pathway established in accordance with the applicable provisions of 29 CFR 2510; or

2. Was previously established or is newly formed under federal regulatory guidance effective prior to August 20, 2018.

B. "Bona fide association health plan" means a health benefit plan that is sponsored by a bona fide association as defined in subsection A of this section.

C. The provisions of the Small Employer Health Insurance Reform Act shall not apply to a health benefit plan issued to a bona fide association health plan.

D. Each bona fide association health plan that meets the requirements of this section shall be considered a large group for purposes of application of the Oklahoma Insurance Code.

E. A bona fide association health plan shall be subject to the following requirements:

1. The bona fide association health plan shall be delivered or issued for delivery to a bona fide association in a form that meets the requirements of Section 4502 of Title 36 of the Oklahoma Statutes;

2. The bona fide association health plan shall comply with any federal nondiscrimination requirement applicable to the association health plan;

3. Small employer groups that have two (2) or more eligible employees and that are members of the association may not be excluded from the association health plan;

4. a. Except as provided in subparagraph b of this paragraph, the association health plan shall maintain an eighty percent (80%) retention rate.

b. The eighty percent (80%) retention rate specified in subparagraph a of this paragraph shall not include employer groups or working owners that:

(1) go out of business, whether through merger, acquisition or any other reason,

(2) no longer meet eligibility requirements for membership in the association,

(3) no longer meet participation requirements for employers that are set forth in the plan documents, or

(4) fail to pay premiums.

c. A bona fide association health plan that fails to maintain the eighty percent (80%) retention rate during any year may have twelve (12) months to correct the retention level before being required to become subject to the requirements of the Small Employer Health Insurance Reform Act.

d. A bona fide association health plan may not require a contract under this subsection between the bona fide

association health plan and the member to be effective for a period of longer than two (2) years. This provision shall not be construed to prevent a contract from being extended for additional two-year periods or preventing the member from voluntarily electing a contract period of longer than two (2) years; and

5. Each bona fide association health plan shall be available to be marketed and sold by all licensed agents and brokers of the health carrier, at the health carrier's standard commission and/or fee schedule for the calendar year.

SECTION 4. This act shall become effective November 1, 2019.

Passed the Senate the 13th day of March, 2019.

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Presiding Officer of the Senate

Passed the House of Representatives the 23rd day of April, 2019.

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Presiding Officer of the House
of Representatives

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this _____

day of _____, 20_____, at _____ o'clock _____ M.

By: _____

Approved by the Governor of the State of Oklahoma this _____

day of _____, 20_____, at _____ o'clock _____ M.

_____
Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _____

day of _____, 20 _____, at _____ o'clock _____ M.

By: _____