

By: Hendrick of the Senate
and
Cox of the House

An Act relating to insurance; amending 36 O.S. 1991, Sections 4424, as amended by Section 1, Chapter 136, O.S.L. 1993, 4426, as last amended by Section 8, Chapter 294, O.S.L. 1994 and Section 2, Chapter 244, O.S.L. 1995 (36 O.S. Supp. 1996, Sections 4424, 4426 and 4426.2), which relate to the Long-Term Care Insurance Act; modifying definition of certain terms; adding certain definitions; providing for refund to applicant for qualified long-term care contracts; requiring certain disclosure statement; providing time limit for delivery of a qualified long-term care insurance contract; requiring certain information be provided upon denial of certain contracts; stating nonforfeiture benefits for qualified long-term care insurance contracts; providing for refund in certain circumstances; modifying provisions for minimum nonforfeiture credit; amending Section 3, Chapter 304, O.S.L. 1992, as last amended by Section 1, Chapter 224, O.S.L. 1995 (36 O.S. Supp. 1996, Section 4509.2), which relates to acceptance of insured of succeeding employer; modifying acceptance requirements to included certain dependents and individual insurance plans; modifying time to apply for new coverage; allowing individual insurance carriers to underwrite and

decline coverage; requiring carriers to advise denied individual about the Oklahoma Health Insurance High Risk Pool; amending Section 2, Chapter 250, O.S.L. 1995, as amended by Section 2, Chapter 249, O.S.L. 1996, Section 4, Chapter 250, O.S.L. 1995, as amended by Section 3, Chapter 249, O.S.L. 1996, Section 12, Chapter 250, O.S.L. 1995, as amended by Section 7, Chapter 249, O.S.L. 1996 (36 O.S. Supp. 1996, Sections 6532, 6534 and 6542), which relate to the Health Insurance High Risk Pool Act; expanding definitions; expanding persons eligible for coverage; prohibiting application of certain provisions of law to federally defined eligible individuals; providing for exemption and waiver of certain waiting periods for certain applicant; and declaring an emergency.

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

SECTION 1. AMENDATORY 36 O.S. 1991, Section 4424, as amended by Section 1, Chapter 136, O.S.L. 1993 (36 O.S. Supp. 1996, Section 4424), is amended to read as follows:

Section 4424. Unless the context requires otherwise, the definitions in this section apply throughout the Long-Term Care Insurance Act, Section 4421 et seq. of this title.

1. a. "Long-term care insurance" means any insurance policy or rider, including qualified long-term care insurance contracts, which are advertised, marketed, offered or designed primarily to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital.
- b. This term includes group and individual health policies or riders or group and individual life policies or annuities or riders which provide, directly or as a supplement, coverage for long-term care, whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health

maintenance organizations, life care communities, or any similar organization.

- c. This term also includes a policy or rider which provides for payment of long-term care benefits based upon cognitive impairment or the loss of functional capacity.
- d. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage or related asset-protection coverage, catastrophic coverage, comprehensive coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.
- e. With regard to life insurance, this term does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.
- f. Notwithstanding any other provision contained herein, any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this act.

2. "Applicant" means:

- a. in the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits, and
- b. in the case of a group long-term care insurance policy, the proposed certificate holder.

3. "Certificate" means any certificate issued under a group long-term care insurance policy, which certificate has been delivered, or issued for delivery, in this state.

4. "Group long-term care insurance" means a long-term care insurance policy which is delivered, or issued for delivery, in this state and issued to:

- a. one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof or for members or former members, or a combination thereof, of the labor organizations, or
- b. any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:
 - (1) is composed of individuals, all of whom are or were actively engaged in the same profession, trade or occupation, and
 - (2) has been maintained in good faith for purposes other than insurance, or
- c. an association, a trust, or the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or

the insurer of the association or associations, shall file evidence with the Insurance Commissioner that the association or associations shall have at the outset of transacting long-term care insurance in this state a minimum of one hundred (100) persons in the association or associations and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least one (1) year; and shall have a constitution and bylaws which provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members, (ii) except for credit unions, the association or associations collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees. Thirty (30) days after such filing the association or associations shall be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements, or

d. a group other than as described in subparagraphs a, b and c of this paragraph, subject to a finding by the Commissioner that:

- (1) the issuance of the group policy is not contrary to the best interest of the public,
- (2) the issuance of the group policy would result in economies of acquisition or administration, and
- (3) the benefits are reasonable in relation to the premiums charged.

5. "Life care community" means any arrangement pursuant to which a person contracts for a place of residence and personal care services, including but not limited to services which progress from independent living to semi-dependent nursing care to acute nursing care, in consideration of a payment or payments of fees prior to the delivery of services and accommodations. Life care community shall not include traditional residential landlord and tenant agreements utilizing periodic rental and security deposit payments.

6. "Policy" means any policy, contract, certificate, subscriber agreement, rider or endorsement delivered, or issued for delivery, in this state by an insurer, fraternal benefit society, nonprofit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization, life care community, or any similar organization.

7. "Qualified long-term care insurance contract" means any:

- a. individual or group insurance contract if the contract meets the requirements of Section 7702(B) of the Internal Revenue Code, as amended, and if:
 1. the only insurance protection provided under the contract is coverage of qualified long-term care services,
 2. the contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to contracts where Medicare is a secondary payor, or where the contract makes per diem or other periodic payments without regard to expenses,
 3. the contract is guaranteed renewable,

4. the contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed. All refunds of premiums and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund of the aggregate premium paid under the contract may be allowed in the event of death of the insured or a complete surrender or cancellation of the contract, and
5. the contract contains the consumer protection provisions set forth in Section 7702(B)(g) of the Internal Revenue Code; or
- b. life insurance contract which provides long-term care coverage by rider or as part of the contract if the contract complies with the applicable provisions of Section 7702(B) of the Internal Revenue Code, as amended.

8. "Qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance for personal care services for which an insured is eligible under a qualified long-term care insurance contract, and which are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

SECTION 2. AMENDATORY 36 O.S. 1991, Section 4426, as last amended by Section 8, Chapter 294, O.S.L. 1994 (36 O.S. Supp. 1996, Section 4426), is amended to read as follows:

Section 4426. A. No long-term care insurance policy shall:

1. Be canceled, nonrenewed, or otherwise terminated on the grounds of age or the deterioration of the mental or physical health of the insured individual or certificate holder;
2. Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or
3. Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

B. 1. No long-term care insurance policy or certificate shall use a definition of "preexisting condition" which is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.

2. No long-term care insurance policy or certificate shall exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

3. The definition of "preexisting condition" does not prohibit an insurer:

- a. from using an application form designed to elicit the complete health history of an applicant, and
- b. from underwriting, on the basis of the answers on that application, in accordance with that insurer's established underwriting standards.

4. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph 2 of subsection B of this section expires. No long-

term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph 2 of subsection B of this section.

C. Prior hospitalization/institutionalization:

1. No long-term care insurance policy may be delivered or issued in this state if such policy:
 - a. conditions eligibility for any benefits on a prior hospitalization requirement,
 - b. conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care, or
 - c. conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.
2.
 - a. A long-term care insurance policy containing post-confinement, post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.
 - b. A long-term care insurance policy or rider which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

D. No law, rule or regulation shall establish loss ratio standards for long-term care insurance policies unless a specific reference to long-term care insurance policies is contained in such law, rule or regulation.

E. Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days after its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied with the policy, for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page of the policy or attached thereto, stating in substance, that the applicant shall have the right to return the policy or certificate within thirty (30) days after its delivery and to have the premium refunded if, after examination of the policy, or certificate, the applicant is not satisfied with the policy, for any reason. If an application for a qualified long-term care contract is denied, the issuer shall refund to the applicant any premium and any other fees submitted by the applicant within thirty (30) days of the date of the denial. If the insurer does not return any premiums or moneys paid therefor within thirty (30) days from the date of cancellation, the insurer shall pay interest on the proceeds which shall be the same rate of interest as the average United States Treasury Bill rate of the preceding calendar year, as certified to the Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two (2) percentage points, which shall accrue from the date of cancellation until the premiums or moneys are returned. In such event, the long-term care policy shall be deemed to have been canceled on the date the policy was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery of such policy or annuity to the insurer.

F. An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of

the recipient to the document and its purpose. The Insurance Commissioner shall prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage. In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form. In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form. Such outline of coverage shall include, but not be limited to:

1. A description of the principal benefits and coverage provided in the policy;

2. A statement of the principal exclusions, reductions and limitations contained in the policy;

3. A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premiums. Continuation or conversion provisions of group coverage shall be specifically described;

4. A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

5. A description of the terms under which the policy or certificate may be returned and premium refunded;

6. A brief description of the relationship of cost of care and benefits; and

7. If the policy or certificate is intended to be a qualified long-term care insurance contract, a statement that discloses to the policyholder or certificate holder that the policy is intended to be a qualified long-term care insurance contract.

G. The issuer of a qualified long-term care insurance contract shall deliver to the applicant, policyholder, or certificate holder the contract or certificate no later than thirty (30) days after the date of approval.

H. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

1. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

2. An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any, for each covered person;

3. Any exclusions, reductions and limitations on benefits of long-term care; and

4. If applicable to the policy type, the summary shall also include:

a. a disclosure of the effects of exercising other rights under the policy,

b. a disclosure of guarantees related to long-term care costs of insurance charges, and

c. current and projected maximum lifetime benefit.

I. Any time a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. Such report shall include:

1. Any long-term care benefits paid out during the month;

2. An explanation of any changes in the policy, e.g. death benefits or cash values, due to long-term care benefits being paid out; and

3. The amount of long-term care benefits existing or remaining.

J. If a claim under a qualified long-term care insurance contract is denied, the issuer shall, within sixty (60) days of the date of a written request by the policyholder or certificate holder, or a representative thereof:

1. Provide a written explanation of the reasons for the denial; and

2. Make available all information directly related to such denial.

K. No policy shall be advertised, marketed or offered as long-term care insurance unless it complies with the provisions of the Long-Term Care Insurance Act.

L. Policies or contracts issued by life care communities which are not licensed insurers in this state shall contain the following statement in conspicuous bold-face type on the front of the policy or contract: "The financial condition of the entity issuing this contract is not subject to review by or the jurisdiction of the Oklahoma Insurance Commissioner. This contract is not subject to the protection of any guaranty association."

SECTION 3. AMENDATORY Section 2, Chapter 244, O.S.L. 1995 (36 O.S. Supp. 1996, Section 4426.2), is amended to read as follows:

Section 4426.2 A. 1. No insurer may offer a long-term care insurance policy unless the insurer also offers to the applicant the option to purchase a policy that provides for nonforfeiture benefits.

2. This section shall not apply to life insurance policies or riders containing accelerated long-term care benefits.

3. For certificates issued on or after the effective date of this act, under a group long-term care insurance policy as defined in Section 4424 of Title 36 of the Oklahoma Statutes, which policy was in force at the time this act became effective, the provisions of this section shall not apply.

B. The Insurance Commissioner shall promulgate rules which are consistent with the National Association of Insurance Commissioners (NAIC) Long-Term Care Model Regulation and which specify the types of nonforfeiture benefits to be included in policies and certificates, the standards for the benefits, and the date nonforfeiture benefits must commence.

C. 1. For purposes of this section, the nonforfeiture benefit shall be a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefit amounts and frequency in effect at the time of lapse, but not increased thereafter, shall be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph 3 of this subsection.

2. Nonforfeiture benefits for qualified long-term care insurance contracts shall include at least a reduced paid-up insurance benefit, an extended term insurance benefit, the offer of a shortened benefit period, or other similar offerings approved by the Insurance Commissioner, and shall be provided as specified in regulations. The issuer of such a contract may refund premiums upon the death of the insured or upon complete surrender or cancellation of the contract or policy, as long as the refund does not exceed the aggregate premiums paid for the contract or policy.

3. The standard nonforfeiture credit shall be equal to one hundred percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard

nonforfeiture credit for that duration. However for lapses occurring at the end of the third policy year and thereafter, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation set forth in subsection D of this section.

4. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

5. There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

D. All benefits paid by the insurer while the policy or certificate is in premium paying status and in paid-up status shall not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.

SECTION 4. AMENDATORY Section 3, Chapter 304, O.S.L. 1992, as last amended by Section 1, Chapter 224, O.S.L. 1995 (36 O.S. Supp. 1996, Section 4509.2), is amended to read as follows:

Section 4509.2 A. When an individual or a dependent who was covered by individual or group insurance pursuant to the provisions of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, gains employment with an employer who provides for health insurance through a group plan or applies for individual insurance, the succeeding carrier shall accept the individual and dependents of the individual who were covered under the prior coverage and shall not apply preexisting conditions limitations or exclusions of preexisting conditions or apply waiting period requirements for the individual insured or the dependents of the insured beyond the time when any surviving exclusion or waiting period with the prior carrier would have been fulfilled. The individual insured and any dependents of such individual must apply for the new coverage within sixty-three (63) days following the date of termination of prior creditable coverage. Individual insurance carriers may underwrite the risk and decline coverage based on the underwriting guidelines of the insurance carrier. Upon denial of coverage, the individual insurance carrier shall advise the applicant of the existence of and how to apply for coverage under the Oklahoma Health Insurance High Risk Pool.

B. When there is a lapse in the coverage of the individual insured or a dependent of the individual insured provided for by subsection A of this section for any reason other than a probationary period or similar waiting period imposed by the employment or personnel policies of an employer, the provisions of subsection A of this section shall not apply to the person whose coverage lapsed.

SECTION 5. AMENDATORY Section 2, Chapter 250, O.S.L. 1995, as amended by Section 2, Chapter 249, O.S.L. 1996 (36 O.S. Supp. 1996, Section 6532), is amended to read as follows:

Section 6532. As used in the Health Insurance High Risk Pool Act:

1. "Agent" means any person who is licensed to sell health insurance in this state;

2. "Board" means the Board of Directors of the Health Insurance High Risk Pool;

3. "Church plan" has the meaning given such term under Section 3(33) of the Employee Retirement Income Security Act of 1974;

4. "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

a. a group health plan,

b. health insurance coverage,

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

- d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 of such act,
 - e. Chapter 55 of Title 10, U.S. Code,
 - 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, U.S. Code,
 - i. a public health plan as defined in federal regulations, or
 - j. a health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);
5. "Federally defined eligible individual" means an individual:
- a. for whom, as of the date on which the individual seeks coverage under the Health Insurance High Risk Pool Act, the aggregate of the periods of creditable coverage, as defined in Section 1D of the Employee Retirement Income Security Act of 1974, is eighteen (18) or more months,
 - b. whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in conjunction with any such plan,
 - c. who is not eligible for coverage under a group health plan, part A or B of Title XVIII of the Social Security Act, or a state plan under Title XIX of such Act or any successor program and who does not have other health insurance coverage,
 - d. with respect to whom the most recent coverage under a COBRA continuation provision or under a similar state program, elected such coverage, and
 - e. who has exhausted such continuation coverage under such provision or program, if the individual elected the continuation coverage described in paragraph 5 of this section;

6. "Governmental plan" has the same meaning given such term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan;

7. "Group health benefit plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care as defined in Section 3N of the Employee Retirement Income Security Act of 1974 and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise;

8. "Health insurance" means any individual or group hospital or medical expense-incurred policy or health care benefits plan or contract. The term does not include any policy governing short-term accidents only, a fixed-indemnity policy, a limited benefit policy, a specified accident policy, a specified disease policy, a Medicare supplement policy, a long-term care policy, medical payment or personal injury coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance, a disability policy, or workers' compensation;

9. "Insurer" means any individual, corporation, association, partnership, fraternal benefit society, or any other entity engaged in the health insurance business, except insurance agents and brokers. This term shall also include not-for-profit hospital service and medical indemnity plans, health maintenance organizations, preferred provider organizations, prepaid health plans, the State and Education Employees Group Health Insurance

Plan, and any reinsurer reinsuring health insurance in this state, which shall be designated as engaged in the business of insurance for the purposes of Section 6531 et seq. of this title;

10. "Medical care" means amounts paid for:

- a. the diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,
- b. transportation primarily for and essential to medical care referred to in paragraph 1 of this section, and
- c. insurance covering medical care referred to in paragraphs 1 and 2 of this section;

11. "Medicare" means coverage under Parts A and B of Title XVIII of the Social Security Act (Public Law 74-271, 42 U.S.C., Section 1395 et seq., as amended);

12. "Pool" means the Health Insurance High Risk Pool;

13. "Physician" means a doctor of medicine and surgery, doctor of osteopathic medicine, doctor of chiropractic, doctor of podiatric medicine, doctor of optometry, and, for purposes of oral and maxillofacial surgery only, a doctor of dentistry, each duly licensed by this state;

14. "Plan" means the comprehensive health insurance benefit plan as adopted by the Board of Directors of the Health Insurance High Risk Pool, or by rule; and

15. "Reinsurer" means any insurer as defined in Section 103 of this title from whom any person providing health insurance to Oklahoma insureds procures insurance for itself as the insurer, with respect to all or part of the health insurance risk of the person.

SECTION 6. AMENDATORY Section 4, Chapter 250, O.S.L. 1995, as amended by Section 3, Chapter 249, O.S.L. 1996 (36 O.S. Supp. 1996, Section 6534), is amended to read as follows:

Section 6534. A. Except as otherwise provided in this section, any person who maintains a primary residence in this state for at least one (1) year or is a federally defined eligible individual shall be eligible for coverage under the plan of the Health Insurance High Risk Pool including:

1. The spouse of the insured; and

2. Any dependent unmarried child of the insured, from the moment of birth. Such coverage shall terminate at the end of the premium period in which the child marries, ceases to be a dependent of the insured, or attains the age of nineteen (19) years, whichever occurs first. However, if the child is a full-time student at an accredited institution of higher learning, the coverage may continue while the child remains unmarried and a full-time student, but not beyond the premium period in which the child reaches the age of twenty-three (23) years.

B. 1. No person is eligible for coverage under the Pool plan unless such person has been rejected by at least two insurers for coverage substantially similar to the plan coverage. As used in this paragraph, rejection includes an offer of coverage with a material underwriting restriction or an offer of coverage at a rate equal to or greater than the Pool plan rate. No person is eligible for coverage under the plan if such person has, on the date of issue of coverage under the plan, equivalent coverage under another health insurance contract or policy. This paragraph shall not apply to federally defined eligible individuals.

2. No person who is currently receiving, or is entitled to receive, health care benefits under any federal or state program providing financial assistance or preventive and rehabilitative social services is eligible for coverage under the plan.

3. No person who is covered under the plan and who terminates coverage is again eligible for coverage unless twelve (12) months

has elapsed since the coverage was terminated; provided, however, this provision shall not apply to an applicant who is a federally defined eligible individual. The Board of Directors of the Health Insurance High Risk Pool may waive the twelve-month waiting period under circumstances to be determined by the Board.

4. No person on whose behalf the plan has paid out Five Hundred Thousand Dollars (\$500,000.00) in covered benefits is eligible for coverage under the plan.

5. No inmate incarcerated in any state penal institution or confined to any narcotic detention, treatment, and rehabilitation facility shall be eligible for coverage under the plan; provided, however, this provision shall not apply with respect to an applicant who is a federally defined eligible individual.

C. The Board may establish an annual enrollment cap if the Board determines it is necessary to limit costs to the plan. However, federally defined eligible individuals shall be guaranteed access to the Pool without regard to any enrollment caps that are set for nonfederally defined eligible individuals.

D. The coverage of any person who ceases to meet the eligibility requirements of this section may be terminated at the end of the month in which an individual no longer meets the eligibility requirements.

SECTION 7. AMENDATORY Section 12, Chapter 250, O.S.L. 1995, as amended by Section 7, Chapter 249, O.S.L. 1996 (36 O.S. Supp. 1996, Section 6542), is amended to read as follows:

Section 6542. A. 1. The plan shall offer as one basic option an annually renewable policy with coverage as specified in this section for each eligible person, except, that if an eligible person is also eligible for Medicare coverage, the plan shall not pay or reimburse any person for expenses paid by Medicare.

2. Any person whose health insurance is involuntarily terminated for any reason other than nonpayment of premium or fraud may apply for coverage under the plan. If such coverage is applied for within sixty-three (63) days after the involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage shall be the date of termination of the previous coverage.

3. The plan shall provide that, upon the death, annulment of marriage or divorce of the individual in whose name the contract was issued, every other person covered in the contract may elect within sixty-three (63) days to continue coverage under a continuation or conversion policy.

4. No coverage provided to a person who is eligible for Medicare benefits shall be issued as a Medicare supplement policy.

B. The plan shall offer comprehensive coverage to every eligible person who is not eligible for Medicare. Comprehensive coverage offered under the plan shall pay an eligible person's covered expenses, subject to the limits on the deductible and coinsurance payments authorized under subsection E of this section up to a lifetime limit of Five Hundred Thousand Dollars (\$500,000.00) per covered individual. The maximum limit under this paragraph shall not be altered by the Board of Directors of the Health Insurance High Risk Pool, and no actuarially equivalent benefit may be substituted by the Board.

C. Except for a health maintenance organization and prepaid health plan or preferred provider organization utilized by the Board or a covered person, the usual customary charges for the following services and articles, when prescribed by a physician, shall be covered expenses:

1. Hospital services;
2. Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental, which are

rendered by a physician or by others at the direction of a physician;

3. Drugs requiring a physician's prescription;

4. Services of a licensed skilled nursing facility for eligible individuals, ineligible for Medicare, for not more than one hundred eighty (180) calendar days during a policy year, if the services are the type which would qualify as reimbursable services under Medicare;

5. Services of a home health agency, if the services are of a type which would qualify as reimbursable services under Medicare;

6. Use of radium or other radioactive materials;

7. Oxygen;

8. Anesthetics;

9. Prosthesis, other than dental prosthesis;

10. Rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses and hearing aids;

11. Diagnostic x-rays and laboratory tests;

12. Oral surgery for partially or completely erupted, impacted teeth and oral surgery with respect to the tissues of the mouth when not performed in connection with the extraction or repair of teeth;

13. Services of a physical therapist;

14. Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

15. Processing of blood including, but not limited to, collecting, testing, fractioning, and distributing blood; and

16. Services for the treatment of alcohol and drug abuse, but the plan shall be required to make a fifty percent (50%) co-payment and the payment of the plan shall not exceed Four Thousand Dollars (\$4,000.00).

Usual and customary charges shall not exceed the reimbursement rate for charges as set by the State and Education Employees Group Insurance Board.

D. 1. Covered expenses shall not include the following:

a. any charge for treatment for cosmetic purposes, other than for repair or treatment of an injury or congenital bodily defect to restore normal bodily functions,

b. any charge for care which is primarily for custodial or domiciliary purposes which do not qualify as eligible services under Medicaid,

c. any charge for confinement in a private room to the extent that such charge is in excess of the charge by the institution for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician,

d. that part of any charge for services or articles rendered or provided by a physician or other health care personnel which exceeds the prevailing charge in the locality where the service is provided, or any charge for services or articles not medically necessary,

e. any charge for services or articles the provision of which is not within the authorized scope of practice of the institution or individual providing the service or articles,

f. any expense incurred prior to the effective date of the coverage under the plan for the person on whose behalf the expense was incurred,

g. any charge for routine physical examinations in excess of one every twenty-four (24) months,

h. any charge for the services of blood donors and any fee for the failure to replace the first three (3)

pints of blood provided to an eligible person annually, and

- i. any charge for personal services or supplies provided by a hospital or nursing home, or any other nonmedical or nonprescribed services or supplies.

2. The plan may provide an option for a person to have coverage for the expenses set out in paragraph 1 of this subsection or any benefits payable under any other health insurance policy or plan, commensurate with the deductible and coinsurance selected.

E. 1. The plan shall provide for a choice of annual deductibles per person covered for major medical expenses in the amounts of Five Hundred Dollars (\$500.00), One Thousand Dollars (\$1,000.00), One Thousand Five Hundred Dollars (\$1,500.00), Two Thousand Dollars (\$2,000.00), Five Thousand Dollars (\$5,000.00) and Seven Thousand Five Hundred Dollars (\$7,500.00), plus the additional benefits payable at each level of deductible; provided, if two individual members of a family satisfy the applicable deductible, no other members of the family shall be required to meet deductibles for the remainder of that calendar year.

2. The schedule of premiums and deductibles shall be established by the Board.

3. Rates for coverage issued by the Pool may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing coverage.

4. Separate schedules of premium rates based on age may apply for individual risks.

5. Rates are subject to approval by the Insurance Commissioner.

6. Standard risk rates for coverages issued by the Pool shall be established by the Board, subject to the approval of the Insurance Commissioner, using reasonable actuarial techniques, and shall reflect anticipated experiences and expenses of such coverage for standard risks.

7. a. The rating plan established by the Board shall initially provide for rates equal to one hundred twenty-five percent (125%) of the average standard risk rates of the five largest insurers doing business in the state.

b. Any change to the initial rates shall be based on experience of the plan and shall reflect reasonably anticipated losses and expenses. The rates shall not increase more than five percent (5%) annually with a maximum rate not to exceed one hundred fifty percent (150%) of the average standard risk rates.

8. a. A Pool policy may contain provisions under which coverage is excluded during a period of twelve (12) months following the effective date of coverage with respect to a given covered person's preexisting condition, as long as:

(1) the condition manifested itself within a period of six (6) months before the effective date of coverage, or

(2) medical advice or treatment for the condition was recommended or received within a period of six (6) months before the effective date of coverage. The provisions of this paragraph shall not apply to a person who is a federally defined eligible individual.

b. The Board shall waive the twelve-month period if the person had continuous coverage under another policy with respect to the given condition within a period of six (6) months before the effective date of coverage under the Pool plan. The Board shall also waive any

preexisting waiting periods for an applicant who is a federally defined eligible individual.

9. a. No amounts paid or payable by Medicare or any other governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may be made or recognized as claims under such policy, or be recognized as or towards satisfaction of applicable deductibles or out-of-pocket maximums, or to reduce the limits of benefits available.
- b. The Board shall have a cause of action against a covered person for any benefits paid to a covered person which should not have been claimed or recognized as claims because of the provisions of this paragraph, or because otherwise not covered.

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