

# An Act

ENROLLED HOUSE  
BILL NO. 1062

By: Roberts (Dustin), Hardin,  
Moore and Mulready of the  
House

and

Brecheen, Adelson and Sykes  
of the Senate

An Act relating to state government; amending 74 O.S. 2001, Section 1307, which relates to the Health Insurance Plan specifications and requirements; directing Plan to contract for certain services; authorizing certain exceptions; allowing participants to opt out of state-provided health insurance benefits; requiring certain payment; requiring certain evidence and affidavit; amending 74 O.S. 2001, Section 1370, as last amended by Section 2 of Enrolled Senate Bill No. 623 of the 1st Session of the 53rd Oklahoma Legislature, which relates to the flexible benefit allowance plan; authorizing certain participants to opt out of certain coverage; providing for certain monthly payment; amending 74 O.S. 2001, Section 1371, as last amended by Section 6, Chapter 269, O.S.L. 2007 (74 O.S. Supp. 2010, Section 1371), which relates to the election of certain benefits; authorizing certain participants to opt out of certain coverage; directing State and Education Employees Group Insurance Board to make certain health savings accounts available to enrollees; specifying requirements; directing Board to contract for certain incentive program; stating purpose of contract; specifying program requirements; specifying participation shall be voluntary; directing Board to continue contract in certain circumstance; providing for codification; and providing an effective date.

SUBJECT: State health insurance and benefits

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

SECTION 1. AMENDATORY 74 O.S. 2001, Section 1307, is amended to read as follows:

Section 1307. A. The specifications drawn by the Board for the Health Insurance Plan shall provide for comprehensive hospital medical and surgical benefits. The Health Insurance Plan may limit coverage for a particular illness, disease, injury or condition; but, except for such limits, shall not exclude or limit particular services or procedures that can be provided for the diagnosis and treatment of an illness, disease, injury or condition, so long as the services and procedures provided are of sound efficacy, are medically necessary, and fall within the licensed scope of practice of the practitioner providing same. The Health Insurance Plan may contract with providers for specific services based on levels of outcomes defined by the State and Education Employees Group Insurance Board and achieved by the provider. The Health Insurance Plan may provide for the application of deductibles and copayment or coinsurance provisions, when equally applied to all covered charges for services and procedures that can be provided by any practitioner for the diagnosis and treatment of a particular illness, disease, injury or condition unless deductibles, copayments or coinsurance variations are based on contracts with providers for specific services based on levels of outcomes.

B. The Life Insurance Plan shall include Accidental Death and Dismemberment Benefits and additional optional life insurance coverage.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1308.3 of Title 74, unless there is created a duplication in numbering, reads as follows:

Any active employee eligible to participate or who is a participant may opt out of the state's basic plan as outlined in Sections 1370 and 1371 of Title 74 of the Oklahoma Statutes, provided that the participant is currently covered by a separate group health insurance plan. Any active employee eligible to participate or who is a participant opting out of coverage pursuant to this section shall provide proof of the separate health insurance plan participation and sign an affidavit attesting that the

participant is currently covered and does not require state-provided health insurance each plan year. Any active employee opting out of coverage pursuant to this section shall receive One Hundred Fifty Dollars (\$150.00) in lieu of the flexible benefit amount the employee would be otherwise eligible to receive. Any savings realized by the state as a result of a participant opting out of health insurance plan coverage shall be retained by the state.

SECTION 3. AMENDATORY 74 O.S. 2001, Section 1370, as last amended by Section 2 of Enrolled Senate Bill No. 623 of the 1st Session of the 53rd Oklahoma Legislature, is amended to read as follows:

Section 1370. A. Subject to the requirement that a participant must elect the default benefits, the basic plan, or is a person who has retired from a branch of the United States military and has been provided with health care through a federal plan, to the extent that it is consistent with federal law, or is an active employee who is eligible to participate and who is a participant who has opted out of the state's basic plan according to the provisions of Section 2 of this act, and provides proof of this coverage, flexible benefit dollars may be used to purchase any of the benefits offered by the Oklahoma State Employees Benefits Council under the flexible benefits plan. A participant who has opted out of the state's basic plan and provided proof of other coverage as described in this subsection shall not receive One Hundred Fifty Dollars (\$150.00) in lieu of the flexible benefit dollars if the person elects not to purchase any benefits monthly. A participant's flexible benefit dollars for a plan year shall consist of the sum of (1) flexible benefit allowance credited to a participant by the participating employer, and (2) pay conversion dollars elected by a participant.

B. Each participant shall be credited annually with a specified amount as a flexible benefit allowance which shall be available for the purchase of benefits. The amount of the flexible benefit allowance credited to each participant shall be communicated to him or her prior to the enrollment period for each plan year.

C. Except as provided in subsection D of this section, for the plan year ending December 31, 2012, and each plan year thereafter, the amount of a participant's benefit allowance, which shall be the total amount the employer contributes for the payment of insurance premiums or other benefits, shall be:

1. The greater of Two Hundred Sixty-two Dollars and nineteen cents (\$262.19) per month or an amount equal to the sum of the average monthly premiums of all high option health insurance plans, excluding the point-of-service plans, the average monthly premiums of the dental plans, the monthly premium of the disability plan, and the monthly premium of the basic life insurance plan offered to state employees or the amount determined by the Council based on a formula for determining a participant's benefit credits consistent with the requirements of 26 U.S.C., Section 125(g)(2) and regulations thereunder; or

2. The greater of Two Hundred Twenty-four Dollars and sixty-nine cents (\$224.69) per month or an amount equal to the sum of the average monthly premiums of all high option health insurance plans, excluding the point-of-service plans, the average monthly premiums of the dental plans, the monthly premium of the disability plan, and the monthly premium of the basic life insurance plan offered to state employees plus one of the additional amounts as follows for participants who elect to include one or more dependents:

- a. for a spouse, seventy-five percent (75%) of the average price of all high option benefit plans, excluding the point-of-service plans, available for coverage of a spouse,
- b. for one child, seventy-five percent (75%) of the average price of all high option benefit plans available, excluding the point-of-service plans, for coverage of one child,
- c. for two or more children, seventy-five percent (75%) of the average price of all high option benefit plans available, excluding the point-of-service plans, for coverage of two or more children,
- d. for a spouse and one child, seventy-five percent (75%) of the average price of all high option benefit plans available, excluding the point-of-service plans, for coverage of a spouse and one child, or
- e. for a spouse and two or more children, seventy-five percent (75%) of the average price of all high option benefit plans available, excluding the point-of-service plans, for coverage of a spouse and two or more children.

D. To the extent that it is consistent with federal laws and regulations, and in particular the regulations set forth by the Secretary of Defense in 32 C.F.R. Section 199.8(d)(6), a benefit may be provided to an employee who is an eligible TRICARE beneficiary whereby he or she may purchase a group TRICARE Supplemental product under a qualifying cafeteria plan consistent with the requirements of 26 U.S.C., Section 125, provided that (i) the State, as employer may not provide any payment for nor receive any consideration or compensation for offering the benefit, (ii) the employer's only involvement is in providing the administrative support for the benefit under the cafeteria plan and (iii) the employee's participation in the plan is completely voluntary. The benefit allowance under paragraph 2 of subsection C of this section of an employee whose plan participation includes a group TRICARE Supplemental benefit shall not include any allowance or portion thereof for such TRICARE Supplemental benefit.

E. This section shall not prohibit payments for supplemental health insurance coverage made pursuant to Section 1314.4 of this title or payments for the cost of providing health insurance coverage for dependents of employees of the Grand River Dam Authority.

F. If a participant desires to buy benefits whose sum total of benefit prices is in excess of his or her flexible benefit allowance, the participant may elect to use pay conversion dollars to purchase such excess benefits. Pay conversion dollars may be elected through a salary reduction agreement made pursuant to the election procedures of Section 1371 of this title. The elected amount shall be deducted from the participant's compensation in equal amounts each pay period over the plan year. On termination of employment during a plan year, a participant shall have no obligation to pay the participating employer any pay conversion dollars allocated to the portion of the plan year after the participant's termination of employment.

G. If a participant elects benefits whose sum total of benefit prices is less than his or her flexible benefit allowance, he or she shall receive any excess flexible benefit allowance as taxable compensation. Such taxable compensation will be paid in substantially equal amounts each pay period over the plan year. On termination during a plan year, a participant shall have no right to receive any such taxable cash compensation allocated to the portion of the plan year after the participant's termination. Nothing herein shall affect a participant's obligation to elect the minimum

benefits or to accept the default benefits of the plan with corresponding reduction in the sum of his or her flexible benefit allowance equal to the sum total benefit price of such minimum benefits or default benefits.

SECTION 4. AMENDATORY 74 O.S. 2001, Section 1371, as last amended by Section 6, Chapter 269, O.S.L. 2007 (74 O.S. Supp. 2010, 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 2 of this act. 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 State Employees Benefits Council shall design the basic plan for the next plan year to insure 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 Council 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 Council, 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, 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, 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.

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 Council. 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, ~~Section 85.1 et seq. of this title.~~ The Council 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 Council shall be accepted. The Council shall have the authority to reject the bid or restrict enrollment in any health maintenance organization for which the Council determines the benefit price to be excessive. The Council 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 Council 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 Council, 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 Council 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 Council 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 Council 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 Council, 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 Council, 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, Oklahoma State Employees Benefits Council and State and Education Employees Group Insurance 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 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1329 of Title 74, unless there is created a duplication in numbering, reads as follows:

The State and Education Employees Group Insurance Board ("Board"), and the Office of State Finance, shall contract with a vendor to make available a health savings account to all enrollees in the HealthChoice qualified high-deductible health plan. Any employer or employee contributions to the health savings account shall be allowable as a remittance to the vendor through payroll deduction in conjunction with the employer's Section 125 Plan and shall not be subject to any assessment of administrative fees by the Board, the Office of State Finance or any state agency for remittance to the vendor. The State of Oklahoma, the Board, the Office of State Finance and the Oklahoma State Employees Benefits Council shall take necessary measures to make any employer or employee health savings account contributions permissible under the state's Section 125 Plan.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1329.1 of Title 74, unless there is created a duplication in numbering, reads as follows:

The State and Education Employees Group Insurance Board shall contract for 2012 with a vendor that offers a Health Insurance

Portability and Accountability Act (HIPAA) compliant web-based, doctor-patient mutual accountability incentive program. The purpose of the contract is to conduct a pilot project to test the value proposition of a program that offers financial incentives to both the health care provider and the patient for each care encounter in which the provider and patient incorporate evidence-based medicine treatment guidelines, patient health education remedies and other proven medical interventions made available and recorded through the program in the rendering and utilization of health care. The Board shall use its operating funds to underwrite the cost of this pilot project and shall not pass these costs along to the participating state agencies, or school boards or providers. The Board may retain or share with participating state agencies or school boards any savings realized as a result of the pilot program. The program will demonstrate a self-sustaining financial model that, through the savings incurred by better utilization health care programs, will offset the costs of this program with savings. This program will offer the health care provider the flexibility to use the health care provider's clinical judgment to adhere to or deviate from the program's treatment guidelines and still receive a financial incentive, as long as the health care provider communicates care guidelines and patient health education remedies to the patient that include an explanation of the provider's adherence or reason for nonadherence to the guideline. The vendor managing the pilot program shall offer a financial reward to the patient for responding to the vendor's guidelines for care and patient education remedies by demonstrating the patient's understanding of the patient's health condition, by declaring or demonstrating adherence to recommended care, by agreeing to allow the patient's physician to view patient's responses and acknowledge the patient's health accomplishments, and by judging the quality of care given to the patient against these guidelines and recommended care. Any communications to patient and provider shall be in compliance with all HIPAA regulations and standards. Participation in the program shall be voluntary to both the provider and patient on an encounter-by-encounter basis. The program shall be offered and administered by the program vendor through an Internet application that is HIPAA-compliant. This pilot project shall include a minimum of 15,000 beneficiaries of the Board to achieve a statistical significance and collect and analyze data over a period of three (3) years in order to determine the program's effectiveness and ability to become self-funded.

SECTION 7. This act shall become effective November 1, 2011.

Passed the House of Representatives the 18th day of May, 2011.



Presiding Officer of the House of  
Representatives

Passed the Senate the 19th day of May, 2011.



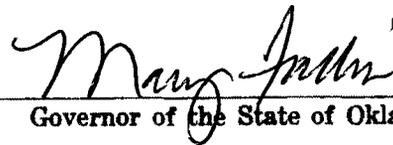
Presiding Officer of the Senate

**OFFICE OF THE GOVERNOR**

Received by the Governor this 20<sup>th</sup>  
day of May, 20 11,  
at 6:33 o'clock PM.

By: Jessica R. Rogers

Approved by the Governor of the State of Oklahoma the 25<sup>th</sup> day of  
May, 20 11, at 9:57 o'clock AM.



Governor of the State of Oklahoma

**OFFICE OF THE SECRETARY OF STATE**

Received by the Secretary of State this \_\_\_\_\_  
25<sup>th</sup> day of May, 20 11,  
at 11:19 o'clock A M.

By: Michelle R. Day