TITLE 365. INSURANCE DEPARTMENT

CHAPTER 10. LIFE, ACCIDENT AND HEALTH

SUBCHAPTER 19. HEALTH INSURANCE PURCHASING GROUPS

365:10-19-1. Definitions

The following terms used in this Part, shall have the same meaning as set out in 36 O.S. § 4522 of the Act, unless the context clearly indicates otherwise:

"Act" means the Employer Health Insurance Purchasing Group Act, 36 O.S. § 4521, et seq.

"Dependent" means a spouse, newly born child, adopted child, child placed for adoption from the moment of placement, child of the insured under the age of majority who is a natural child of the insured, and/or a step-child under the age of majority who is dependent upon the insured for support or maintenance. Dependent shall also include any dependent child who is incapable of self sustaining employment due to mental retardation or physical handicap on the date that such child's coverage would otherwise terminate under the policy due to the attainment of a specified age limit for children, if the child is chiefly dependent on the insured for support and maintenance.

"New entrant" means an eligible employee or individual who becomes an eligible employee after the initial period for enrollment in a health benefit plan.

[**Source:** Added at 20 Ok Reg 1731, eff 7-14-03]

365:10-19-2. Applicability and scope

(a) This Part shall apply to any health benefit plan written for a Health Insurance Purchasing Group pursuant to the Act.

(b) This Part shall apply to any health benefit plan that issues or delivers a policy or certificate in this state pursuant to the Act.

(c) The provisions of the Act and this Part shall not apply to an individual health benefit plan delivered or issued for delivery in this state.

(d) The provisions of the Act and this Part shall apply to HIPGs formed for citizens in the State of Oklahoma.

(e) For the purpose of this act, a health insurer does not include a MEWA as defined in 36 O.S. § 634.

(f) If an eligible employer is issued a health benefit plan pursuant to the Act, the provisions of the Act and this Part shall continue to apply to the health benefit plan in the case that the employer subsequently employs more than one hundred (100) eligible employees. A HIPG health carrier providing coverage to such an employer shall, within sixty (60) days of becoming aware that the employer has more than one hundred (100) eligible employees but no later than the anniversary date of the employer's health benefit plan, notify the employer that the provisions of the Act and this Part shall cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan.

(g) A HIPG health carrier providing coverage to an employer pursuant to the Act shall, within sixty (60) days of becoming aware that the employer has fifty (50) or fewer eligible employees, notify the employer of the options and protections available to the employer under the Small Employer Health Insurance Reform Act as set out pursuant to 36 O.S. § 6511 et seq., including the employer's option to purchase a small employer health benefit plan from any small employer carrier.

(h) A carrier that is not operating as a Health Insurance Purchasing Group carrier in this state shall not become subject to the provisions of the Act and this Part solely because an employer that was issued a health insurance purchasing group plan in another state by that HIPG health carrier moves to this state and the coverage remains in force.

[**Source:** Added at 20 Ok Reg 1731, eff 7-14-03]

365:10-19-3. Establishment of business

(a) A health insurer that establishes a health benefit plan pursuant to 36 O.S. § 4522, shall maintain on file for inspection by the Commissioner the following information with respect to each health benefit plan so established:

(1) A description of each criterion employed by the HIPG health carrier (or any of its agents) for determining membership in the health benefit plan;

(2) A statement disclosing which, if any, health benefit plans are currently available for purchase by Health Insurance Purchasing Groups.

(b) A HIPG health carrier may not directly or indirectly discriminate against Health Insurance Purchasing Groups in the offer of coverage to a group.

[**Source:** Added at 20 Ok Reg 1731, eff 7-14-03]

365:10-19-4. Board of directors and plan of operations

(a) Individuals on the Board of Directors as required under 36 O.S. § 4523 shall be owners or employees of the participating employer groups.

(1) Be composed of Directors of the employers participating in the Health Insurance Purchasing Group;

(2) A vacancy on the board may be filled by a member of the employer group from which the vacancy occurred if that employer is still participating in the Health Insurance Purchasing Group plan or any other employer group which is participating in the Health Insurance Purchasing Group plan;

(3) A board member may be removed from the board for cause.

(b) Within one hundred eighty (180) days after the appointment of the initial board, the board shall adopt a plan of operations and, thereafter, any amendments thereto necessary or suitable to ensure the fair, reasonable and equitable administration of the program, and to provide for the sharing of information to other members of the Health Insurance Purchasing Group.

(c) The plan of operations shall be in a written document available for review by all members of the Health Insurance Purchasing Group.

(d) The plan of operations shall establish a procedure for the implementation, administration of the HIPG and accounting of the program members, including but not limited to employees and dependents covered, and employees declining coverage.

(e) The plan of operations shall establish a procedure for an annual written report to be provided to all participating employers of the Health Insurance Purchasing Group.

[**Source:** Added at 20 Ok Reg 1731, eff 7-14-03]

365:10-19-5. Requirement to insure all employees of the purchaser and new entrants

(a) **Offer of coverage.**

(1) A HIPG health carrier that offers coverage to a HIPG shall offer to provide coverage to each eligible employee and their dependents and to each new entrant to the plan and to each dependent of the new entrant. New entrants shall be covered upon the first day of the calendar month following any established waiting periods of the HIPG.

(2) A HIPG health carrier shall offer the eligible employees of a HIPG the option of choosing among one or more health benefit plans, one of which shall contain the mandated benefits pursuant to the entire Oklahoma Insurance Code, provided that each employee may choose any of the offered plans. The choice among benefit plans may not be limited, restricted or conditioned based upon the risk characteristics of the employees or their dependents.

(b) **List of eligible employees and waivers**.

(1) A HIPG health carrier shall require each employer of the HIPG that applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees as defined in 36 O.S. § 4522(2) & (4). The HIPG health carrier shall require the Purchaser to provide appropriate supporting documentation (such as the W-2 Summary Wage and Tax Form, or other proof of employment as may be determined by the Oklahoma Insurance Department) to verify the information required under this section.

(2) A HIPG health carrier shall obtain a waiver with respect to each eligible employee and each dependent of such an eligible employee who declines an offer of coverage under a health benefit plan provided to a Purchaser. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall require that the reason for declining coverage be stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the HIPG health carrier for the period in which the coverage is in effect.

(c) **Inducement to decline coverage due to the individual's risk characteristics prohibited.**

(1) A HIPG health carrier shall not issue coverage to a Purchaser if the HIPG health carrier, or a producer for such HIPG health carrier, has reason to believe that the Purchaser has induced or pressured an eligible employee or dependent of an eligible employee to decline coverage due to the individual's risk characteristics.

(2) A producer shall notify a HIPG health carrier, prior to submitting an application for coverage with the HIPG health carrier on behalf of a Purchaser, of any circumstances that would indicate that the Purchaser has induced or pressured an eligible employee or dependent of an eligible employee to decline coverage due to the individual's risk characteristics.

[**Source:** Added at 20 Ok Reg 1731, eff 7-14-03]

365:10-19-6. Prohibited provisions and other requirements

(a) No HIPG or HIPG health carrier shall make provisions establishing a probationary or waiting period during which no coverage is available to eligible employees for a period of more than three months from the date of hire.

(b) No HIPG or HIPG health carrier shall enter into exclusive agreements between the HIPG and the HIPG health carrier. A HIPG health carrier shall not enter into any contract that would bind a HIPG health carrier to a specific HIPG.

(c) No HIPG shall have or use a name that tends to mislead, deceive, or confuse. The Oklahoma Insurance Department shall determine whether the name of the HIPG has a tendency to mislead, deceive or confuse.

(d) No HIPG shall use any documents of a HIPG health carrier after termination of the HIPG and shall return all documents produced and/or provided by the HIPG health carrier immediately upon termination of the HIPG.

(e) Employer eligibility requirements shall not be more restrictive than those found in the Small Employer Health Insurance Reform Act.

[**Source:** Added at 20 Ok Reg 1731, eff 7-14-03]

365:10-19-7. Filing requirements

(a) Prior to the formation on a HIPG the HIPG shall provide the following documents to the Oklahoma Insurance Department for review and approval:

(1) All HIPG documents.

(2) Contracts between the HIPG and HIPG health carrier.

(3) All administrative agreements.

(4) Plan of Operations.

(5) Marketing methods to be used.

(6) Constitutions and/or bylaws.

(7) Names of five representatives of eligible employers.

(8) Employer eligibility requirements

(9) Requirements for membership and disclosure requirements.

(b) HIPG contracts shall contain a termination provision that shall provide for the following:

(1) Basis for HIPG employer to terminate participation in the HIPG.

(2) Provisions for a refund of all deposits collected upon termination.

(3) Reasons for termination, including but not limited to failure of the HIPG to perform pursuant to the HIPG documents.

(c) Plan documents shall be written by the HIPG insurance carrier

(d) Contracts that provide for the automatic renewal after the initial twelve month period shall allow employers to exit the HIPG without penalty after the initial twelve months have expired.

(e) Contracts that include additional contract periods shall provide for the termination of the contracts at the discretion of the employer during said additional twelve month periods.

(f) The HIPG contract that extends for additional periods of time may be terminated by written notice of termination by the employer. Such notice shall be given no later than thirty days prior to the expiration of the current contract period.

(g) The documents submitted shall not be used by the HIPG until approved by the Oklahoma Insurance Department.

[**Source:** Added at 20 Ok Reg 1731, eff 7-14-03]

365:10-19-8. Annual reporting requirements

(a) A HIPG health carrier shall file annually the following information with the Commissioner related to health benefit plans issued by the HIPG health carrier to HIPGs in this state:

(1) The number of Purchasers that were issued the limited benefit health benefit plans in the previous calendar year (separated as to newly issued plans and renewals and the number of covered lives);

(2) The number of Purchasers that were issued providing the state-mandated health benefits in the previous calendar year (separated as to newly issued plans and renewals and as to class of business and the number of covered lives);

(3) The number of Purchaser health benefit plans that were voluntarily not renewed by Purchasers in the previous calendar year;

(4) The number of HIPG health benefit plans that were terminated or nonrenewed (for reasons other than nonpayment of premium) by the HIPG health carrier in the previous calendar year; and

(5) The number of HIPG health benefit plans that were issued to Purchaser that were uninsured for at least the three (3) months prior to issue.

(b) The information described in this Section shall be filed no later than March 15 of each year.

(c) A HIPG health carrier shall file the health benefit plans intended to be issued to HIPGs for approval prior to use pursuant to 36 O.S. § 3610.

[**Source:** Added at 20 Ok Reg 1731, eff 7-14-03]