INSURE OKLAHOMA ESI HEALTH PLAN APPLICATION PROCESS FOR INSURANCE CARRIERS

Evaluation Procedure

The Oklahoma Health Care Authority (OHCA) will conduct a comprehensive and fair evaluation of individual health plans received in response to this application. Applications will be evaluated based upon requirements set by OHCA.

Carriers must be able to submit all required and requested information and documentation to OHCA for each benefit plan to be considered for qualification. Carriers must be able to supply specific claim payment scenarios as requested by OHCA. Carriers must also provide the name, address, telephone number, and, if available, email address of a contact individual who is able to verify employer enrollment status in a qualified benefit plan.

Step 1: Qualified Benefit Plan Requirements

(a) Participating qualified benefit plans must offer, at a minimum, benefits that include:

(1) Hospital services;
(2) Physician services;
(3) Clinical laboratory and radiology;
(4) Pharmacy;
(5) Visits;
(6) Well baby/well child exams;
(7) Age appropriate immunizations as required by law; and
(8) Emergency services as required by law.

(b) The benefit plan, if required, must be approved by the Oklahoma Insurance Department for participation in the Oklahoma market. All benefit plans must share in the cost of covered services and pharmacy products in addition to any negotiated discounts with network providers, pharmacies, or pharmaceutical manufacturers. If the benefit plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits described in this subsection.

(1) An annual in-network out-of-pocket maximum cannot exceed $3,000 per individual, excluding separate pharmacy deductibles.
(2) Office visits with Primary Care Provider cannot require a co-payment exceeding $50 per visit.
(3) If there is a separate annual in-network pharmacy deductible, it cannot exceed $500 per individual.

(c) Qualified benefit plans will provide an EOB, an expense summary, or required documentation for paid and/or denied claims subject to member co-insurance or member deductible calculations. The required documentation must contain, at a minimum, the:

(1) Provider's name;
(2) Patient's name;
(3) Date(s) of service;
(4) Code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);
(5) Reason code(s) and description(s) for any denied service(s);
(6) Amount due and/or paid from the patient or responsible party; and
(7) Provider network status (in-network or out-of-network provider).

Step 2: Complete the application process
Please address each section of the application process separately and label each section according to the chapters below. Carrier should ensure that the response to this application addresses each section. Failure to follow the requested format may result in the plan being returned to Carrier unevaluated. Submit an electronic media copy via email to insureok@okhca.org

Step 3: Chapter 1 – Qualified Health Plan Application
Complete the Health Plan Application (Attachment A) and insert under chapter one. Only one health plan may be submitted per application (i.e. if you are submitting more than one health plan for review you must complete the entire process for each health plan submitted).

Step 4: Chapter 2 - Statement of Benefits
Provide a sample of the health plan coverage policy description. This description is provided to the employer. The description must include the deductibles, co-pay and coinsurance information and additional riders attached to the policy. The description should include all possible permutations.

Step 5: Chapter 3 - Covered Benefits
Provide information regarding health and pharmacy benefits

Step 6: Chapter 4 – Description of Premium Calculation
Provide examples of all types of rating methods or calculations for the subscriber, subscriber's spouse and children. We need to know if the rates are based on age, location or any other methodology used to determine health plan rates for the subscriber and their family member. Also provide the age-up policy used for the subscriber and subscriber's spouse. Complete Attachment B.

Step 7: Chapter 5 - Explanation of Benefits (EOB) and Premium Rate Sheet
Provide a sample EOB, premium rate sheet and a sample invoice for the health plan.

Step 8: Chapter 6 - Oklahoma Insurance Department Filing Information
Please complete all of the fields in Attachment C.