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| POLICY TRANSMITTAL NO. 05-51  | DATE: NOVEMBER 2, 2005  |
| FAMILY SUPPORT SERVICES<br>DIVISION/OKLAHOMA HEALTH CARE<br>AUTHORITY | DEPARTMENT OF HUMAN SERVICES<br>OFFICE OF PLANNING, POLICY & RESEARCH |

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TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:45-1-1 through 45-1-3; 45-3-1 through 45-3-2; 45-5-1 through 45-5-2; 45-7-1 through 45-7-8; and 45-9-1 through 45-9-8.

EXPLANATION: **Policy revisions were approved by the Board and the Governor as required by the Administrative Procedures Act.**

Rules are issued to implement the Oklahoma Employer and Employee Partnership for Insurance Coverage Program (O-EPIC). The program establishes access to affordable health coverage for approximately 25,000 low-income working adults and their spouses.

Original signed on 11-2-05

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Mary Stalnaker, Director  
Family Support Services Division

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Sharon Neuwald, Co-Interim Administrator  
Office of Planning, Policy & Research

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WF # 05-DD (DT)

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## **INSTRUCTIONS FOR FILING MANUAL MATERIAL**

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following a “DHS” number, such as personnel policy at DHS:2-1 and personnel rules at OAC 340:2-1. The “340” is the Title number that designates DHS as the rulemaking agency; the “2” specifies the Chapter number; and the “1” specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, DHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, DHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at (405) 521-3611.

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**CHAPTER 45. OKLAHOMA EMPLOYER AND EMPLOYEE  
PARTNERSHIP FOR INSURANCE COVERAGE**

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317:45-1-1. Purpose and general program provisions

The purpose of this Chapter is to provide rules, in compliance with all applicable federal and state regulations, for the Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) program that establishes access to affordable health coverage for low-income working adults and their spouses. The Oklahoma Health Care Authority (OHCA) contracts with a Third Party Administrator (TPA) for administration of the Program.



317:45-1-2. Program limitations

(a) The O-EPIC program is contingent upon sufficient funding that is collected and dispersed through a revolving fund within the State Treasury designated as the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund". This fund is a continuing fund, not subject to fiscal year limitations.

(b) All monies accruing to the credit of the fund are budgeted and expended by the OHCA to implement the Program.

(c) The Program is funded through a portion of monthly proceeds from the Tobacco Tax, House Bill 2660, that are collected and dispersed through the HEEIA revolving fund.

(d) The Program is limited in scope such that budgetary limits are not exceeded. If at any time it becomes apparent there is risk the budgetary limits may be exceeded, OHCA must take action to ensure the O-EPIC program continues to operate within its fiscal capacity.

(1) O-EPIC may limit eligibility based on:

(A) the federally-approved capacity of the O-EPIC services for the Health Insurance Flexibility and Accountability (HIFA) Waiver/1115 Waiver; and

(B) Tobacco Tax collections.

(2) The O-EPIC program may limit eligibility when the utilization of services is projected to exceed the spending authority, or, may suspend new eligibility determinations instead, establishing a waiting list of employers.

(A) Employers, not previously enrolled and participating in the program, submitting new applications for the O-EPIC program are placed on a waiting list. These applications are date and time stamped when received by the TPA.

(B) The waiting list utilizes a "first in - first out" method of selecting eligible employers.

(C) When an employer group is determined eligible and moves from the waiting list to active participation, the employer must submit a new application. All eligible employees of

that employer will have an opportunity to participate in O-EPIC during the employer's eligibility period.

(D) Only employers will be subject to the waiting list.

(E) Enrolled employers who are currently participating in the O-EPIC program are not subject to the waiting list.

(i) If the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate in O-EPIC during the employer's current eligibility period.

(ii) If the employer has an employee who has a Qualifying Event after the employer's program eligibility begins, the employee is allowed to make changes pertaining to the Qualifying Event.

**317:45-1-3. Definitions**

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

**"Carrier"** means:

(A) an insurance company, group health service or Health Maintenance Organization (HMO) that provides health benefits pursuant to Title 36 O.S., Section 6512;

(B) A Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department; or

(C) A domestic MEWA exempt from licensing pursuant to Title 36 O.S., Section 634(B) that otherwise meets or exceeds all of the licensing and financial requirements of MEWAs as set out in Article 6A of Title 36.

**"Eligibility period"** means the period of eligibility extending from an approval date to an end date.

**"O-EPIC"** means the Oklahoma Employer and Employee Partnership for Insurance Coverage program.

**"Oklahoma Employer and Employee Partnership for Insurance Coverage"** means a health plan purchasing strategy in which a state uses public funds to pay for a portion of the premium costs of employer-sponsored health plans for eligible populations.

**"OESC"** means the Oklahoma Employment Security Commission.

**"OKDHS"** means the Oklahoma Department of Human Services.

**"OHCA"** means the Oklahoma Health Care Authority.

**"Premium"** means a monthly payment to a Carrier for health plan coverage.

**"Qualified Health Plan"** means a health plan that has been approved by the OHCA for participation in the O-EPIC program.

"Qualifying Event" means the occurrence of an event that permits individuals to join a group health plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying Events are defined by the employer's health plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"State" means the State of Oklahoma, acting by and through the Oklahoma Health Care Authority or its designee.

"TPA" means the Third Party Administrator.

"Third Party Administrator" means the entity contracted by the State to provide the administration of the Oklahoma Employer and Employee Partnership for Insurance Coverage program.

317:45-3-1. Carrier eligibility

Carriers must file a quarterly financial statement with the Oklahoma Insurance Department and submit requested information to OHCA for each health plan to be considered for qualification.



317:45-3-2. Audits

Carriers are subject to audits related to health plan qualifications. These audits may be conducted periodically to determine if Qualified Health Plans continue to meet all requirements as defined in OAC 317:45-5-1.



317:45-5-1. Qualified Health Plan requirements

(a) Qualified Health Plans participating in O-EPIC must offer, at a minimum, benefits that include:

- (1) hospital services;
- (2) physician services;
- (3) clinical laboratory and radiology;
- (4) pharmacy; and
- (5) office visits.

(b) The health plan, if required, must be approved by the Oklahoma Department of Insurance for participation in the Oklahoma market. All health 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 health plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits described in this subsection.

- (1) An annual out-of-pocket maximum cannot exceed \$3,000 per individual. This amount includes any individual, annual deductible amount, except for pharmacy.
- (2) Office visits cannot require a co-payment exceeding \$50 per visit.
- (3) Annual pharmacy deductibles cannot exceed \$500 per individual.

(c) Qualified Health Plans may provide an Explanation of Benefits (EOB) for paid or denied claims subject to member co-insurance or member deductible calculations. If an EOB is provided it 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); and

(6) amount due from the patient or responsible party.

317:45-5-2. Closure criteria for health plans

Eligibility for the Carrier's health plans ends when:

(1) changes to the design or benefits of the Qualified Health Plan such that it no longer meets O-EPIC requirements for Qualified Health Plans. Carriers are required to report to OHCA any changes in health plans potentially affecting its qualification for participation in the O-EPIC program not less than 90 days prior to the effective date of such change(s).

(2) the Carrier no longer meets the definition set forth in OAC 317:45-1-3.

(3) the health plan is no longer an available product in the Oklahoma market.

(4) the health plan fails to meet or comply with all requirements for a Qualified Health Plan as defined OAC 317:45-5-1.



**317:45-7-1. Employer application and eligibility requirements for O-EPIC**

(a) In order for an employer to be eligible to participate in the O-EPIC program the employer must:

(1) have no more than a total of 25 employees on its payroll, including those working at the corporate level and within all subsidiaries.

(A) Subsidiaries are defined as:

(i) a company effectively controlled by another or associated with others under common ownership or control; or

(ii) two or more employers sharing common ownership, management, or control, all for the purpose of achieving a common business interest.

(B) The number of employees is determined based on the third month employee count of the most recently filed OES-3 form with the Oklahoma Employment Security Commission (OESC) and that is in compliance with all requirements of the OESC;

(2) have a business that is physically located in Oklahoma;

(3) be currently offering or contracted to offer within 30 calendar days an O-EPIC Qualified Health Plan;

(4) offer Qualified Health Plan coverage to employees in accordance with Oklahoma Small Business Statutes, Oklahoma Department of Insurance, and all other regulatory agencies;

(5) contribute a minimum 25 percent of the eligible employee monthly health plan premium;

(b) An employer who meets all requirements listed in subsection (a) of this Section must complete and submit an employer enrollment packet to the TPA.

(c) The employer must provide its Federal Employee Identification Number (FEIN).

(d) The employer must notify the TPA, within 5 working days from occurrence, of any changes in an employee's employment status.

**317:45-7-2. Employer eligibility determination**

Eligibility for employers is determined by the TPA using the eligibility requirements listed in OAC 317:45-7-1. An employer determined eligible for O-EPIC is approved for a 12 month period. The eligibility period begins on the first day of the month following the date of approval. The TPA notifies the employer of the eligibility decision for employer and employees.



317:45-7-3. Employer cost sharing

Employers are responsible for a portion of the eligible employee's monthly health plan premium as defined in OAC 317:45-7-1. Employers are not required to contribute to an eligible spouse's coverage.



317:45-7-4. Qualifying Event

Employers must allow an employee to enroll or change coverage following a Qualifying Event. The employer files form OEPIC-4, Small Business Employer Change Form, with the TPA for that employee experiencing the Qualifying Event.



317:45-7-5. Reimbursement

In order to receive a premium subsidy, the employer must submit the current health plan invoice to the TPA via electronic submission, fax or mail.



317:45-7-6. Credits and adjustments

When an overpayment has occurred, the employer must immediately refund the TPA, by check, to the attention of the Finance Division.

The TPA system has the capability of automatic credits and debits.

When an erroneous payment occurs, that results in an overpayment, an automatic recoupment is made to the employer's account against monies owed to the employer on behalf of their employee(s).



317:45-7-7. Audits

Employers are subject to audits related to eligibility status and subsidy payments. Eligibility may be revoked at any time if inconsistencies are found. Any monies paid in error are subject to recoupment.



317:45-7-8. Closure

Eligibility provided under the O-EPIC program ends during the eligibility period when:

(1) the employer terminates its contract with all Qualified Health Plan;

(2) the employer fails to pay premiums to the Carrier;

(3) the employer fails to provide an invoice verifying the monthly health plan premium has been paid;

(4) an audit indicates a discrepancy that makes the employer ineligible;

(5) the employer no longer has a business location in Oklahoma;

(6) the Qualified Health Plan or Carrier no longer qualifies for O-EPIC; or

(7) the employer's eligibility period ends and is not renewed.



317:45-9-1. Employee eligibility requirements

(a) Employee premium assistance applications are made with the TPA. Employees of an O-EPIC eligible employer must apply within 30 days from the date the employer is approved for O-EPIC or within 30 days from the date they are hired to work for a participating employer. Employees may also apply during the employer's health plan open enrollment period.

(b) The TPA electronically submits the application to the Oklahoma Department of Human Services (OKDHS) for a determination of eligibility. The eligibility determination is processed within 30 days from the date the application is received by the TPA. The employee is notified in writing of the eligibility decision.

(c) All O-EPIC eligible employees described in this Section are enrolled through their Employer Sponsored Health Plan (ESHP). Employees eligible for O-EPIC must:

(1) have a household income at or below 185% of the Federal Poverty Level;

(2) be US citizens or aliens as described in OAC 317:35-5-27;

(3) be Oklahoma residents;

(4) provide his/her social security number;

(5) be otherwise ineligible for Medicaid/Medicare;

(6) be employed with a qualified employer at a business location in Oklahoma;

(7) be age 19 or older;

(8) be eligible for enrollment in the employer's Qualified Health Plan;

(9) be working for employers (if multiple) who all meet the eligible employer guidelines;

(10) select one of the Qualified Health Plans the employer is offering; and

(11) make application within 30 days of the employer being approved or have a Qualifying Event.

(d) An employee's spouse is eligible for O-EPIC if:

(1) the employer's health plan includes coverage for spouses;

(2) the employee is eligible for O-EPIC;

(3) if employed, the spouse's employer meets O-EPIC employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and

(4) the spouse is enrolled in the same health plan as the employee.

(e) If an employee or spouse is eligible for multiple O-EPIC Qualified Health Plans, each may receive a subsidy under only one health plan.

317:45-9-2. Employee eligibility period

(a) Employee eligibility is contingent upon the employer's program eligibility.

(b) The employee's eligibility is determined by the TPA using the eligibility requirements listed in OAC 317:45-9-1.

(c) If the employee is determined eligible for O-EPIC, he/she is approved for a period not greater than 12 months. The length of the eligibility period is based on the remaining number of months the employer has left in its eligibility period.

(d) The employee's eligibility period begins on the first day of the month following the date of approval.



317:45-9-3. Qualifying Event

(a) Employees are allowed 30 calendar days to apply for O-EPIC following a Qualifying Event.

(b) An employee's spouse may become eligible for coverage and is allowed 30 calendar days to apply for O-EPIC following a Qualifying Event of the employee or spouse.



317:45-9-4. Employee cost sharing

Employees are responsible for up to 15% percent of their health plan premium. The employees are also responsible for up to 15% of their spouse's health plan premium if the spouse is included in the program. The combined portion of the employee's cost sharing for health plan premiums cannot exceed three percent of his/her gross annual household income computed monthly.



317:45-9-5. Reimbursement for out-of-pocket medical expenses

(a) Employees are responsible for all out-of-pocket expenses. Out-of-pocket expenses for services covered by the health plan, as defined by the health plan's benefit summary and policies, that exceed 5% of the employee's gross annual household income during the current eligibility period may be reimbursable.

(b) The employee must submit a reimbursement claim form with appropriate documentation to the TPA. Information may be submitted at any time but no later than 90 days after the close of their eligibility period. Appropriate supporting documentation includes an original EOB or paid receipt. Both EOB and paid receipts must include required information listed in OAC 317:45-5-1(c)(1)-(6). Reimbursement for out-of-pocket medical expenses is made for the amount indicated as the member's responsibility on the EOB or receipt reflecting the amount paid for medical expenses, including prescribed prescriptions.

(c) Reimbursement for qualified medical expenses are subject to a fixed cap amount. The fixed cap for reimbursement is established annually and is calculated using local and national data concerning individual out-of-pocket health care expenses. The objective of the fixed cap is to set the amount high enough such that, in the great majority of households, all of the costs above the 5% threshold would be absorbed.



317:45-9-6. Audits

Individuals participating in the O-EPIC program are subject to audits related to their eligibility, subsidy payments, and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.



317:45-9-7. Closure

(a) Employer and employees eligibility are tied together. If the employer no longer meets the requirements for O-EPIC then eligibility for the associated employees enrolled under that employer are also ineligible. Employees are mailed a written notice 10 days prior to closure of eligibility.

(b) The employee's certification period may be terminated when:

(1) termination of employment, either voluntary or involuntary, occurs;

(2) the employee moves out-of-state;

(3) the covered employee dies;

(4) the employer ends its contract with the Qualified Health Plan;

(5) the employer's eligibility ends;

(6) an audit indicates a discrepancy that makes the employee or employer ineligible;

(7) the employer is terminated from O-EPIC;

(8) the employer fails to pay the premium;

(9) the Qualified Health Plan or Carrier is no longer qualified;

(10) the employee becomes eligible for Medicaid/Medicare;

(11) the employee or employer reports to the OHCA or the TPA any change affecting eligibility; or

(12) the employee is no longer listed as a covered person on the employer's health plan invoice.



**317:45-9-8. Appeals**

(a) Employee appeal procedures based on denial of eligibility due to income are described at OAC 317:2-1-2.

(b) Employee appeals regarding out-of-pocket expenses are made to the TPA. If the employee disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final.