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## **HUB CREDENTIALING TEAM**

### 8 HOUR ADVANCED HUB COURSE OUTLINE

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### **SOONERCARE**

1. What is SoonerCare and who qualifies?
2. Highlight all programs under the SoonerCare umbrella.
3. Application Process
4. What does SoonerCare cover?
5. Schedule of Benefits
6. Plan Design?
7. Network of Providers?
8. When is the individual eligible/effective?
9. How long does the coverage last?

### **INSURE OKLAHOMA**

#### **Employer Sponsored Insurance---Insure Oklahoma**

1. Website: [www.insureoklahoma.org](http://www.insureoklahoma.org)
2. Provide Oklahoma Health Care Authority and EDS contact information, and whom you go to for what types of questions. 1-888-365-3742 option
3. Explanation of what constitutes a qualified health plan and who qualifies.
  - a. Changes—new carriers, new plans, changes in QHP Numbers and How to deal with dual network plans.
4. Explanation of FPL (federal poverty level) and how this fits with Sooner Care.
3. How to calculate percentages for each entity,
  - a. Important that for talking and planning to use 60/25/15% and that the employee contribution share will vary by employee upon on-line enrollment. The maximum they can be charged is 15% and if the ER takes a full 15% as a payroll deduction and their approval letter states 10% - then the ER owes the employee a refund due to over contribution.

4. Employee eligibility and annual re-approval process for Insure OK subsidy. Income requirements apply.
5. The timing and coordination of getting the Group Medical Plan approved, the employer doing the application and when the employees do their applications. The agent must understand what needs to be done in what order.
6. QHP requirements: only the plans on the website can be sold/implemented; not plans an agent may think meets the QHP requirements.
7. How to make changes for terms and adds.
  - a. Teach the group contact to submit monthly New Hires and Terminated Employees by using the Small Business Change Form (from the website).
  - b. Add new Hires in order to get their PINs to enroll and remove terminated employees from their former ER roster so they can re-enroll in their new ER's plan (if they have IO).
8. Ongoing Employer administration of the subsidy program
  - a. Fax the entire monthly medical insurance bill to EDS.
  - b. Premium subsidy payment will not be made if bill is not submitted.
  - c. Employer must pay the total monthly health plan invoice to the health plan carrier on time.
  - d. ER cannot take credits on bills for terminated employees.
  - e. If the invoice shows prior outstanding balances, subsidy payments may be delayed.
  - f. The first subsidy payment is typically made with a paper check.
  - g. All subsequent payments are electronic deposits into the Employers' accounts.
  - h. Employer Change Form is required for a number of items. The most common use is adding and deleting employees, even if the employer is not receiving premium subsidy.
    - i. The bill from the carrier must match the staff listing at Insure Oklahoma.
    - ii. Premium payments will not be made if the Insure Oklahoma list of employees does not match the carrier billing.
    - iii. EDS reconciles the medical plan billing against the staff listing provided by the employer.
9. Reimbursement
  - a. How it works and how long it lasts
  - b. ESI is only reimbursed after the ER is approved, employees enrolled and approved and the carrier monthly invoice is received.
  - c. Payout is made only when the invoiced rates match the system built rates submitted with the ER paperwork.
10. Insure OK subsidy is for employees, spouses, full time college students and out-of-pocket expenses.
11. Children are not eligible for subsidy. The children of parents who qualify for subsidy will typically be eligible for Soonercare.

12. Employee/Spouse enrollment must match on invoice and Insure Oklahoma application. If employee and spouse are listed as separate on invoice, they must have applied separately for subsidy. If applying separately, they still need to report all income for each person.
13. Income Requirements apply and are designed for people with incomes of 200% or less of the federal poverty level. Income levels vary based on the size of the family and if anyone is self employed.
14. Insure Oklahoma will reimburse for out-of-pocket expenses upon receipt of the proper forms and once the family has spent 5% of their annual gross household income.
15. College student coverage
16. Expansions and plans for the future

### **Individual Insure Oklahoma**

1. Agents do not sell this plan. It is available directly to the public via the OHCA.
2. Eligibility Requirements
3. Income Requirements apply and are designed for people with family incomes of 200% or less of the federal poverty level. Income levels vary based on the size of the family and if anyone is self employed.
4. Premium is capped at 4% of the monthly gross household income
5. Basic benefits are available with copays. Not a comprehensive plan.
6. College student coverage
7. No medical underwriting
8. Agents can use this plan as a service to offer if the prospect is not economically able or medically able to have an individual policy written. The agent can give the prospect the brochure or 1-888 number to contact (OHCA) Oklahoma Health Care Authority.

### **HIGH RISK POOL**

1. Discuss what the Risk Pool is and why it's available.
2. [www.okhrp.org](http://www.okhrp.org)
3. Provide TPA contact information.
4. Who is eligible?
5. The criteria to be eligible to apply
6. Plan designs and premiums
7. Underwriting Paperwork
8. Provide application and submission information
9. Agent Compensation

## GROUP

### Groups of 2-50 Employees – Comprehensive Major Medical

1. Definition of a small employer group of 2-50 lives. The Carriers typically use the OK State Quarterly Wage and Contribution Report (OES-3) information to determine what size the group is. Employee Eligibility: Number of hours an employee must work to be eligible. Discuss 24 hour per week requirement versus the newly passed hourly requirement law.
2. Educate agents on Small Group Reform regulations, some of which are listed below.
3. Management carve-outs, or not making the plan available to all employees if they work the minimum amount of hours to be eligible, is not allowed on 2-50 sized groups.
4. 24 hour coverage for owners, officers and partners. Some carriers charge for this and others include it in their rates. If the carrier charges premium for this benefit and the employer elects to not buy the option, work related claims are not covered.
5. Terminating current coverage: some carriers allow the employer to cancel during the grace period. Others require termination notification prior to the termination date. This varies by carrier.
6. New Policy Rates
  - a. Rates are subject to limitation set out in small group reform legislation. Restrictions set out in state law.
  - b. Explain pooling and how rates are generated by demographics, location, industry, etc. Then medical load added after manual rate generated.
7. Renewal Policy Rates
  - a. Rates are subject to limitation set out in small group reform legislation. Restrictions set out in state law.
  - b. Explain pooling and how rates are generated by demographics, location, industry, etc. Then medical load added after manual rate generated.
8. ERISA
9. TEFRA – Federal Maternity Law for 15+ lives. Employer can self-fund maternity claims if the group doesn't buy maternity covered as any other illness on the medical plan. Include the definition of whether or not the 15 lives includes part time employees.
10. Eligibility of Husband and Wife Groups
11. State and Federal laws for small groups
12. Explain Pooling and how rates are generated by demographics, location, industry, etc. Then medical load added after manual rate generated.
13. Explain RFP submission to carriers
14. State benefit mandates

15. Direct to carrier vs. through an agent
16. Make sure you know your carrier information. Don't misquote. Take carrier out if you have to.

### **Groups 51+ Employees**

1. Carve-outs and writing by class are allowed as long as the class definitions are non-discriminatory. Example: Writing only Owners and Management Only is allowed, and excluding all other employees is acceptable.
2. There is no maximum medical load limitation.
3. Groups can be declined if the carrier does not want to offer coverage due to medical history.
4. Medical history may be underwritten a variety of ways: fully underwritten, simplified issue, Employer Application questions, claims and shock loss experience, or a combination thereof.
5. ERISA
6. TEFRA – Federal Maternity Law for 15+ lives. Employer can self-fund maternity claims if the group doesn't buy maternity covered as any other illness on their medical plan. Include the definition of whether or not the 15 lives includes part time employees.

### **Health Savings Account Medical Plan – Group and Individual Both**

1. This is a website from the IRS and SBA to educate people about HSA's. [www.sba.gov/hsa](http://www.sba.gov/hsa)
2. High deductible concept with minimum deductibles for individual and families
3. Limited amount of out-of-pocket allowed
4. Benefits not allowed: first dollar benefits such as doctor copays and drug cards with copays until deductible is met.
5. Optional benefits allowed: supplemental accident benefit and wellness/preventative.
6. The client can open a Health Savings Account with a bank or institution that is approved to offer them. The insured must have a qualified HSA plan approved before opening an HSA bank account.
  - a. Insured can deposit tax free money into the account to be used for IRS approved medical expenses, up to the annual limit allowed by the IRS.
  - b. People age 55 and above can deposit additional funds into their HSA accounts, over and above the amount allowed for people under 55. There is an annual limit on this "catch up" funding.
  - c. If it's an employer-based plan and the employer has a Section 125 or Premium Only Plan in place, the employee can deposit money into the account pre-tax through payroll deduction. This saves the

employer and the employee a tremendous amount of federal FICA/Medicare taxes.

### **Group Limited Medical Plans**

1. Limited medical plans are available for groups of 2 or more employees.
2. It is not comprehensive major medical coverage.
3. The benefits are limited by dollar amount payable and the types of covered services.
4. Some plan designs are a defined benefit. Example: go to doctor and plan pays the insured \$50, regardless of what the actual charge is.
5. Underwriting is typically guaranteed issue.
6. Priced lower than comprehensive major medical plans.
7. Type of groups buying this type of plan
  - a. Firms who do not have medical coverage now
  - b. Firms who can no longer afford to offer a comprehensive medical plan.
  - c. Firms who have low wage employees and want to offer that class of employees some type of coverage. Nursing homes, restaurants, fast food restaurants, etc.
8. If a group moves from a limited benefit plan to a group comprehensive medical plan new group carrier must determine if creditable coverage is applicable.

### **Group Medicare Supplement Plans**

1. Available to groups sizes 2-19 lives only for active employees and their dependents that are age 65 or older. Premiums are billed to the employer.
2. Available to age 65 or older retirees only on groups of 20 or more. These folks have their premiums billed directly to each retiree, not through the employer.
3. This plan becomes the medical plan for all employees and their dependents age 65 or older. The employer contributes the same percentage of premium like they do for the employees under age 65.
4. For groups of 2-19, Medicare is primary and the Group Medicare Supplement is secondary.
5. Having the option to provide Group Medicare Supplement plans to these employees removes the potential for discrimination if the employees drop the group plan and go to an individual Medicare supplement plan and Part D plan because the employer or agent suggested they do.

## **INDIVIDUAL PLANS**

## **Comprehensive Individual Major Medical Plans**

1. Contracts can be filed on an individual or as an association group plan. Individual policies have free look period, whereas association group plans typically do not have a free look period.
2. Benefits include all OK state mandates. Educate agents on what they are and how they work (i.e. if ded, copay or coinsurance apply, or if it's a 100% first dollar benefit, and if there is a maximum benefit amount).
3. Typically they are fully underwritten to determine if the offer is a preferred or standard rate, a rate up, a condition specific exclusion rider, condition specific deductible, or decline.
4. Oklahoma Confirmation of Source of Payment: Employer cannot pay any portion of the premium. Client signs on the application or separate form stating this, and premium reimbursement cannot happen through payroll reimbursement.
5. How should an agent handle the Oklahoma Confirmation of Source of Payment requirements when the current carrier is not enforcing it? It's a delicate subject an agent runs into when working with clients.
6. Confirmation of Sole Employee Entity for sole proprietors. Form is required when a sole proprietor writes a business check for the premium. Discuss how this is different than the OK Confirmation of Source of Payment for employees.
7. List billing allowed through an employer, but only if the employer is payroll deducting 100% of the premiums from the employees' paychecks. The employer is not allowed to contribute any part of the premium.
8. HIPAA Eligibility and how it works
9. There is no creditable coverage when moving from group coverage to individual coverage
10. Time frames for pre-existing condition clauses vary by carrier. Medical history revealed on the application and not excluded may or may not be covered during the pre-ex period; it varies by carrier.
11. Applicant and Dependent Eligibility
12. 24 hour coverage for owners, officers and partners. Some carriers charge for this benefit and others include it in their rate. If the carrier charges premium for this benefit and the applicant elects to not buy the option, work related claims are not covered.

## **Limited Individual Medical Plans** (also applies to group)

1. It is not comprehensive major medical coverage.
2. The benefits are limited by dollar amount payable and the types of covered services.
3. Some plan designs are a defined benefit. Example: go to doctor and plan pays the insured \$50, regardless of what the actual charge is.

4. Underwriting is typically guaranteed issue or simplified issue; varies by type of plan and carrier.
5. Priced lower than comprehensive major medical plans.
6. If someone moves from an individual limited benefit plan to a group medical plan, new group carrier must determine if creditable coverage is applicable.

### **Short Term Medical Plans**

1. Medical plans designed for people with a temporary need for medical insurance. Examples:
  - a. Employees in their waiting periods
  - b. COBRA alternative
  - c. People between jobs
  - d. People who cannot afford anything else and want some type of coverage
  - e. People age 64 who don't want to go through full medical underwriting with a permanent policy and need something until they go on Medicare.
  - f. Students and college graduates
2. Benefits can be comprehensive or limited; it varies by carrier.
3. Prescription Drugs are typically either not covered or a discount Rx card only.
4. Limited underwriting. It is underwritten off the application without telephone interviews, medical records or exams.
5. Less expensive than a comprehensive major medical plan
6. Agents need to tell applicants that it is a temporary plan. Coverage is typically for either a pre-set time frame from 30 – 365 day or paid for by the month for 6 or 12 months. Limited rewrite typical.
7. Pre-existing conditions' definitions by carrier. Claims are reviewed for preexisting.
8. Typically the carrier provides access to a PPO network for discounts, but the insured can typically use any provider without being penalized.
9. If someone moves from a comprehensive Short Term Medical plan to a group medical plan, is creditable coverage.

### **Medicare**

1. Plans available to beneficiaries: Medicare A & B, Medicare Advantage, Part D and Individual and Group Medicare Supplements, and in general terms the differences between these products.
2. Part A
3. Part B
4. Medicare Advantage Plans
  - a. Product and marketing regulations are under CMS jurisdiction.

- b. Initial 8 hour CE course with 4 hour biannual CE course required to sell these products.
  - c. Annual certification courses required for each carrier for each product being sold, which includes marketing regulations is required for all agents selling MA products.
  - d. Product types available: HMO, Private Fee for Service (PFFS), PPO and POS
  - e. General differences in the products
  - f. Underwriting: GI except if person has ESRD and must have Part A & B.
  - g. General Plan designs: no deductibles, have copays and coinsurance. Some plans have maximum out-of-pocket expenses, but not all.
  - h. Pre-existing conditions covered
  - i. Open enrollment (ICEP, AEP and OEP)
  - j. Lock In
  - k. Special Election Periods (SEP's)
  - l. General marketing regulations
  - m. Standardized commissions
5. Part D Plans
- a. Product and marketing regulations are under CMS jurisdiction.
  - b. 8 and 4 hour CE course requirement does not apply to selling Part D.
  - c. Annual certification courses required for each carrier for each product being sold, which includes marketing regulations is required for all agents selling Part D products
  - d. Eligibility for over and under 65 and Part A and/or B requirement
  - e. Penalty for not enrolling
  - f. No medical underwriting
  - g. Pre-existing conditions covered
  - h. Standardized plan design from the Feds, and what the general plan variances are in the market place.
  - i. Formulary lists
  - j. Open enrollment (ICEP and AEP)
  - k. Lock in
  - l. SEP's
  - m. General marketing regulations
6. Standardized Medicare Supplement Plans
- a. Standardized Plans
  - b. Initial open enrollment time frame
  - c. Commissions

## ETHICS

1. Definition of Ethics

2. Why ethics are important.
3. Be honest; tell your client what you know to help make the best decision based on the information provided.
4. Don't do anything that might be fraudulent or put your license in jeopardy.
5. Don't advise on anything you don't know the answer.
6. Don't guess; always ask questions.
7. Be respectful, have integrity and do your job with pride.
8. Importance of following code of ethics
9. Relationship between Insured, Broker and Insurer
10. Morality – concepts of right and wrong behaviors
11. Prudent person "law"
13. Make sure you know your carrier information. Don't misquote.
14. Replacement process- Never have an individual or group client terminate the current coverage prior to receiving notification that the new plan is approved.
15. The agent must put the needs of the client above his or her own need to make the sale.
16. Doing what's right for the client is the #1 priority.
17. You will be rewarded in other ways by doing the right thing for the client.
18. Understanding all of the options available to the client is important so the client can make an informed decision on what is best for the client the situation and budget.
17. HIPAA Basics
  - a. Portability-creditable coverage
  - b. Privacy
  - c. Data Security

## **COBRA/STATE CONTINUATION**

1. What is COBRA?
2. What is state continuation? If not Cobra, state law continuation
3. Explanation of laws
4. Difference between the two options
5. Eligibility for each option
6. Definition of 20 employees under federal law (COBRA)
7. How does each one work for groups under 20 versus over 20 employees?
8. Application process
9. Time limitations for applying
10. How they are administered?
11. Who regulates each?
12. Length of time for coverage continuance for each employee or dependent
13. If answering any questions regarding COBRA his or her agent should preface that the client should be seeking answers from the attorney.
14. New ARRA regulations
15. State continuation regulations.

## HIPAA

1. HIPAA Portability
2. Definition of Pre-existing condition
3. Pre-ex
  - a. Duration
  - b. Look back period
  - c. Genetics
  - d. Pregnancy
  - e. HMO's do not have Pre-ex if they are federally qualified
  - f. Creditable coverage defined
  - g. Calculating coverage
  - h. Break in coverage
  - i. Waiting periods
4. Limits on Pre-ex exclusions
5. Providing certification
6. Special enrollment provisions
7. Non-discrimination and eligibility
8. Guaranteed availability and renewability
9. HIPAA Privacy
  - a. Protected health info
  - b. Uses and disclosures
  - c. Authorization and consent
  - d. Administrative requirements
  - e. Security and Privacy, including the four security processes

## HUB WEBSITE

1. Matrix of every carrier offering every type of product; carriers will offer their plans to HUB for certification; if certified, will be listed on the web site,
  - i.e. Small Group would show BCBS, Aetna, Coventry, Community Care, Principal, PacifiCare, United Healthcare and so on. Individuals would show their carriers and contact information. Sooner Care and High Risk Pool would be listed under the individual. Insure OK could be listed both under group and individual.
2. How to become a qualified/certified
3. List of qualified/certified agents and how to find the agent list on the website
4. The HUB website is for whom?
5. What will be available on the website?
6. Application Process
7. Online applications

## GENERAL HUB LEGISLATION

1. Review of the law
2. Purpose of legislation
3. Who regulates the HUB?
4. Agents must be certified to solicit and sell the HUB plans.
5. How to become a qualified agent?
6. Through HUB, insurers can offer a “standard health benefit plan” that offers some or no state mandate benefits, so the premiums will be less expensive.
7. “Standard health benefit plan” will be available to applicants under age 40.
8. Carriers will make and price HUB plans for agents to sell.
9. Agents will be paid commissions by the carriers to sell HUB plans.
10. HUB website will educate agents, consumers and providers about the HUB program.
11. Target market is Oklahomans in the 200 – 400% federal poverty level income bracket.

## MOTIVATION

1. The reason we do what we do in selling insurance is ultimately to help people. Any time we sell a product we get paid. There should be no motivation other than we have dedicated our lives to educating the public about insurance. This program/portal/HUB is another mechanism to help us become better at what we do and to help more people. What more do we need?
2. Marketing to consumers regarding the cost of the uninsured and what the HUB can do for them
3. Cost saving plans for those that qualify
4. Advise those interested to contact an agent
5. Agent certification will educate agents more thoroughly about the variety of benefits available to individuals and groups in today’s market.
6. Certified Agents will be able to write and earn commissions selling the HUB plans.
7. Certified Agents will get their names and contact information posted on the HUB website so they can get leads.
8. The HUB Professional Designation shows they specialize in the field of health insurance, which gives them more credibility with clients.
9. Promoting lower health insurance premiums with HUB will be important. Cost is the major factor in why people go uninsured.
10. Having Providers refer people to HUB for insurance is a great idea; this way they can get exposed to the various options out there by an agent.

