ENGROSSED HOUSE
BILL NO. 2842

By: Steele, Balkman, Cox, Denney, DeWitt, Terrill and Worthen of the House

and

Crain of the Senate

An Act relating to public health and safety; creating the Oklahoma Medicaid Reform Act of 2006; providing powers, duties, and responsibilities of the Oklahoma Health Care Authority under the program; requiring the Health Care Authority to submit any waivers to the Legislature for approval before implementation; allowing the Health Care Authority to develop rules; requiring the Health Care Authority to contract for electronic records for Medicaid providers; authorizing the Oklahoma Health Care Authority to provide programs for personal health accounts, disease management, and alternatives for long-term care; authorizing the Oklahoma Health Care Authority to establish an incentivizing reimbursement program for nursing homes; specifying certain duties of the Oklahoma Health Care Authority; making appropriation to the Oklahoma Health Care Authority; stating purpose; amending 63 O.S. 2001, Section 1-1925.2, as last amended by Section 1, Chapter 216, O.S.L. 2005 (63 O.S. Supp. 2005, Section 1-1925.2), which relates to minimum standards for facilities; terminating the Oklahoma Nursing Facility Funding Advisory Committee upon certain condition; amending 36 O.S. 2001, Section 6060, as amended by Section 1, Chapter 78, O.S.L. 2002 (36 O.S. Supp. 2005, Section 6060), which relates to mammography screening; limiting certain coverage; amending 36 O.S. 2001, Section 6060.1, which relates to bone density testing; limiting certain coverage; amending 36 O.S. 2001, Section 6060.2, which relates to treatment of diabetes; limiting certain coverage; amending 36 O.S. 2001, Section 6060.3, as amended by Section 5, Chapter 464, O.S.L. 2003 (36 O.S. Supp. 2005, Section 6060.3), which relates to maternity benefits; limiting certain coverage; amending Section 1, Chapter 397, O.S.L. 2004 (36 O.S. Supp. 2005, Section 6060.3a), which relates to annual examinations; limiting certain coverage; amending 36 O.S. 2001, Section 6060.4, as amended by Section 6, Chapter 464, O.S.L. 2003 (36 O.S. Supp. 2005, Section 6060.4), which relates to child immunization; limiting certain coverage; amending 36 O.S. 2001, Section 6060.5, as amended by Section 7, Chapter 464, O.S.L. 2003 (36 O.S. Supp. 2005, Section 6060.5), which relates to the Oklahoma Breast Cancer Patient Protection Act; limiting certain coverage; amending 36 O.S. 2001, Section 6060.6, which relates to dental procedures; limiting certain coverage; amending 36 O.S. 2001, Section 6060.7, as amended by Section 1, Chapter 30, O.S.L.

2002 (36 O.S. Supp. 2005, Section 6060.7), which relates to audiological services; limiting certain coverage; amending 36 O.S. 2001, Section 6060.8, as amended by Section 8, Chapter 464, O.S.L. 2003 (36 O.S. Supp. 2005, Section 6060.8), which relates to prostate cancer; limiting certain coverage; amending 36 O.S. 2001, Section 6060.8a, which relates to colorectal cancer; limiting certain coverage; amending 36 O.S. 2001, Section 6060.9, which relates to wigs; exempting certain program; amending 36 O.S. 2001, Section 6060.10, which relates to definitions; limiting certain coverage; amending 36 O.S. 2001, Section 6060.11, which relates to mental illness; limiting certain coverage; providing for codification; providing for noncodification; and providing an effective date.

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

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.1 of Title 56, unless there is created a duplication in numbering, reads as follows:

Sections 1 through 12 of this act shall be known and cited as the "Oklahoma Medicaid Reform Act of 2006".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.2 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Health Care Authority is authorized to seek waivers to create a statewide program to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Oklahoma Medicaid Program.

B. Phase one of the Program shall be implemented within a contiguous area of the state with rural and urban characteristics. The Oklahoma Health Care Authority shall evaluate and expand the Program within two (2) years after the rural and urban Program becomes operational. It is the intent of the Legislature that components of the Program be phased in across the state within five (5) years from the time the Oklahoma Medicaid Reform Act of 2006 becomes law.

C. Upon completion of an evaluation by the Oklahoma Health Care Authority, the Oklahoma Health Care Authority shall request a waiver for statewide expansion of the Program from the Centers for Medicare and Medicaid Services.

D. The purpose of the Oklahoma Medicaid Reform Act of 2006 is to:

1. Provide Medicaid recipients more options in the selection of a health care plan that meets the needs of recipients and allows recipients to exercise greater control over the medical care that recipients receive;

2. Stabilize Medicaid expenditures in the Program areas compared to Medicaid expenditures in the test areas for the three (3) years preceding implementation of the Program, while ensuring:

a. consumer education and choice,

b. access to medically necessary services,

c. coordination of preventative, acute and long-term care services, and

d. reductions in unnecessary service utilization;

3. Provide an opportunity to evaluate the progress of statewide implementation of the Oklahoma Medicaid Reform Act of 2006 as a replacement for the current Medicaid system; and

4. Introduce competition as a factor that drives the cost of the Program.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.3 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Health Care Authority shall have the following powers, duties, and responsibilities with respect to the development of the Program established in Section 2 of this act:

1. To develop a system to encourage and allow commercial insurers to offer varying benefit packages to include federally mandated services;

2. To develop an average cost, or actuarially sound cost, per beneficiary within different age groups and other relevant categories including health status to provide medically necessary services which may be separated to cover comprehensive care, enhanced services, and catastrophic care. This cost would be converted into a credit or instrument of value;

3. In conjunction with the Oklahoma Insurance Department, to determine Program standards and credentialing requirements for commercial insurers to participate in the Program;

4. To develop a system to ensure that there is record of recipient acknowledgment that choice counseling has been provided;

5. To develop a choice counseling system to ensure that the choice counseling process and related material are designed to provide counseling through face-to-face interaction, by telephone, and in writing and through other forms of relevant media. Materials shall be written at the sixth-grade reading level and available in a language other than English when five percent (5%) of the county speaks a language other than English. Choice counseling shall also use language lines and other services for impaired recipients, such as TTD/TTY;

6. To develop a system that prohibits health plan providers, representatives of health plan providers, and providers employed by or contracted with the health plan providers from recruiting persons eligible for or enrolled in Medicaid, from providing inducements to Medicaid recipients to select a particular health plan, and from prejudicing Medicaid recipients against other health plans. The system shall require the entity performing choice counseling to determine if the recipient has made a choice of a plan or has opted out because of duress, threats, payment to the recipient, or incentives promised to the recipient by a third party. If the choice counseling entity determines that the decision to choose a plan was unlawfully influenced, the choice counseling entity shall

immediately report the violation to the Oklahoma Health Care Authority. Verification of choice counseling by the recipient shall include a stipulation that the recipient acknowledges the provisions of this paragraph;

7. To develop a choice counseling system that promotes health literacy and includes an educational component that is intended to promote proper utilization of the health care system;

8. To develop a system to monitor the provision of health care services in the Program, including utilization and quality of health care services for the purpose of ensuring access to medically necessary services. This system shall include an encounter data information system that collects and reports utilization information. The system shall include a method for verifying data integrity within the database and within the medical records of the provider;

9. To develop a grievance-resolution process for Medicaid recipients enrolled in a health plan credentialed pursuant to this section. This process shall include a mechanism for an expedited review of a grievance if the life of a Medicaid recipient is in imminent and emergent jeopardy;

10. To develop a grievance-resolution process for health care providers employed by or contracted with a health plan credentialed pursuant to this section to settle disputes among the provider and the health plan or the provider and the Oklahoma Health Care Authority;

11. To develop agreements with other state or local governmental programs or institutions for the coordination of health care to eligible individuals receiving services from such programs or institutions;

12. To ensure that the following coverages are made available to recipients in at least one of the credentialed health plans. These coverages need not be included in a single plan:

a. mammography screening, as provided for in Section 6060 of Title 36 of the Oklahoma Statutes,

b. bone density testing, as provided for in Section 6060.1 of Title 36 of the Oklahoma Statutes,

c. supplies and services for the treatment of diabetes, as provided for in Section 6060.2 of Title 36 of the Oklahoma Statutes,

d. certain inpatient hospital maternity benefits, as provided for in Section 6060.3 of Title 36 of the Oklahoma Statutes,

e. annual obstetrical/gynecological examinations, as provided for in Section 6060.3a of Title 36 of the Oklahoma Statutes,

f. child immunizations, as provided for in Section 6060.4 of Title 36 of the Oklahoma Statutes,

g. certain inpatient hospital care following breast cancer treatment, as provided for in Section 6060.5 of Title 36 of the Oklahoma Statutes,

h. administration of anesthesia during dental procedures for certain persons, as provided for in Section 6060.6 of Title 36 of the Oklahoma Statutes,

i. audiological services for children, as provided for in Section 6060.7 of Title 36 of the Oklahoma Statutes,

j. prostate cancer screening, as provided for in Section 6060.8 of Title 36 of the Oklahoma Statutes,

k. colorectal cancer screening, as provided for in Section 6060.8a of Title 36 of the Oklahoma Statutes,

l. wigs and other scalp prostheses following cancer treatment, as provided for in Section 6060.9 of Title 36 of the Oklahoma Statutes, and

m. treatment of severe mental illness, as provided for in Section 6060.11 of Title 36 of the Oklahoma Statutes;

13. To require credentialed health plan providers to make a good-faith effort to execute agreements with school districts regarding the provision of services and execute agreements with county health departments regarding the provision of services to a Medicaid-eligible child. To ensure continuity of care for Medicaid patients, the Oklahoma Health Care Authority, the State Department of Health, and the State Department of Education shall develop procedures for ensuring that a health care provider of a student receives information relating to services provided;

14. To develop a mechanism in which Medicaid recipients in the Program areas shall have a reasonable amount of time in which to select a health plan provider. Those Medicaid recipients who do not make a choice shall be assigned to a health plan provider in accordance with subsection B of this section;

15. To develop a system to allow beneficiaries considered uninsurable by risk-adjusted standards to be covered by the Oklahoma Medicaid Program; and

16. To develop service delivery mechanisms within the health plans that are credentialed pursuant to this subsection to provide Medicaid services to Medicaid-eligible children in foster care. These services must be coordinated with community-based care providers, where available, and be sufficient to meet the medical, developmental, and emotional needs of these children.

B. The Oklahoma Health Care Authority shall apply for federal waivers from the Centers for Medicare and Medicaid Services to allow recipients to purchase health care coverage through an employer-sponsored health insurance plan instead of through a Medicaid-certified plan. This provision shall be known as the opt-out option.

1. A recipient who chooses the Medicaid opt-out option shall have an opportunity for a specified period of time, as authorized under a waiver granted by the Centers for Medicare and Medicaid

Services, to select and enroll in a Medicaid-certified plan. If the recipient remains in the employer-sponsored plan after the specified period, the recipient shall remain in the opt-out program for at least one (1) year or until the recipient no longer has access to employer-sponsored coverage, until the open enrollment period of the employer for a person who opts out in order to participate in employer-sponsored coverage, or until the person is no longer eligible for Medicaid, whichever time period is shorter.

2. Notwithstanding any other provision of this section, coverage, cost sharing, and any other component of employer-sponsored health insurance shall be governed by applicable state and federal laws.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.4 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Health Care Authority shall develop and submit for approval applications for waivers of applicable federal laws and regulations as necessary to implement the provisions of the Oklahoma Medicaid Reform Act of 2006. All waiver applications shall be provided for review and comment to the appropriate committees of the Oklahoma House of Representatives and the State Senate for at least ten (10) working days prior to submission. Copies of all waivers submitted to and approved by the United States Centers for Medicare and Medicaid Services under this section shall be provided to the Legislature within ten (10) days of their approval. The Oklahoma Health Care Authority shall submit a plan containing a recommended timeline for implementation of any waivers and budgetary projections of the effect of the Oklahoma Medicaid Reform Act of 2006 on the total Medicaid budget for the 2007-2008 through 2009-2010 state fiscal years. This implementation plan shall be submitted to the Speaker of the House of Representatives and the President Pro

Tempore of the Senate at the same time copies of waivers are submitted to the Legislature.

B. Upon review and approval of the applications for waivers of applicable federal laws and regulations to implement the provisions of the Oklahoma Medicaid Reform Act of 2006 by the Legislature, the Oklahoma Health Care Authority Board shall promulgate rules necessary to implement and administer the provisions of the Oklahoma Medicaid Reform Act of 2006.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.5 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. By April 1, 2007, the Oklahoma Health Care Authority shall contract with an entity to design a database of clinical utilization information or electronic medical records for Medicaid providers. This system shall be web-based and allow providers to review on a real-time basis the utilization of Medicaid services, including, but not limited to, physician office visits, inpatient and outpatient hospitalizations, laboratory and pathology services, radiological and other imaging services, dental care, and patterns of dispensing prescription drugs in order to coordinate care and identify potential fraud and abuse.

B. The Oklahoma Health Care Authority shall design and implement a system of electronic prescribing, including contracting with specialized vendors as necessary for the successful completion of the system. The system may include, but is not limited to, providing hardware, software, and connectivity for a limited number of prescribers. The prescribers who participate may be given vouchers for hardware, software, and connectivity, or the Oklahoma Health Care Authority may use direct vendor contracts. The system shall:

1. Alert prescribers to patients who fail to refill prescriptions in a timely fashion, are prescribed multiple drugs

that may be redundant or contraindicated, or may have other potential medication problems; and

2. Track spending trends for prescription drugs and deviation from best-practice guidelines.

C. The Oklahoma Health Care Authority shall apply for any federal waivers needed to administer this section.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.6 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Health Care Authority in cooperation with the State Department of Health, a statewide organization of the elderly, and representatives of both statewide associations of nursing facility operators shall develop a graduated reimbursement rate plan for nursing facilities that is based on, but not limited to, the following:

1. Quality of life indicators of the resident;

2. Quality of care indicators;

3. Family satisfaction survey results;

4. State Department of Health survey results;

5. Certified Nurse Aide (“CNA”) absenteeism and turnover rates;

6. CNA training and education requirements;

7. Patient acuity level; and

8. Direct care expenditures.

B. The Oklahoma Health Care Authority is directed to apply for waivers from the Centers for Medicaid and Medicare Services that will accomplish the purpose outlined in subsection A of this section. The Oklahoma Health Care Authority is further directed to negotiate with Centers for Medicaid and Medicare Services to include in the waivers the authority to base provider reimbursement rates for nursing facilities on the criteria specified in subsection A of this section.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.7 of Title 56, unless there is created a duplication in numbering, reads as follows:

The Oklahoma Health Care Authority shall develop a plan to implement a personal health account system for Program recipients. Monies deposited into a personal health account shall only be used by the recipient to defray health-care-related costs including, but not limited to, copayments, noncovered benefits, and wellness initiatives. The Health Care Authority shall promulgate rules guiding personal health account transactions.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.8 of Title 56, unless there is created a duplication in numbering, reads as follows:

The Oklahoma Health Care Authority shall develop a formal program for disease management that shall improve the quality of care for recipients and reduce the cost of care. The program shall include, but not be limited to, asthma, diabetes, congestive heart failure, and depression. The disease management program shall consist of:

1. Claims data analysis;

2. Population selection and targeting;

3. Intervention through educational tools for patients and providers, and treatment guidelines for physicians;

4. Quality measurement of the program structure, performance indicators, and outcomes measures; and

5. Reporting of outcome measure data.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.9 of Title 56, unless there is created a duplication in numbering, reads as follows:

The Oklahoma Health Care Authority shall develop and administer a plan for the implementation of alternatives for long-term care. The plan shall include, but not be limited to:

1. The development and funding of community-based options throughout the State of Oklahoma;

2. The establishment of a cash and counseling program that focuses on increasing personal responsibility, efficiency in utilization, and consumer satisfaction;

3. The establishment of a program providing for state incentives to Oklahoma citizens for long-term care planning; and

4. Stronger private/public partnerships at the community level in order to address unmet patient needs.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.10 of Title 56, unless there is created a duplication in numbering, reads as follows:

The Oklahoma Health Care Authority shall develop and administer a program that will encourage the timely and appropriate use of primary care services in lieu of emergency room utilization. The program shall include, but not be limited to, the implementation of:

1. Educational strategies;

2. Technology-based monitoring; and

3. Copayment structures.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.11 of Title 56, unless there is created a duplication in numbering, reads as follows:

The Oklahoma Health Care Authority shall extend the lookback period for determining long-term care Medicaid eligibility from three (3) to five (5) years.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.12 of Title 56, unless there is created a duplication in numbering, reads as follows:

When funds are available, the Oklahoma Health Care Authority shall expand and improve their programs and methods to deter abuse and reduce errors in Medicaid billing, payment, and eligibility

through the use of technology and accountability measures for the Oklahoma Health Care Authority, providers, and recipients.

SECTION 13. NEW LAW A new section of law not to be codified in the Oklahoma Statutes reads as follows:

There shall hereby be appropriated to the Oklahoma Health Care Authority the sum of Ninety-three Million Dollars ($93,000,000.00), or so much thereof as may be necessary to perform the duties imposed on the Health Care Authority by law, from any monies not otherwise appropriated from the General Revenue Fund of the State Treasury for the fiscal year ending June 30, 2007.

SECTION 14. AMENDATORY 63 O.S. 2001, Section 1-1925.2, as last amended by Section 1, Chapter 216, O.S.L. 2005 (63 O.S. Supp. 2005, Section 1-1925.2), is amended to read as follows:

Section 1-1925.2 A. The Oklahoma Health Care Authority shall fully recalculate and reimburse nursing facilities and intermediate care facilities for ~~the mentally retarded~~ people with mental retardation (ICFs/MR) from the Nursing Facility Quality of Care Fund beginning October 1, 2000, the average actual, audited costs reflected in previously submitted cost reports for the cost-reporting period that began July 1, 1998, and ended June 30, 1999, inflated by the federally published inflationary factors for the two (2) years appropriate to reflect present-day costs at the midpoint of the July 1, 2000, through June 30, 2001, rate year.

1. The recalculations provided for in this subsection shall be consistent for both nursing facilities and intermediate care facilities for ~~the mentally retarded~~ people with mental retardation (ICFs/MR), and shall be calculated in the same manner as has been mutually understood by the long-term care industry and the Oklahoma Health Care Authority.

2. The recalculated reimbursement rate shall be implemented September 1, 2000.

B. 1. From September 1, 2000, through August 31, 2001, all nursing facilities subject to the Nursing Home Care Act, in addition to other state and federal requirements related to the staffing of nursing facilities, shall maintain the following minimum direct-care-staff-to-resident ratios:

a. from 7:00 a.m. to 3:00 p.m., one direct-care staff to every eight residents, or major fraction thereof,

b. from 3:00 p.m. to 11:00 p.m., one direct-care staff to every twelve residents, or major fraction thereof, and

c. from 11:00 p.m. to 7:00 a.m., one direct-care staff to every seventeen residents, or major fraction thereof.

2. From September 1, 2001, through August 31, 2003, nursing facilities subject to the Nursing Home Care Act and intermediate care facilities for the mentally retarded with seventeen or more beds shall maintain, in addition to other state and federal requirements related to the staffing of nursing facilities, the following minimum direct-care-staff-to-resident ratios:

a. from 7:00 a.m. to 3:00 p.m., one direct-care staff to every seven residents, or major fraction thereof,

b. from 3:00 p.m. to 11:00 p.m., one direct-care staff to every ten residents, or major fraction thereof, and

c. from 11:00 p.m. to 7:00 a.m., one direct-care staff to every seventeen residents, or major fraction thereof.

3. On and after September 1, 2003, subject to the availability of funds, nursing facilities subject to the Nursing Home Care Act and intermediate care facilities for the mentally retarded with seventeen or more beds shall maintain, in addition to other state and federal requirements related to the staffing of nursing facilities, the following minimum direct-care-staff-to-resident ratios:

a. from 7:00 a.m. to 3:00 p.m., one direct-care staff to every six residents, or major fraction thereof,

b. from 3:00 p.m. to 11:00 p.m., one direct-care staff to every eight residents, or major fraction thereof, and

c. from 11:00 p.m. to 7:00 a.m., one direct-care staff to every fifteen residents, or major fraction thereof.

4. Effective immediately, facilities shall have the option of varying the starting times for the eight-hour shifts by one (1) hour before or one (1) hour after the times designated in this section without overlapping shifts.

5. a. On and after January 1, 2004, a facility that has been determined by the State Department of Health to have been in compliance with the provisions of paragraph 3 of this subsection since the implementation date of this subsection, may implement flexible staff scheduling; provided, however, such facility shall continue to maintain a direct-care service rate of at least two and eighty-six one-hundredths (2.86) hours of direct-care service per resident per day.

b. At no time shall direct-care staffing ratios in a facility with flexible staff-scheduling privileges fall below one direct-care staff to every sixteen residents, and at least two direct-care staff shall be on duty and awake at all times.

c. As used in this paragraph, "flexible staff-scheduling" means maintaining:

(1) a direct-care-staff-to-resident ratio based on overall hours of direct-care service per resident per day rate of not less than two and eighty-six one-hundredths (2.86) hours per day,

(2) a direct-care-staff-to-resident ratio of at least one direct-care staff person on duty to every sixteen residents at all times, and

(3) at least two direct-care staff persons on duty and awake at all times.

6. a. On and after January 1, 2004, the Department shall require a facility to maintain the shift-based, staff-to-resident ratios provided in paragraph 3 of this subsection if the facility has been determined by the Department to be deficient with regard to:

(1) the provisions of paragraph 3 of this subsection,

(2) fraudulent reporting of staffing on the Quality of Care Report,

(3) a complaint and/or survey investigation that has determined substandard quality of care, or

(4) a complaint and/or survey investigation that has determined quality-of-care problems related to insufficient staffing.

b. The Department shall require a facility described in subparagraph a of this paragraph to achieve and maintain the shift-based, staff-to-resident ratios provided in paragraph 3 of this subsection for a minimum of three (3) months before being considered eligible to implement flexible staff scheduling as defined in subparagraph c of paragraph 5 of this subsection.

c. Upon a subsequent determination by the Department that the facility has achieved and maintained for at least three (3) months the shift-based, staff-to-resident ratios described in paragraph 3 of this subsection, and has corrected any deficiency described in subparagraph a of this paragraph, the Department shall notify the facility of its eligibility to implement flexible staff-scheduling privileges.

7. a. For facilities that have been granted flexible staff-scheduling privileges, the Department shall monitor and evaluate facility compliance with the flexible staff-scheduling staffing provisions of paragraph 5 of this subsection through reviews of monthly staffing reports, results of complaint investigations and inspections.

b. If the Department identifies any quality-of-care problems related to insufficient staffing in such facility, the Department shall issue a directed plan of correction to the facility found to be out of compliance with the provisions of this subsection.

c. In a directed plan of correction, the Department shall require a facility described in subparagraph b of this paragraph to maintain shift-based, staff-to-resident ratios for the following periods of time:

(1) the first determination shall require that shift-based, staff-to-resident ratios be maintained until full compliance is achieved,

(2) the second determination within a two-year period shall require that shift-based, staff-to-resident ratios be maintained for a minimum period of six (6) months, and

(3) the third determination within a two-year period shall require that shift-based, staff-to-resident ratios be maintained for a minimum period of twelve (12) months.

C. Effective September 1, 2002, facilities shall post the names and titles of direct-care staff on duty each day in a conspicuous place, including the name and title of the supervising nurse.

D. The State Board of Health shall promulgate rules prescribing staffing requirements for intermediate care facilities for the

mentally retarded serving six or fewer clients and for intermediate care facilities for the mentally retarded serving sixteen or fewer clients.

E. Facilities shall have the right to appeal and to the informal dispute resolution process with regard to penalties and sanctions imposed due to staffing noncompliance.

F. 1. When the state Medicaid program reimbursement rate reflects the sum of Ninety-four Dollars and eleven cents ($94.11), plus the increases in actual audited costs over and above the actual audited costs reflected in the cost reports submitted for the most current cost-reporting period and the costs estimated by the Oklahoma Health Care Authority to increase the direct-care, flexible staff-scheduling staffing level from two and eighty-six one-hundredths (2.86) hours per day per occupied bed to three and two-tenths (3.2) hours per day per occupied bed, all nursing facilities subject to the provisions of the Nursing Home Care Act and intermediate care facilities for the mentally retarded with seventeen or more beds, in addition to other state and federal requirements related to the staffing of nursing facilities, shall maintain direct-care, flexible staff-scheduling staffing levels based on an overall three and two-tenths (3.2) hours per day per occupied bed.

2. When the state Medicaid program reimbursement rate reflects the sum of Ninety-four Dollars and eleven cents ($94.11), plus the increases in actual audited costs over and above the actual audited costs reflected in the cost reports submitted for the most current cost-reporting period and the costs estimated by the Oklahoma Health Care Authority to increase the direct-care flexible staff-scheduling staffing level from three and two-tenths (3.2) hours per day per occupied bed to three and eight-tenths (3.8) hours per day per occupied bed, all nursing facilities subject to the provisions of the Nursing Home Care Act and intermediate care facilities for the

mentally retarded with seventeen or more beds, in addition to other state and federal requirements related to the staffing of nursing facilities, shall maintain direct-care, flexible staff-scheduling staffing levels based on an overall three and eight-tenths (3.8) hours per day per occupied bed.

3. When the state Medicaid program reimbursement rate reflects the sum of Ninety-four Dollars and eleven cents ($94.11), plus the increases in actual audited costs over and above the actual audited costs reflected in the cost reports submitted for the most current cost-reporting period and the costs estimated by the Oklahoma Health Care Authority to increase the direct-care, flexible staff-scheduling staffing level from three and eight-tenths (3.8) hours per day per occupied bed to four and one-tenth (4.1) hours per day per occupied bed, all nursing facilities subject to the provisions of the Nursing Home Care Act and intermediate care facilities for the mentally retarded with seventeen or more beds, in addition to other state and federal requirements related to the staffing of nursing facilities, shall maintain direct-care, flexible staff-scheduling staffing levels based on an overall four and one-tenth (4.1) hours per day per occupied bed.

4. The Board shall promulgate rules for shift-based, staff-to-resident ratios for noncompliant facilities denoting the incremental increases reflected in direct-care, flexible staff-scheduling staffing levels.

5. In the event that the state Medicaid program reimbursement rate for facilities subject to the Nursing Home Care Act, and intermediate care facilities for the mentally retarded having seventeen or more beds is reduced below actual audited costs, the requirements for staffing ratio levels shall be adjusted to the appropriate levels provided in paragraphs 1 through 4 of this subsection.

G. For purposes of this subsection:

1. “Direct-care staff” means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility; and

2. Prior to September 1, 2003, activity and social services staff who are not providing direct, hands-on care to residents may be included in the direct-care-staff-to-resident ratio in any shift. On and after September 1, 2003, such persons shall not be included in the direct-care-staff-to-resident ratio.

H. 1. The Oklahoma Health Care Authority shall require all nursing facilities subject to the provisions of the Nursing Home Care Act and intermediate care facilities for the mentally retarded with seventeen or more beds to submit a monthly report on staffing ratios on a form that the Authority shall develop.

2. The report shall document the extent to which such facilities are meeting or are failing to meet the minimum direct-care-staff-to-resident ratios specified by this section. Such report shall be available to the public upon request.

3. The Authority may assess administrative penalties for the failure of any facility to submit the report as required by the Authority. Provided, however:

a. administrative penalties shall not accrue until the Authority notifies the facility in writing that the report was not timely submitted as required, and

b. a minimum of a one-day penalty shall be assessed in all instances.

4. Administrative penalties shall not be assessed for computational errors made in preparing the report.

5. Monies collected from administrative penalties shall be deposited in the Nursing Facility Quality of Care Fund and utilized for the purposes specified in the Oklahoma Healthcare Initiative Act.

I. 1. All entities regulated by this state that provide long-term care services shall utilize a single assessment tool to determine client services needs. The tool shall be developed by the Oklahoma Health Care Authority in consultation with the State Department of Health.

2. a. The Oklahoma Nursing Facility Funding Advisory Committee is hereby created and shall consist of the following:

(1) four members selected by the Oklahoma Association of Health Care Providers,

(2) three members selected by the Oklahoma Association of Homes and Services for the Aging, and

(3) two members selected by the State Council on Aging.

The Chair shall be elected by the committee. No state employees may be appointed to serve.

b. The purpose of the advisory committee will be to develop a new methodology for calculating state Medicaid program reimbursements to nursing facilities by implementing facility-specific rates based on expenditures relating to direct care staffing. No nursing home will receive less than the current rate at the time of implementation of facility-specific rates pursuant to this subparagraph.

c. The advisory committee shall be staffed and advised by the Oklahoma Health Care Authority.

d. The new methodology will be submitted for approval to the Board of the Oklahoma Health Care Authority by January 15, 2005, and shall be finalized by July 1, 2005. The new methodology will apply only to new funds that become available for Medicaid nursing

facility reimbursement after the methodology of this paragraph has been finalized. Existing funds paid to nursing homes will not be subject to the methodology of this paragraph. The methodology as outlined in this paragraph will only be applied to any new funding for nursing facilities appropriated above and beyond the funding amounts effective on January 15, 2005.

e. The new methodology shall divide the payment into two components:

(1) direct care which includes allowable costs for registered nurses, licensed practical nurses, certified medication aides and certified nurse aides. The direct care component of the rate shall be a facility-specific rate, directly related to each facility's actual expenditures on direct care, and

(2) other costs.

f. The Oklahoma Health Care Authority, in calculating the base year prospective direct care rate component, shall use the following criteria:

(1) to construct an array of facility per diem allowable expenditures on direct care, the Authority shall use the most recent data available. The limit on this array shall be no less than the ninetieth percentile,

(2) each facility's direct care base-year component of the rate shall be the lesser of the facility's allowable expenditures on direct care or the limit,

(3) other rate components shall be determined by the Oklahoma Nursing Facility Funding Advisory

Committee in accordance with federal regulations and requirements, and

(4) rate components in divisions (2) and (3) of this subparagraph shall be re-based and adjusted for inflation when additional funds are made available.

g. The Oklahoma Nursing Facility Funding Advisory Committee shall terminate upon the establishment of the graduated reimbursement rate plan for nursing facilities pursuant to Section 6 of this act.

3. The Department of Human Services shall expand its statewide toll-free, Senior-Info Line for senior citizen services to include assistance with or information on long-term care services in this state.

4. The Oklahoma Health Care Authority shall develop a nursing facility cost-reporting system that reflects the most current costs experienced by nursing and specialized facilities. The Oklahoma Health Care Authority shall utilize the most current cost report data to estimate costs in determining daily per diem rates.

J. 1. When the state Medicaid program reimbursement rate reflects the sum of Ninety-four Dollars and eleven cents ($94.11), plus the increases in actual audited costs, over and above the actual audited costs reflected in the cost reports submitted for the most current cost-reporting period, and the direct-care, flexible staff-scheduling staffing level has been prospectively funding at four and one-tenth (4.1) hours per day per occupied bed, the Authority may apportion funds for the implementation of the provisions of this section.

2. The Authority shall make application to the United States Centers for Medicare and Medicaid Service for a waiver of the uniform requirement on health-care-related taxes as permitted by Section 433.72 of 42 C.F.R.

3. Upon approval of the waiver, the Authority shall develop a program to implement the provisions of the waiver as it relates to all nursing facilities.

SECTION 15. AMENDATORY 36 O.S. 2001, Section 6060, as amended by Section 1, Chapter 78, O.S.L. 2002 (36 O.S. Supp. 2005, Section 6060), is amended to read as follows:

Section 6060. A. All individual and group health insurance policies providing coverage on an expense incurred basis, and all individual and group service or indemnity type contracts issued by a nonprofit corporation, including the Oklahoma State and Education Employees Group Insurance Board, which provide coverage for a female thirty-five (35) years old or older in this state, except for policies that provide coverage for specified disease or other limited benefit coverage, shall include the coverage specified by this section for a routine low-dose mammography screening in a reimbursement amount not to exceed One Hundred Fifteen Dollars ($115.00) for the presence of occult breast cancer. Such coverage shall not:

1. Be subject to the policy deductible, co-payments and co-insurance limits of the plan; or

2. Require that a female undergo a mammography screening at a specified time as a condition of payment.

B. 1. Any female thirty-five (35) through thirty-nine (39) years of age shall be entitled pursuant to the provisions of this section to coverage for a low-dose mammography screening once every five (5) years.

2. Any female forty (40) years of age or older shall be entitled pursuant to the provisions of this section to coverage for an annual low-dose mammography screening.

C. For the purposes of this section, the term “low-dose mammography” means the x-ray examination of the breast using equipment dedicated specifically for mammography, including but not

limited to the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

D. The provisions of this section shall not apply to policies issued pursuant to the Oklahoma Medicaid Reform Act of 2006 unless otherwise federally mandated.

SECTION 16. AMENDATORY 36 O.S. 2001, Section 6060.1, is amended to read as follows:

Section 6060.1 A. All individual and group health insurance policies providing coverage on an expense incurred basis, and all individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a female forty-five (45) years of age or older in this state, except for policies that provide coverage for specified disease or other limited benefit coverage, shall include the coverage specified by this section for a bone density test to qualified individuals covered by the policy when such test is requested by a primary care or referral physician. The test shall be subject to the policy deductible, copayments and coinsurance limits of the plan; provided, however, no policy or contract shall be required to reimburse more than One Hundred Fifty Dollars ($150.00) for any such test.

B. For purposes of this section:

1. "Qualified individual" means an individual:

a. with an estrogen hormone deficiency,

b. with:

(1) vertebral abnormalities,

(2) primary hyperparathyroidism, or

(3) a history of fragility bone fractures,

c. who is receiving long-term glucocorticoid, or

d. who is currently under treatment for osteoporosis; and

2. "Bone density test" means a medically accepted measurement of bone mass used to detect low bone mass and to determine a qualified individual's risk for osteoporosis.

C. The provisions of this section shall not apply to policies issued pursuant to the Oklahoma Medicaid Reform Act of 2006 unless otherwise federally mandated.

SECTION 17. AMENDATORY 36 O.S. 2001, Section 6060.2, is amended to read as follows:

Section 6060.2 A. 1. For policies, contracts or agreements issued or renewed on and after November 1, 1996, any individual or group health insurance policy, contract or agreement providing coverage on an expense-incurred basis; any policy, contract or agreement issued for individual or group coverage by a not-for-profit hospital service and indemnity and medical service and indemnity corporation; contracts issued by health benefit plans including, but not limited to, health maintenance organizations, preferred provider organizations, health services corporations, physician sponsored networks, or physician hospital organizations; medical coverage provided by self-insureds that includes coverage for physician services in a physician's office, including coverage through private third-party payors; coverage provided through the State and Education Employees Group Insurance Board; and every policy, contract, or agreement which provides medical, major medical or similar comprehensive type coverage, group or blanket accident and health coverage, or medical expense, surgical, medical equipment, medical supplies, or drug prescription benefits shall, subject to the terms of the policy contract or agreement, include coverage for the following equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes, when medically necessary and when recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe under the laws of this state:

a. blood glucose monitors,

b. blood glucose monitors to the legally blind,

c. test strips for glucose monitors,

d. visual reading and urine testing strips,

e. insulin,

f. injection aids,

g. cartridges for the legally blind,

h. syringes,

i. insulin pumps and appurtenances thereto,

j. insulin infusion devices,

k. oral agents for controlling blood sugar, and

l. podiatric appliances for prevention of complications associated with diabetes.

2. The State Board of Health shall develop and annually update, by rule, a list of additional diabetes equipment, related supplies and health care provider services that are medically necessary for the treatment of diabetes, for which coverage shall also be included, subject to the terms of the policy, contract, or agreement, if such equipment and supplies have been approved by the federal Food and Drug Administration (FDA). Such additional FDA-approved diabetes equipment and related supplies, and health care provider services shall be determined in consultation with a national diabetes association affiliated with this state, and at least three ~~(3)~~ medical directors of health benefit plans, to be selected by the State Department of Health.

3. All policies specified in this section shall also include coverage for:

a. podiatric health care provider services as are deemed medically necessary to prevent complications from diabetes, and

b. diabetes self-management training. As used in this subparagraph, "diabetes self-management training"

means instruction in an inpatient or outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. Diabetes self-management training shall comply with standards developed by the State Board of Health in consultation with a national diabetes association affiliated with this state and at least three (3) medical directors of health benefit plans selected by the State Department of Health. Such coverage for diabetes self-management training, including medical nutrition therapy relating to diet, caloric intake, and diabetes management, but excluding programs the only purpose of which are weight reduction, shall be limited to the following:

(1) visits medically necessary upon the diagnosis of diabetes,

(2) a physician diagnosis which represents a significant change in the patient's symptoms or condition making medically necessary changes in the patient's self-management, and

(3) visits when reeducation or refresher training is medically necessary;

provided, however, payment for the coverage required for diabetes self-management training pursuant to the provisions of this section shall be required only upon certification by the health care provider providing the training that the patient has successfully completed diabetes self-management training.

4. Diabetes self-management training shall be supervised by a licensed physician or other licensed health care provider legally authorized to prescribe under the laws of this state. Diabetes self-management training may be provided by the physician or other

appropriately registered, certified, or licensed health care professional as part of an office visit for diabetes diagnosis or treatment. Training provided by appropriately registered, certified, or licensed health care professionals may be provided in group settings where practicable.

5. Coverage for diabetes self-management training and training related to medical nutrition therapy, when provided by a registered, certified, or licensed health care professional, shall also include home visits when medically necessary and shall include instruction in medical nutrition therapy only by a licensed registered dietician or licensed certified nutritionist when authorized by the patient's supervising physician when medically necessary.

6. Such coverage may be subject to the same annual deductibles or coinsurance as may be deemed appropriate and as are consistent with those established for other covered benefits within a given policy.

B. 1. Health benefit plans shall not reduce or eliminate coverage due to the requirements of this section.

2. Enforcement of the provisions of this act shall be performed by the Insurance Department and the State Department of Health.

3. The provisions of this section shall not apply to:

a. health benefit plans designed only for issuance to subscribers eligible for coverage under Title XVIII of the Social Security Act or any similar coverage under a state or federal government plan,

b. a health benefit plan which covers persons employed in more than one state where the benefit structure was the subject of collective bargaining affecting persons employed in more than one state, and

c. agreements, contracts, or policies that provide coverage for a specified disease or other limited benefit coverage.

C. The provisions of this section shall not apply to policies issued pursuant to the Oklahoma Medicaid Reform Act of 2006 unless otherwise federally mandated.

SECTION 18. AMENDATORY 36 O.S. 2001, Section 6060.3, as amended by Section 5, Chapter 464, O.S.L. 2003 (36 O.S. Supp. 2005, Section 6060.3), is amended to read as follows:

Section 6060.3 A. Every health benefit plan contract issued, amended, renewed or delivered in this state on or after July 1, 1996, that provides maternity benefits shall provide for coverage of:

1. A minimum of forty-eight (48) hours of inpatient care at a hospital, or a birthing center licensed as a hospital, following a vaginal delivery, for the mother and newborn infant after childbirth, except as otherwise provided in this section;

2. A minimum of ninety-six (96) hours of inpatient care at a hospital following a delivery by caesarean section for the mother and newborn infant after childbirth, except as otherwise provided in this section; and

3. a. Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. The coverage shall provide for one home visit within forty-eight (48) hours of childbirth by a licensed health care provider whose scope of practice includes providing postpartum care. Visits shall include, at a minimum:

(1) physical assessment of the mother and the newborn infant,

(2) parent education, to include, but not be limited to:

(a) the recommended childhood immunization schedule,

(b) the importance of childhood immunizations, and

(c) resources for obtaining childhood immunizations,

(3) training or assistance with breast or bottle feeding, and

(4) the performance of any medically necessary and appropriate clinical tests.

b. At the mother's discretion, visits may occur at the facility of the plan or the provider.

B. Inpatient care shall include, at a minimum:

1. Physical assessment of the mother and the newborn infant;

2. Parent education, to include, but not be limited to:

a. the recommended childhood immunization schedule,

b. the importance of childhood immunizations, and

c. resources for obtaining childhood immunizations;

3. Training or assistance with breast or bottle feeding; and

4. The performance of any medically necessary and appropriate clinical tests.

C. A plan may limit coverage to a shorter length of hospital inpatient stay for services related to maternity and newborn infant care provided that:

1. In the sole medical discretion or judgment of the attending physician licensed by the ~~Oklahoma~~ State Board of Medical Licensure and Supervision or the State Board of Osteopathic Examiners or the certified nurse midwife licensed by the Oklahoma Board of Nursing providing care to the mother and to the newborn infant, it is determined prior to discharge that an earlier discharge of the mother and newborn infant is appropriate and meets medical criteria contained in the most current treatment standards of the American Academy of Pediatrics and the American College of Obstetricians and

Gynecologists that determine the appropriate length of stay based upon:

a. evaluation of the antepartum, intrapartum and postpartum course of the mother and newborn infant,

b. the gestational age, birth weight and clinical condition of the newborn infant,

c. the demonstrated ability of the mother to care for the newborn infant postdischarge, and

d. the availability of postdischarge follow-up to verify the condition of the newborn infant in the first forty-eight (48) hours after delivery.

A plan shall adopt these guidelines by July 1, 1996; and

2. The plan covers one home visit, within forty-eight (48) hours of discharge, by a licensed health care provider whose scope of practice includes providing postpartum care. Such visits shall include, at a minimum:

a. physical assessment of the mother and the newborn infant,

b. parent education, to include, but not be limited to:

(1) the recommended childhood immunization schedule,

(2) the importance of childhood immunizations, and

(3) resources for obtaining childhood immunizations,

c. training or assistance with breast or bottle feeding, and

d. the performance of any medically necessary and clinical tests.

At the mother's discretion, visits may occur at the facility of the plan or the provider.

D. The plan shall include, but is not limited to, notice of the coverage required by this section in the plan's evidence of coverage, and shall provide additional written notice of the

coverage to the insured or an enrollee during the course of the insured's or enrollee's prenatal care.

E. In the event the coverage required by this section is provided under a contract that is subject to a capitated or global rate, the plan shall be required to provide supplementary reimbursement to providers for any additional services required by that coverage if it is not included in the capitation or global rate.

F. No health benefit plan subject to the provisions of this section shall terminate the services of, reduce capitation payments for, refuse payment for services, or otherwise discipline a licensed health care provider who orders care consistent with the provisions of this section.

G. As used in this section, "health benefit plan" means individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions.

H. The Insurance Commissioner shall promulgate any rules necessary to implement the provisions of this section.

I. The provisions of this section shall not apply to policies issued pursuant to the Oklahoma Medicaid Reform Act of 2006 unless otherwise federally mandated.

SECTION 19. AMENDATORY Section 1, Chapter 397, O.S.L. 2004 (36 O.S. Supp. 2005, Section 6060.3a), is amended to read as follows:

Section 6060.3a A. Any health benefit plan, including the State and Education Employees Group Health Insurance plan, that is offered, issued or renewed in this state on or after January 1,

2005, that provides medical and surgical benefits shall provide coverage for routine annual obstetrical/gynecological examinations.

B. The benefit required to be provided by this section shall in no way diminish or limit diagnostic benefits otherwise allowable under a health benefit plan.

C. Nothing in this section shall be construed as requiring such routine annual examination to be performed by an obstetrician, gynecologist, or obstetrician/gynecologist.

D. As used in this section, "health benefit plan" means group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions. The term shall not include short-term, accident, fixed indemnity or specified disease policies, disability income contracts, limited benefit or credit disability insurance, workers' compensation insurance coverage, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance.

E. The provisions of this section shall not apply to policies or certificates issued to individuals or groups with fewer than fifty employees.

F. The provisions of this section shall not apply to policies issued pursuant to the Oklahoma Medicaid Reform Act of 2006 unless otherwise federally mandated.

SECTION 20. AMENDATORY 36 O.S. 2001, Section 6060.4, as amended by Section 6, Chapter 464, O.S.L. 2003 (36 O.S. Supp. 2005, Section 6060.4), is amended to read as follows:

Section 6060.4 A. A health benefit plan delivered, issued for delivery or renewed in this state on or after January 1, 1998, that provides benefits for the dependents of an insured individual shall provide coverage for each child of the insured, from birth through the date such child is eighteen (18) years of age for:

1. Immunization against:

a. diphtheria,

b. hepatitis B,

c. measles,

d. mumps,

e. pertussis,

f. polio,

g. rubella,

h. tetanus,

i. varicella,

j. haemophilus influenzae type B, and

k. hepatitis A; and

2. Any other immunization subsequently required for children by the State Board of Health.

B. Benefits required pursuant to subsection A of this section shall not be subject to a deductible, co-payment, or coinsurance requirement.

C. 1. For purposes of this section, "health benefit plan" means a plan that:

a. provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, and

b. is offered by any insurance company, group hospital service corporation, the State and Education Employees Group Insurance Board, or health maintenance organization that delivers or issues for delivery an individual, group, blanket, or franchise insurance

policy or insurance agreement, a group hospital service contract, or an evidence of coverage, or, to the extent permitted by the Employee Retirement Income Security Act of 1974, 29 U.S.C., Section 1001 et seq., by a multiple employer welfare arrangement as defined in Section 3 of the Employee Retirement Income Security Act of 1974, or any other analogous benefit arrangement.

2. The term "health benefit plan" shall not include:

a. a plan that provides coverage:

(1) only for a specified disease,

(2) only for accidental death or dismemberment,

(3) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury, or

(4) as a supplement to liability insurance,

b. a Medicare supplemental policy as defined by Section 1882(g)(1) of the Social Security Act (42 U.S.C., Section 1395ss),

c. ~~worker's~~ workers' compensation insurance coverage,

d. medical payment insurance issued as part of a motor vehicle insurance policy,

e. a long-term care policy, including a nursing home fixed indemnity policy, unless a determination is made that the policy provides benefit coverage so comprehensive that the policy meets the definition of a health benefit plan, or

f. short-term health insurance issued on a nonrenewable basis with a duration of six (6) months or less.

D. The provisions of this section shall not apply to policies issued pursuant to the Oklahoma Medicaid Reform Act of 2006 unless otherwise federally mandated.

SECTION 21. AMENDATORY 36 O.S. 2001, Section 6060.5, as amended by Section 7, Chapter 464, O.S.L. 2003 (36 O.S. Supp. 2005, Section 6060.5), is amended to read as follows:

Section 6060.5 A. This section shall be known and may be cited as the "Oklahoma Breast Cancer Patient Protection Act".

B. Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 1998, that provides medical and surgical benefits with respect to the treatment of breast cancer and other breast conditions shall ensure that coverage is provided for not less than forty-eight (48) hours of inpatient care following a mastectomy and not less than twenty-four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer.

C. Nothing in this section shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

D. Any plan subject to subsection B of this section shall also provide coverage for reconstructive breast surgery performed as a result of a partial or total mastectomy. Because breasts are a paired organ, any such reconstructive breast surgery shall include coverage for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed, provided that the reconstructive surgery and any adjustments made to the nondiseased breast must occur within twenty-four (24) months of reconstruction of the diseased breast.

E. In implementing the requirements of this section, a health benefit plan may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required pursuant to subsections B and D of this section.

F. A health benefit plan shall provide notice to each insured or enrollee under such plan regarding the coverage required by this section in the plan's evidence of coverage, and shall provide additional written notice of the coverage to the insured or enrollee as follows:

1. In the next mailing made by the plan to the employee;

2. As part of any yearly informational packet sent to the enrollee; or

3. Not later than December 1, 1997;

whichever is earlier.

G. As used in this act, "health benefit plan" means any plan or arrangement as defined in subsection G of Section 6060.3 of this title.

H. The Insurance Commissioner shall promulgate any rules necessary to implement the provisions of this section.

I. The provisions of this section shall not apply to policies issued pursuant to the Oklahoma Medicaid Reform Act of 2006 unless otherwise federally mandated.

SECTION 22. AMENDATORY 36 O.S. 2001, Section 6060.6, is amended to read as follows:

Section 6060.6 A. Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 1999, that provides hospitalization benefits shall provide coverage for anesthesia expenses including anesthesia practitioner expenses for the administration of the anesthesia, and hospital and ambulatory surgical center expenses associated with any medically necessary dental procedure when provided to a covered person who is:

1. Severely disabled; or

2. A minor eight (8) years of age or under,

and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care.

B. A health benefit plan may require prior authorization for either inpatient or outpatient hospitalization for dental care in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

C. Coverage provided for in subsection A of this section shall be subject to the same annual deductibles, copayments or coinsurance limits as established for all other covered benefits under the health benefit plan.

D. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of ~~Title 36 of the Oklahoma Statutes~~ this title.

E. The provisions of this section shall not apply to policies issued pursuant to the Oklahoma Medicaid Reform Act of 2006 unless otherwise federally mandated.

SECTION 23. AMENDATORY 36 O.S. 2001, Section 6060.7, as amended by Section 1, Chapter 30, O.S.L. 2002 (36 O.S. Supp. 2005, Section 6060.7), is amended to read as follows:

Section 6060.7 A. 1. Any group health insurance or health benefit plan agreement, contract or policy, including the State and Education Employees Group Insurance Board and any indemnity plan, not-for-profit hospital or medical service or indemnity contract, prepaid or managed care plan or provider agreement, and Multiple Employer Welfare Arrangement (MEWA) or employer self-insured plan, except as exempt under federal ERISA provisions, that is offered, issued, or renewed on or after the effective date of this act shall provide coverage for audiological services and hearing aids for children up to eighteen (18) years of age.

2. Such coverage:

a. shall only apply to hearing aids that are prescribed, filled and dispensed by a licensed audiologist, and

b. may limit the hearing aid benefit payable for each hearing-impaired ear to every forty-eight (48) months;

provided, however, such coverage may provide for up to four additional ear molds per year for children up to two (2) years of age.

B. Nothing in this section shall be construed to extend the practice or privileges of any health care provider beyond that provided in the laws governing the provider's practice and privileges.

C. This requirement shall not apply to agreements, contracts or policies that provide coverage for a specified disease or other limited benefit coverage, or groups with fifty or fewer employees.

D. The provisions of this section shall not apply to policies issued pursuant to the Oklahoma Medicaid Reform Act of 2006 unless otherwise federally mandated.

SECTION 24. AMENDATORY 36 O.S. 2001, Section 6060.8, as amended by Section 8, Chapter 464, O.S.L. 2003 (36 O.S. Supp. 2005, Section 6060.8), is amended to read as follows:

Section 6060.8 A. Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 2000, that provides coverage to men forty (40) years of age or older in this state shall offer coverage for annual screening for the early detection of prostate cancer in men over the age of fifty (50) years and in men over the age of forty (40) years who are in high-risk categories. The coverage shall not be subject to policy deductibles. The coverage shall not exceed the actual cost of the prostate cancer screening up to a maximum of Sixty-five Dollars ($65.00) per screening.

B. The benefit required to be provided by subsection A of this section shall in no way diminish or limit diagnostic benefits otherwise allowable under a health benefit plan.

C. The prostate cancer screening coverage shall be offered as follows:

1. The screening shall be performed by a qualified medical professional including, but not limited to, a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner, or physician assistant;

2. The screening shall consist, at a minimum, of the following tests:

a. a prostate-specific antigen blood test, and

b. a digital rectal examination;

3. At least one screening per year shall be covered for any man fifty (50) years of age or older; and

4. At least one screening per year shall be covered for any man from forty (40) to fifty (50) years of age who is at increased risk of developing prostate cancer as determined by a physician.

D. As used in this section, "health benefit plan" means group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions. The term shall not include short-term, accident, fixed indemnity, or specified disease policies, disability income contracts, limited benefit or credit disability insurance, workers' compensation insurance coverage, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance.

<u>E. The provisions of this section shall not apply to policies issued pursuant to the Oklahoma Medicaid Reform Act of 2006 unless otherwise federally mandated.</u>

SECTION 25. AMENDATORY 36 O.S. 2001, Section 6060.8a, is amended to read as follows:

Section 6060.8a A. Any health benefit plan, including the State and Education Employees Group Health Insurance Plan, that is offered, issued or renewed in this state on or after January 1, 2002, which provides medical and surgical benefits, shall offer coverage for colorectal cancer examinations and laboratory tests for cancer for any nonsymptomatic covered individual, in accordance with standard, accepted published medical practice guidelines for colorectal cancer screening, who is:

1. At least fifty (50) years of age; or

2. Less than fifty (50) years of age and at high risk for colorectal cancer according to the standard, accepted published medical practice guidelines.

B. The coverage provided for by this section shall be subject to the same annual deductibles, co-payments or coinsurance limits as established for other covered benefits under the health plan.

C. To minimize costs for nonsymptomatic screening, third-party reimbursement may be at the existing Medicaid rate which shall be payment in full.

D. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection D of Section 6060.8 of ~~Title 36 of the Oklahoma Statutes~~ this title; provided, however, the provisions of this section shall not apply to policies or certificates issued to individuals or to groups with fifty (50) or fewer employees, or to plans offered under the state Medicaid program.

E. The provisions of this section shall not apply to policies issued pursuant to the Oklahoma Medicaid Reform Act of 2006 unless otherwise federally mandated.

SECTION 26. AMENDATORY 36 O.S. 2001, Section 6060.9, is amended to read as follows:

Section 6060.9 A. Any health benefit plan, including the State and Education Employees Group Health Insurance Plan, that is

offered, issued, or renewed in this state on or after January 1, 2001, that provides medical and surgical benefits with respect to the treatment of cancer and other conditions treated by chemotherapy or radiation therapy shall provide coverage for wigs or other scalp prostheses necessary for the comfort and dignity of the covered person.

B. The coverage provided for by this section shall be subject to the same annual deductibles, copayments, or coinsurance limits as established for all other covered benefits under the health benefit plan not to exceed One Hundred Fifty Dollars ($150.00) annually.

C. A health benefit plan shall provide notice to each insured or enrollee under such plan regarding the coverage required by this section in the plan's evidence of coverage and shall provide additional written notice of the coverage to the insured or enrollee as follows:

1. In the next mailing made by the plan to the insured or enrolled employee;

2. As part of any yearly informational packet sent to the enrollee; or

3. Not later than December 1, 2000;

whichever is earlier.

D. As used in this act, "health benefit plan" means any plan or arrangement as defined in subsection D of Section 6060.8 of ~~Title 36 of the Oklahoma Statutes~~ this title. However, this section shall not apply to policies or certificates issued to individuals or groups with fifty (50) or fewer employees or plans offered under the State Medicaid Program.

E. The Insurance Commissioner shall promulgate any rules necessary to implement the provisions of this section.

F. The provisions of this section shall not apply to policies issued pursuant to the Oklahoma Medicaid Reform Act of 2006 unless otherwise federally mandated.

SECTION 27. AMENDATORY 36 O.S. 2001, Section 6060.10, is amended to read as follows:

Section 6060.10 A. As used in this act:

1. "Base period" means the period of coverage pursuant to the issuance or renewal of a health benefit plan that is required to provide benefits pursuant to the provisions of Section ~~2~~ 6060.11 of this ~~act~~ title;

2. a. "Health benefit plan" means:

(1) group hospital or medical insurance coverages,

(2) not-for-profit hospital or medical service or indemnity plans,

(3) prepaid health plans,

(4) health maintenance organizations,

(5) preferred provider plans,

(6) the State and Education Employees Group Insurance Plan,

(7) Multiple Employer Welfare Arrangements (MEWA), or

(8) employer self-insured plans that are not exempt pursuant to the federal Employee Retirement Income Security Act (ERISA) provisions.

b. The term "health benefit plan" shall not include individual plans; plans that only provide coverage for a specified disease, accidental death, or dismemberment for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury or as a supplement to liability insurance; Medicare supplemental policies as defined in Section 1882(g)(1) of the federal Social Security Act (42 U.S.C., Section 1395ss); workers' compensation insurance coverages; medical payment insurance issued as a part of a motor vehicle insurance policy; or long term care policies including

nursing home fixed indemnity policies, unless the Insurance Commissioner determines that the policy provides comprehensive benefit coverage sufficient to meet the definition of a health benefit plan;

3. "Severe mental illness" means any of the following biologically based mental illnesses for which the diagnostic criteria are prescribed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

a. schizophrenia,

b. bipolar disorder (manic-depressive illness),

c. major depressive disorder,

d. panic disorder,

e. obsessive-compulsive disorder, and

f. schizoaffective disorder; and

4. "Small employer" means any person, firm, corporation, partnership, limited liability company, association, or other legal entity that is actively engaged in business that, on at least fifty percent (50%) of its working days during the preceding calendar year, employed no more than fifty (50) employees who work on a full-time basis, which means an employee has a normal work week of twenty-four (24) or more hours.

B. The provisions of this section shall not apply to policies issued pursuant to the Oklahoma Medicaid Reform Act of 2006 unless otherwise federally mandated.

SECTION 28. AMENDATORY 36 O.S. 2001, Section 6060.11, is amended to read as follows:

Section 6060.11 A. Subject to the limitations set forth in this section and Sections ~~3~~ 6060.12 and ~~4~~ 6060.13 of this ~~act~~ title, any health benefit plan that is offered, issued, or renewed in this state on or after the effective date of this act shall provide benefits for treatment of severe mental illness.

B. The provisions of subsection A of this section shall pertain to all aspects of any health benefit plan that is offered, issued, or renewed in this state. Benefits required by subsection A of this section shall be equal to benefits for treatment of and shall be subject to the same preauthorization and utilization review mechanisms and other terms and conditions as all other physical diseases and disorders, including, but not limited to:

1. Coverage of inpatient hospital services for either twenty-six (26) days or the limit for other covered illnesses, whichever is greater;

2. Coverage of outpatient services;

3. Coverage of medication;

4. Maximum lifetime benefits;

5. Co-payments;

6. Coverage of home health visits;

7. Individual and family deductibles; and

8. Coinsurance.

C. The provisions of subsection A of this section shall not apply to coverage provided by a health benefit plan for a small employer.

D. The provisions of this section shall not apply to policies issued pursuant to the Oklahoma Medicaid Reform Act of 2006 unless otherwise federally mandated.

SECTION 29. This act shall become effective November 1, 2006.

Passed the House of Representatives the 13th day of March, 2006.

_____
Presiding Officer of the House of
Representatives

Passed the Senate the ____ day of _____, 2006.

_____
Presiding Officer of the Senate