

SENATE CHAMBER

STATE OF OKLAHOMA

DISPOSITION BY SENATE

FLOOR AMENDMENT

No. _____

(Date)

Mr./Madame President:

I move to amend Senate Bill No. 553, Page 9, Line 20 1/2,

as follows:

By inserting new SECTIONS 3 and 4 to read as per attached, by renumbering subsequent sections, and by amending the title to conform.

Submitted by:

Senator Gumm

Gumm-ARE-FA-SB553

2/25/2009 10:19 AM

1 SECTION 3. AMENDATORY 36 O.S. 2001, Section 6542, as last amended by Section
2 6, Chapter 404, O.S.L. 2008 (36 O.S. Supp. 2008, Section 6542), is amended to read as follows:
3 Section 6542.

4 A. 1. The primary plan shall offer as the basic option an annually renewable policy with
5 coverage as specified in this section for each eligible person, except, that if an eligible person is also
6 eligible for Medicare coverage, the plan shall not pay or reimburse any person for expenses paid by
7 Medicare.

8 2. Any person whose health insurance is involuntarily terminated for any reason other than
9 nonpayment of premium or fraud may apply for coverage under any of the plans offered by the
10 Board of Directors of the Health Insurance High Risk Pool. If such coverage is applied for within

1 sixty-three (63) days after the involuntary termination and if premiums are paid for the entire period
2 of coverage, the effective date of the coverage shall be the date of termination of the previous
3 coverage.

4 3. The primary plan shall provide that, upon the death, annulment of marriage or divorce of
5 the individual in whose name the contract was issued, every other person covered in the contract
6 may elect within sixty-three (63) days to continue coverage under a continuation or conversion
7 policy.

8 4. No coverage provided to a person who is eligible for Medicare benefits shall be issued as a
9 Medicare supplement policy.

10 B. The primary plan shall offer comprehensive coverage to every eligible person who is not
11 eligible for Medicare. Comprehensive coverage offered under the primary plan shall pay an eligible
12 person's covered expenses, subject to the limits on the deductible and coinsurance payments
13 authorized under subsection E of this section up to a lifetime limit of One Million Dollars
14 (\$1,000,000.00) per covered individual. The maximum limit under this paragraph shall not be
15 altered by the Board of Directors of the Health Insurance High Risk Pool, and no actuarially
16 equivalent benefit may be substituted by the Board.

17 C. Except for a health maintenance organization and prepaid health plan or preferred provider
18 organization utilized by the Board or a covered person, the usual customary charges for the
19 following services and articles, when prescribed by a physician, shall be covered expenses in the
20 primary plan:

- 21 1. Hospital services;
- 22 2. Professional services for the diagnosis or treatment of injuries, illness, or conditions, other
23 than dental, which are rendered by a physician or by others at the direction of a physician;
- 24 3. Drugs requiring a physician's prescription;
- 25 4. Services of a licensed skilled nursing facility for eligible individuals, ineligible for
26 Medicare, for not more than one hundred eighty (180) calendar days during a policy year, if the
27 services are the type which would qualify as reimbursable services under Medicare;
- 28 5. Services of a home health agency, if the services are of a type which would qualify as
29 reimbursable services under Medicare;
- 30 6. Use of radium or other radioactive materials;
- 31 7. Oxygen;
- 32 8. Anesthetics;
- 33 9. Prosthesis, other than dental prosthesis;
- 34 10. Rental or purchase, as appropriate, of durable medical equipment, other than eyeglasses
35 and hearing aids;
- 36 11. Diagnostic x-rays and laboratory tests;
- 37 12. Oral surgery for partially or completely erupted, impacted teeth and oral surgery with
38 respect to the tissues of the mouth when not performed in connection with the extraction or repair of
39 teeth;
- 40 13. Services of a physical therapist;
- 41 14. Transportation provided by a licensed ambulance service to the nearest facility qualified
42 to treat the condition;
- 43 15. Processing of blood including, but not limited to, collecting, testing, fractioning, and
44 distributing blood; and
- 45 16. Services for the treatment of alcohol and drug abuse, but the plan shall be required to
46 make a fifty percent (50%) co-payment and the payment of the plan shall not exceed Four Thousand
47 Dollars (\$4,000.00).

48 Usual and customary charges shall not exceed the reimbursement rate for charges as set by the
49 State and Education Employees Group Insurance Board.

1 D. 1. Covered expenses in the primary plan shall not include the following:

- 2 a. any charge for treatment for cosmetic purposes, other than for repair or
- 3 treatment of an injury or congenital bodily defect to restore normal bodily
- 4 functions,
- 5 b. any charge for care which is primarily for custodial or domiciliary purposes
- 6 which do not qualify as eligible services under Medicaid,
- 7 c. any charge for confinement in a private room to the extent that such charge is in
- 8 excess of the charge by the institution for its most common semiprivate room,
- 9 unless a private room is prescribed as medically necessary by a physician,
- 10 d. that part of any charge for services or articles rendered or provided by a
- 11 physician or other health care personnel which exceeds the prevailing charge in
- 12 the locality where the service is provided, or any charge for services or articles
- 13 not medically necessary,
- 14 e. any charge for services or articles the provision of which is not within the
- 15 authorized scope of practice of the institution or individual providing the
- 16 service or articles,
- 17 f. any expense incurred prior to the effective date of the coverage under the plan
- 18 for the person on whose behalf the expense was incurred,
- 19 g. any charge for routine physical examinations in excess of one every twenty-
- 20 four (24) months,
- 21 h. any charge for the services of blood donors and any fee for the failure to
- 22 replace the first three (3) pints of blood provided to an eligible person annually,
- 23 and
- 24 i. any charge for personal services or supplies provided by a hospital or nursing
- 25 home, or any other nonmedical or nonprescribed services or supplies.

26 2. The primary plan may provide an option for a person to have coverage for the expenses set
27 out in paragraph 1 of this subsection or any benefits payable under any other health insurance policy
28 or plan, commensurate with the deductible and coinsurance selected.

29 E. 1. The primary plan shall provide for a choice of annual deductibles per person covered for
30 major medical expenses in the amounts of Five Hundred Dollars (\$500.00), One Thousand Dollars
31 (\$1,000.00), One Thousand Five Hundred Dollars (\$1,500.00), Two Thousand Dollars (\$2,000.00),
32 Five Thousand Dollars (\$5,000.00) and Seven Thousand Five Hundred Dollars (\$7,500.00), plus the
33 additional benefits payable at each level of deductible; provided, if two individual members of a
34 family satisfy the applicable deductible, no other members of the family shall be required to meet
35 deductibles for the remainder of that calendar year.

36 2. The schedule of premiums and deductibles shall be established by the Board.

37 3. Rates for coverage issued by the Pool may not be unreasonable in relation to the benefits
38 provided, the risk experience and the reasonable expenses of providing coverage.

39 4. Separate schedules of premium rates based on age may apply for individual risks.

40 5. Rates are subject to approval by the Insurance Commissioner.

41 6. Standard risk rates for coverages issued by the Pool shall be established by the Board,
42 subject to the approval of the Insurance Commissioner, using reasonable actuarial techniques, and
43 shall reflect anticipated experiences and expenses of such coverage for standard risks.

44 7. a. The rating plan established by the Board shall initially provide for rates equal to
45 one hundred twenty-five percent (125%) of the average standard risk rates of
46 the five largest insurers doing business in the state.

47 b. Any change to the initial rates shall be based on experience of the plans and
48 shall reflect reasonably anticipated losses and expenses. The rates shall not

1 increase more than five percent (5%) annually with a maximum rate not to
2 exceed one hundred fifty percent (150%) of the average standard risk rates.

3 8. a. A Pool policy may contain provisions under which coverage is excluded during
4 a period of twelve (12) months following the effective date of coverage with
5 respect to a given covered person's preexisting condition, as long as:

6 (1) the condition manifested itself within a period of six (6) months before
7 the effective date of coverage, or

8 (2) medical advice or treatment for the condition was recommended or
9 received within a period of six (6) months before the effective date of
10 coverage. The provisions of this paragraph shall not apply to a person
11 who is a federally defined eligible individual.

12 b. The Board shall waive the twelve-month period if the person had continuous
13 coverage under another policy with respect to the given condition within a
14 period of six (6) months before the effective date of coverage under the Pool
15 plan. The Board shall also waive any preexisting waiting periods for an
16 applicant who is a federally defined eligible individual.

17 c. In the case of an individual who is eligible for the credit for health insurance
18 costs under Section 35 of the Internal Revenue Code of 1986, the preexisting
19 conditions limitation will not apply if the individual maintained creditable
20 health insurance coverage for an aggregate period of three (3) months as of the
21 date on which the individual seeks to enroll in coverage under the Pool plan,
22 not counting any period prior to a sixty-three-day break in coverage.

23 9. a. No amounts paid or payable by Medicare or any other governmental program
24 or any other insurance, or self-insurance maintained in lieu of otherwise
25 statutorily required insurance, may be made or recognized as claims under such
26 policy, or be recognized as or towards satisfaction of applicable deductibles or
27 out-of-pocket maximums, or to reduce the limits of benefits available.

28 b. The Board shall have a cause of action against a covered person for any
29 benefits paid to a covered person which should not have been claimed or
30 recognized as claims because of the provisions of this paragraph, or because
31 otherwise not covered.

32
33 F. Notwithstanding any other provisions of this section, the primary plan shall provide
34 coverage for the screening, diagnosis, testing, and treatment of an autism spectrum disorder.
35 Coverage provided under this subsection is limited to generally recognized services and treatments
36 that are prescribed by the insured individual's treating physician in accordance with a treatment
37 plan.

38 1. The coverage required under this subsection shall not be subject to dollar limits, visit
39 limitations, deductibles or co-insurance provisions that are less favorable to an insured individual
40 than the dollar limits, visit limitations, deductibles, or coinsurance provisions that apply to the
41 primary plan. Coverage of services may be subject to other general exclusions and limitations of the
42 health benefit plan, including, but not limited to:

43 a. The coordination of benefits;

- 1 b. Participating provider requirements;
- 2 c. Services provided by family or household member restrictions;
- 3 d. Eligibility; and
- 4 e. Appeals processes.

5 2. The treatment plan shall include all elements necessary for the insurer to appropriately pay
6 claims. These elements shall include, but not be limited to:

- 7 a. A diagnosis;
- 8 b. Proposed treatment or treatments by type, frequency and duration;
- 9 c. The anticipated outcomes stated as goals;
- 10 d. The frequency by which the treatment plan will be updated; and
- 11 e. The treating physician's signature.

12 The insurer shall have the right to request an updated treatment plan not more than once every
13 twelve (12) months from the treating physician to review medical necessity, unless the insurer and
14 the provider agree that a more frequent review is necessary due to emerging clinical circumstances.

15 3. A diagnosis of an autism spectrum disorder by a licensed physician or board certified
16 therapist shall be required to be eligible for benefits and coverage under this subsection. The
17 prescribing medical practitioner must be:

- 18 a. licensed, certified, or registered by an appropriate agency of the state of Oklahoma and
19 whose professional credential is recognized and accepted by an appropriate agency of the United
20 States: or
- 21 b. certified as a provider under the TRICARE military health system.

22 The benefits and coverage provided under this subsection shall be provided to any eligible
23 person less than twenty-one (21) years of age.

24 4. The primary plan shall provide coverage for all therapies, treatments, diagnoses and testing,
25 medicines, special diets, and supplements prescribed by a licensed physician or board certified
26 therapist, including but not limited to coverage for pharmacy care, psychological care, psychiatric
27 care, therapeutic care, rehabilitative care, habilitative care, and Applied Behavior Analysis therapy.

28 5. Coverage for Applied Behavior Analysis therapy shall be subject to a maximum benefit of
29 Thirty-Six-Thousand-Dollars (\$36,000.00) per year. Payments made by an insurer on behalf of a
30 covered individual for treatment of a health condition unrelated to or distinguishable from the
31 individual's autism spectrum disorder, or for non-applied behavior analysis therapeutic treatment,
32 shall not be applied toward any maximum benefit established under this subsection.

1 6. The primary plan shall not deny or refuse to issue coverage on, refuse to contract with, refuse
2 to renew, refuse to reissue, or otherwise terminate or restrict coverage on an individual under an
3 insurance policy solely because the individual is diagnosed with an autistic spectrum disorder.

4 7. As used in this subsection:

5 a. “Applied Behavior Analysis” means the design, implementation and evaluation of
6 environmental modifications, using behavioral stimuli and consequences, to produce socially
7 significant improvement in human behavior or to prevent loss of attained skill or function, including
8 the use of direct observation, measurement and functional analysis of the relationship between
9 environment and behavior;

10 b. “Autism service provider” means a person, entity or group providing treatment of autism
11 spectrum disorders, pursuant to a treatment plan, that is licensed or certified in this State or is a
12 Behavior Analyst with a valid certificate issued by the Behavior Analyst Certification Board;

13 c. “Autism spectrum disorder” means any of the pervasive developmental disorders as defined
14 by the most recent edition of the Diagnostic and Statistical Manual of the Mental Disorders (DSM)
15 including Autistic Disorder, Asperger’s Disorder, Pervasive Developmental Disorder not otherwise
16 specified (NOS), Rett Disorder, and Childhood Degenerative Disorder (CDD);

17 d. “Diagnostic assessment of autism spectrum disorders” means medically necessary
18 assessments, evaluations or tests performed by a licensed physician, licensed physician assistant,
19 licensed psychologist or certified registered nurse practitioner to diagnose whether an individual has
20 an autism spectrum disorder;

21 e. “Medically necessary” means any care, treatment, intervention, service, or item which is
22 prescribed, provided or ordered by a licensed physician, licensed psychologist, or registered nurse
23 practitioner in accordance with accepted standards of practice and which will or is reasonable and
24 which will, or is reasonably expected to, do any of the following:

25 (i) prevent the onset of an illness, condition injury or disability;

26 (ii) reduce or ameliorate the physical, mental or developmental effects of an illness,
27 condition, injury, or disability;

28 (iii) assist to achieve or maintain maximum functional capacity in performing daily
29 activities, taking into account both the functional capacity of the recipient and those functional
30 capacities that are appropriate of recipients of the same age;

31 f. “Pharmacy care” means medications prescribed by a licensed physician, licensed physician
32 assistant or certified registered nurse practitioner and any assessment, evaluation or test prescribed

1 or ordered by a licensed physician, licensed physician assistant or certified registered nurse
2 practitioner to determine the need or effectiveness of such medications;

3 g. "Psychiatric care" means direct or consultative services provided by a physician who
4 specializes in psychiatry;

5 h. "Psychological care" means direct or consultative services provided by a psychologist;

6 i. "Rehabilitative care" means professional services and treatment programs, including applied
7 behavior analysis, provided by an autism service provider to produce socially significant
8 improvements in human behavior or to prevent the loss of attained skill or function;

9 j. "Therapeutic care" means services provided by licensed or certified speech therapists,
10 occupational therapists, or physical therapists; and

11 k. "Treatment plan" means a plan for the treatment of autism spectrum disorders developed by a
12 licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation.

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14 SECTION 4. Section 3 of this act shall become effective January 1, 2010.

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