OKLAHOMA STATE SENATE
CONFERENCE
COMMITTEE REPORT

May 13, 2019

Mr. President:

Mr. Speaker:

The Conference Committee, to which was referred

SB 948

By: Rader of the Senate and Martinez and Steagall of the House

Title: Dental insurance; prohibiting denial of dental coverage except in certain circumstances after prior authorization. Effective date.

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together with Engrossed House Amendments thereto, beg leave to report that we have had the same under consideration and herewith return the same with the following recommendations:

1. That the House recede from all Amendments.

2. That the attached Conference Committee Substitute be adopted.

Respectfully submitted,

SENATE CONFEREES:

Rader

Stanley

Quinn

Brooks

Haste

Matthews

HOUSE CONFEREES:

Conference Committee on Insurance

Senate Action_____Date_____ House Action_____Date_____

SB948 CCR (A)
HOUSE CONFEREES

Bennett, Forrest		Marti, T.J.	
McEntire, Marcus		Moore, Lewis	
Sims, Lonnie		Sneed, Chris	Chris A. Sneed
Stone, Shane		Taylor, Zack	Zack Taylor

STATE OF OKLAHOMA

1st Session of the 57th Legislature (2019)

CONFERENCE COMMITTEE SUBSTITUTE
FOR ENGROSSED
SENATE BILL NO. 948 By: Rader of the Senate

and

Martinez and Steagall of the House

CONFERENCE COMMITTEE SUBSTITUTE

An Act relating to health insurance coverage requirements; defining terms; prohibiting denial of dental coverage after prior authorization except in certain circumstances; specifying circumstances in which denial is authorized; prohibiting requirement of certain documentation; requiring issuance of prior authorization within thirty days of request; applying certain provision to act; prohibiting recoupment of claim under certain circumstances; amending Section 1, Chapter 230, O.S.L. 2016 (36 O.S. Supp. 2018, Section 6060.21), which relates to the treatment of autism spectrum disorder; adding supervised assistant behavior analyst to covered providers for certain services; modifying definition; providing for codification; 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 7303 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. For the purposes of this section, "prior authorization" means any predetermination, prior authorization, or similar authorization that is verifiable, whether through issuance of letter, facsimile, email, or similar means, indicating that a specific procedure is, or multiple procedures are, covered under the patient's dental plan and reimbursable at a specific amount, subject to applicable coinsurance and deductibles, and issued in response to a request submitted by a dentist using a format prescribed by the insurer.

B. A dental service contractor shall not deny any claim subsequently submitted for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations such as annual maximums and frequency limitations not applicable at the time of the prior authorization are reached due to utilization subsequent to issuance of the prior authorization;

2. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

3. If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized

procedure would no longer be considered medically necessary, based on the prevailing standard of care;

4. If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would at that time required disapproval pursuant to the terms and conditions for coverage under the plan of the patient in effect at the time the prior authorization was used; or

5. The denial of the dental service contractor was due to one of the following:

a. another payor is responsible for payment,

b. the dentist has already been paid for the procedures identified on the claim,

c. the claim was submitted fraudulently or the prior authorization was based in whole or material part on erroneous information provided to the dental service contractor by the dentist, patient, or other person not related to the carrier, or

d. the person receiving the procedure was not eligible to receive the procedure on the date of service and the dental service contractor did not know, and with the exercise of reasonable care could not have known, of their eligibility status.

C. A dental service contractor shall not require any information be submitted for a prior authorization request that would not be required for submission of a claim.

D. A dental service contractor shall issue a prior authorization within thirty (30) days of the date a request is submitted by a dentist.

E. The provisions of Section 7301 of Title 36 of the Oklahoma Statutes shall apply to any denial of a claim pursuant to subsection B of this section for a procedure included in a prior authorization.

F. The dental service contractor shall not recoup a claim solely due to a loss of coverage of a patient or ineligibility if, at the time of treatment, the contractor erroneously confirms coverage and eligibility, but had sufficient information available to it indicating that the patient was no longer covered or was ineligible for coverage.

SECTION 2. AMENDATORY Section 1, Chapter 230, O.S.L. 2016 (36 O.S. Supp. 2018, Section 6060.21), is amended to read as follows:

Section 6060.21. A. For all plans issued or renewed on or after November 1, 2016, a health benefit plan and the Oklahoma Employees Health Insurance Plan shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in individuals less than nine (9) years of age, or if an individual is not diagnosed or treated until after three (3) years of age,

coverage shall be provided for at least six (6) years, provided that the individual continually and consistently shows sufficient progress and improvement as determined by the health care provider. No insurer shall terminate coverage, or refuse to deliver, execute, issue, amend, adjust or renew coverage to an individual solely because the individual is diagnosed with or has received treatment for an autism spectrum disorder.

B. Except as provided in subsection E of this section, coverage under this section shall not be subject to any limits on the number of visits an individual may make for treatment of autism spectrum disorder.

C. Coverage under this section shall not be subject to dollar limits, deductibles or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles or coinsurance provisions that apply to substantially all medical and surgical benefits under the health benefit plan, except as otherwise provided in subsection E of this section.

D. This section shall not be construed as limiting benefits that are otherwise available to an individual under a health benefit plan.

E. Coverage for applied behavior analysis shall be subject to a maximum benefit of twenty-five (25) hours per week and no more than Twenty-five Thousand Dollars ($25,000.00) per year. Beginning January 1, 2018, the Oklahoma Insurance Commissioner shall, on an

annual basis, adjust the maximum benefit for inflation by using the Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers (CPI-U). The Commissioner shall submit the adjusted maximum benefit for publication annually before January 1, 2018, and before the first day of January of each calendar year thereafter, and the published adjusted maximum benefit shall be applicable in the following calendar year to the Oklahoma Employees Health Insurance Plan and health benefit plans subject to this section. Payments made by an insurer on behalf of a covered individual for treatment other than applied behavior analysis shall not be applied toward any maximum benefit established under this section.

F. Coverage for applied behavior analysis shall include the services ~~of the~~ provided or supervised by a board-certified behavior analyst, a board-certified assistant behavior analyst or a licensed doctoral-level psychologist.

G. Except for inpatient services, if an insured is receiving treatment for an autism spectrum disorder, an insurer shall have the right to review the treatment plan annually, unless the insurer and the insured's treating physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall apply only to a particular insured being treated for an autism spectrum disorder and shall not apply to all individuals being treated for autism

spectrum disorder by a physician or psychologist. The cost of obtaining any review or treatment plan shall be borne by the insurer.

H. This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program or an individualized service plan.

I. Nothing in this section shall apply to nongrandfathered plans in the individual and small group markets that are required to include essential health benefits under the federal Patient Protection and Affordable Care Act, Public Law 111-148, or to Medicare supplement, accident-only, specified disease, hospital indemnity, disability income, long-term care or other limited benefit hospital insurance policies.

J. As used in this section:

1. "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior;

2. "Autism spectrum disorder" means any of the pervasive developmental disorders or autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of

Mental Disorders (DSM) or the edition that was in effect at the time of diagnosis;

3. "Behavioral health treatment" means counseling and treatment programs, including applied behavior analysis, that are:

a. necessary to develop, maintain or restore, to the maximum extent practicable, the functioning of an individual, and

b. provided or supervised by a board-certified behavior analyst, a board-certified assistant behavior analyst or by a licensed doctoral-level psychologist so long as the services performed are commensurate with the psychologist's university training and experience;

4. "Diagnosis of autism spectrum disorder" means medically necessary assessment, evaluations or tests to diagnose whether an individual has an autism spectrum disorder;

5. "Health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of Title 36 of the Oklahoma Statutes;

6. "Oklahoma Employees Health Insurance Plan" means "Health Insurance Plan" as defined in Section 1303 of Title 74 of the Oklahoma Statutes;

7. "Pharmacy care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications;

8. "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

9. "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

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

11. "Treatment for autism spectrum disorder" means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed doctoral-level psychologist who determines the care to be medically necessary, including, but not limited to:

a. behavioral health treatment,

b. pharmacy care,

c. psychiatric care,

d. psychological care, and

e. therapeutic care.

SECTION 3. This act shall become effective November 1, 2019.

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