HOUSE OF REPRESENTATIVES - FLOOR VERSION

STATE OF OKLAHOMA

2nd Session of the 58th Legislature (2022)

ENGROSSED SENATE
BILL NO. 861

By: Hicks, Matthews, and Simpson of the Senate

and

Worthen of the House

An Act relating to health benefit plans; amending 36 O.S. 2021, Sections 6060.2 and 6060.4, which relate to coverage for diabetes treatment and child immunization; requiring health benefit plans provide certain coverage; modifying definition; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2021, Section 6060.2, is amended to read as follows:

Section 6060.2. A. 1. Every health benefit plan issued or renewed on or after November 1, 1996, 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 the equipment and supplies have been approved by the federal Food and Drug Administration (FDA). 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 medical directors of health benefit plans selected by the State Department of Health. 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 symptoms or condition of the patient making medically necessary changes in the self-management of the patient, 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 supervising physician of the patient when medically necessary.

6. 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.

7. Any ~~carrier~~ health benefit plan, as defined pursuant to Section 6060.4 of this title, that provides coverage for insulin pursuant to this section shall cap the total amount that a covered person is required to pay for insulin at an amount not to exceed Thirty Dollars ($30.00) per thirty-day supply or Ninety Dollars ($90.00) per ninety-day supply of insulin for each covered insulin prescription, regardless of the amount or type of insulin needed to fill the prescription or prescriptions of the covered person.

a. Nothing in this paragraph shall prevent a ~~carrier~~ health benefit plan from reducing the cost-sharing of a covered person to an amount less than Thirty Dollars ($30.00) per thirty-day supply or Ninety Dollars ($90.00) per ninety-day supply.

b. The Insurance Commissioner shall ensure all ~~carriers~~ health benefit plans comply with the requirements of this paragraph.

c. The Commissioner may promulgate rules as necessary to implement and administer the requirements of this paragraph and to align with federal requirements.

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.

C. As used in this section, "health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of this title.

SECTION 2. AMENDATORY 36 O.S. 2021, 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 the 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, whether the payment is fixed or by indemnity~~

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 or employee self-insured plan as permitted under Employee Retirement Income Security Act of 1974.

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

a. a plan that provides coverage:

(1) only for a specified disease or diseases or under an individual limited benefit policy,

(2) only for accidental death or dismemberment,

(3) only for dental or vision care,

(4) a hospital confinement indemnity policy,

(5) disability income insurance or a combination of accident-only and disability income insurance, or

(6) 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. 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.

SECTION 3. This act shall become effective November 1, 2022.

COMMITTEE REPORT BY: COMMITTEE ON INSURANCE, dated 04/14/2022 - DO PASS.