HOUSE OF REPRESENTATIVES - FLOOR VERSION

STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

HOUSE BILL 3508 By: Sneed

AS INTRODUCED

An Act relating to the Employee Group Insurance Division; transferring the Employee Group Insurance Division from the Office of Management and Enterprise Services to the Oklahoma Public Employee Retirement System; amending 36 O.S. 2021, Section 6802, which relates to definitions for the Oklahoma Telemedicine Act; transferring the Employee Group Insurance Division from the Office of Management and Enterprise Services to the Oklahoma Public Employee Retirement System; amending 63 O.S. 2021, Section 2-309I, as amended by Section 1, Chapter 257, O.S.L. 2022 (63 O.S. Supp. 2023, Section 2-309I), which relates to prescription requirements for opioids and benzodiazepines; transferring the Employee Group Insurance Division from the Office of Management and Enterprise Services to the Oklahoma Public Employee Retirement System; amending 74 O.S. 2021, Section 1304.1, which relates to Oklahoma Employees Insurance and Benefits Board; transferring the Employee Group Insurance Division from the Office of Management and Enterprise Services to the Oklahoma Public Employee Retirement System; amending 85A O.S. 2021, Section 50, which relates to employer required to provide prompt medical treatment and fee schedule; transferring the Employee Group Insurance Division from the Office of Management and Enterprise Services to the Oklahoma Public Employee Retirement System; providing for codification; providing an effective date; and declaring an emergency.

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 1304.2 of Title 74, unless there is created a duplication in numbering, reads as follows:

Effective July 1, 2024, the Employee Group Insurance Division of the Office of Management and Enterprise Services shall be transferred to the Oklahoma Public Employees Retirement System. All unexpended funds, property, records, personnel, and any outstanding financial obligations or encumbrances of the Office of Management and Enterprise Services which relate to the Employee Group Division Insurance Division are hereby transferred to the Oklahoma Public Employees Retirement System.

SECTION 2. AMENDATORY 36 O.S. 2021, Section 6802, is amended to read as follows:

Section 6802. As used in the Oklahoma Telemedicine Act:

1. "Distant site" means a site at which a health care professional licensed to practice in this state is located while providing health care services by means of telemedicine;

2. a. "Health benefits plan" means any plan or arrangement that:

(1) provides benefits for medical or surgical expenses incurred as a result of a health condition, accident or illness, and

(2) is offered by any insurance company, group hospital service corporation 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,

b. Health benefits plan shall not include:

(1) a plan that provides coverage:

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

(b) only for accidental death or dismemberment,

(c) only for dental or vision care,

(d) for a hospital confinement indemnity policy,

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

(f) as a supplement to liability insurance,

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

(3) workers' compensation insurance coverage,

(4) medical payment insurance issued as part of a motor vehicle insurance policy,

(5) 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 benefits plan,

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

(7) a plan offered by the Employees Group Insurance Division of the ~~Office of Management and Enterprise Services~~ Oklahoma Public Employees Retirement System;

3. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law;

4. "Insurer" means any entity providing an accident and health insurance policy in this state including, but not limited to, a

licensed insurance company, a not-for-profit hospital service and medical indemnity corporation, a fraternal benefit society, a multiple employer welfare arrangement or any other entity subject to regulation by the Insurance Commissioner;

5. "Originating site" means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine, which may include, but shall not be restricted to, a patient's home, workplace or school;

6. "Remote patient monitoring services" means the delivery of home health services using telecommunications technology to enhance the delivery of home health care including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose and other condition-specific data, medication adherence monitoring and interactive video conferencing with or without digital image upload;

7. "Store and forward transfer" means the transmission of a patient's medical information either to or from an originating site or to or from the health care professional at the distant site, but does not require the patient being present nor must it be in real time; and

8. "Telemedicine" or "telehealth" means technology-enabled health and care management and delivery systems that extend capacity and access, which includes:

a. synchronous mechanisms, which may include live audiovisual interaction between a patient and a health care professional or real-time provider-to-provider consultation through live interactive audiovisual means,

b. asynchronous mechanisms, which include store and forward transfers, online exchange of health information between a patient and a health care professional and online exchange of health information between health care professionals, but shall not include the use of automated text messages or automated mobile applications that serve as the sole interaction between a patient and a health care professional,

c. remote patient monitoring, and

d. other electronic means that support clinical health care, professional consultation, patient and professional health-related education, public health and health administration.

SECTION 3. AMENDATORY 63 O.S. 2021, Section 2-309I, as amended by Section 1, Chapter 257, O.S.L. 2022 (63 O.S. Supp. 2023, Section 2-309I), is amended to read as follows:

Section 2-309I. A. A practitioner shall not issue an initial prescription for an opioid drug in a quantity exceeding a seven-day

supply for treatment of acute pain. Any opioid prescription for acute pain shall be for the lowest effective dose of an immediate-release drug.

B. Prior to issuing an initial prescription for an opioid drug in a course of treatment for acute or chronic pain, a practitioner shall:

1. Take and document the results of a thorough medical history, including the experience of the patient with nonopioid medication and nonpharmacological pain-management approaches and substance abuse history;

2. Conduct, as appropriate, and document the results of a physical examination;

3. Develop a treatment plan with particular attention focused on determining the cause of pain of the patient;

4. Access relevant prescription monitoring information from the central repository pursuant to Section 2-309D of this title;

5. Limit the supply of any opioid drug prescribed for acute pain to a duration of no more than seven (7) days as determined by the directed dosage and frequency of dosage; provided, however, upon issuing an initial prescription for acute pain pursuant to this section, the practitioner may issue one (1) subsequent prescription for an opioid drug in a quantity not to exceed seven (7) days if:

a. the subsequent prescription is due to a major surgical procedure or "confined to home" status as defined in 42 U.S.C., Section 1395n(a),

b. the practitioner provides the subsequent prescription on the same day as the initial prescription,

c. the practitioner provides written instructions on the subsequent prescription indicating the earliest date on which the prescription may be filled, otherwise known as a "do not fill until" date, and

d. the subsequent prescription is dispensed no more than five (5) days after the "do not fill until" date indicated on the prescription;

6. In the case of a patient under the age of eighteen (18) years, enter into a patient-provider agreement with a parent or guardian of the patient; and

7. In the case of a patient who is a pregnant woman, enter into a patient-provider agreement with the patient.

C. No less than seven (7) days after issuing the initial prescription pursuant to subsection A of this section, the practitioner, after consultation with the patient, may issue a subsequent prescription for the drug to the patient in a quantity not to exceed seven (7) days, provided that:

1. The subsequent prescription would not be deemed an initial prescription under this section;

2. The practitioner determines the prescription is necessary and appropriate to the treatment needs of the patient and documents the rationale for the issuance of the subsequent prescription; and

3. The practitioner determines that issuance of the subsequent prescription does not present an undue risk of abuse, addiction or diversion and documents that determination.

D. Prior to issuing the initial prescription of an opioid drug in a course of treatment for acute or chronic pain and again prior to issuing the third prescription of the course of treatment, a practitioner shall discuss with the patient or the parent or guardian of the patient if the patient is under eighteen (18) years of age and is not an emancipated minor, the risks associated with the drugs being prescribed, including but not limited to:

1. The risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants;

2. The reasons why the prescription is necessary;

3. Alternative treatments that may be available; and

4. Risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed or mixing

sedatives, benzodiazepines or alcohol with opioids can result in fatal respiratory depression.

The practitioner shall include a note in the medical record of the patient that the patient or the parent or guardian of the patient, as applicable, has discussed with the practitioner the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available. The applicable state licensing board of the practitioner shall develop and make available to practitioners guidelines for the discussion required pursuant to this subsection.

E. At the time of the issuance of the third prescription for an opioid drug, the practitioner shall enter into a patient-provider agreement with the patient.

F. When an opioid drug is continuously prescribed for three (3) months or more for chronic pain, the practitioner shall:

1. Review, at a minimum of every three (3) months, the course of treatment, any new information about the etiology of the pain, and the progress of the patient toward treatment objectives and document the results of that review;

2. In the first year of the patient-provider agreement, assess the patient prior to every renewal to determine whether the patient is experiencing problems associated with an opioid use disorder as defined by the American Psychiatric Association and document the results of that assessment. Following one (1) year of compliance

with the patient-provider agreement, the practitioner shall assess the patient at a minimum of every six (6) months;

3. Periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, try other drugs or treatment modalities in an effort to reduce the potential for abuse or the development of an opioid use disorder as defined by the American Psychiatric Association and document with specificity the efforts undertaken;

4. Review the central repository information in accordance with Section 2-309D of this title; and

5. Monitor compliance with the patient-provider agreement and any recommendations that the patient seek a referral.

G. 1. Any prescription for acute pain pursuant to this section shall have the words "acute pain" notated on the face of the prescription by the practitioner.

2. Any prescription for chronic pain pursuant to this section shall have the words "chronic pain" notated on the face of the prescription by the practitioner.

H. This section shall not apply to a prescription for a patient:

1. Who has sickle cell disease;

2. Who is in treatment for cancer or receiving aftercare cancer treatment;

3. Who is receiving hospice care from a licensed hospice;

4. Who is receiving palliative care in conjunction with a serious illness;

5. Who is a resident of a long-term care facility; or

6. For any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence.

I. Every policy, contract or plan delivered, issued, executed or renewed in this state, or approved for issuance or renewal in this state by the Insurance Commissioner, and every contract purchased by the Employees Group Insurance Division of the ~~Office of Management and Enterprise Services~~ Oklahoma Public Employees Retirement System, on or after November 1, 2018, that provides coverage for prescription drugs subject to a copayment, coinsurance or deductible shall charge a copayment, coinsurance or deductible for an initial prescription of an opioid drug prescribed pursuant to this section that is either:

1. Proportional between the cost sharing for a thirty-day supply and the amount of drugs the patient was prescribed; or

2. Equivalent to the cost sharing for a full thirty-day supply of the drug, provided that no additional cost sharing may be charged for any additional prescriptions for the remainder of the thirty-day supply.

J. Any practitioner authorized to prescribe an opioid drug shall adopt and maintain a written policy or policies that include execution of a written agreement to engage in an informed consent

process between the prescribing practitioner and qualifying opioid therapy patient. For the purposes of this section, "qualifying opioid therapy patient" means:

1. A patient requiring opioid treatment for more than three (3) months;

2. A patient who is prescribed benzodiazepines and opioids together for more than one twenty-four-hour period; or

3. A patient who is prescribed a dose of opioids that exceeds one hundred (100) morphine equivalent doses.

K. Nothing in the Anti-Drug Diversion Act shall be construed to require a practitioner to limit or forcibly taper a patient on opioid therapy. The standard of care requires effective and individualized treatment for each patient as deemed appropriate by the prescribing practitioner without an administrative or codified limit on dose or quantity that is more restrictive than approved by the Food and Drug Administration (FDA).

SECTION 4. AMENDATORY 74 O.S. 2021, Section 1304.1, is amended to read as follows:

Section 1304.1 A. The State and Education Employees Group Insurance Board and the Oklahoma State Employees Benefits Council are hereby abolished. Wherever the State and Education Employees Group Insurance Board and the Oklahoma State Employees Benefits Council are referenced in law, that reference shall be construed to mean the Oklahoma Employees Insurance and Benefits Board.

B. There is hereby created the Oklahoma Employees Insurance and Benefits Board.

C. The chair and vice-chair shall be elected by the Board members at the first meeting of the Board and shall preside over meetings of the Board and perform other duties as may be required by the Board. Upon the resignation or expiration of the term of the chair or vice-chair, the members shall elect a chair or vice-chair. The Board shall elect one of its members to serve as secretary.

D. The Board shall consist of seven (7) members to be appointed as follows:

1. The State Insurance Commissioner, or designee;

2. Four members shall be appointed by the Governor;

3. One member shall be appointed by the Speaker of the Oklahoma House of Representatives; and

4. One member shall be appointed by the President Pro Tempore of the State Senate.

E. The appointed members shall:

1. Have demonstrated professional experience in investment or funds management, public funds management, public or private group health or pension fund management, or group health insurance management;

2. Be licensed to practice law in this state and have demonstrated professional experience in commercial matters; or

3. Be licensed by the Oklahoma Accountancy Board to practice in this state as a public accountant or a certified public accountant.

In making appointments that conform to the requirements of this subsection, at least one but not more than three members shall be appointed each from paragraphs 2 and 3 of this subsection by the combined appointing authorities.

F. Each member of the Board shall serve a term of four (4) years from the date of appointment.

G. Members of the Board shall be subject to the following:

1. The appointed members shall each receive compensation of Five Hundred Dollars ($500.00) per month. Appointed members who fail to attend a regularly scheduled meeting of the Board shall not receive the related compensation;

2. The appointed members shall be reimbursed for their expenses, according to the State Travel Reimbursement Act, as are incurred in the performance of their duties, which shall be paid from the Health Insurance Reserve Fund;

3. In the event an appointed member does not attend at least seventy-five percent (75%) of the regularly scheduled meetings of the Board during a calendar year, the appointing authority may remove the member;

4. A member may also be removed for any other cause as provided by law;

5. No Board member shall be individually or personally liable for any action of the Board; and

6. Participation on the Board is contingent upon maintaining all necessary annual training as may be required through the Health Insurance Portability and Accountability Act of 1996, Medicare contracting requirements or other statutory or regulatory guidelines.

H. The Board shall meet as often as necessary to conduct business but shall meet no less than four times a year, with an organizational meeting to be held prior to December 1, 2012. The organizational meeting shall be called by the Insurance Commissioner. A majority of the members of the Board shall constitute a quorum for the transaction of business, and any official action of the Board must have a favorable vote by a majority of the members of the Board present.

I. Except as otherwise provided in this subsection, no member of the Board shall be a lobbyist registered in this state as provided by law, or be employed directly or indirectly by any firm or health care provider under contract to the State and Education Employees Group Insurance Board, the Oklahoma State Employees Benefits Council, or the Oklahoma Employees Insurance and Benefits Board, or any benefit program under its jurisdiction, for any goods or services whatsoever. Any physician member of the Board shall not be subject to the provisions of this subsection.

J. Any vacancy occurring on the Board shall be filled for the unexpired term of office in the same manner as provided for in subsection D of this section.

K. The Board shall act in accordance with the provisions of the Oklahoma Open Meeting Act, the Oklahoma Open Records Act and the Administrative Procedures Act.

L. The Administrative Director of the Courts shall designate grievance panel members as shall be necessary. The members of the grievance panel shall consist of two attorneys licensed to practice law in this state and one state licensed health care professional or health care administrator who has at least three (3) years practical experience, has had or has admitting privileges to a hospital in this state, has a working knowledge of prescription medication, or has worked in an administrative capacity at some point in their career. The state health care professional shall be appointed by the Governor. At the Governor's discretion, one or more qualified individuals may also be appointed as an alternate to serve on the grievance panel in the event the Governor's primary appointee becomes unable to serve.

M. The ~~Office of Management and Enterprise Services~~ Oklahoma Public Employees Retirement System shall have the following duties, responsibilities and authority with respect to the administration of the flexible benefits plan authorized pursuant to the State Employees Flexible Benefits Act:

1. To construe and interpret the plan, and decide all questions of eligibility in accordance with the Oklahoma State Employees Benefits Act and 26 U.S.C.A., Section 1 et seq.;

2. To select those benefits which shall be made available to participants under the plan, according to the Oklahoma State Employees Benefits Act, and other applicable laws and rules;

3. To prescribe procedures to be followed by participants in making elections and filing claims under the plan;

4. Beginning with the plan year which begins on January 1, 2013, to select and contract with one or more providers to offer a group TRICARE Supplement product to eligible employees who are eligible TRICARE beneficiaries. Any membership dues required to participate in a group TRICARE Supplement product offered pursuant to this paragraph shall be paid by the employee. As used in this paragraph, "TRICARE" means the Department of Defense health care program for active duty and retired service members and their families;

5. To prepare and distribute information communicating and explaining the plan to participating employers and participants. Health Maintenance Organizations or other third-party insurance vendors may be directly or indirectly involved in the distribution of communicated information to participating state agency employers and state employee participants subject to the following condition:

the Board shall verify all marketing and communications information for factual accuracy prior to distribution;

6. To receive from participating employers and participants such information as shall be necessary for the proper administration of the plan, and any of the benefits offered thereunder;

7. To furnish the participating employers and participants such annual reports with respect to the administration of the plan as are reasonable and appropriate;

8. To keep reports of benefit elections, claims and disbursements for claims under the plan;

9. To negotiate for best and final offer through competitive negotiation with the assistance and through the purchasing procedures adopted by the ~~Office of Management and Enterprise Services~~ Oklahoma Public Employees Retirement System and contract with federally qualified health maintenance organizations under the provisions of 42 U.S.C., Section 300e et seq., or with Health Maintenance Organizations granted a certificate of authority by the Insurance Commissioner pursuant to the Health Maintenance Reform Act of 2003 for consideration by participants as an alternative to the health plans offered by the Oklahoma Employees Insurance and Benefits Board, and to transfer to the health maintenance organizations such funds as may be approved for a participant electing health maintenance organization alternative services. The Board may also select and contract with a vendor to offer a point-

of-service plan. An HMO may offer coverage through a point-of-service plan, subject to the guidelines established by the Board. However, if the Board chooses to offer a point-of-service plan, then a vendor that offers both an HMO plan and a point-of-service plan may choose to offer only its point-of-service plan in lieu of offering its HMO plan. The Board may, however, renegotiate rates with successful bidders after contracts have been awarded if there is an extraordinary circumstance. An extraordinary circumstance shall be limited to insolvency of a participating health maintenance organization or point-of-service plan, dissolution of a participating health maintenance organization or point-of-service plan or withdrawal of another participating health maintenance organization or point-of-service plan at any time during the calendar year. Nothing in this section of law shall be construed to permit either party to unilaterally alter the terms of the contract;

10. To retain as confidential information the initial Request For Proposal offers as well as any subsequent bid offers made by the health plans prior to final contract awards as a part of the best and final offer negotiations process for the benefit plan;

11. To promulgate administrative rules for the competitive negotiation process;

12. To require vendors offering coverage to provide such enrollment and claims data as is determined by the Board. The Board shall be authorized to retain as confidential any proprietary

information submitted in response to the Board's Request For Proposal. Provided, however, that any such information requested by the Board from the vendors shall only be subject to the confidentiality provision of this paragraph if it is clearly designated in the Request For Proposal as being protected under this provision. All requested information lacking such a designation in the Request For Proposal shall be subject to Section 24A.1 et seq. of Title 51 of the Oklahoma Statutes. From health maintenance organizations, data provided shall include the current Health Plan Employer Data and Information Set (HEDIS);

13. To authorize the purchase of any insurance deemed necessary for providing benefits under the plan including indemnity dental plans, provided that the only indemnity health plan selected by the Board shall be the indemnity plan offered by the Board, and to transfer to the Board such funds as may be approved for a participant electing a benefit plan offered by the Board. All indemnity dental plans shall meet or exceed the following requirements:

a. they shall have a statewide provider network,

b. they shall provide benefits which shall reimburse the expense for the following types of dental procedures:

(1) diagnostic,

(2) preventative,

(3) restorative,

(4) endodontic,

(5) periodontic,

(6) prosthodontics,

(7) oral surgery,

(8) dental implants,

(9) dental prosthetics, and

(10) orthodontics, and

c. they shall provide an annual benefit of not less than One Thousand Five Hundred Dollars ($1,500.00) for all services other than orthodontic services, and a lifetime benefit of not less than One Thousand Five Hundred Dollars ($1,500.00) for orthodontic services;

14. To communicate deferred compensation programs as provided in Section 1701 of Title 74 of the Oklahoma Statutes;

15. To assess and collect reasonable fees from contracted health maintenance organizations and third-party insurance vendors to offset the costs of administration;

16. To accept, modify or reject elections under the plan in accordance with the Oklahoma State Employees Benefits Act and 26 U.S.C.A., Section 1 et seq.;

17. To promulgate election and claim forms to be used by participants;

18. To adopt rules requiring payment for medical and dental services and treatment rendered by duly licensed hospitals,

physicians and dentists. Unless the Board has otherwise contracted with the out-of-state health care provider, the Board shall reimburse for medical services and treatment rendered and charged by an out-of-state health care provider at least at the same percentage level as the network percentage level of the fee schedule established by the Oklahoma Employees Insurance and Benefits Board if the insured employee was referred to the out-of-state health care provider by a physician or it was an emergency situation and the out-of-state provider was the closest in proximity to the place of residence of the employee which offers the type of health care services needed. For purposes of this paragraph, health care providers shall include, but not be limited to, physicians, dentists, hospitals and special care facilities;

19. To enter into a contract with out-of-state providers in connection with any PPO or hospital or medical network plan which shall include, but not be limited to, special care facilities and hospitals outside the borders of the State of Oklahoma. The contract for out-of-state providers shall be identical to the in-state provider contracts. The Board may negotiate for discounts from billed charges when the out-of-state provider is not a network provider and the member sought services in an emergency situation, when the services were not otherwise available in the State of Oklahoma or when the Administrator appointed by the Board approved the service as an exceptional circumstance;

20. To create the establishment of a grievance procedure by which a three-member grievance panel shall act as an appeals body for complaints by insured employees regarding the allowance and payment of claims, eligibility, and other matters. Except for grievances settled to the satisfaction of both parties prior to a hearing, any person who requests in writing a hearing before the grievance panel shall receive a hearing before the panel. The grievance procedure provided by this paragraph shall be the exclusive remedy available to insured employees having complaints against the insurer. Such grievance procedure shall be subject to the Oklahoma Administrative Procedures Act, including provisions thereof for review of agency decisions by the district court. The grievance panel shall schedule a hearing regarding the allowance and payment of claims, eligibility and other matters within sixty (60) days from the date the grievance panel receives a written request for a hearing unless the panel orders a continuance for good cause shown. Upon written request by the insured employee to the grievance panel and received not less than ten (10) days before the hearing date, the grievance panel shall cause a full stenographic record of the proceedings to be made by a competent court reporter at the insured employee's expense; and

21. To intercept monies owing to plan participants from other state agencies, when those participants in turn owe money to the ~~Office of Management and Enterprise Services~~ Oklahoma Public

Employees Retirement System, and to ensure that the participants are afforded due process of law.

N. Except for a breach of fiduciary obligation, a Board member shall not be individually or personally responsible for any action of the Board.

O. The Board shall operate in an advisory capacity to the ~~Office of Management and Enterprise Services~~ Oklahoma Public Employees Retirement System.

P. The members of the Board shall not accept gifts or gratuities from an individual organization with a value in excess of Ten Dollars ($10.00) per year. The provisions of this section shall not be construed to prevent the members of the Board from attending educational seminars, conferences, meetings or similar functions.

SECTION 5. AMENDATORY 85A O.S. 2021, Section 50, is amended to read as follows:

Section 50. A. The employer shall promptly provide an injured employee with medical, surgical, hospital, optometric, podiatric, chiropractic and nursing services, along with any medicine, crutches, ambulatory devices, artificial limbs, eyeglasses, contact lenses, hearing aids, and other apparatus as may be reasonably necessary in connection with the injury received by the employee. The employer shall have the right to choose the treating physician or chiropractor.

B. If the employer fails or neglects to provide medical treatment within five (5) days after actual knowledge is received of an injury, the injured employee may select a physician or chiropractor to provide medical treatment at the expense of the employer; provided, however, that the injured employee, or another in the employee's behalf, may obtain emergency treatment at the expense of the employer where such emergency treatment is not provided by the employer.

C. Diagnostic tests shall not be repeated sooner than six (6) months from the date of the test unless agreed to by the parties or ordered by the Commission for good cause shown.

D. Unless recommended by the treating doctor or chiropractor at the time claimant reaches maximum medical improvement or by an independent medical examiner, continuing medical maintenance shall not be awarded by the Commission. The employer or insurance carrier shall not be responsible for continuing medical maintenance or pain management treatment that is outside the parameters established by the Physician Advisory Committee or ODG. The employer or insurance carrier shall not be responsible for continuing medical maintenance or pain management treatment not previously ordered by the Commission or approved in advance by the employer or insurance carrier.

E. An employee claiming or entitled to benefits under the Administrative Workers' Compensation Act, shall, if ordered by the

Commission or requested by the employer or insurance carrier, submit himself or herself for medical examination. If an employee refuses to submit himself or herself to examination, his or her right to prosecute any proceeding under the Administrative Workers' Compensation Act shall be suspended, and no compensation shall be payable for the period of such refusal.

F. For compensable injuries resulting in the use of a medical device, ongoing service for the medical device shall be provided in situations including, but not limited to, medical device battery replacement, ongoing medication refills related to the medical device, medical device repair, or medical device replacement.

G. The employer shall reimburse the employee for the actual mileage in excess of twenty (20) miles round trip to and from the employee's home to the location of a medical service provider for all reasonable and necessary treatment, for an evaluation of an independent medical examiner and for any evaluation made at the request of the employer or insurance carrier. The rate of reimbursement for such travel expense shall be the official reimbursement rate as established by the State Travel Reimbursement Act. In no event shall the reimbursement of travel for medical treatment or evaluation exceed six hundred (600) miles round trip.

H. Fee Schedule.

1. The Commission shall conduct a review and update of the Current Procedural Terminology (CPT) in the Fee Schedule every two

(2) years pursuant to the provisions of paragraph 14 of this subsection. The Fee Schedule shall establish the maximum rates that medical providers shall be reimbursed for medical care provided to injured employees including, but not limited to, charges by physicians, chiropractors, dentists, counselors, hospitals, ambulatory and outpatient facilities, clinical laboratory services, diagnostic testing services, and ambulance services, and charges for durable medical equipment, prosthetics, orthotics, and supplies. The most current Fee Schedule established by the Administrator of the Workers' Compensation Court prior to February 1, 2014, shall remain in effect, unless or until the Legislature approves the Commission's proposed Fee Schedule.

2. Reimbursement for medical care shall be prescribed and limited by the Fee Schedule. The director of the Employees Group Insurance Division of the ~~Office of Management and Enterprise Services~~ Oklahoma Public Employees Retirement System shall provide the Commission such information as may be relevant for the development of the Fee Schedule. The Commission shall develop the Fee Schedule in a manner in which quality of medical care is assured and maintained for injured employees. The Commission shall give due consideration to additional requirements for physicians treating an injured worker under the Administrative Workers' Compensation Act, including, but not limited to, communication with claims representatives, case managers, attorneys, and representatives of

employers, and the additional time required to complete forms for the Commission, insurance carriers, and employers.

3. In making adjustments to the Fee Schedule, the Commission shall use, as a benchmark, the reimbursement rate for each Current Procedural Terminology (CPT) code provided for in the fee schedule published by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services for use in Oklahoma (Medicare Fee Schedule) on the effective date of this section, workers' compensation fee schedules employed by neighboring states, the latest edition of "Relative Values for Physicians" (RVP), usual, customary and reasonable medical payments to workers' compensation health care providers in the same trade area for comparable treatment of a person with similar injuries, and all other data the Commission deems relevant. For services not valued by CMS, the Commission shall establish values based on the usual, customary and reasonable medical payments to health care providers in the same trade area for comparable treatment of a person with similar injuries.

a. No reimbursement shall be allowed for any magnetic resonance imaging (MRI) unless the MRI is provided by an entity that meets Medicare requirements for the payment of MRI services or is accredited by the American College of Radiology, the Intersocietal Accreditation Commission or the Joint Commission on

Accreditation of Healthcare Organizations. For all other radiology procedures, the reimbursement rate shall be the lesser of the reimbursement rate allowed by the 2010 Oklahoma Fee Schedule and two hundred seven percent (207%) of the Medicare Fee Schedule.

b. For reimbursement of medical services for Evaluation and Management of injured employees as defined in the Fee Schedule adopted by the Commission, the reimbursement rate shall not be less than one hundred fifty percent (150%) of the Medicare Fee Schedule.

c. Any entity providing durable medical equipment, prosthetics, orthotics or supplies shall be accredited by a CMS-approved accreditation organization. If a physician provides durable medical equipment, prosthetics, orthotics, prescription drugs, or supplies to a patient ancillary to the patient's visit, reimbursement shall be no more than ten percent (10%) above cost.

d. The Commission shall develop a reasonable stop-loss provision of the Fee Schedule to provide for adequate reimbursement for treatment for major burns, severe head and neurological injuries, multiple system injuries, and other catastrophic injuries requiring extended periods of intensive care. An employer or

insurance carrier shall have the right to audit the charges and question the reasonableness and necessity of medical treatment contained in a bill for treatment covered by the stop-loss provision.

4. The right to recover charges for every type of medical care for injuries arising out of and in the course of covered employment as defined in the Administrative Workers' Compensation Act shall lie solely with the Commission. When a medical care provider has brought a claim to the Commission to obtain payment for services, a party who prevails in full on the claim shall be entitled to reasonable attorney fees.

5. Nothing in this section shall prevent an employer, insurance carrier, group self-insurance association, or certified workplace medical plan from contracting with a provider of medical care for a reimbursement rate that is greater than or less than limits established by the Fee Schedule.

6. A treating physician may not charge more than Four Hundred Dollars ($400.00) per hour for preparation for or testimony at a deposition or appearance before the Commission in connection with a claim covered by the Administrative Workers' Compensation Act.

7. The Commission's review of medical and treatment charges pursuant to this section shall be conducted pursuant to the Fee Schedule in existence at the time the medical care or treatment was provided. The judgment approving the medical and treatment charges

pursuant to this section shall be enforceable by the Commission in the same manner as provided in the Administrative Workers' Compensation Act for the enforcement of other compensation payments.

8. Charges for prescription drugs dispensed by a pharmacy shall be limited to ninety percent (90%) of the average wholesale price of the prescription, plus a dispensing fee of Five Dollars ($5.00) per prescription. "Average wholesale price" means the amount determined from the latest publication designated by the Commission. Physicians shall prescribe and pharmacies shall dispense generic equivalent drugs when available. If the National Drug Code, or "NDC", for the drug product dispensed is for a repackaged drug, then the maximum reimbursement shall be the lesser of the original labeler's NDC and the lowest-cost therapeutic equivalent drug product. Compounded medications shall be billed by the compounding pharmacy at the ingredient level, with each ingredient identified using the applicable NDC of the drug product, and the corresponding quantity. Ingredients with no NDC area are not separately reimbursable. Payment shall be based on a sum of the allowable fee for each ingredient plus a dispensing fee of Five Dollars ($5.00) per prescription.

9. When medical care includes prescription drugs dispensed by a physician or other medical care provider and the NDC for the drug product dispensed is for a repackaged drug, then the maximum reimbursement shall be the lesser of the original labeler's NDC and

the lowest-cost therapeutic equivalent drug product. Payment shall be based upon a sum of the allowable fee for each ingredient plus a dispensing fee of Five Dollars ($5.00) per prescription. Compounded medications shall be billed by the compounding pharmacy.

10. Implantables are paid in addition to procedural reimbursement paid for medical or surgical services. A manufacturer's invoice for the actual cost to a physician, hospital or other entity of an implantable device shall be adjusted by the physician, hospital or other entity to reflect, at the time implanted, all applicable discounts, rebates, considerations and product replacement programs and shall be provided to the payer by the physician or hospital as a condition of payment for the implantable device. If the physician, or an entity in which the physician has a financial interest other than an ownership interest of less than five percent (5%) in a publically traded company, provides implantable devices, this relationship shall be disclosed to patient, employer, insurance company, third-party commission, certified workplace medical plan, case managers, and attorneys representing claimant and defendant. If the physician, or an entity in which the physician has a financial interest other than an ownership interest of less than five percent (5%) in a publicly traded company, buys and resells implantable devices to a hospital or another physician, the markup shall be limited to ten percent (10%) above cost.

11. Payment for medical care as required by the Administrative Workers' Compensation Act shall be due within forty-five (45) days of the receipt by the employer or insurance carrier of a complete and accurate invoice, unless the employer or insurance carrier has a good-faith reason to request additional information about such invoice. Thereafter, the Commission may assess a penalty up to twenty-five percent (25%) for any amount due under the Fee Schedule that remains unpaid on the finding by the Commission that no good-faith reason existed for the delay in payment. If the Commission finds a pattern of an employer or insurance carrier willfully and knowingly delaying payments for medical care, the Commission may assess a civil penalty of not more than Five Thousand Dollars ($5,000.00) per occurrence.

12. If an employee fails to appear for a scheduled appointment with a physician or chiropractor, the employer or insurance company shall pay to the physician or chiropractor a reasonable charge, to be determined by the Commission, for the missed appointment. In the absence of a good-faith reason for missing the appointment, the Commission shall order the employee to reimburse the employer or insurance company for the charge.

13. Physicians or chiropractors providing treatment under the Administrative Workers' Compensation Act shall disclose under penalty of perjury to the Commission, on a form prescribed by the Commission, any ownership or interest in any health care facility,

business, or diagnostic center that is not the physician's or chiropractor's primary place of business. The disclosure shall include any employee leasing arrangement between the physician or chiropractor and any health care facility that is not the physician's or chiropractor's primary place of business. A physician's or chiropractor's failure to disclose as required by this section shall be grounds for the Commission to disqualify the physician or chiropractor from providing treatment under the Administrative Workers' Compensation Act.

14. a. Beginning on May 28, 2019, the Commission shall conduct an evaluation of the Fee Schedule, which shall include an update of the list of Current Procedural Terminology (CPT) codes, a line item adjustment or renewal of all rates, and amendment as needed to the rules applicable to the Fee Schedule.

b. The Commission shall contract with an external consultant with knowledge of workers' compensation fee schedules to review regional and nationwide comparisons of Oklahoma's Fee Schedule rates and date and market for medical services. The consultant shall receive written and oral comment from employers, workers' compensation medical service and insurance providers, self-insureds, group self-insurance associations of this state and the public. The

consultant shall submit a report of its findings and a proposed amended Fee Schedule to the Commission.

c. The Commission shall adopt the proposed amended Fee Schedule in whole or in part and make any additional updates or adjustments. The Commission shall submit a proposed updated and adjusted Fee Schedule to the President Pro Tempore of the Senate, the Speaker of the House of Representatives and the Governor. The proposed Fee Schedule shall become effective on July 1 following the legislative session, if approved by Joint Resolution of the Legislature during the session in which a proposed Fee Schedule is submitted.

d. Beginning on May 28, 2019, an external evaluation shall be conducted and a proposed amended Fee Schedule shall be submitted to the Legislature for approval during the 2020 legislative session. Thereafter, an external evaluation shall be conducted and a proposed amended Fee Schedule shall be submitted to the Legislature for approval every two (2) years.

I. Formulary. The Commission by rule shall adopt a closed formulary. Rules adopted by the Commission shall allow an appeals process for claims in which a treating doctor determines and documents that a drug not included in the formulary is necessary to treat an injured employee's compensable injury. The Commission by

rule shall require the use of generic pharmaceutical medications and clinically appropriate over-the-counter alternatives to prescription medications unless otherwise specified by the prescribing doctor, in accordance with applicable state law.

SECTION 6. This act shall become effective July 1, 2024.

SECTION 7. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

COMMITTEE REPORT BY: COMMITTEE ON GOVERNMENT MODERNIZATION AND TECHNOLOGY, dated 02/13/2024 - DO PASS.