

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.

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

2 SECTION 1. NEW LAW A new section of law to be codified  
3 in the Oklahoma Statutes as Section 1304.2 of Title 74, unless there  
4 is created a duplication in numbering, reads as follows:

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

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

15 Section 6802. As used in the Oklahoma Telemedicine Act:

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

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

21 (1) provides benefits for medical or surgical  
22 expenses incurred as a result of a health  
23 condition, accident or illness, and  
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1 (2) is offered by any insurance company, group  
2 hospital service corporation or health  
3 maintenance organization that delivers or issues  
4 for delivery an individual, group, blanket or  
5 franchise insurance policy or insurance  
6 agreement, a group hospital service contract or  
7 an evidence of coverage, or, to the extent  
8 permitted by the Employee Retirement Income  
9 Security Act of 1974, 29 U.S.C., Section 1001 et  
10 seq., by a multiple employer welfare arrangement  
11 as defined in Section 3 of the Employee  
12 Retirement Income Security Act of 1974, or any  
13 other analogous benefit arrangement, whether the  
14 payment is fixed or by indemnity,

15 b. Health benefits plan shall not include:

16 (1) a plan that provides coverage:

- 17 (a) only for a specified disease or diseases or  
18 under an individual limited benefit policy,  
19 (b) only for accidental death or dismemberment,  
20 (c) only for dental or vision care,  
21 (d) for a hospital confinement indemnity policy,  
22 (e) for disability income insurance or a  
23 combination of accident-only and disability  
24 income insurance, or  
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- 1 (f) as a supplement to liability insurance,  
2 (2) a Medicare supplemental policy as defined by  
3 Section 1882(g)(1) of the Social Security Act (42  
4 U.S.C., Section 1395ss),  
5 (3) workers' compensation insurance coverage,  
6 (4) medical payment insurance issued as part of a  
7 motor vehicle insurance policy,  
8 (5) a long-term care policy including a nursing home  
9 fixed indemnity policy, unless a determination is  
10 made that the policy provides benefit coverage so  
11 comprehensive that the policy meets the  
12 definition of a health benefits plan,  
13 (6) short-term health insurance issued on a  
14 nonrenewable basis with a duration of six (6)  
15 months or less, or  
16 (7) a plan offered by the Employees Group Insurance  
17 Division of the ~~Office of Management and~~  
18 ~~Enterprise Services~~ Oklahoma Public Employees  
19 Retirement System;

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

23 4. "Insurer" means any entity providing an accident and health  
24 insurance policy in this state including, but not limited to, a  
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1 licensed insurance company, a not-for-profit hospital service and  
2 medical indemnity corporation, a fraternal benefit society, a  
3 multiple employer welfare arrangement or any other entity subject to  
4 regulation by the Insurance Commissioner;

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

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

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

21 8. "Telemedicine" or "telehealth" means technology-enabled  
22 health and care management and delivery systems that extend capacity  
23 and access, which includes:  
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- 1 a. synchronous mechanisms, which may include live  
2 audiovisual interaction between a patient and a health  
3 care professional or real-time provider-to-provider  
4 consultation through live interactive audiovisual  
5 means,  
6 b. asynchronous mechanisms, which include store and  
7 forward transfers, online exchange of health  
8 information between a patient and a health care  
9 professional and online exchange of health information  
10 between health care professionals, but shall not  
11 include the use of automated text messages or  
12 automated mobile applications that serve as the sole  
13 interaction between a patient and a health care  
14 professional,  
15 c. remote patient monitoring, and  
16 d. other electronic means that support clinical health  
17 care, professional consultation, patient and  
18 professional health-related education, public health  
19 and health administration.

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

23 Section 2-309I. A. A practitioner shall not issue an initial  
24 prescription for an opioid drug in a quantity exceeding a seven-day  
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1 supply for treatment of acute pain. Any opioid prescription for  
2 acute pain shall be for the lowest effective dose of an immediate-  
3 release drug.

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

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

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

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

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

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



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

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

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

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

17           2. The reasons why the prescription is necessary;

18           3. Alternative treatments that may be available; and

19           4. Risks associated with the use of the drugs being prescribed,  
20 specifically that opioids are highly addictive, even when taken as  
21 prescribed, that there is a risk of developing a physical or  
22 psychological dependence on the controlled dangerous substance, and  
23 that the risks of taking more opioids than prescribed or mixing  
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1 sedatives, benzodiazepines or alcohol with opioids can result in  
2 fatal respiratory depression.

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

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

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

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

20 2. In the first year of the patient-provider agreement, assess  
21 the patient prior to every renewal to determine whether the patient  
22 is experiencing problems associated with an opioid use disorder as  
23 defined by the American Psychiatric Association and document the  
24 results of that assessment. Following one (1) year of compliance  
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1 with the patient-provider agreement, the practitioner shall assess  
2 the patient at a minimum of every six (6) months;

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

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

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

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

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

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

21 1. Who has sickle cell disease;

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

24 3. Who is receiving hospice care from a licensed hospice;  
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1 4. Who is receiving palliative care in conjunction with a  
2 serious illness;

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

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

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

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

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

22 J. Any practitioner authorized to prescribe an opioid drug  
23 shall adopt and maintain a written policy or policies that include  
24 execution of a written agreement to engage in an informed consent  
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1 process between the prescribing practitioner and qualifying opioid  
2 therapy patient. For the purposes of this section, "qualifying  
3 opioid therapy patient" means:

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

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

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

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

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

19 Section 1304.1 A. The State and Education Employees Group  
20 Insurance Board and the Oklahoma State Employees Benefits Council  
21 are hereby abolished. Wherever the State and Education Employees  
22 Group Insurance Board and the Oklahoma State Employees Benefits  
23 Council are referenced in law, that reference shall be construed to  
24 mean the Oklahoma Employees Insurance and Benefits Board.  
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1 B. There is hereby created the Oklahoma Employees Insurance and  
2 Benefits Board.

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

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

11 1. The State Insurance Commissioner, or designee;

12 2. Four members shall be appointed by the Governor;

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

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

17 E. The appointed members shall:

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

22 2. Be licensed to practice law in this state and have  
23 demonstrated professional experience in commercial matters; or  
24

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

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

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

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

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

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

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

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

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

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

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

16 I. Except as otherwise provided in this subsection, no member  
17 of the Board shall be a lobbyist registered in this state as  
18 provided by law, or be employed directly or indirectly by any firm  
19 or health care provider under contract to the State and Education  
20 Employees Group Insurance Board, the Oklahoma State Employees  
21 Benefits Council, or the Oklahoma Employees Insurance and Benefits  
22 Board, or any benefit program under its jurisdiction, for any goods  
23 or services whatsoever. Any physician member of the Board shall not  
24 be subject to the provisions of this subsection.  
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1 J. Any vacancy occurring on the Board shall be filled for the  
2 unexpired term of office in the same manner as provided for in  
3 subsection D of this section.

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

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

20 M. ~~The Office of Management and Enterprise Services~~ Oklahoma  
21 Public Employees Retirement System shall have the following duties,  
22 responsibilities and authority with respect to the administration of  
23 the flexible benefits plan authorized pursuant to the State  
24 Employees Flexible Benefits Act:  
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1 1. To construe and interpret the plan, and decide all questions  
2 of eligibility in accordance with the Oklahoma State Employees  
3 Benefits Act and 26 U.S.C.A., Section 1 et seq.;

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

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

9 4. Beginning with the plan year which begins on January 1,  
10 2013, to select and contract with one or more providers to offer a  
11 group TRICARE Supplement product to eligible employees who are  
12 eligible TRICARE beneficiaries. Any membership dues required to  
13 participate in a group TRICARE Supplement product offered pursuant  
14 to this paragraph shall be paid by the employee. As used in this  
15 paragraph, "TRICARE" means the Department of Defense health care  
16 program for active duty and retired service members and their  
17 families;

18 5. To prepare and distribute information communicating and  
19 explaining the plan to participating employers and participants.  
20 Health Maintenance Organizations or other third-party insurance  
21 vendors may be directly or indirectly involved in the distribution  
22 of communicated information to participating state agency employers  
23 and state employee participants subject to the following condition:  
24

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

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

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

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

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

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

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

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

22 12. To require vendors offering coverage to provide such  
23 enrollment and claims data as is determined by the Board. The Board  
24 shall be authorized to retain as confidential any proprietary  
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1 information submitted in response to the Board's Request For  
2 Proposal. Provided, however, that any such information requested by  
3 the Board from the vendors shall only be subject to the  
4 confidentiality provision of this paragraph if it is clearly  
5 designated in the Request For Proposal as being protected under this  
6 provision. All requested information lacking such a designation in  
7 the Request For Proposal shall be subject to Section 24A.1 et seq.  
8 of Title 51 of the Oklahoma Statutes. From health maintenance  
9 organizations, data provided shall include the current Health Plan  
10 Employer Data and Information Set (HEDIS);

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

- 19 a. they shall have a statewide provider network,
- 20 b. they shall provide benefits which shall reimburse the  
21 expense for the following types of dental procedures:
  - 22 (1) diagnostic,
  - 23 (2) preventative,
  - 24 (3) restorative,
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- 1 (4) endodontic,
- 2 (5) periodontic,
- 3 (6) prosthodontics,
- 4 (7) oral surgery,
- 5 (8) dental implants,
- 6 (9) dental prosthetics, and
- 7 (10) orthodontics, and

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

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

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

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

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

23 18. To adopt rules requiring payment for medical and dental  
24 services and treatment rendered by duly licensed hospitals,  
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1 physicians and dentists. Unless the Board has otherwise contracted  
2 with the out-of-state health care provider, the Board shall  
3 reimburse for medical services and treatment rendered and charged by  
4 an out-of-state health care provider at least at the same percentage  
5 level as the network percentage level of the fee schedule  
6 established by the Oklahoma Employees Insurance and Benefits Board  
7 if the insured employee was referred to the out-of-state health care  
8 provider by a physician or it was an emergency situation and the  
9 out-of-state provider was the closest in proximity to the place of  
10 residence of the employee which offers the type of health care  
11 services needed. For purposes of this paragraph, health care  
12 providers shall include, but not be limited to, physicians,  
13 dentists, hospitals and special care facilities;

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

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

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



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

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

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

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

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

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

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

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

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

23 E. An employee claiming or entitled to benefits under the  
24 Administrative Workers' Compensation Act, shall, if ordered by the  
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1 Commission or requested by the employer or insurance carrier, submit  
2 himself or herself for medical examination. If an employee refuses  
3 to submit himself or herself to examination, his or her right to  
4 prosecute any proceeding under the Administrative Workers'  
5 Compensation Act shall be suspended, and no compensation shall be  
6 payable for the period of such refusal.

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

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

22 H. Fee Schedule.

23 1. The Commission shall conduct a review and update of the  
24 Current Procedural Terminology (CPT) in the Fee Schedule every two  
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1 (2) years pursuant to the provisions of paragraph 14 of this  
2 subsection. The Fee Schedule shall establish the maximum rates that  
3 medical providers shall be reimbursed for medical care provided to  
4 injured employees including, but not limited to, charges by  
5 physicians, chiropractors, dentists, counselors, hospitals,  
6 ambulatory and outpatient facilities, clinical laboratory services,  
7 diagnostic testing services, and ambulance services, and charges for  
8 durable medical equipment, prosthetics, orthotics, and supplies.  
9 The most current Fee Schedule established by the Administrator of  
10 the Workers' Compensation Court prior to February 1, 2014, shall  
11 remain in effect, unless or until the Legislature approves the  
12 Commission's proposed Fee Schedule.

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

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

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

- 19 a. No reimbursement shall be allowed for any magnetic  
20 resonance imaging (MRI) unless the MRI is provided by  
21 an entity that meets Medicare requirements for the  
22 payment of MRI services or is accredited by the  
23 American College of Radiology, the Intersocietal  
24 Accreditation Commission or the Joint Commission on  
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1 Accreditation of Healthcare Organizations. For all  
2 other radiology procedures, the reimbursement rate  
3 shall be the lesser of the reimbursement rate allowed  
4 by the 2010 Oklahoma Fee Schedule and two hundred  
5 seven percent (207%) of the Medicare Fee Schedule.

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

11 c. Any entity providing durable medical equipment,  
12 prosthetics, orthotics or supplies shall be accredited  
13 by a CMS-approved accreditation organization. If a  
14 physician provides durable medical equipment,  
15 prosthetics, orthotics, prescription drugs, or  
16 supplies to a patient ancillary to the patient's  
17 visit, reimbursement shall be no more than ten percent  
18 (10%) above cost.

19 d. The Commission shall develop a reasonable stop-loss  
20 provision of the Fee Schedule to provide for adequate  
21 reimbursement for treatment for major burns, severe  
22 head and neurological injuries, multiple system  
23 injuries, and other catastrophic injuries requiring  
24 extended periods of intensive care. An employer or  
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1 insurance carrier shall have the right to audit the  
2 charges and question the reasonableness and necessity  
3 of medical treatment contained in a bill for treatment  
4 covered by the stop-loss provision.

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

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

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

21 7. The Commission's review of medical and treatment charges  
22 pursuant to this section shall be conducted pursuant to the Fee  
23 Schedule in existence at the time the medical care or treatment was  
24 provided. The judgment approving the medical and treatment charges  
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1 pursuant to this section shall be enforceable by the Commission in  
2 the same manner as provided in the Administrative Workers'  
3 Compensation Act for the enforcement of other compensation payments.

4 8. Charges for prescription drugs dispensed by a pharmacy shall  
5 be limited to ninety percent (90%) of the average wholesale price of  
6 the prescription, plus a dispensing fee of Five Dollars (\$5.00) per  
7 prescription. "Average wholesale price" means the amount determined  
8 from the latest publication designated by the Commission.

9 Physicians shall prescribe and pharmacies shall dispense generic  
10 equivalent drugs when available. If the National Drug Code, or  
11 "NDC", for the drug product dispensed is for a repackaged drug, then  
12 the maximum reimbursement shall be the lesser of the original  
13 labeler's NDC and the lowest-cost therapeutic equivalent drug  
14 product. Compounded medications shall be billed by the compounding  
15 pharmacy at the ingredient level, with each ingredient identified  
16 using the applicable NDC of the drug product, and the corresponding  
17 quantity. Ingredients with no NDC area are not separately  
18 reimbursable. Payment shall be based on a sum of the allowable fee  
19 for each ingredient plus a dispensing fee of Five Dollars (\$5.00)  
20 per prescription.

21 9. When medical care includes prescription drugs dispensed by a  
22 physician or other medical care provider and the NDC for the drug  
23 product dispensed is for a repackaged drug, then the maximum  
24 reimbursement shall be the lesser of the original labeler's NDC and  
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1 the lowest-cost therapeutic equivalent drug product. Payment shall  
2 be based upon a sum of the allowable fee for each ingredient plus a  
3 dispensing fee of Five Dollars (\$5.00) per prescription. Compounded  
4 medications shall be billed by the compounding pharmacy.

5 10. Implantables are paid in addition to procedural  
6 reimbursement paid for medical or surgical services. A  
7 manufacturer's invoice for the actual cost to a physician, hospital  
8 or other entity of an implantable device shall be adjusted by the  
9 physician, hospital or other entity to reflect, at the time  
10 implanted, all applicable discounts, rebates, considerations and  
11 product replacement programs and shall be provided to the payer by  
12 the physician or hospital as a condition of payment for the  
13 implantable device. If the physician, or an entity in which the  
14 physician has a financial interest other than an ownership interest  
15 of less than five percent (5%) in a publically traded company,  
16 provides implantable devices, this relationship shall be disclosed  
17 to patient, employer, insurance company, third-party commission,  
18 certified workplace medical plan, case managers, and attorneys  
19 representing claimant and defendant. If the physician, or an entity  
20 in which the physician has a financial interest other than an  
21 ownership interest of less than five percent (5%) in a publicly  
22 traded company, buys and resells implantable devices to a hospital  
23 or another physician, the markup shall be limited to ten percent  
24 (10%) above cost.

1 11. Payment for medical care as required by the Administrative  
2 Workers' Compensation Act shall be due within forty-five (45) days  
3 of the receipt by the employer or insurance carrier of a complete  
4 and accurate invoice, unless the employer or insurance carrier has a  
5 good-faith reason to request additional information about such  
6 invoice. Thereafter, the Commission may assess a penalty up to  
7 twenty-five percent (25%) for any amount due under the Fee Schedule  
8 that remains unpaid on the finding by the Commission that no good-  
9 faith reason existed for the delay in payment. If the Commission  
10 finds a pattern of an employer or insurance carrier willfully and  
11 knowingly delaying payments for medical care, the Commission may  
12 assess a civil penalty of not more than Five Thousand Dollars  
13 (\$5,000.00) per occurrence.

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

21 13. Physicians or chiropractors providing treatment under the  
22 Administrative Workers' Compensation Act shall disclose under  
23 penalty of perjury to the Commission, on a form prescribed by the  
24 Commission, any ownership or interest in any health care facility,  
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1 business, or diagnostic center that is not the physician's or  
2 chiropractor's primary place of business. The disclosure shall  
3 include any employee leasing arrangement between the physician or  
4 chiropractor and any health care facility that is not the  
5 physician's or chiropractor's primary place of business. A  
6 physician's or chiropractor's failure to disclose as required by  
7 this section shall be grounds for the Commission to disqualify the  
8 physician or chiropractor from providing treatment under the  
9 Administrative Workers' Compensation Act.

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

16 b. The Commission shall contract with an external  
17 consultant with knowledge of workers' compensation fee  
18 schedules to review regional and nationwide  
19 comparisons of Oklahoma's Fee Schedule rates and date  
20 and market for medical services. The consultant shall  
21 receive written and oral comment from employers,  
22 workers' compensation medical service and insurance  
23 providers, self-insureds, group self-insurance  
24 associations of this state and the public. The  
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1 consultant shall submit a report of its findings and a  
2 proposed amended Fee Schedule to the Commission.

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

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

20 I. Formulary. The Commission by rule shall adopt a closed  
21 formulary. Rules adopted by the Commission shall allow an appeals  
22 process for claims in which a treating doctor determines and  
23 documents that a drug not included in the formulary is necessary to  
24 treat an injured employee's compensable injury. The Commission by  
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1 rule shall require the use of generic pharmaceutical medications and  
2 clinically appropriate over-the-counter alternatives to prescription  
3 medications unless otherwise specified by the prescribing doctor, in  
4 accordance with applicable state law.

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

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

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