Oklahoma State Radiological Society
State Legislative Report - First Session 53rd Legislature
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The First Session of Oklahoma's 53rd Legislature convened on Feb. 7 and adjourned on May 27. In the first session, or 2011 session, of the Legislature:

- 969 Senate bills and 44 Joint Resolutions were introduced.
- 1,168 House bills and 41 Joint Resolutions were introduced.
- Governor Fallin signed 388 bills into law.

Bills and resolutions that were not heard in committee or on the floor or voted "do not pass" may be considered in the Second Session beginning in February 2012.

Workers' Compensation Reform

HB 2038, *Sykes/Sullivan,* authorizes the Workers' Compensation Court administrator to compile annual reports relating to characteristics of cases including the amount of surgeries, length of temporary total disability, permanent partial disability, and other medical treatments and therapies. Effective date: Aug. 26, 2011. *Status: Signed by the governor*.

SB 878, *Sykes/Sullivan*, is comprehensive legislation that significantly changes the Oklahoma workers' compensation law. The 222-page measure is a result of a proposal brought forward by a working group representing workers' compensation lawyers, the business community, and the medical community. The overall goal of the measure is to reduce the cost of workers' compensation to businesses while revising processes for injured workers receiving medical treatment.

It was clear during negotiations of this measure that treatment guidelines and medical fees would be the most contentious part for the medical community. SB 878 contains the following key provisions:

Medical Fees

The measure requires the Workers' Compensation Court administrator to develop a **new medical fee schedule** by Jan. 1, 2012. The new medical fee schedule is to reflect an overall 5 percent savings in current medical reimbursement rates. The administrator is charged with using the Medicare fee schedule as a benchmark in this calculation.

Implantables will be paid in addition to procedural reimbursement for medical and surgical care. The manufacturer's invoice less any applicable discounts or rebates must be provided to receive the additional reimbursement by the provider.

The reimbursement floor for **physician evaluation and management** codes will be no less than 150 percent of the Medicare fee schedule. According to a Preliminary Cost Impact Analysis

by the National Council on Compensation Insurance, Inc. (NCCI) dated May 16, 2011, the current fee schedule for these services is approximately 109 percent of Medicare. This change reflects a positive outcome for physicians who perform evaluation and management for these injuries.

Radiology reimbursement will be limited to the lesser of the reimbursement rate allowed by the 2010 Oklahoma Fee Schedule or 207 percent of the Medicare fee schedule. NCCI's preliminary report (mentioned above) reflects that the current Oklahoma fee schedules are on average 195 percent of Medicare. As the fee schedule increases to 207 percent of Medicare, physicians could see an increase.

Charges for **prescription drugs** dispensed by a pharmacy will be limited to 90 percent of average wholesale price of the script plus a dispensing fee of $5. Physicians will prescribe and pharmacists will dispense generic drugs when available.

When a physician provides **durable medical equipment, prosthetics, orthotics, prescription drugs, or supplies** ancillary to the patient, reimbursement is limited to no more than 10 percent above cost.

This legislation removes the current **stop loss** provision of $70,000 threshold by directing the Court Administrator to develop a new stop loss reimbursement methodology related to catastrophic injuries.

Treatment Guidelines

Currently the Physician Advisory Committee is made up of nine physician members who determine the **Oklahoma Treatment Guidelines (OTG)** for worker's compensation treatment. However, the treatment guidelines on the scope and duration of medical care for all body parts except the spine will be based upon the Official Disability Guidelines (ODG) effective Feb. 1, 2012. ODG will be the primary mandatory guideline for spine cases unless the ODG does not cover or recommend specified treatment, the Oklahoma Treatment Guidelines shall prevail.

The measure provides that the terms of the members *serving* on the **Physician Advisory Committee** on the effective date of this act shall *end* on the effective date of this act, Aug. 26, 2011. Thereafter, each position will be filled by the appointing official for a term of three years. Members shall be subject to reappointment, with any new appointee to serve out the remainder of the unexpired term of the Committee member so replaced.

No reimbursement will be allowed for **magnetic resonance imaging** (MRI) unless the MRI unit produces a field strength that is equal or greater than 1.0 Tesla. Despite a strong argument by OSRS and others in the medical community that this section should be replaced with American College of Radiology standards and guidelines and not magnet strength, legislative leadership was not willing to change this legislation but vowed to look at this in the next legislative session. In essence, this standard will not allow for payment for open MRI procedures on any workers' compensation injury.

Disclosure of Ownership

The measure has significant new language regarding disclosure by the physician to the administrator of the Workers' Compensation Court regarding ownership or interest in any health care facility, business or diagnostic center that is not the physician's primary place of business. The disclosure includes leasing arrangements between the physician and any health care facility that is not the physician's primary place of business. Failure to disclose shall be grounds for disqualifying the physician from providing treatment under this act.

Further, disclosure of ownership by the physician to the patient is required if the physician owns more than 5 percent in a publically traded company that provides implantable devices.

Other Provisions

- Payment for medical care is due within 45 days of a completed claim. Judges of the court may award a penalty up to 25 percent for any amount due under the fee schedule that is unpaid for no good faith reason.
- Employers are required to promptly file a Form 2 and post a notice of right to workers' compensation benefits.
- Employers are required to provide medical care within seven days of knowledge of an injury. The employer selects the treating physician. If the employer fails to do so, an injured employee may select a physician at the expense of the employer.
- Expands the number of Oklahoma Workers' Compensation Court judges from eight to 10.

Effective date: Aug. 26, 2011. *Status: Signed by the governor*.

Lawsuit Reform

HB 1209, *Kirby/Marlatt*, **Athletic Malpractice Exemption**, exempts from liability for damages any physician acting as a ring official at an event sanctioned by the Oklahoma State Athletic Commission who renders or attempts to render emergency care to an injured participant in need of immediate medical aid. The measure does not include acts of gross negligence or willful or wanton negligence. Effective date: July 1, 2011. *Status: Signed by the governor*.

HB 2023, *Sullivan/Sykes*, **Medical Bills**, requires the actual amount paid for medical bills, including pharmacy, incurred in treatment to be the amount admissible at trial in any civil case involving personal injury, not the amounts billed for expenses incurred in treatment. The measure also states:

- If no payment has been made, the Medicare reimbursement rates in effect at the time of the injury are admissible.

- If a medical provider has filed a lien in the case for an amount in excess of the amount paid, then bills in excess of the amount paid but not more than the amount of the lien are admissible.
- In addition to evidence of nonpayment, a signed statement acknowledged by the medical provider or an authorized representative that the provider will accept payment at the Medicare reimbursement rate, less cost of recovery, is also admitted.
- In addition to evidence of payment, a signed statement acknowledged by the medical provider or an authorized representative that the provider, in consideration of the patient's efforts to collect the funds to pay the provider, will accept the amount paid as full payment of the obligation, is also admitted.
- The statement shall be part of the record as an exhibit but need not be shown to the jury.
- The bill makes the language applicable to civil cases involving personal injury filed on or after Nov. 1, 2011, which is the effective date of the act.

Effective date: Nov. 1, 2011. *Status: Signed by the Governor.*

HB 2024, *Sullivan/Sykes*, **Periodic Payments**, authorizes a court to order that future damages incurred after the date of judgment that exceed $100,000 be paid in whole or in part in periodic payments rather than in a lump sum payment. The periodic payments cannot exceed seven years from the date of entry of judgment. The measure provides requirements for the judgment ordering the payment of future damages and the defendant must provide evidence of financial responsibility. The order for future payments will constitute a release of the health care liability claim filed by the plaintiff. It states that upon the death of a recipient, money damages are to continue to be paid to the estate of the recipient. For purposes of computing attorney fees, the bill directs the court to place a total value on the payments based on the plaintiff's projected life expectancy and reduce the amount to present value. It directs periodic payments to include principal and interest. Effective date: Nov. 1, 2011. *Status: Signed by the governor*.

HB 2128, *Steele/Sykes*, lowers the **Cap on Noneconomic Damages** recoverable in a civil action for bodily injury from $400,000 to $350,000. The measure creates an exception so that there is no limit on noneconomic damages in a civil action arising from bodily injury resulting from negligence if there is clear and convincing evidence that the defendant’s acts or failures to act were:

- In reckless disregard for the rights of others;
- Grossly negligent;
- fraudulent, or
- Intentional or with malice.

The bill also removes language regarding lifting the cap upon findings that the plaintiff or injured person suffered permanent or substantial physical abnormality or disfigurement, loss of use of a

limb or loss or substantial impairment to a major body organ or system. Effective date: Nov. 1, 2011. *Status: Signed by the governor*.

SB 272, *Aldridge/Faught*, **Damage Limits - Compulsory Insurance Law**, limits the amount of recoverable damages in an action arising out of an accident involving the operation of a motor vehicle, or for any claim against the motor vehicle liability insurance coverage of another party, if the plaintiff is not in compliance with the compulsory insurance laws. Damages are limited to the amount of medical costs, property damage, and lost income and must not include any award for pain and suffering, with certain exceptions. Effective date: Nov. 1, 2011. *Status: Signed by the governor*.

SB 704, *Johnson/Sullivan*, **Class Action**, allows an action to be maintained as a class action if the complaint in the class action contains factual allegations sufficient to demonstrate a plausible claim for relief. Effective date: Nov. 1, 2011. *Status: Signed by the governor*.

SB 862, *Sykes/Sullivan*, **Elimination of Joint & Several Liability**, makes a defendant responsible for the portion of damages that the defendant actually caused. The measure removes:

- the requirement that a defendant, in certain civil actions, be jointly and severally liable for all damages if the defendant is found to be more than 50 percent at fault; and,
- the requirement that a joint tortfeasor will be jointly and severally liable for all damages if the tortfeasor acted with willful and wanton conduct or reckless disregard for the consequences.

Effective date: Nov. 1, 2011. *Status: Signed by the governor*.

Hospital Provider Fee
Supplemental Hospital Offset Payment Program (SHOPP)

Since 2005 the Oklahoma Hospital Association has attempted to pass a hospital provider fee to allow hospitals to contribute the state share to the Medicaid program in order to receive the federal match of approximately $2.00 to every $1.00 the state contributes. The purpose is to allow participating hospitals to close the Upper Payment Limit (UPL) gap and receive the cost of providing care to Medicaid patients or what Medicare would pay for the same service. This requires an act of the legislature.

HB 1381, *Cox/Myers***, Supplemental Hospital Offset Payment Program, SHOPP,** was signed into law on May 13, by Governor Mary Fallin. SHOPP will not become law until 90 days after sine die adjournment, which was Friday, May 27 making the effective date of the act August 26, 2011. Additionally, the SHOPP fee cannot be assessed until the arrangement is approved at the federal level.

CMS approval sought: As of June 2011, SHOPP is being prepared for regulatory approval following the signature of House Bill 1381 by Gov. Mary Fallin on May 13. Hospitals not exempted from SHOPP will be required to pay an assessment of 2.5 percent of net hospital

patient revenue. *The Oklahoma Medicaid program will use this money for supplemental payments for Medicaid hospital services and to maintain hospital and other provider payment rates at current levels*.

SHOPP must be approved by the federal Centers for Medicare & Medicaid Services (CMS) before the Oklahoma Health Care Authority (OHCA) can collect assessments or make supplemental payments to hospitals. OHCA's filing of a State Plan Amendment will be an important step in the approval process. Any time a state changes Medicaid benefits or reimbursement methods, a State Plan Amendment (SPA) must be submitted by the state and approved by CMS.

CMS approval of SHOPP may take 90 days and may take longer if CMS has questions about the SPA or waiver request. It is anticipated the program will have a retroactive effective date of July 1, 2011. OHCA has 45 days after CMS approval to notify hospitals of their quarterly assessment amount, and hospitals will then have 30 days to review and verify the assessment information. The SHOPP law requires OHCA to distribute supplemental payments to hospitals within 10 days of the assessment due date.

OHA achieves "Supermajority": Even though the Oklahoma Hospital Association did not consider the hospital provider fee to be a tax under the provisions of SQ 640, it was the goal to achieve the "supermajority" in both houses of the Legislature. By achieving the "supermajority," HB 1381 will avoid a potential challenge in court testing the tax vs. fee issue specified in SQ 640. A "supermajority" is 76 votes in the House and 36 votes in the Senate. SHOPP votes were:

- 3/10/11: Third Reading in the House: 76 Aye, 22 Nay, 3 Excused
- 4/25/11: Third Reading in the Senate: 39 Aye, 9 Nay
- 5/11/11: Fourth Reading in the House: 80 Aye, 15 Nay, 6 Excused

Following are the provisions of SHOPP:

1. The SHOPP Proposal

- $152 million generated by assessed hospitals;
- Federal match will generate $269 million;
- Total funds - $421 million - <u>of this</u>:
    - $338 million would be paid to hospitals as supplemental payments; and,
    - $83 million would be used to maintain current SoonerCare payment rates for providers, including <u>all</u> hospitals
- 77 hospitals are assessed 2.5% of annual net patient revenue based upon 2009 Medicare cost reports.

- 71 hospitals are exempt from the assessment:
    - 34 critical access hospitals – *25 beds or less with average length of stay of less than four days - entitled to 101% of cost (same rate paid by Medicare). SHOPP would bring hospitals below this rate to cost*;
    - 14 long-term care hospitals
    - 14 specialty hospitals, defined as hospitals for which a majority of inpatient days are for cardiac, brain injury, cancer, surgical or obstetrical services.
    - Seven state-owned hospitals including OU Medical Center.
    - One Medicare-certified children's hospital (The Children's Center in Bethany).
    - One hospital that provides a majority of care under a state agency contract.

2. $30 million in additional funds: This additional funding helps to stabilize current payment rates to assure access to care. Hospitals are approximately 30 percent of OHCA/Medicaid expenditures and are the safety net provider when optional programs are cut and physicians no longer contract with Medicaid. Further, many hospitals now employ physicians. Including the federal match, $83 million are available for rates.

3. Passing on to the patient is prohibited: This is not allowed under HB 1381. Again, the purpose of SHOPP is to "cover the cost of care" and the federal match makes that happen.

4. **Cost shift:** SHOPP will **diminish** the need for cost shifting. According to the State Coverage Initiative report, July 14, 2009, all Oklahomans are impacted by a $954 million hidden health care tax. This hidden health care tax manifests itself through "cost shifting" to other payers. That is, patients and businesses through their insurance carriers pay more than the cost of the care they receive to make up for inadequate Medicaid payments and other uncompensated care.

5. Federal government safeguards: If the state plan amendment is not approved or if federal matching funds become unavailable, all assessments from hospitals will cease.

6. Sunset provision: HB 1381 sunsets in 2014 and will require legislation to be enacted after that date.
Effective date: Aug. 26, 2011. *Status: Signed by the governor.*

Legislation of Interest

HB 1442, *Faught/Russell*, **Stem Cell Research**, creates the Destructive Human Embryo Research Act, making it unlawful to intentionally or knowingly conduct destructive research on a human embryo; buy, sell, receive or transfer a human embryo with knowledge it will be subjected to destructive research; or buy, sell, receive or transfer gametes with the knowledge that an embryo will be produced from such gametes to be used in destructive research. *Status: Dormant; Passed the House; Held in Senate committee*.

HB 2033, *Sullivan/Anderson*, modifies language related to the **Standards for Workplace Drug and Alcohol Testing Act**.

Provisions related to employees include:

- allows an employee to be tested at any time if an employer reasonably believes an employee is under the influence, has contraband on them, appears impaired, has tampered with testing or reports drug or alcohol use, has negative performance patterns or has excessive or unexplained absenteeism;
- prohibits an employee from receiving workers' compensation if the employee refuses to take a drug or alcohol test required by the employer.

Provisions related to employers include:

- requiring any employer that may request or require an employee to undergo a drug and alcohol test to adopt a written policy setting forth the specifics of its testing program.
- removing language requiring an employer to give 30 days' notice of changes to testing policy.
- nothing in the act prohibits an employer from adopting a policy that allows for testing of alcohol or drugs by another method that is reasonably calculated to detect the presence of drugs or alcohol, including a breathalyzer or single-use device.
- modifies language related to an employer's maintenance of records for alcohol and drug test results.
- directs an employer's policy to state disciplinary actions if positive test results are found and repeals language requiring programs.
- modifies language related to the State Board of Health's rules for regulation of testing facilities.

The bill removes criminal charges for those who violate the act. The bill modifies language about the causes for testing. Effective date: Nov. 1, 2011. *Status: Signed by the governor*.

SB 136, *Russell/Faught*, **Stem Cell Research**, prohibits a person from knowingly conducting scientific research on a human embryo, fetus or fetal part; transferring a human embryo, fetus or fetal part with the knowledge that the embryo, fetus or fetal part will be subjected to scientific research. It creates a felony for violating the act, punishable by at least one year to life in prison and a fine of $100,000. *Status: Dormant; Held in Senate committee*.

SB 250, *Marlatt/Armes*, **ME - Release of Records**, requires copies of reports provided by the chief medical examiner to be issued to the spouse of the deceased or any person within one degree of consanguinity of the deceased upon request and within five business days of the request once the cause and manner of death have been determined and the death certificate has been issued. The bill states that reports of the medical examiner made prior to Nov. 1,

2011, may be appealed by the spouse of the deceased or any person within one degree of consanguinity and must be filed by Nov. 1, 2012. Effective date: Nov. 1, 2011. *Status: Signed by the governor*.

SB 544, *Sykes/Blackwell*, allows a **certified registered nurse anesthetist**, in collaboration with a medical doctor, osteopathic physician, podiatric physician or dentist, to select, order, obtain and administer legend drugs, Schedule II and V controlled substances, devices and medical gases. SB 544 changes physician "supervision" to "in collaboration with" a physician. **HB 1351**, *Blackwell*, the same bill, was filed in the House and is dormant. *Status: Dormant; on General Order in the Senate*.

SB 701, *Aldridge/Sullivan*, **Medical Records**, sets the maximum fee that may be charged for digital records at 12 cents per digital page. It also prohibits a mailing fee from being charged for copies provided by facsimile. The measure permits patients of record, upon request, to obtain "pathology slides" which are added by amendment to the section of current law dealing with x-rays and other photographic images. The measure also states that disclosure regarding a deceased patient requires either a court order or a written release of an executor, administrator or personal representative appointed by the court, or the spouse or a responsible family member if there is no court-appointed individual. Effective date: Nov. 1, 2011. *Status: Signed by the governor.*

SB 772, *Jolley/Murphey*, creates, until Dec. 1, 2011, a 15-member **Business and Professional License Facilitation Task Force** to study the existing governmental models of Florida, Ohio and other states that have established a central contact point or agency for the facilitation of the majority of business and professional licenses and applications. It requires the task force to report its findings and make recommendations to the Senate president pro tempore, House speaker and governor by Dec. 1, 2011. Effective date: Aug. 26, 2011. *Status: Signed by the governor*.

Medicaid - Oklahoma Health Care Authority (OHCA)

HB 1736, *Peterson/Jolley*, **Eligibility Fraud**, authorizes the director of the Department of Human Services to investigate cases of Medicaid recipient eligibility fraud. It states that any person who obtains or attempts to obtain or aids by means of a false statement or representation, false impersonation or by knowing and willful failure to report to DHS or the OHCA material eligibility factors at the time of applying for or while receiving assistance, he/she is guilty of a misdemeanor or felony. The bill also creates a misdemeanor or felony for the sale, barter, possession or use of any medical identification card or device authorizing participation in the Oklahoma Medicaid program for a person not entitled or for attempting to obtain Medicaid or Insure Oklahoma benefits by omitting income, property, household members or other material eligibility factors. Effective date: Nov. 1, 2011. *Status: Signed by the governor*.

HB 2173, *Sears/Myers*, **Medicaid False Claims Collections**, authorizes the attorney general to collect all fines, penalties, restitution or interest accruing on any amount levied under the Oklahoma Medicaid False Claims Act, or any other charge, cause, action or other settlement

that recovers money wrongfully paid by the OHCA on a *claim* submitted to it. Effective date: Aug. 26, 2011. *Status: Signed by the governor*.

SB 412, *Brown/Cox*, requires any entity that provides health insurance to accept the Oklahoma Health Care Authority **right of recovery** and the assignment of rights and to not charge the authority or any of its authorized agents any fees for the processing of claims or eligibility requests. Effective date: Nov. 1, 2011. *Status: Signed by the governor*.

Public Health

HB 1211, *Kirby/Newberry*, **Social Host**, modifies language related to underage drinking, prohibiting anyone from knowingly permitting someone under age 21 who is invited to a person's residence, building, room or other property to possess or consume any alcoholic beverage, low-point beer, controlled dangerous substance or combination, and established fines and penalties. The bill also allows cities and towns to enact and municipal police officers to enforce ordinances. It requires the ordinances to be the same as state law and the penalties to be no more stringent than those under state law. The bill also allows municipal ordinances to prohibit anyone under age 21 from consuming or possessing with the intent to consume low-point beer. Effective date: Nov. 1, 2011*. Status: Signed by the governor.*

HB 1212, *Kirby/Marlatt*, requires those seeking a license from the **Oklahoma State Athletic Commission to include a certified copy of lab results** for every participant verifying that they are not infected with the human immunodeficiency virus, the hepatitis B virus or the hepatitis C virus. The bill prohibits a license from being issued to anyone with a positive result. Effective date: Jan 1, 2012. *Status: Signed by the governor*.

HB 1397, *Cox/Jolley*, **Board of Health (BOH) Omnibus Bill**:

- **Insurance Payments** - permits claims to be filed when BOH practitioners perform health-related services within the practitioner's scope of practice as prescribed by state law, the Board of Health or other standards, and if health services are covered by insurance. It also allows a city-county health department to perform health-related services and submit claims to an insurance provider.

- **Birth Certificates** - directs a certificate of birth to be filed with a state registrar rather than a local district registrar. It states that if the live birth results from a delivering mother who was carrying a child for another woman under a pre-arranged legal contract, the original birth certificate is to be filed with the personal information of the woman who delivered the child. It directs a new birth certificate to be placed on file once the state registrar receives a court order and completed form that identifies the various parties and documents the personal information of the intended parents. The measure prohibits an heirloom birth certificate from being used as evidence of live birth or for identification. It also requires fetal death certificates to be filed with the state registrar. It makes it a felony to present a false or forged birth, death or stillbirth certificate for filing.

- **Disinterment Permit** - makes it unlawful for any person to create, issue or present a fictitious disinterment permit; apply for such a permit under false pretenses; alter

information on a disinterment permit; obtain or display a disinterment permit for fraudulent purposes; making a false statement or knowingly concealing fact or committing fraud to apply for a permit; or reinterring the remains in a location other than that specified on the permit. It makes violations a misdemeanor and establishes penalties.

- **Vital Statistics** - grants the State Board of Health the power and duty to promulgate rules for situations in which the state registrar of vital statistics receives false information regarding the identity of a parent.

- **Adult Day Care** - allows licenses to be issued to adult day care centers and nursing homes for 12 to 24 months for the licensing period following Nov. 1, 2011, to permit equitable distribution of license expiration dates to all months of the year.

- **Venereal Disease** - repeals language making it a felony for anyone infected with a venereal disease to marry or expose another person to the venereal disease before being cured. The bill also changes reference from "venereal disease" to "sexually transmitted infection."

Effective date: Nov. 1, 2011*. Status: Signed by the governor.*

HB 1888, *Peterson/Jolley*, creates the **Pain-Capable Unborn Child Protection Act**, prohibiting an abortion from being performed or induced or attempted unless the physician has first made a determination of the probable post fertilization age of the unborn child. Persons are prohibited from performing, inducting or attempting an abortion on a woman when it is determined by the physician that the probable post fertilization age of the woman's unborn child is 20 or more weeks, unless in reasonable medical judgment it is determined she has a condition which so complicates her condition to necessitate the abortion of her pregnancy to avert her death or serious risk of substantial and irreversible physical impairment of a major bodily function.

- Physician requirements include failure to make such a determination constitutes unprofessional conduct;

- Reporting requirements and penalties include:

- Physicians performing abortions shall report to the Department of Health if the determination of post fertilization age was made, the woman's condition that necessitated the abortion and the method used for the abortion.

- Physicians who fail to submit a required report within 30 days are subject to a $500 late fee for each additional 30-day period. It allows a physician who has not submitted or filed an incomplete report more than one year after the event to be brought under actions before the Department of Health, be directed by a court to submit a complete report as stated within a court order or be subject to civil contempt.

- Intentional or reckless falsification of any report required is a misdemeanor. The measure states that anyone who intentionally or recklessly performs or induces or attempts an abortion in violation of the act is guilty of a felony.
- The Department of Health by June 30 of each year is to issue a report providing statistics for the previous calendar year.
- It prohibits the woman upon whom the abortion was performed or attempted from being penalized. However, it allows the woman upon whom the abortion was performed or the father of the unborn child to bring action against the person who performed or induced the abortion in intentional and reckless violation of the act for actual and punitive damages.
- It also allows a cause of action for injunctive relief to be brought by the woman upon whom an abortion was performed or attempted; by the spouse, parent, sibling, guardian or former licensed health care provider of the woman; by a district attorney; or by the attorney general.
- It states that in every civil or criminal proceeding brought under the act, the court must rule on whether the anonymity of any child upon whom an abortion has been performed or attempted will be preserved from public disclosure unless consent is given.
- The bill also states legislative intent that the interest in protecting unborn children from the stage at which there is medical evidence they are capable of feeling pain is intended to be independent from the state's interest in protecting the unborn from the stage of viability. Neither state interest is intended to replace the other.
- It also states that nothing in the act repeals current laws on the grounds to abort a viable fetus. It also states that compliance with the act does not signify compliance with any current laws related to abortion of a viable fetus, and that compliance with current laws related to the abortion of a viable fetus does not signify compliance with the act.

Effective date: Nov. 1, 2011*. Status: Signed by the governor.*

HB 1970, *Grau/Treat*, requires any physician giving or prescribing mifepristone or any **abortion-inducing drug** to first examine the woman and document the gestational age and intrauterine location of the pregnancy in the woman's medical chart. It requires the drug be administered in the same room and in the physical presence of the physician who provided the drug to the patient. Effective date: Nov. 1, 2011*. Status: Signed by the governor.*

HB 2135, *Steele/Meyers*, **Restore Local Rights.** The Oklahoma Smoke Free Coalition initiated legislation to repeal the state preemption clause in the local tobacco ordinances which will restore the rights of city councils to pass tobacco control ordinances and prevention policies in their communities. Oklahoma is one of two states that, by state law, prohibits cities from passing policies stronger than state law. The measure passed the House Committee on Public Health but was stalled due to House internal politics. The Coalition plans to pursue passage in the 2012 session. *Status: Dormant*; *on General Order in the House.*

SB 111, *Myers/Cox*, **Comprehensive Tobacco Free Initiative**, removes exemptions from the statewide ban on smoking in public places and indoor workplaces for stand-alone bars and taverns. It removes exemptions for public buildings with separate smoking rooms. It requires that no restaurant be allowed to have designated smoking rooms after Sept. 1, 2013. It states that no restaurant may build a separate smoking room after Sept. 1, 2011. The bill retains and clarifies an exemption for cigar bars. OHA position: support. *Status: Held in Senate committee.*

SB 178, *Crain*, **Emergency Response**, authorizes the State Board of Health to adopt rules and requirements as necessary to establish adaptive standards of care where an extreme emergency exists, as defined in the Oklahoma Emergency Response Act. *Status: Held in Senate committee.*

SB 919, *Sykes/Derby*, **Narcotics**, adds specific substances as Schedule I - V narcotics. The measure authorizes electronic prescribing for Schedule III and IV narcotics. Effective date: Nov. 1, 2011. *Status: Signed by the governor.*

SB 949, *Nichols/Enns*, **Oklahoma Sports Eye Safety Program Act**, establishes a provision for donation of money from individual income tax returns to the Oklahoma Sports Eye Safety Program Revolving Fund. Effective date: Nov. 1, 2011. *Status: Signed by the governor.*

Insurance & OSEEGIB

HB 1062, *D. Roberts/Brecheen*, **State Employee Opt Out - Provider Outcomes**:

- **Opt-out** - allows any participant in an OSEEGIB state health insurance plan to opt out of the plan; however, they must have other coverage.
- **Center of Excellence** - permits contracting with providers for specific services based on levels of outcomes defined by the Board and achieved by the provider. Further, the Health Plan may provide for the application of deductibles and copayment or coinsurance provisions, when equally applied to all covered charges for services and procedures that can be provided by any practitioner for diagnosis and treatment *unless* deductibles, copayments or coinsurance variations are based on contracts with providers for specific services based on levels of outcomes.
- **Pilot** - directs the Board to contract for plan year 2012 with a vendor that offers a web-based health care cost containment program that incorporates doctor-patient mutual accountability incentives for the purpose of conducting a pilot project to test a program's value proposition that offers financial incentives to both the health care provider and the patient.

Effective date: Nov. 1, 2011. *Status: Signed by the governor*.

HB 1520, *Nollan/Brown*, **Auto Liability Verification**, allows rather than requires the court to access information from the online verification system to confirm liability coverage. Effective date: Nov. 1, 2011. *Status: Signed by the governor*.

HB 1969, *Mulready/Brown*, **Health Savings Account**, allows rather than requires an employee with the State and Education Employees Group Insurance Board who selects the high option plan to establish a health savings account option as defined by the Internal Revenue Code. Effective date: Nov. 1, 2011. *Status: Signed by the governor*.

HB 2072, *Key/Brown*, and **SB 778,** *Aldridge/Sullivan,* **Insurance Department Omnibus Bill**: Both bills are comprehensive request bills of the State Insurance Commissioner and have many overlapping features outlined below.

- **Applications** - makes changes to the provisions requiring the insurance commissioner to review and analyze applications requesting to transact insurance in the state. Further, the measure allows rather than requires the commissioner to place prohibitions or restrictions on insurers or agents from other states operating in Oklahoma when such state is imposing similar restrictions on Oklahoma insurers or agents.

- **Surplus Lines** - creates the Unauthorized Insurers and Surplus Lines Insurance Act with numerous sections in both **HB 2072** and **SB 778** including:

- Authorizing the insurance commissioner to enter into Non-Admitted Insurance Multi-State Agreement or any multi-state agreement.

- Prohibiting persons to engage in certain actions without being a surplus lines licensee or broker with additional guidelines for surplus lines brokers or licensees.

- Authorizing a tax by the insurance commissioner applicable to non-admitted insurance lines under certain surplus lines premiums.

- **Taxation** - provides for taxation of Oklahoma insurers.

- **Renewal of Policies** - requires an insurer to give to the insured of an auto or homeowner's policy a 30-day written notice of renewal. If the insurer fails to provide the notice, the existing policy will remain in force until notice is given or until the effective date of the replacement coverage obtained by the insured.

- **Anti-Fraud** - creates the revolving Insurance Department Anti-Fraud Revolving Fund.

- **Rate Filings** - requires every health benefit plan by Nov. 1, 2011, to file all initial rates and all rate adjustments for approval with the insurance commissioner. It states that if the commissioner determines that the initial rate or rate adjustment is unreasonable or not justified or the initial rate or adjustment renders the policy form unjust, unfair or inequitable, the commissioner shall make a written determination within 30 days, unless the commissioner extends it for an additional 30 days.

- **External Review** - creates the Uniform Health Carrier External Review Act following model law recommended by the National Association of Insurance Commissioners (NAIC) to follow direction in the federal Accountable Care Act. This is substantial new law requiring for external review procedures to provide uniform standards for review of adverse determinations by health carriers. Specifically, the act requires:

- Such carriers to notify the covered person in writing of the right to an external review. It allows a covered person to submit a request for external review to the commissioner if the carrier's internal grievance process has been exhausted.

- An expedited review in cases of an adverse determination in which the timeframe for internal review would seriously jeopardize the life or health of the covered person, or their ability to regain maximum function; a final adverse determination where the covered person has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize life, health or the ability to regain maximum function or where the final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from the facility.

- The commissioner to make a determination of eligibility for review based on the person's coverage. It authorizes the commissioner to assign an independent review organization to the review. It establishes guidelines for the expedited and standard review processes. The bill states that the review process is binding on the health carrier and the covered person except to the extent that either has other remedies available under applicable law.

- Eligibility requirements for independent review organizations. It requires the cost of the review board to be paid by the health carrier. It requires carriers to include a description of external review processes with the policy or other evidence of coverage. It directs the commissioner to prescribe the format for disclosure.

- **Closed Claims** - deletes closed claims reporting requirements for medical professional liability.

- Repeals the Oklahoma Managed Care External Review Act.

- SB 778 also adds new law expanding the definitions of Company Action Level Events by health maintenance organizations to include an adjusted capital trigger language.

Effective date: Aug. 26, 2011. *Status: Signed by the governor*.

SB 547, *Sykes/D. Johnson*, **Abortion Coverage**, prohibits inclusion of elective abortion coverage in any health insurance policy offered by the state's health exchange, as established by the federal Patient Protection and Affordable Care Act. It prohibits elective abortion coverage in any plan not offered by the exchange but offered within the state, except by supplemental coverage with a separate premium. Effective date: Nov. 1, 2011. *Status: Signed by the governor*.

SB 563, *Brown/Mulready*, **High Risk Pool**, includes a temporary high risk pool referred to as the Pre-Existing Condition Insurance Plan program, offered by the Patient Protection and Affordable Care Act under the definition of "creditable coverage" as it relates to Health Insurance High Risk Pool Act. It states that the 18-month creditable coverage period shall not

apply to an individual with such coverage. Effective date: Aug. 26, 2011. *Status: Signed by the governor*.

SB 623, *Aldridge/Mulready*, expands the duties of the **Oklahoma Employees Benefits Council** to select and contract with one or more providers to offer a group **Tricare Supplement** product to eligible state employees who are eligible Tricare beneficiaries. The bill states that any membership dues required to participate in a group Tricare Supplement product be paid by the employee. The bill states that for an employee that has opted not to purchase health care coverage and purchases a group Tricare Supplemental product, the amount of the participant's benefit allowance shall be equal to the sum of the monthly premium of the group. It states that an employee who is an eligible Tricare beneficiary may be provided a benefit to purchase a group Tricare supplement but will not be provided any allowance for the supplement for dependents. Effective date: July 1, 2011. *Status: Signed by the governor*.

SB 722, *Jolley/Mulready*, **Compacts/Block Grants**, asserts state control in the regulation of health care by creating a compact between certain states and sets forth formulas for determining the right to federal funds for each member state, often commonly known as "block grants". The bill also creates the Interstate Advisory Health Care Commission and establishes membership requirements of the commission as well as duties of the commission, primarily assisting the legislatures of member states in the regulation of health care. It states the formation of the compact is contingent upon approval from the U.S. Congress. The bill states that each member state, within its state, may suspend by legislation the operation of all federal laws, rules, regulations and orders regarding health care that are inconsistent with the laws and regulations adopted by the member states under the compact. It clarifies language regarding federal funds. It also stipulates that the compact will be in effect upon its adoption by at least two member states and the consent of the U.S. Congress. It allows any state to join the compact after the date on which Congress consents to it. Effective date: Aug. 26, 2011. *Status: Signed by the governor*.

SB 971, *Myers/Sears*, establishes the **Health Insurance Private Enterprise Network** as a state-beneficiary public trust. SB 971 was one of three bills introduced to address this topic and none advanced. Oklahoma was one of seven states to be awarded a $54 million Early Innovator Grant from the federal government to help design and implement the information technology infrastructure to operate a health insurance exchange. The governor and legislative leaders held a press conference on April 14 announcing that Oklahoma would not accept the grant.

SB 971 states that the network will be governed by a seven-member board of directors, comprised of:

- one member appointed by the governor representing health insurance carriers granted a certificate of authority by the Oklahoma Insurance Department;
- one member appointed by the House speaker representing consumers who has purchased or is reasonably expected to purchase policies through the network;

- one member appointed by the governor who shall be a health care provider, one member appointed by the governor who shall be a representative of employer groups;
- one member by the Senate president pro tempore who shall be an insurance agent or broker;
- the insurance commissioner; and,
- the secretary of health and human services.

The measure also grants the network the minimum authority under state law that is necessary to avoid the establishment of a federal exchange, requiring:

- funding to come from state and private sources;
- to increase choice and competition in the health insurance market of Oklahoma;
- the network board to establish a system of certification for insurance programs offered in the state to be offered by the network;
- the network board to promulgate rules as necessary to implement the purposes of the act; and
- establishing a system for credentialing licensed insurance producers who intend to market insurance programs certified by the state.

Status: Dormant.