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STATE OF OKLAHOMA

2nd Session of the 57th Legislature (2020)

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 3388

By: **Sneed, Townley, Boatman,
Roe, Pae, Sterling, Davis,
Marti, Cornwell, Moore,
Frix, Olsen, Sims,
Randleman, Sanders and
Tadlock** of the House

and

David of the Senate

COMMITTEE SUBSTITUTE

An Act relating to insurance; creating the Oklahoma Out-of-Network Surprise Billing and Transparency Act; providing for applicability; defining terms; authorizing the Attorney General to bring a civil action for certain required usual, customary, and reasonable reimbursement rates; authorizing the Attorney General to bring a civil action for surprise billing prohibition; providing for emergency services provided by an out-of-network provider; providing for emergency services provided at an out-of-network facility; providing for nonemergency services provided by an out-of-network provider at an in-network facility; providing for nonemergency services provided by an out-of-network provider at an out-of-network facility; providing for a benchmarking database; requiring the Insurance Commissioner to select an organization to maintain a benchmarking database; providing for availability of arbitration; requiring participation for certain cases; providing time limitation for requesting arbitration in certain cases; requiring written notice; directing the Insurance Commissioner to promulgate rules for

1 submitting multiple claims to arbitration; limiting
2 issues arbitrator may address; providing for basis
3 for determination; prohibiting civil action until
4 conclusion of arbitration; providing for selection
5 and approval of arbitrators; providing for
6 arbitration procedures; providing for arbitrator
7 decision; requiring written notice; providing for
8 court review on arbitrator decision; providing for
9 bad faith in arbitration; providing penalties;
10 directing the Insurance Commissioner and the Oklahoma
11 Board of Medical Licensure and Supervision to adopt
12 certain rules; requiring Insurance Department and
13 Oklahoma Board of Medical Licensure and Supervision
14 to maintain certain information; requiring the
15 Insurance Department to conduct biennium study;
16 requiring written report to Legislature; requiring
17 written notice of benefits and billing prohibitions;
18 amending 12 O.S. 2011, Section 1854, which relates to
19 the Uniform Arbitration Act; providing an exception;
20 providing for codification; and providing an
21 effective date.

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

SECTION 1. NEW LAW A new section of law to be codified
in the Oklahoma Statutes as Section 6060.60 of Title 36, unless
there is created a duplication in numbering, reads as follows:

Sections 1 through 21 of this act shall be known and may be
cited as the "Oklahoma Out-of-Network Surprise Billing and
Transparency Act".

SECTION 2. NEW LAW A new section of law to be codified
in the Oklahoma Statutes as Section 6060.61 of Title 36, unless
there is created a duplication in numbering, reads as follows:

1 The Oklahoma Out-of-Network Surprise Billing and Transparency
2 Act shall apply to all state-regulated health benefit plans except:

3 1. HealthChoice health benefit plans administered by the
4 Oklahoma Office of Management and Enterprise Services;

5 2. Medicaid;

6 3. Medicare; and

7 4. The Employee Retirement Income Security Act of 1974 health
8 benefit plans.

9 SECTION 3. NEW LAW A new section of law to be codified
10 in the Oklahoma Statutes as Section 6060.62 of Title 36, unless
11 there is created a duplication in numbering, reads as follows:

12 As used in the Oklahoma Out-of-Network Surprise Billing and
13 Transparency Act:

14 1. "Arbitration" means a process in which an impartial
15 arbitrator issues a binding determination in a dispute between a
16 health benefit plan issuer or administrator and an out-of-network
17 provider and/or facility or the provider or facilities
18 representative to settle a health benefit claim;

19 2. "Geozip" means an area that includes all zip codes with
20 identical first three digits;

21 3. "Surprise billing" means the practice by a health care
22 provider or facility who does not, or is unable to, participate in
23 an enrollee's health benefit plan network, and charges an enrollee
24 the difference between the provider's or facility's fee and the sum

1 of what the enrollee's health benefit plan pays and what the
2 enrollee is required to pay in applicable deductibles, copayments,
3 coinsurance or other cost-sharing amounts required by the health
4 benefit plan; and

5 4. "Usual, customary, and reasonable rate" or "UCR rate" means
6 the eightieth percentile of all charges for the particular health
7 care service performed by a health care provider in the same or
8 similar specialty and provided in the same geographical area as
9 reported in an independent benchmarking database maintained by a
10 nonprofit organization specified by the Insurance Commissioner;
11 provided, the nonprofit organization shall not be financially
12 affiliated with an insurance carrier or health care provider.

13 SECTION 4. NEW LAW A new section of law to be codified
14 in the Oklahoma Statutes as Section 6060.63 of Title 36, unless
15 there is created a duplication in numbering, reads as follows:

16 All health insurance benefit policies must reference the usual,
17 customary, and reasonable rate for the purpose of providing an
18 enrollee with reimbursement transparency for out-of-network health
19 care providers and facilities. The charges for services reflected
20 by the Current Procedural Terminology code as reflected in the
21 eightieth percentile of charge data supplied by an independent
22 benchmarking database on November 1, 2020, shall constitute the
23 baseline for provider or facility charges. Beginning November 1,
24 2020, provider or facility charges may change anytime the charge

1 data supplied by an independent benchmarking database changes, but
2 may not increase at a rate greater than the Consumer Price Index.

3 SECTION 5. NEW LAW A new section of law to be codified
4 in the Oklahoma Statutes as Section 6060.64 of Title 36, unless
5 there is created a duplication in numbering, reads as follows:

6 If a health benefit plan issuer or administrator has restricted
7 or prohibited a health care provider or health care facility from
8 billing an insured, participant or enrollee from applicable
9 copayment, coinsurance, and deductible amounts required under the
10 Oklahoma Out-of-Network Surprise Billing and Transparency Act, the
11 Attorney General may bring a civil action in the name of the state
12 to ensure the health care provider, health care facility or
13 administrator may bill an enrollee the applicable copayment,
14 coinsurance, and deductible amounts. If the Attorney General
15 prevails in an action brought against a health benefit plan issuer
16 or administrator, the Attorney General may recover reasonable
17 attorney fees, costs and expenses, including court costs and witness
18 fees incurred in bringing the action.

19 SECTION 6. NEW LAW A new section of law to be codified
20 in the Oklahoma Statutes as Section 6060.65 of Title 36, unless
21 there is created a duplication in numbering, reads as follows:

22 If a health care provider, health care facility or administrator
23 has billed an enrollee an amount greater than the applicable
24 copayment, coinsurance, and deductible amount required under the

1 Oklahoma Out-of-Network Surprise Billing and Transparency Act, the
2 Attorney General may bring a civil action in the name of the state
3 to ensure the enrollee is not responsible for an amount greater than
4 the applicable copayment, coinsurance, and deductible amounts. If
5 the Attorney General prevails in an action brought against a health
6 benefit plan issuer or administrator, the Attorney General may
7 recover reasonable attorney fees, costs and expenses, including
8 court costs and witness fees incurred in bringing the action.

9 SECTION 7. NEW LAW A new section of law to be codified
10 in the Oklahoma Statutes as Section 6060.66 of Title 36, unless
11 there is created a duplication in numbering, reads as follows:

12 A. When an enrollee in a health benefit plan that covers
13 emergency services receives the services from an out-of-network
14 provider or out-of-network facility, the health benefit plan shall
15 ensure that the enrollee shall incur no greater out-of-pocket costs
16 for the emergency services than the enrollee would have incurred
17 with an in-network provider.

18 B. If a covered person receives covered emergency services by
19 an out-of-network provider or out-of-network facility, the carrier
20 shall pay the out-of-network provider directly and the initial
21 payment shall be the greater of the:

- 22 1. Medicare rate;
- 23 2. In-network rate;
- 24 3. Usual, customary, and reasonable rate; or

1 4. Agreed upon rate.

2 C. The insurer shall make payment required by this section
3 directly to the provider no later than, as applicable:

4 1. Thirty (30) days after the date the insurer receives an
5 electronic clean claim for those services that includes all
6 information necessary for the insurers to pay the claim; or

7 2. Forty-five (45) days after the date the insurer receives a
8 nonelectronic clean claim for those services that includes all
9 information necessary for the insurer to pay the claim.

10 SECTION 8. NEW LAW A new section of law to be codified
11 in the Oklahoma Statutes as Section 6060.67 of Title 36, unless
12 there is created a duplication in numbering, reads as follows:

13 A. If a covered person receives covered services at an in-
14 network facility from an out-of-network provider, the carrier shall
15 pay the out-of-network provider directly and initial payment shall
16 be at the usual, customary, and reasonable rate or at an agreed upon
17 rate.

18 B. The enrollee who receives care shall not be responsible for
19 any amount greater than his or her applicable in-network copay,
20 coinsurance, and deductible amount.

21 C. The insurer shall make payment required by this section
22 directly to the provider no later than, as applicable:
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1 1. Thirty (30) days after the date the insurer receives an
2 electronic clean claim for those services that includes all
3 information necessary for the insurers to pay the claim; or

4 2. Forty-five (45) days after the date the insurer receives a
5 nonelectronic clean claim for those services that includes all
6 information necessary for the insurer to pay the claim.

7 SECTION 9. NEW LAW A new section of law to be codified
8 in the Oklahoma Statutes as Section 6060.68 of Title 36, unless
9 there is created a duplication in numbering, reads as follows:

10 A. If a covered person with out-of-network health benefits
11 elects to receive covered services at an out-of-network facility
12 from an out-of-network provider, the carrier shall pay the out-of-
13 network provider and facility directly and the initial payment shall
14 be paid at the usual, customary, and reasonable rate or an agreed
15 upon rate.

16 The enrollee who receives care shall not be responsible for any
17 amount greater than his or her applicable out-of-network copay,
18 coinsurance, and deductible amount.

19 B. The insurer shall make payment required by this section
20 directly to the provider and facility no later than, as applicable:

21 1. Thirty (30) days after the date the insurer receives an
22 electronic clean claim for those services that includes all
23 information necessary for the insurer to pay the claim; or
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1 2. Forty-five (45) days after the date the insurer receives a
2 nonelectronic clean claim for those services that includes all
3 information necessary for the insurer to pay the claim.

4 C. Nothing in this section shall be construed to prohibit an
5 out-of-network provider or out-of-network facility from accepting
6 less than the usual, customary, and reasonable rate so long as an
7 agreement has been made between the enrollee and out-of-network
8 health care provider or out-of-network facility.

9 SECTION 10. NEW LAW A new section of law to be codified
10 in the Oklahoma Statutes as Section 6060.69 of Title 36, unless
11 there is created a duplication in numbering, reads as follows:

12 A. A health care or medical service or supply provided at a
13 location that does not have a zip code is considered to be provided
14 in the geozip area closest to the location at which the service or
15 supply is provided.

16 B. The Insurance Commissioner shall select an organization to
17 maintain a benchmarking database in accordance with this section.
18 The organization shall not:

19 1. Be affiliated with a health benefit plan issuer or
20 administrator, a health care practitioner or other health care
21 provider; or

22 2. Have any other conflict of interest.
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1 C. The benchmarking database shall contain the following
2 information necessary to calculate, with respect to a health care or
3 medical service or supply, for each geozip area in this state:

4 1. Percentiles of billed charges for all out-of-network
5 providers and facilities; and

6 2. Percentiles of rates paid to participating providers and
7 facilities.

8 D. Insurers shall be required to submit data necessary for the
9 use of the benchmarking database as specified in this section.

10 E. The Commissioner may adopt rules governing the submission of
11 information for the benchmarking database.

12 SECTION 11. NEW LAW A new section of law to be codified
13 in the Oklahoma Statutes as Section 6060.70 of Title 36, unless
14 there is created a duplication in numbering, reads as follows:

15 A. An out-of-network provider, out-of-network facility, and
16 health benefit plan issuer or administrator may request arbitration
17 of a settlement of an out-of-network health benefit claim through a
18 portal on the Oklahoma Insurance Department's website if:

19 1. There is an amount billed by the out-of-network provider or
20 out-of-network facility and unpaid by the issuer or administrator
21 after copayments, coinsurance, and deductibles for which an enrollee
22 may not be billed; or

23 2. a. The required usual, customary, and reasonable rate
24 paid by an insurer is deemed unreasonable, and

1 b. The health benefit claim is for:

2 (1) nonemergency care provided at an out-of-network
3 facility,

4 (2) nonemergency care provided by an out-of-network
5 provider,

6 (3) emergency care provided at an out-of-network
7 facility,

8 (4) emergency care provided by an out-of-network
9 provider, or

10 (5) an emergency claim denial is based on a review of
11 the patient's diagnosis code.

12 B. If a person requests arbitration under this section, and
13 depending who initiates, the out-of-network provider, out-of-network
14 facility, or a representative of the provider or facility, and the
15 health benefit plan issuer or the administrator, as appropriate,
16 shall participate in the arbitration.

17 C. Not later than the ninety (90) days after the date an out-
18 of-network provider or out-of-network facility receives the initial
19 payment for a health care or medical service or supply, the out-of-
20 network provider, health care facility, or representative of the
21 out-of-network health care provider or out-of-network facility,
22 health benefit plan issuer or administrator may request arbitration
23 of a settlement of an out-of-network health benefit claim through a
24 portal on the Department's website if:

1 1. There is an amount billed by the out-of-network provider or
2 out-of-network facility and unpaid by the issuer or administrator
3 after copayments, coinsurance, and deductibles for which an enrollee
4 may not be billed; or

5 2. a. The required usual, customary, and reasonable rate
6 paid by an insurer is deemed unreasonable, and

7 b. The health benefit claim is for:

8 (1) nonemergency care provided at an out-of-network
9 facility,

10 (2) nonemergency care provided by an out-of-network
11 provider,

12 (3) emergency care provided at an out-of-network
13 facility,

14 (4) emergency care provided by an out-of-network
15 provider, or

16 (5) an emergency claim denial is based on a review of
17 the patient's diagnosis code.

18 D. Nothing in this section shall prohibit a health care
19 provider or facility from utilizing arbitration in cases where
20 medical necessity is disputed.

21 E. If a person requests arbitration, the out-of-network
22 provider, out-of-network facility, or an appropriate representative,
23 and the health benefit plan issuer or administrator, as appropriate,
24 shall participate in the arbitration.

1 F. The party who requests arbitration shall provide written
2 notice on the date the arbitration is requested in the form and
3 manner prescribed by the Commissioner rule to:

4 1. The Department; and

5 2. Each party.

6 G. In an effort to settle the claim before arbitration, all
7 parties shall participate in an informal settlement teleconference
8 no later than thirty (30) days after the date on which the
9 arbitration is requested. A health benefit plan issuer or
10 administrator, as applicable, shall make a reasonable effort to
11 arrange the teleconference.

12 H. The Commissioner shall promulgate rules providing
13 requirements for submitting multiple claims to arbitration in one
14 proceeding. The rules shall provide:

15 1. The total amount in controversy for multiple claims in one
16 proceeding shall not exceed Five Thousand Dollars (\$5,000.00); and

17 2. The multiple claims in one proceeding shall be limited to
18 the same out-of-network provider or facility, and health benefit
19 plan issuer.

20 I. Nothing in this section shall be construed to limit the
21 amount in controversy for an individual claim in one arbitration
22 proceeding.

SECTION 12. NEW LAW A new section of law to be codified

in the Oklahoma Statutes as Section 6060.71 of Title 36, unless
there is created a duplication in numbering, reads as follows:

A. The only issue the arbitrator may determine is the
reasonable amount for the health care or medical services or
supplies provided to the enrollee by an out-of-network provider or
out-of-network facility.

B. The determination shall take into account:

1. Whether there is a disparity between the fee billed by the
out-of-network provider or out-of-network facility;

2. Fees paid to the out-of-network provider or out-of-network
facility;

3. Level of training, education, and experience of the out-of-
network provider;

4. The out-of-network provider's or facility's usual billed
charge for comparable services or supplies with regard to other
enrollees for which the provider or facility is out-of-network;

5. The circumstances and complexity of the enrollee's
particular case, including the time and place of the provision of
service or supply;

6. Individual enrollee characteristics;

7. Medical journals and peer-reviewed articles pertaining to
medical necessity;

1 8. Percentiles of out-of-network billed charges for the same
2 service or supply performed by a health care provider or facility in
3 the same or similar specialty and provided in the same geozip as
4 reported in a benchmarking database;

5 9. The usual, customary, and reasonable rate as defined in
6 Section 3 of this act;

7 10. The history of networking contracting between the parties;

8 11. Historical data for percentiles; and

9 12. An offer made during the informal settlement
10 teleconference.

11 SECTION 13. NEW LAW A new section of law to be codified
12 in the Oklahoma Statutes as Section 6060.72 of Title 36, unless
13 there is created a duplication in numbering, reads as follows:

14 A. An out-of-network provider, facility or health benefit plan
15 issuer or administrator may not file suit for an out-of-network
16 claim subject to the Oklahoma Out-of-Network Surprise Billing and
17 Transparency Act until the conclusion of the arbitration on the
18 issue of the amount to be paid in the out-of-network claim dispute.

19 B. The arbitration conducted under the Oklahoma Out-of-Network
20 Surprise Billing and Transparency Act is not subject to the Uniform
21 Arbitration Act.

22 SECTION 14. NEW LAW A new section of law to be codified
23 in the Oklahoma Statutes as Section 6060.73 of Title 36, unless
24 there is created a duplication in numbering, reads as follows:

1 A. If parties are unable to mutually agree on an arbitrator
2 within thirty (30) days after the date the arbitration is requested,
3 the party requesting arbitration shall notify the Insurance
4 Commissioner, and the Commissioner shall select an arbitrator from
5 the Commissioner's list of approved arbitrators.

6 B. In selecting an arbitrator, the Commissioner shall give
7 preference to an arbitrator who is knowledgeable and experienced in
8 applicable principles of contract and insurance law and the health
9 care industry generally.

10 C. In approving an individual as an arbitrator, the
11 Commissioner shall ensure that the individual does not have a
12 conflict of interest that would adversely impact the arbitrator's
13 independence and impartiality in rendering a decision in an
14 arbitration. A conflict of interest includes current or recent
15 ownership or employment of the individual or a close family member
16 as a health benefit issuer or administrator, physician, health care
17 practitioner, or other health care provider.

18 D. The Commissioner shall immediately terminate the approval of
19 an arbitrator who no longer meets the requirements adopted by the
20 Commissioner.

21 SECTION 15. NEW LAW A new section of law to be codified
22 in the Oklahoma Statutes as Section 6060.74 of Title 36, unless
23 there is created a duplication in numbering, reads as follows:
24

1 A. The arbitrator shall set a date for submission of all
2 information to be considered by the arbitrator.

3 B. A party shall not engage in discovery in connection with the
4 arbitration.

5 C. On agreement of all parties, any deadline may be extended.

6 D. The party which is not awarded the amount submitted to
7 arbitration shall pay all expenses and fees required by the
8 arbitrator.

9 E. Information submitted to the arbitrator is confidential and
10 not public record.

11 SECTION 16. NEW LAW A new section of law to be codified
12 in the Oklahoma Statutes as Section 6060.75 of Title 36, unless
13 there is created a duplication in numbering, reads as follows:

14 A. No later than fifty-one (51) days after the date the
15 arbitration is requested, an arbitrator shall provide the parties
16 with a written decision in which the arbitrator:

17 1. Determines whether the health care provider or health care
18 facilities charge is reasonable;

19 2. Determines whether the usual, customary, and reasonable rate
20 paid by an insurer is unreasonable; and

21 3. Selects the amount determined to be the closest as the
22 binding award.

23 B. An arbitrator shall not modify the binding award amount.
24

1 C. An arbitrator shall provide written notice in the form and
2 manner prescribed by the Insurance Commissioner rule of the
3 reasonable amount for the services or supplies and the binding award
4 amount. If the parties settle before a decision, the parties shall
5 provide written notice in the form and manner prescribed by
6 Commissioner rule of the amount of settlement. The Oklahoma State
7 Insurance Department shall maintain a record of notices.

8 SECTION 17. NEW LAW A new section of law to be codified
9 in the Oklahoma Statutes as Section 6060.76 of Title 36, unless
10 there is created a duplication in numbering, reads as follows:

11 A. An arbitrator's decision shall be binding.

12 B. No later than forty-five (45) days after the date of an
13 arbitrator's decision, a party not satisfied with the decision may
14 file an action to determine the payment due.

15 C. In an action filed, the court shall determine whether the
16 arbitrator's decision is proper based on a substantial evidence
17 review.

18 D. No later than thirty (30) days after the date of an
19 arbitrator's decision, a health benefit plan issuer or administrator
20 shall pay the amount necessary to satisfy the binding award.

21 E. Based on the arbitrator's binding award amount, the losing
22 party shall be required to pay the arbitrator's fees and expenses.
23
24

1 SECTION 18. NEW LAW A new section of law to be codified
2 in the Oklahoma Statutes as Section 6060.77 of Title 36, unless
3 there is created a duplication in numbering, reads as follows:

4 A. The following constitutes bad faith participation in
5 arbitration:

6 1. Failing to participate in the informal settlement
7 teleconference;

8 2. Failing to provide information the arbitrator believes
9 necessary to facilitate a decision or agreement; or

10 3. Failing to designate a representative participating in the
11 arbitration with full authority to enter into any agreement.

12 B. Failure to reach an agreement is not conclusive proof of bad
13 faith participation.

14 SECTION 19. NEW LAW A new section of law to be codified
15 in the Oklahoma Statutes as Section 6060.78 of Title 36, unless
16 there is created a duplication in numbering, reads as follows:

17 A. Bad faith participation or otherwise failing to comply with
18 arbitration requirements is grounds for imposition of an
19 administrative penalty by the regulatory agency that issued a
20 license or certificate of authority to the party who committed the
21 violation.

22 B. Except for good cause shown, on a report of an arbitrator
23 and appropriate proof of bad faith participation, the regulatory
24 agency shall impose an administrative penalty.

1 C. The Insurance Commissioner and the Oklahoma Board of Medical
2 Licensure and Supervision or other regulatory agency, as
3 appropriate, shall adopt rules regulating the investigation and
4 review of a complaint filed that relates to the settlement of an
5 out-of-network health benefit claim.

6 1. The rules adopted shall distinguish between complaints for
7 out-of-network coverage or payment and give priority to
8 investigating allegations of delayed health care or medical care;

9 2. Develop a form for filing a complaint; and

10 3. Ensure that a complaint is not dismissed without appropriate
11 consideration.

12 D. The Oklahoma State Insurance Department and Oklahoma Medical
13 Board or other appropriate regulatory agency shall maintain the
14 following information on each complaint filed that concerns a claim
15 and arbitration:

16 1. The type of services or supplies that gave rise to the
17 dispute;

18 2. The type of specialty, if any, of the out-of-network
19 provider or facility who provided the out-of-network service or
20 supply;

21 3. The county and metropolitan area in which health care or
22 medical service or supply was provided;

23 4. Whether the health care or medical service or supply was for
24 emergency care;

1 5. Any other information about the health benefit plan issuer
2 or administrator that the Commissioner by rule requires; or

3 6. The out-of-network provider or facility that the Oklahoma
4 Medical Board or other appropriate regulatory agency by rule
5 requires.

6 E. All information collected is public information and may not
7 include personally identifiable information.

8 SECTION 20. NEW LAW A new section of law to be codified
9 in the Oklahoma Statutes as Section 6060.79 of Title 36, unless
10 there is created a duplication in numbering, reads as follows:

11 A. The Oklahoma State Insurance Department shall, each
12 biennium, conduct a study on the impacts of the Oklahoma Out-of-
13 Network Surprise Billing and Transparency Act and shall include:

14 1. Trends and changes in billed amounts;

15 2. Trends and changes in paid amounts;

16 3. Trends and changes in network participation;

17 4. Trends and changes in paid amounts to in-network providers
18 or facilities;

19 5. Trends and changes in paid amounts to out-of-network
20 providers or facilities; and

21 6. Number of complaints and results of claims that enter
22 arbitration, including effectiveness of arbitration.

23 B. Beginning December 1, 2021, and no later than December 1 of
24 every other year thereafter, the Department shall prepare and submit

1 a written report on the results of the study to the Legislature and
2 appropriate committees.

3 SECTION 21. NEW LAW A new section of law to be codified
4 in the Oklahoma Statutes as Section 6060.80 of Title 36, unless
5 there is created a duplication in numbering, reads as follows:

6 An insurer shall provide by written notice an explanation of
7 benefits provided to the insured and the physician or health care
8 provider in connection with a medical care or health care service or
9 supply provided by an out-of-network provider or facility. The
10 notice shall include a statement of the billing prohibition as
11 applicable to the Oklahoma Out-of-Network Surprise Billing and
12 Transparency Act that includes:

13 1. The total amount the health care provider or facility may
14 bill the insured under the insured's health benefit plan and an
15 itemization of copayments, coinsurance, deductibles, and other
16 amounts included in the total;

17 2. An explanation of benefits provided to the health care
18 provider or facility with information required by rule advising the
19 health care provider or facility of the availability of arbitration,
20 as applicable under the Oklahoma Out-of-Network Surprise Billing and
21 Transparency Act; and

22 3. For elective services that are covered by an enrollee's
23 health benefit plan, if requested by an enrollee before a scheduled
24 service and explanation of benefits, the provider's average amounts

1 paid to comparable in-network health care providers or facilities
2 for covered services.

3 SECTION 22. AMENDATORY 12 O.S. 2011, Section 1854, is
4 amended to read as follows:

5 Section 1854. A. The Uniform Arbitration Act governs an
6 agreement to arbitrate made on or after January 1, 2006.

7 B. The Uniform Arbitration Act governs an agreement to
8 arbitrate made before January 1, 2006, if all the parties to the
9 agreement or to the arbitration proceeding so agree in a record.

10 C. Beginning January 1, 2006, the Uniform Arbitration Act
11 governs an agreement to arbitrate whenever made.

12 D. The Uniform Arbitration Act shall not apply to the Oklahoma
13 Out-of-Network Surprise Billing and Transparency Act.

14 SECTION 23. This act shall become effective November 1, 2020.
15

16 COMMITTEE REPORT BY: COMMITTEE ON INSURANCE, dated 02/26/2020 - DO
17 PASS, As Amended and Coauthored.
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