COMMITTEE AMENDMENT

HOUSE OF REPRESENTATIVES
State of Oklahoma

SPEAKER:

CHAIR:

I move to amend HB2125
Of the printed Bill

Page _____ Section _____ Lines _____
Of the Engrossed Bill

By striking the Title, the Enacting Clause, the entire bill, and by inserting in lieu thereof the following language:

AMEND TITLE TO CONFORM TO AMENDMENTS

Amendment submitted by: Marcus McEntire

Adopted: _____

_____
Reading Clerk

STATE OF OKLAHOMA

2nd Session of the 58th Legislature (2022)

PROPOSED COMMITTEE
SUBSTITUTE
FOR
HOUSE BILL NO. 2125 By: McEntire

PROPOSED COMMITTEE SUBSTITUTE

An Act relating to surprise billing; defining terms; providing for the Attorney General to bring civil action to enjoin certain persons or entities in certain circumstances; authorizing the Attorney General to recover reasonable costs and fees; authorizing certain regulatory boards to take disciplinary action against certain persons or entities under certain circumstances; authorizing the Insurance Department to take disciplinary action against certain persons or entities under certain circumstances; authorizing Insurance Department and certain regulatory boards to promulgate rules; construing provisions; providing for administrator of exclusive provider benefit plan to reimburse out-of-network provider at usual and customary rate by certain date; prohibiting insured's liability for payments exceeding certain applicable amounts; requiring insurer provide written notice of explanation of benefits that includes certain provisions to certain persons by certain date; requiring insurer to reimburse emergency care not conducted by a preferred provider at usual and customary rate under certain circumstances by certain date; prohibiting insured liability for payments exceeding certain applicable amounts for emergency care; requiring insurer pay for certain covered services and supplies provided by an out-of-network provider by certain date; prohibiting insured's liability for payments exceeding certain applicable amounts for care provided by an out-of-network facility-based provider in certain circumstances; requiring certain notice be provided to enrollee and physician or health care provider; providing contents

of notice; stating application of certain provisions; directing certain regulatory boards and agency to promulgate rules; requiring Insurance Department to establish benchmarking database for certain billed charges and rates; requiring Insurance Department establish mediation program and procedures for mediation; establishing qualifications for participating mediators; establishing circumstances for mediation; requiring submission of mediation results to certain persons and entities by certain date; requiring Insurance Department to establish arbitration program and procedures; establishing circumstances for arbitration; establishing qualifications for participating arbitrators; requiring submission of arbitration results to certain persons and entities by certain date; prohibiting arbitrator from modifying binding award amount; establishing procedures for filing action following arbitration; establishing provisions for bad faith participation; requiring certain regulatory boards and agency to promulgate rules for filing complaint; requiring Insurance Department conduct biennial study regarding effects of act and procedures therein; amending 51 O.S. 2021, Section 24A.3, which relates to Oklahoma Open Records Act; modifying definition of record to exclude certain information submitted pursuant to act; providing for codification; and providing an effective date.

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 7410 of Title 36, unless there is created a duplication in numbering, reads as follows:

For the purposes of this act:

1. "Administrator" means the claims administrator for a health benefit plan and an administering firm for a health benefit plan as

defined pursuant to Section 6060.4 of Title 36 of the Oklahoma Statutes;

2. "Arbitration" means a process in which an impartial arbiter issues a binding determination in a dispute between a health benefit plan issuer or administrator and an out-of-network provider or the provider's representative to settle a health benefit claim;

3. "Emergency care" means health care services provided in a hospital emergency facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

a. placing the person's health in serious jeopardy,

b. serious impairment to bodily functions,

c. serious dysfunction of a bodily organ or part,

d. serious disfigurement, or

e. in the case of a pregnant woman, serious jeopardy to the health of the fetus;

4. "Emergency care provider" means health care provider as defined pursuant to Section 1219.6 of Title 36 of the Oklahoma Statutes who provides and bills an enrollee, administrator, or health benefit plan for emergency care;

5. "Enrollee" means an enrollee as defined pursuant to subsection 1 of Section 6592 of Title 36 of the Oklahoma Statutes;

6. "Exclusive provider benefit plan" means a plan that requires members to use a set network of doctors, hospitals, and other healthcare providers except in an emergency;

7. "Provider" means a physician health care provider, of any specialty, who provides health care services to patients;

8. "Geozip area" means an area that includes all ZIP codes with identical first three digits. For purposes of this act, a health care or medical service or supply provided at a location that does not have a ZIP code is considered to be provided in the geozip area closest to the location at which the service or supply is provided;

9. "Mediation" means a process in which an impartial mediator facilitates and promotes agreement between the health benefit plan issuer or the administrator and an out-of-network provider or the provider's representative to settle a health benefit claim of an enrollee;

10. "Out-of-network provider" means any provider, regardless of a specialty, that is not a participating provider for a health benefit plan;

11. "Party" means a health benefit plan issuer offering a health benefit plan, an administrator, or an out-of-network provider or the provider's representative who participates in a mediation or arbitration conducted under this act;

12. "Physician" means a physician as defined pursuant to subsection 7 of Section 2202 of Title 36 of the Oklahoma Statutes; and

13. "Usual and customary rate" means the relevant allowable amount as described by the applicable master benefit plan document or policy.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7411 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If the Attorney General of the State of Oklahoma receives a referral from an appropriate regulatory agency indicating that an individual or entity, including a health benefit plan issuer or administrator, has exhibited a pattern of intentionally violating a law that prohibits the individual or entity from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement related to that prohibition, the Attorney General may bring a civil action in the name of the state to enjoin the individual or entity from the violation.

B. If the Attorney General prevails in an action brought under subsection A of this section, the Attorney General may recover reasonable attorney fees, costs, and expenses, including court costs and witness fees, incurred in bringing the action.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7412 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An appropriate regulatory board that licenses, certifies, or otherwise authorizes a physician, health care practitioner, health care facility, or other health care provider to practice or operate in this state may take disciplinary action against the physician, practitioner, facility, or provider if the physician, practitioner, facility, or provider violates a law that prohibits the physician, practitioner, facility, or provider from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, and deductible under the insured's, participant's, or enrollee's managed care plan or that imposes a requirement related to that prohibition.

B. The Insurance Department may take disciplinary action against a health benefit plan issuer or administrator if the issuer or administrator violates a law requiring the issuer or administrator to provide notice of a balance billing prohibition or make a related disclosure.

C. The appropriate regulatory board described by subsection A of this section and the Insurance Department may adopt rules as necessary to implement this section.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7413 of Title 36, unless there is created a duplication in numbering, reads as follows:

Except as provided by Sections 5, 7, and 8 of this act, this act shall not be construed to require an exclusive provider benefit plan to compensate a nonpreferred provider for services provided to an insured.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7414 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If an out-of-network provider provides emergency care as defined by paragraph 3 of Section 1 of this act to an enrollee in an exclusive provider benefit plan, the issuer of the plan shall reimburse the out-of-network provider at the usual and customary rate or at a rate agreed to by the issuer and the out-of-network provider for the provision of the services and any supplies related to those services. The insurer shall make a payment required by this subsection directly to the provider not later than, as applicable:

1. The thirtieth day after the date the insurer receives an electronic claim for those services that includes all information necessary for the insurer to pay the claim; or

2. The forty-fifth day after the date the insurer receives a nonelectronic claim for those services that includes all information necessary for the insurer to pay the claim.

B. For emergency care subject to this section or supplies related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's exclusive provider benefit plan that:

1. Is based on:

a. the amount initially determined payable by the insurer, or

b. if applicable, a modified amount as determined under the insurer’s internal appeal process; and

2. Is not based on any additional amount determined to be owed to the provider under Sections 10 through 23 of this act.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7415 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An insurer shall provide written notice in accordance with this section in an explanation of benefits provided to the insured and the provider in connection with a medical care or health care

service or supply provided by an out-of-network provider. The notice shall include:

1. A statement of the billing prohibition under Section 5, 7, or 8 of this act, as applicable;

2. The total amount the physician or provider may bill the insured under the insured's preferred provider benefit plan and an itemization of copayments, coinsurance, deductibles, and other amounts included in that total; and

3. For an explanation of benefits provided to the physician or provider, information advising the physician or provider of the availability of mediation or arbitration pursuant to Sections 13 and 19 of this act.

B. An insurer shall provide the explanation of benefits with the notice required by this section to a physician or health care provider not later than the date the insurer makes a payment under Section 5, 7, or 8 of this act, as applicable.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7416 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If an insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the usual and customary rate or at an agreed rate and at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider:

1. A medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists;

2. Necessary emergency care services, including the treatment and stabilization of an emergency medical condition;

3. Services originating in a hospital emergency facility or following treatment or stabilization of an emergency medical condition; and

4. Supplies related to a service described by this subsection.

B. For emergency care subject to this section or a supply related to that care, an insurer shall make a payment required by this section directly to the out-of-network provider not later than, as applicable:

1. The thirtieth day after the date the insurer receives an electronic claim for those services that includes all information necessary for the insurer to pay the claim; or

2. The forty-fifth day after the date the insurer receives a nonelectronic claim for those services that includes all information necessary for the insurer to pay the claim.

C. For emergency care subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider shall not bill an insured in, and the insured shall not have financial

responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's preferred provider benefit plan that:

1. Is based on:

a. the amount initially determined payable by the insurer, or

b. if applicable, a modified amount as determined under the insurer's internal appeal process; and

2. Is not based on any additional amount determined to be owed to the provider.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7417 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as provided by subsection C of this section, an insurer shall pay for a covered medical care or health care service performed for or a covered supply related to that service provided to an insured by an out-of-network provider who is a facility-based provider at the usual and customary rate or at an agreed rate if the provider performed the service at a health care facility that is a preferred provider. The insurer shall make a payment required by this subsection directly to the provider not later than, as applicable:

1. The thirtieth day after the date the insurer receives an electronic claim for those services that includes all information necessary for the insurer to pay the claim; or

2. The forty-fifth day after the date the insurer receives a nonelectronic claim for those services that includes all information necessary for the insurer to pay the claim.

B. Except as provided by subsection C of this section, an out-of-network provider who is a facility-based provider or a person asserting a claim as an agent or assignee of the provider may not bill an insured receiving a medical care or health care service or supply described by subsection A of this section in, and the insured does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the insured's preferred provider benefit plan that:

1. Is based on:

a. the amount initially determined payable by the insurer, or

b. if applicable, a modified amount as determined under the insurer's internal appeal process; and

2. Is not based on any additional amount determined to be owed to the provider under Sections 10 through 23 of this act.

C. This section does not apply to an emergency health care or medical service:

1. That an insured elects to receive in writing, at least three (3) days, in advance of the service with respect to each out-of-network provider providing the service; and

2. For which an out-of-network provider, before providing the scheduled service, provides a complete written disclosure to the insured that:

a. explains that the provider does not have a contract with the insured's preferred provider benefit plan,

b. discloses projected amounts for which the insured may be responsible, and

c. discloses the circumstances under which the insured would be responsible for those amounts.

3. Provider may collect that amount from the insured prior to or at time of scheduled service.

4. A good faith estimate is not required for any services that are not scheduled at least three (3) days in advance.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7418 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The administrator of a managed care plan provided under the group benefits program shall pay for covered emergency care performed by or a covered supply related to that care provided by an out-of-network provider at the usual and customary rate or at an agreed rate. The administrator shall make a payment required by

this subsection directly to the provider not later than, as applicable:

1. The thirtieth day after the date the administrator receives an electronic claim for those services that includes all information necessary for the administrator to pay the claim; or

2. The forty-fifth day after the date the administrator receives a nonelectronic claim for those services that includes all information necessary for the administrator to pay the claim.

B. For emergency care subject to this section or a supply related to that care, an out-of-network provider or a person asserting a claim as an agent or assignee of the provider may not bill a participant in, and the participant does not have financial responsibility for, an amount greater than an applicable copayment, coinsurance, and deductible under the participant's managed care plan that:

1. Is based on:

a. the amount initially determined payable by the administrator, or

b. if applicable, a modified amount as determined under the administrator's internal appeal process; and

2. Is not based on any additional amount determined to be owed to the provider under Sections 10 through 23 of this act.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7419 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Sections 10 through 23 of this act shall only apply to:

1. A health benefit plan offered by a health maintenance organization operating under the Health Maintenance Organization Act of 2003;

2. A preferred provider benefit plan, including an exclusive provider benefit plan, offered by an insurer in this state; and

3. An administrator of a health benefit plan, other than those provided for in paragraph 1 of this subsection.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7420 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Department, State Board of Medical Licensure and Supervision, and State Board of Osteopathic Examiners shall promulgate rules as necessary to implement their respective powers and duties under Sections 10 through 23 of this act.

B. Sections 11 through 15 of this act shall not be construed to prohibit:

1. A health benefit plan issuer or administrator from, at any time, offering a reformed claim settlement; or

2. An out-of-network provider from, at any time, offering a reformed charge for health care or medical services or supplies.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7421 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Department shall select an organization to maintain a benchmarking database in accordance with this section. The organization may not:

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

2. Have any other conflict of interest.

B. The benchmarking database must contain information necessary to calculate, with respect to a health care or medical service or supply, for each geozip area in this state:

1. The eightieth percentile of billed charges of all physicians or health care providers who are not facilities; and

2. The fiftieth percentile of rates paid to participating providers who are not facilities.

C. The Department may adopt rules governing the submission of information for the benchmarking database described by subsection B of this section.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7422 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Sections 10 through 23 of this act shall apply only with respect to a health benefit claim submitted by an out-of-network provider that is a facility and shall not be construed to apply to a health benefit claim for the professional or technical component of a physician service.

B. The Insurance Department shall establish and administer a mediation program to resolve disputes over out-of-network provider charges in accordance with this section.

C. The Department shall adopt rules, forms, and procedures necessary for the implementation and administration of the mediation program, including the establishment of a portal on the Department's Internet website through which a request for mediation may be submitted. The Department shall maintain a list of qualified mediators for the program.

D. An out-of-network provider or a health benefit plan issuer or administrator may request mediation of a settlement of an out-of-network health benefit claim through a portal on the Department's Internet website if there is an amount billed by the provider and unpaid by the issuer or administrator after copayments, deductibles, and coinsurance for which an enrollee may not be billed.

E. If an out-of-network person requests mediation under this act, the out-of-network provider or the provider's representative and the health benefit plan issuer or the administrator, as appropriate, shall participate in the mediation.

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7423 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. To qualify for an appointment as a mediator under this section a person must have completed at least forty (40) classroom hours of training in dispute resolution techniques in a course conducted by an alternative dispute resolution organization or other dispute resolution organization approved by the Insurance Department.

B. A person may not act as mediator for a claim settlement dispute if the person has been employed by, consulted for, or otherwise had a business relationship with a health benefit plan issuer or administrator or a physician, health care practitioner, or other health care provider during the three (3) years immediately preceding the request for mediation.

C. The Department shall immediately terminate the approval of a mediator who no longer meets the requirements under this section and rules adopted under this section.

D. If the parties to a mediation do not select a mediator by mutual agreement on or before the thirtieth day after the date the mediation is requested, the party requesting the mediation shall notify the Department, and the Department shall select a mediator from the Department’s list of approved mediators.

E. The mediator's fees shall be split evenly and paid by the health benefit plan issuer or administrator and the out-of-network provider.

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7424 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An out-of-network provider or a health benefit plan issuer or administrator may request mandatory mediation under this section.

B. The person who requests the mediation shall provide written notice on the date the mediation is requested in the form and manner provided by the Insurance Department rule to the Insurance Department and each other party.

C. In an effort to settle the claim before mediation, all parties must participate in an informal settlement teleconference not later than the thirtieth day after the date on which a person submits a request for mediation under this section.

SECTION 16. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7425 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Information submitted by the parties to the mediator is confidential and shall not be defined as a record pursuant to Section 24A.3 of Title 51 of the Oklahoma Statutes.

B. A mediation shall be held not later than the one-hundred-eightieth day after the date of the request for mediation.

C. A health care or medical service or supply provided by an out-of-network provider may not be summarily disallowed. This subsection shall not require a health benefit plan issuer or administrator to pay for an uncovered service or supply.

D. On agreement of all parties, any deadline under Sections 10 through 23 of this act may be extended.

E. In a mediation under this section, the parties shall evaluate whether:

1. The amount charged by the out-of-network provider for the health care or medical service or supply is excessive; and

2. The amount paid by the health benefit plan issuer or administrator represents the usual and customary rate for the health care or medical service or supply or is unreasonably low.

F. The out-of-network provider may present information regarding the amount charged for the health care or medical service or supply. The health benefit plan issuer or administrator may present information regarding the amount paid by the issuer or administrator.

G. The goal of the mediation shall be to reach an agreement between the out-of-network provider and the health benefit plan issuer or administrator, as applicable, as to the amount paid by the issuer or administrator to the out-of-network provider and the amount charged by the out-of-network provider.

H. Not later than the forty-fifth day after the date the mediation concludes, the mediator shall report to the Insurance Department, State Board of Medical Licensure and Supervision, and State Board of Osteopathic Examiners:

1. The names of the parties to the mediation; and

2. Whether the parties reached an agreement.

SECTION 17. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7426 of Title 36, unless there is created a duplication in numbering, reads as follows:

Not later than the forty-fifth day after the date that the mediator's report is provided to the Department under Section 16 of this act, either party to a mediation for which there was no agreement may file a civil action to determine the amount due to an out-of-network provider. A party may not bring a civil action before the conclusion of the mediation process under this act.

SECTION 18. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7427 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Department shall establish and administer an arbitration program to resolve disputes over out-of-network provider charges in accordance with this subchapter.

B. The Department shall:

1. Adopt rules, forms, and procedures necessary for the implementation and administration of the arbitration program,

including the establishment of a portal on the Department's Internet website through which a request for arbitration under Section 19 of this act may be submitted; and

2. Maintain a list of qualified arbitrators for the program.

C. The only issue that an arbitrator may determine under this section shall be the reasonable amount for the health care or medical services or supplies provided to the enrollee by an out-of-network provider.

D. The determination shall take into account:

1. Whether there is a gross disparity between the fee billed by the out-of-network provider and:

a. fees paid to the out-of-network provider for the same services or supplies rendered by the provider to other enrollees for which the provider is an out-of-network provider, and

b. fees paid by the health benefit plan issuer to reimburse similarly qualified out-of-network providers for the same services or supplies in the same region;

2. The level of training, education, and experience of the out-of-network provider;

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

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

5. Individual enrollee characteristics;

6. The eightieth percentile of all billed charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geozip area as reported in an independent non-for-profit benchmarking database described by Section 12 of this act;

7. The fiftieth percentile of rates for the service or supply paid to participating providers in the same or similar specialty and provided in the same geozip area as reported in an independent non-for-profit benchmarking database described by Section 12 of this act;

8. Prior contracts between the parties during the previous four (4) years or good faith efforts between the parties to enter into a contract;

9. A final offer made during the informal settlement teleconference required under Section 15 of this act.

SECTION 19. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7428 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Not later than the ninetieth day after the date an out-of-network provider receives the initial payment for a health care or

medical service or supply, the out-of-network provider may request arbitration of a settlement of an out-of-network health benefit claim through a portal on the Insurance Department's Internet website if there is a charge billed by the provider and unpaid by the issuer or administrator after copayments, coinsurance, and deductibles for which an enrollee may not be billed.

B. If an out-of-network provider requests arbitration under this section, the out-of-network provider or the provider's representative, and the health benefit plan issuer or the administrator, as appropriate, shall participate in the arbitration.

C. The out-of-network provider, or designated representative who requests the arbitration shall provide written notice on the date the arbitration is requested in the form and manner prescribed by Department rule to the Department and each other party.

D. In an effort to settle the claim before arbitration, all parties must participate in an informal settlement teleconference not later than the thirtieth day after the date on which the arbitration is requested. A health benefit plan issuer or administrator, as applicable, shall make a reasonable effort to arrange the teleconference.

E. The Insurance Department shall adopt rules providing requirements for submitting multiple claims to arbitration in one proceeding. The rules must provide that the multiple claims in one proceeding must be limited to the same health benefit plan and out-

of-network provider, or provider group when such multiples claims are billed under the same tax identification number.

F. An out-of-network provider or health benefit plan issuer or administrator may not file suit for an out-of-network claim subject to this section until the conclusion of the arbitration on the issue of the amount to be paid in the out-of-network claim dispute.

SECTION 20. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7429 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. If the parties do not select an arbitrator by mutual agreement on or before the thirtieth day after the date the arbitration is requested, the party requesting the arbitration shall notify the Insurance Department, and the Department shall select an arbitrator from the Department's list of approved arbitrators.

B. In selecting an arbitrator under this section, the Department shall give preference to an arbitrator who is knowledgeable and experienced in applicable principles of contract and insurance law and the health care industry generally.

C. In approving an individual as an arbitrator, the Department shall ensure that the individual does not have a conflict of interest that would adversely impact the individual's independence and impartiality in rendering a decision in an arbitration. A conflict of interest includes current or recent ownership or employment of the individual or a close family member in any health

benefit plan issuer or administrator or physician, health care practitioner, or other health care provider.

D. The Department shall immediately terminate the approval of an arbitrator who no longer meets the requirements under this section and rules adopted under this section.

SECTION 21. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7430 of Title 36, unless there is created a duplication in numbering, reads as follows:

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

B. A party may not engage in discovery in connection with the arbitration.

C. On agreement of all parties, any deadline under this section may be extended.

D. Unless otherwise agreed to by the parties, an arbitrator may not determine whether a health benefit plan covers a particular health care or medical service or supply.

E. Information submitted by the parties to the arbitrator is confidential and shall not be considered a record pursuant to Section 24A.3 of Title 51 of the Oklahoma Statutes.

F. The losing party in an arbitration shall pay the arbitrator’s fees and expenses.

SECTION 22. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7431 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Not later than the thirtieth day after the date the arbitration is requested, an arbitrator shall provide the parties with a written decision in which the arbitrator:

1. Determines whether the final offers submitted to the arbitrator to the parties is the closest to the reasonable amount for the services or supplies; and

2. Selects the amount determined to be closest under paragraph 1 of this subsection as the binding award amount.

B. An arbitrator shall not modify the binding award amount selected under subsection A of this section.

C. An arbitrator shall provide written notice in the form and manner prescribed by Insurance Department rule of the reasonable amount for the services or supplies and the binding award amount. If the parties settle before a decision, the parties shall provide written notice in the form and manner prescribed by Department rule of the amount of the settlement. The Department shall maintain a record of notices provided under this subsection.

D. An arbitrator's decision under this section is binding. Not later than the thirtieth day after the date of an arbitrator's decision under this section, a party not satisfied with the decision

may file an action to determine the payment due to an out-of-network provider.

E. In an action filed under subsection D of this section, the court shall determine whether the arbitrator's decision is proper based on a substantial evidence standard of review.

F. Not later than the thirtieth day after the date of an arbitrator's decision under subsection D of this section, a health benefit plan issuer or administrator shall pay to an out-of-network provider any additional amount necessary to satisfy the binding award.

SECTION 23. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7432 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The following conduct constitutes bad faith participation for purposes of this section:

1. Failing to participate in the informal settlement teleconference under subsection C of Section 15 of this act, subsection D of Section 19 of this act, or an arbitration or mediation under this act;

2. Failing to provide information the arbitrator or mediator believes is necessary to facilitate a decision or an agreement; or

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

B. Failure to reach an agreement under mediation or arbitration shall not be considered conclusive proof of bad-faith participation.

C. Bad-faith participation or otherwise failing to comply with mediation or arbitration provisions pursuant to this act shall be grounds for imposition of an administrative penalty by the Insurance Department, State Board of Medical Licensure and Supervision, or State Board of Osteopathic Examiners, as applicable to the party who committed the violation.

D. Except for good cause shown, on a report of a mediator and appropriate proof of bad-faith participation, the Department or Board that issued the license or certificate of authority shall impose an administrative penalty.

SECTION 24. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7433 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Department, State Board of Medical Licensure and Supervision, and State Board of Osteopathic Examiners, as appropriate, shall adopt rules regulating the investigation and review of a complaint filed that relates to the settlement of an out-of-network health benefit claim that is subject to this chapter. The rules adopted under this section shall:

1. Distinguish among complaints for out-of-network coverage or payment and give priority to investigating allegations of delayed health care or medical care;

2. Develop a form for filing a complaint; and

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

B. The Insurance Department, State Board of Medical Licensure and Supervision, and State Board of Osteopathic Examiners shall maintain information, including:

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

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

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

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

5. Any other information about:

a. the health benefit plan issuer or administrator that the Department by rule requires, or

b. the out-of-network provider that the State Board of Medical Licensure and Supervision or State Board of Osteopathic Examiners by rule requires.

C. The information collected and maintained under subsection B of this section shall be considered public information; provided, however, such information shall not include personally identifiable information or health care or medical information.

SECTION 25. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 7434 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Department shall, each biennium, conduct a study on the impacts of this act on Oklahoma consumers and health coverage in this state, including:

1. Trends in billed amounts for health care or medical services or supplies;

2. Comparison of the total amount spent on out-of-network medical services or supplies by calendar year and provider type or physician specialty;

3. Trends and changes in network participation by providers by provider type or physician specialty, including whether any terminations were initiated by a health benefit plan issuer, administrator, or provider;

4. Trends and changes in the amounts paid to participating providers;

5. The number of complaints, completed investigations, and disciplinary sanctions for billing by providers of emergency services, laboratory services, diagnostic imaging services, or facility-based services of enrollees for amounts greater than the enrollee’s responsibility under an applicable health benefit plan, including applicable copayments, coinsurance, and deductibles;

6. Trends in amounts paid to out-of-network providers;

7. Trends in the usual and customary rate for health care or medical services or supplies; and

8. The effectiveness of the claim dispute resolution process under this act.

B. In conducting the study described by subsection A of this section, the Department shall collect settlement data and verdicts or arbitration awards, as applicable, from parties to mediation or arbitration under this act.

C. The Department may not publish a particular rate paid to a participating provider in the study described by subsection A of this section, identifying information of a physician or health care provider, or non-aggregated study results. Information described by this subsection is confidential and shall not be considered a record pursuant to Section 24A.3 of Title 51 of the Oklahoma Statutes.

D. The Department:

1. Shall collect data quarterly from a health benefit plan issuer or administrator subject this act to conduct the study required by this section; and

2. May utilize any reliable external resource or entity to acquire information reasonably necessary to prepare the report required by subsection E of this section.

E. Not later than December 1 of each even-numbered year, the Department shall prepare and submit a written report on the results

of the study under this section, including the Department's findings, to the Legislature.

SECTION 26. AMENDATORY 51 O.S. 2021, Section 24A.3, is amended to read as follows:

Section 24A.3 As used in the Oklahoma Open Records Act:

1. "Record" means all documents, including, but not limited to, any book, paper, photograph, microfilm, data files created by or used with computer software, computer tape, disk, record, sound recording, film recording, video record or other material regardless of physical form or characteristic, created by, received by, under the authority of, or coming into the custody, control or possession of public officials, public bodies, or their representatives in connection with the transaction of public business, the expenditure of public funds or the administering of public property. "Record" does not mean:

a. computer software,

b. nongovernment personal effects,

c. unless public disclosure is required by other laws or regulations, vehicle movement records of the Oklahoma Transportation Authority obtained in connection with the Authority's electronic toll collection system,

d. personal financial information, credit reports or other financial data obtained by or submitted to a public body for the purpose of evaluating credit

worthiness, obtaining a license, permit, or for the purpose of becoming qualified to contract with a public body,

e. any digital audio/video recordings of the toll collection and safeguarding activities of the Oklahoma Transportation Authority,

f. any personal information provided by a guest at any facility owned or operated by the Oklahoma Tourism and Recreation Department or the Board of Trustees of the Quartz Mountain Arts and Conference Center and Nature Park to obtain any service at the facility or by a purchaser of a product sold by or through the Oklahoma Tourism and Recreation Department or the Quartz Mountain Arts and Conference Center and Nature Park,

g. a Department of Defense Form 214 (DD Form 214) filed with a county clerk, including any DD Form 214 filed before July 1, 2002, ~~or~~

h. except as provided for in Section 2-110 of Title 47 of the Oklahoma Statutes,

(1) any record in connection with a Motor Vehicle Report issued by the Department of Public Safety, as prescribed in Section 6-117 of Title 47 of the Oklahoma Statutes, or

(2) personal information within driver records, as defined by the Driver's Privacy Protection Act, 18 United States Code, Sections 2721 through 2725, which are stored and maintained by the Department of Public Safety~~.~~,

i. information submitted to a mediator by the parties of a claim dispute pursuant to Section 16 of this act,

j. information submitted to an arbitrator by the parties of an arbitration pursuant to Section 21 of this act, or

k. information containing the particular rate paid to a participating provider, identifying information of a physician or health care provider, or nonaggregated study results utilized by the Insurance Department pursuant to Section 25 of this act;

2. "Public body" shall include, but not be limited to, any office, department, board, bureau, commission, agency, trusteeship, authority, council, committee, trust or any entity created by a trust, county, city, village, town, township, district, school district, fair board, court, executive office, advisory group, task force, study group, or any subdivision thereof, supported in whole or in part by public funds or entrusted with the expenditure of public funds or administering or operating public property, and all committees, or subcommittees thereof. Except for the records

required by Section 24A.4 of this title, "public body" does not mean judges, justices, the Council on Judicial Complaints, the Legislature, or legislators;

3. "Public office" means the physical location where public bodies conduct business or keep records;

4. "Public official" means any official or employee of any public body as defined herein; and

5. "Law enforcement agency" means any public body charged with enforcing state or local criminal laws and initiating criminal prosecutions, including, but not limited to, police departments, county sheriffs, the Department of Public Safety, the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control, the Alcoholic Beverage Laws Enforcement Commission, and the Oklahoma State Bureau of Investigation.

SECTION 27. This act shall become effective November 1, 2022.

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