

STATE OF OKLAHOMA

1st Session of the 58th Legislature (2021)

HOUSE BILL 2807

By: Sneed

AS INTRODUCED

An Act relating to insurance; creating the Oklahoma Out-of-Network Surprise Billing and Transparency Act; providing for applicability; defining terms; requiring policies to reference certain rates; providing for certain baseline charges; limiting rate increases; 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; 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 submitting multiple claims to arbitration; limiting issues arbitrator may address; providing for basis for determination; prohibiting civil action until conclusion of arbitration; exempting arbitration from the Uniform Arbitration Act; providing for selection and approval of arbitrators; providing for arbitration procedures; providing for arbitrator decision; requiring written notice; providing for court review of arbitrator decision; providing for bad faith in arbitration; providing penalties; directing the Insurance Commissioner and the Oklahoma Board of Medical

1 Licensure and Supervision to adopt certain rules;
2 requiring Insurance Department and Oklahoma Board of
3 Medical Licensure and Supervision to maintain certain
4 information; requiring the Insurance Department to
5 conduct biennium study; requiring written report to
6 Legislature; requiring written notice of benefits and
7 billing prohibitions; amending 12 O.S. 2011, Section
8 1854, which relates to the Uniform Arbitration Act;
9 providing an exception; providing for codification;
10 and providing an 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:

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

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

1 4. The Employee Retirement Income Security Act of 1974 health
2 benefit plans.

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

6 As used in the Oklahoma Out-of-Network Surprise Billing and
7 Transparency Act:

8 1. "Arbitration" means a process in which an impartial
9 arbitrator issues a binding determination in a dispute between a
10 health benefit plan issuer or administrator and an out-of-network
11 provider and/or facility or the provider or facility's
12 representative to settle a health benefit claim;

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

15 3. "Surprise billing" means the practice by a health care
16 provider or facility who does not, or is unable to, participate in
17 an enrollee's health benefit plan network, and charges an enrollee
18 the difference between the provider's or facility's fee and the sum
19 of what the enrollee's health benefit plan pays and what the
20 enrollee is required to pay in applicable deductibles, copayments,
21 coinsurance or other cost-sharing amounts required by the health
22 benefit plan; and

23 4. "Usual, customary, and reasonable rate" or "UCR rate" means
24 the eightieth percentile of all charges for the particular health

1 care service performed by a health care provider in the same or
2 similar specialty and provided in the same geographical area as
3 reported in an independent benchmarking database maintained by a
4 nonprofit organization specified by the Insurance Commissioner;
5 provided, the nonprofit organization shall not be financially
6 affiliated with an insurance carrier or health care provider.

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

10 All health insurance benefit policies must reference the usual,
11 customary, and reasonable rate for the purpose of providing an
12 enrollee with reimbursement transparency for out-of-network health
13 care providers and facilities. The charges for services reflected
14 by the Current Procedural Terminology code as reflected in the
15 eightieth percentile of charge data supplied by an independent
16 benchmarking database on November 1, 2021, shall constitute the
17 baseline for provider or facility charges. Beginning November 1,
18 2021, provider or facility charges may change anytime the charge
19 data supplied by an independent benchmarking database changes, but
20 may not increase at a rate greater than the Consumer Price Index.

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

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

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

17 If a health care provider, health care facility or administrator
18 has billed an enrollee an amount greater than the applicable
19 copayment, coinsurance, and deductible amounts required under the
20 Oklahoma Out-of-Network Surprise Billing and Transparency Act, the
21 Attorney General may bring a civil action in the name of the state
22 to ensure the enrollee is not responsible for an amount greater than
23 the applicable copayment, coinsurance, and deductible amounts. If
24 the Attorney General prevails in an action brought against a health

1 benefit plan issuer or administrator, the Attorney General may
2 recover reasonable attorney fees, costs and expenses, including
3 court costs and witness fees incurred in bringing the action.

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

7 A. When an enrollee in a health benefit plan that covers
8 emergency services receives the services from an out-of-network
9 provider or out-of-network facility, the health benefit plan shall
10 ensure that the enrollee shall incur no greater out-of-pocket costs
11 for the emergency services than the enrollee would have incurred
12 with an in-network provider.

13 B. If a covered person receives covered emergency services by
14 an out-of-network provider or out-of-network facility, the carrier
15 shall pay the out-of-network provider directly and the initial
16 payment shall be the greater of the:

- 17 1. Medicare rate;
- 18 2. In-network rate;
- 19 3. Usual, customary, and reasonable rate; or
- 20 4. Agreed upon rate.

21 C. The insurer shall make the 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 8. NEW LAW A new section of law to be codified
8 in the Oklahoma Statutes as Section 6060.67 of Title 36, unless
9 there is created a duplication in numbering, reads as follows:

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

15 B. The enrollee who receives care shall not be responsible for
16 any amount greater than his or her applicable in-network copayment,
17 coinsurance, and deductible amounts.

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

20 1. Thirty (30) days after the date the insurer receives an
21 electronic clean claim for those services that includes all
22 information necessary for the insurers 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 SECTION 9. NEW LAW A new section of law to be codified
5 in the Oklahoma Statutes as Section 6060.68 of Title 36, unless
6 there is created a duplication in numbering, reads as follows:

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

13 The enrollee who receives care shall not be responsible for any
14 amount greater than his or her applicable out-of-network copayment,
15 coinsurance, and deductible amounts.

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

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

21 2. Forty-five (45) days after the date the insurer receives a
22 nonelectronic clean claim for those services that includes all
23 information necessary for the insurer to pay the claim.
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1 C. Nothing in this section shall be construed to prohibit an
2 out-of-network provider or out-of-network facility from accepting
3 less than the usual, customary, and reasonable rate so long as an
4 agreement has been made between the enrollee and out-of-network
5 health care provider or out-of-network facility.

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

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

13 B. The Insurance Commissioner shall select an organization to
14 maintain a benchmarking database in accordance with this section.
15 The organization shall not:

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

19 2. Have any other conflict of interest.

20 C. The benchmarking database shall contain the following
21 information necessary to calculate, with respect to a health care or
22 medical service or supply, for each geozip area in this state:

23 1. Percentiles of billed charges for all out-of-network
24 providers and facilities; and

1 2. Percentiles of rates paid to participating providers and
2 facilities.

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

5 E. The Commissioner may adopt rules governing the submission of
6 information for the benchmarking database.

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

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

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

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

20 b. The health benefit claim is for:

21 (1) nonemergency care provided at an out-of-network
22 facility,

23 (2) nonemergency care provided by an out-of-network
24 provider,

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

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

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

7 B. If a person requests arbitration under this section, and
8 depending on who initiates, the out-of-network provider, out-of-
9 network facility, or a representative of the provider or facility,
10 and the health benefit plan issuer or the administrator, as
11 appropriate, shall participate in the arbitration.

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

20 1. There is an amount billed by the out-of-network provider or
21 out-of-network facility and unpaid by the issuer or administrator
22 after copayments, coinsurance, and deductibles for which an enrollee
23 may not be billed; or
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1 2. a. The required usual, customary, and reasonable rate
2 paid by an insurer is deemed unreasonable, and

3 b. The health benefit claim is for:

4 (1) nonemergency care provided at an out-of-network
5 facility,

6 (2) nonemergency care provided by an out-of-network
7 provider,

8 (3) emergency care provided at an out-of-network
9 facility,

10 (4) emergency care provided by an out-of-network
11 provider, or

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

14 D. Nothing in this section shall prohibit a health care
15 provider or facility from utilizing arbitration in cases where
16 medical necessity is disputed.

17 E. If a person requests arbitration, the out-of-network
18 provider, out-of-network facility, or an appropriate representative,
19 and the health benefit plan issuer or administrator, as appropriate,
20 shall participate in the arbitration.

21 F. The party who requests arbitration shall provide written
22 notice on the date the arbitration is requested in the form and
23 manner prescribed by Insurance Commissioner rule to:

24 1. The Department; and

2. Each party.

G. In an effort to settle the claim before arbitration, all parties shall participate in an informal settlement teleconference no later than thirty (30) days 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.

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

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

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

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

1 supplies provided to the enrollee by an out-of-network provider or
2 out-of-network facility.

3 B. The determination shall take into account:

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

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

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

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

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

16 6. Individual enrollee characteristics;

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

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

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

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

2 11. Historical data for percentiles; and

3 12. An offer made during the informal settlement
4 teleconference.

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

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

13 B. The arbitration conducted under the Oklahoma Out-of-Network
14 Surprise Billing and Transparency Act is not subject to the Uniform
15 Arbitration Act.

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

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

1 B. In selecting an arbitrator, the Commissioner shall give
2 preference to an arbitrator who is knowledgeable and experienced in
3 applicable principles of contract and insurance law and the health
4 care industry generally.

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

13 D. The Commissioner shall immediately terminate the approval of
14 an arbitrator who no longer meets the requirements adopted by the
15 Commissioner.

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

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

21 B. A party shall not engage in discovery in connection with the
22 arbitration.

23 C. On agreement of all parties, any deadline may be extended.
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1 D. The party which is not awarded the amount submitted to
2 arbitration shall pay all expenses and fees required by the
3 arbitrator.

4 E. Information submitted to the arbitrator is confidential and
5 not public record.

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

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

12 1. Determines whether the health care provider or health care
13 facility's charge is reasonable;

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

16 3. Selects the amount determined to be the closest as the
17 binding award.

18 B. An arbitrator shall not modify the binding award amount.

19 C. An arbitrator shall provide written notice in the form and
20 manner prescribed by the Insurance Commissioner rule of the
21 reasonable amount for the services or supplies and the binding award
22 amount. If the parties settle before a decision, the parties shall
23 provide written notice in the form and manner prescribed by
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1 Commissioner rule of the amount of settlement. The Oklahoma
2 Insurance Department shall maintain a record of notices.

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

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

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

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

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

16 E. Based on the arbitrator's binding award amount, the losing
17 party shall be required to pay the arbitrator's fees and expenses.

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

21 A. The following constitutes bad faith participation in
22 arbitration:

23 1. Failing to participate in the informal settlement
24 teleconference;

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

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

5 B. Failure to reach an agreement is not conclusive proof of bad
6 faith participation.

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

10 A. Bad faith participation or otherwise failing to comply with
11 arbitration requirements is grounds for imposition of an
12 administrative penalty by the regulatory agency that issued a
13 license or certificate of authority to the party who committed the
14 violation.

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

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

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

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

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

7 D. The Oklahoma Insurance Department and State Board of Medical
8 Licensure and Supervision or other appropriate regulatory agency
9 shall maintain the following information on each complaint filed
10 that concerns a claim and arbitration:

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

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

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

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

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

22 6. The out-of-network provider or facility that the State Board
23 of Medical Licensure and Supervision or other appropriate regulatory
24 agency by rule requires.

1 E. All information collected is public information and may not
2 include personally identifiable information.

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

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

- 9 1. Trends and changes in billed amounts;
- 10 2. Trends and changes in paid amounts;
- 11 3. Trends and changes in network participation;
- 12 4. Trends and changes in paid amounts to in-network providers
13 or facilities;
- 14 5. Trends and changes in paid amounts to out-of-network
15 providers or facilities; and
- 16 6. Number of complaints and results of claims that enter
17 arbitration, including effectiveness of arbitration.

18 B. Beginning December 1, 2022, and no later than December 1 of
19 every other year thereafter, the Department shall prepare and submit
20 a written report on the results of the study to the Legislature and
21 appropriate committees.

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

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

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

12 2. An explanation of benefits provided to the health care
13 provider or facility with information required by rule advising the
14 health care provider or facility of the availability of arbitration,
15 as applicable under the Oklahoma Out-of-Network Surprise Billing and
16 Transparency Act; and

17 3. For elective services that are covered by an enrollee's
18 health benefit plan, if requested by an enrollee before a scheduled
19 service and explanation of benefits, the provider's average amounts
20 paid to comparable in-network health care providers or facilities
21 for covered services.

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

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

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

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

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

10 SECTION 23. This act shall become effective November 1, 2021.

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12 58-1-6816 AB 12/29/20

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