

1 STATE OF OKLAHOMA

2 2nd Session of the 58th Legislature (2022)

3 SENATE BILL 1813

By: Pugh

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5  
6 AS INTRODUCED

7 An Act relating to surprise billing; defining terms;  
8 providing for the Attorney General to bring civil  
9 action to enjoin certain persons or entities in  
10 certain circumstances; authorizing the Attorney  
11 General to recover reasonable costs and fees;  
12 authorizing certain regulatory boards to take  
13 disciplinary action against certain persons or  
14 entities under certain circumstances; authorizing the  
15 Insurance Department to take disciplinary action  
16 against certain persons or entities under certain  
17 circumstances; authorizing Insurance Department and  
18 certain regulatory boards to promulgate rules;  
19 construing provisions; providing for issuer of  
20 exclusive provider benefit plan to reimburse out-of-  
21 network provider at usual and customary rate by  
22 certain date; prohibiting insured liability for  
23 payments exceeding certain applicable amounts;  
24 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 who is facility-based by certain date;  
prohibiting insureds liability for payments exceeding  
certain applicable amounts for care provided by an  
out-of-network facility-based provider in certain  
circumstances; requiring insurer to reimburse care by  
a diagnostic imaging provider or a laboratory service  
provider at usual and customary rate under certain  
circumstances by certain date; prohibiting insured

1 liability for payments exceeding certain applicable  
2 amounts for care provided by an out-of-network  
3 diagnostic imaging provider or laboratory service  
4 provider in certain circumstances; requiring  
5 administrator of managed care plan provide written  
6 notice of explanation of benefits that includes  
7 certain provisions to certain persons by certain  
8 date; requiring administrator to reimburse emergency  
9 care conducted by an out-of-network provider at usual  
10 and customary rate under certain circumstances by  
11 certain date; prohibiting certain persons be  
12 responsible for payments exceeding certain applicable  
13 amounts for emergency care provided by an out-of-  
14 network provider in certain circumstances; requiring  
15 administrator pay for certain covered services and  
16 supplies provided by an out-of-network provider who  
17 is facility-based by certain date; prohibiting  
18 certain persons be responsible for payments exceeding  
19 certain applicable amounts for care provided by an  
20 out-of-network provider who is facility-based in  
21 certain circumstances; requiring administrator to  
22 reimburse care by a diagnostic imaging provider or a  
23 laboratory service provider at usual and customary  
24 rate under certain circumstances by certain date;  
25 prohibiting certain persons be responsible for  
26 payments exceeding certain applicable amounts for  
27 care provided by an out-of-network diagnostic imaging  
28 provider or laboratory service provider in certain  
29 circumstances; requiring certain notice be provided  
30 to enrollee and physician or health care provider;  
31 providing contents of notice; stating application of  
32 certain provisions; directing certain regulatory  
33 boards and agency to promulgate rules; requiring  
34 Department to establish benchmarking database for  
35 certain billed charges and rates; requiring  
36 Department establish mediation program and procedures  
37 for mediation; establishing qualifications for  
38 participating mediators; establishing circumstances  
39 for mediation; requiring submission of mediation  
40 results to certain persons and entities by certain  
41 date; requiring Department to establish arbitration  
42 program and procedures; establishing circumstances  
43 for arbitration; establishing qualifications for  
44 participating arbitrators; requiring submission of  
45 arbitration results to certain persons and entities  
46 by certain date; prohibiting arbitrator from  
47 modifying binding award amount; establishing

1 procedures for filing action following arbitration;  
2 establishing provisions for bad faith participation;  
3 requiring certain regulatory boards and agency to  
4 promulgate rules for filing complaint; requiring  
5 Department conduct biennial study regarding effects  
6 of act and procedures therein; amending 51 O.S. 2021,  
7 Section 24A.3, which relates to Oklahoma Open Records  
8 Act; modifying definition of record to exclude  
9 certain information submitted pursuant to act;  
10 providing for codification; and providing an  
11 effective date.

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

13 SECTION 1. NEW LAW A new section of law to be codified  
14 in the Oklahoma Statutes as Section 7410 of Title 36, unless there  
15 is created a duplication in numbering, reads as follows:

16 For the purposes of this act:

17 1. "Administrator" means the claims administrator for a health  
18 benefit plan and an administering firm for a health benefit plan as  
19 defined pursuant to Section 6060.4 of Title 36 of the Oklahoma  
20 Statutes;

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

25 3. "Diagnostic imaging provider" means a health care provider  
26 who performs a diagnostic imaging service on a patient for a fee or  
27 interprets imaging produced by a diagnostic imaging service;

1 4. "Diagnostic imaging service" means magnetic resonance  
2 imaging, computed tomography, positron emission tomography, or any  
3 hybrid technology that combines any of those imaging modalities;

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

- 12 a. placing the person's health in serious jeopardy,
- 13 b. serious impairment to bodily functions,
- 14 c. serious dysfunction of a bodily organ or part,
- 15 d. serious disfigurement, or
- 16 e. in the case of a pregnant woman, serious jeopardy to  
17 the health of the fetus;

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

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

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

4 9. "Facility-based provider" means a health care provider who  
5 provides health care services to patients of a particular health  
6 care facility;

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

13 11. "Laboratory service provider" means an accredited facility  
14 in which a specimen taken from a human body is interpreted and  
15 pathological diagnoses are made or a physician who makes an  
16 interpretation of or diagnosis based on a specimen or information  
17 provided by a laboratory based on a specimen;

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

23 13. "Out-of-network provider" means a diagnostic imaging  
24 provider, emergency care provider, facility-based provider, or  
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1 laboratory service provider that is not a participating provider for  
2 a health benefit plan;

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

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

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

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

16 A. If the Attorney General of the State of Oklahoma receives a  
17 referral from an appropriate regulatory agency indicating that an  
18 individual or entity, including a health benefit plan issuer or  
19 administrator, has exhibited a pattern of intentionally violating a  
20 law that prohibits the individual or entity from billing an insured,  
21 participant, or enrollee in an amount greater than an applicable  
22 copayment, coinsurance, and deductible under the insured's,  
23 participant's, or enrollee's managed care plan or that imposes a  
24 requirement related to that prohibition, the Attorney General may

1 bring a civil action in the name of the state to enjoin the  
2 individual or entity from the violation.

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

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

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

21 B. The Insurance Department may take disciplinary action  
22 against a health benefit plan issuer or administrator if the issuer  
23 or administrator violates a law requiring the issuer or  
24

1 administrator to provide notice of a balance billing prohibition or  
2 make a related disclosure.

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

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

9 Except as provided by Sections 5, 7, 8, and 9 of this act, this  
10 act shall not be construed to require an exclusive provider benefit  
11 plan to compensate a nonpreferred provider for services provided to  
12 an insured.

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

16 A. If an out-of-network provider provides emergency care as  
17 defined by paragraph 5 of section 1 of this act to an enrollee in an  
18 exclusive provider benefit plan, the issuer of the plan shall  
19 reimburse the out-of-network provider at the usual and customary  
20 rate or at a rate agreed to by the issuer and the out-of-network  
21 provider for the provision of the services and any supply related to  
22 those services. The insurer shall make a payment required by this  
23 subsection directly to the provider not later than, as applicable:  
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1           1. The thirtieth day after the date the insurer receives an  
2 electronic claim for those services that includes all information  
3 necessary for the insurer to pay the claim; or

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

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

14           1. Is based on:

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

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

19           2. Is not based on any additional amount determined to be owed  
20 to the provider under Sections 22 through 35 of this act.

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

1 A. An insurer shall provide written notice in accordance with  
2 this section in an explanation of benefits provided to the insured  
3 and the physician or health care provider in connection with a  
4 medical care or health care service or supply provided by an out-of-  
5 network provider. The notice shall include:

6 1. A statement of the billing prohibition under Sections 5, 7,  
7 8, or 9 of this act, as applicable;

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

12 3. For an explanation of benefits provided to the physician or  
13 provider, information advising the physician or provider of the  
14 availability of mediation or arbitration pursuant to Sections 25 and  
15 31 of this act.

16 B. An insurer shall provide the explanation of benefits with  
17 the notice required by this section to a physician or health care  
18 provider not later than the date the insurer makes a payment under  
19 Sections 5, 7, 8, or 9 of this act, as applicable.

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

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

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

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

10 3. Services originating in a hospital emergency facility or  
11 freestanding emergency medical care facility following treatment or  
12 stabilization of an emergency medical condition; and

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

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

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

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

1 C. For emergency care subject to this section or a supply  
2 related to that care, an out-of-network provider or a person  
3 asserting a claim as an agent or assignee of the provider shall not  
4 bill an insured in, and the insured shall not have financial  
5 responsibility for, an amount greater than an applicable copayment,  
6 coinsurance, and deductible under the insured's preferred provider  
7 benefit plan that:

8 1. Is based on:

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

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

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

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

18 A. Except as provided by subsection C of this section, an  
19 insurer shall pay for a covered medical care or health care service  
20 performed for or a covered supply related to that service provided  
21 to an insured by an out-of-network provider who is a facility-based  
22 provider at the usual and customary rate or at an agreed rate if the  
23 provider performed the service at a health care facility that is a  
24 preferred provider. The insurer shall make a payment required by

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

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

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

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

17 1. Is based on:

- 18 a. the amount initially determined payable by the  
19 insurer, or  
20 b. if applicable, a modified amount as determined under  
21 the insurer's internal appeal process; and

22 2. Is not based on any additional amount determined to be owed  
23 to the provider under Sections 22 through 35 of this act.

1 C. This section does not apply to a nonemergency health care or  
2 medical service:

3 1. That an insured elects to receive in writing in advance of  
4 the service with respect to each out-of-network provider providing  
5 the service; and

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

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

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

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

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

17 A. Except as provided by subsection C of this section, an  
18 insurer shall pay for a covered medical care or health care service  
19 performed by or a covered supply related to that service provided to  
20 an insured by an out-of-network provider who is a diagnostic imaging  
21 provider or laboratory service provider at the usual and customary  
22 rate or at an agreed rate if the provider performed the service in  
23 connection with a medical care or health care service performed by a  
24 preferred provider. The insurer shall make a payment required by

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

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

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

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

18 1. Is based on:

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

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

23 2. Is not based on any additional amount determined to be owed  
24 to the provider under Sections 22 through 35 of this act.

1 C. This section does not apply to a nonemergency health care or  
2 medical service:

3 1. That an insured elects to receive in writing in advance of  
4 the service with respect to each out-of-network provider providing  
5 the service; and

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

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

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

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

14 SECTION 10. NEW LAW A new section of law to be codified  
15 in the Oklahoma Statutes as Section 7420 of Title 36, unless there  
16 is created a duplication in numbering, reads as follows:

17 A. The administrator of a managed care plan provided under the  
18 group benefits program shall provide written notice in accordance  
19 with this section in an explanation of benefits provided to the  
20 participant and the physician or health care provider in connection  
21 with a health care or medical service or supply provided by an out-  
22 of-network provider. The notice must include:

23 1. A statement of the billing prohibition under Sections 11,  
24 12, or 13 of this act, as applicable;



1           2. The total amount the physician or provider may bill the  
2 participant under the participant's managed care plan and an  
3 itemization of copayments, coinsurance, deductibles, and other  
4 amounts included in that total; and

5           3. For an explanation of benefits provided to the physician or  
6 provider, information advising the physician or provider of the  
7 availability of mediation or arbitration pursuant to Sections 25 and  
8 31 of this act.

9           B. The administrator shall provide the explanation of benefits  
10 with the notice required by this section to a physician or health  
11 care provider not later than the date the administrator makes a  
12 payment under Sections 11, 12, or 13 of this act, as applicable.

13           SECTION 11.       NEW LAW       A new section of law to be codified  
14 in the Oklahoma Statutes as Section 7421 of Title 36, unless there  
15 is created a duplication in numbering, reads as follows:

16           A. The administrator of a managed care plan provided under the  
17 group benefits program shall pay for covered emergency care  
18 performed by or a covered supply related to that care provided by an  
19 out-of-network provider at the usual and customary rate or at an  
20 agreed rate. The administrator shall make a payment required by  
21 this subsection directly to the provider not later than, as  
22 applicable:  
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1 1. The thirtieth day after the date the administrator receives  
2 an electronic claim for those services that includes all information  
3 necessary for the administrator to pay the claim; or

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

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

14 1. Is based on:

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

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

19 2. Is not based on any additional amount determined to be owed  
20 to the provider under Sections 22 through 35 of this act.

21 SECTION 12. NEW LAW A new section of law to be codified  
22 in the Oklahoma Statutes as Section 7422 of Title 36, unless there  
23 is created a duplication in numbering, reads as follows:  
24

1           A. Except as provided by subsection C of this section, the  
2 administrator of a managed care plan provided under the group  
3 benefits program shall pay for a covered health care or medical  
4 service performed for or a covered supply related to that service  
5 provided to a participant by an out-of-network provider who is a  
6 facility-based provider at the usual and customary rate or at an  
7 agreed rate if the provider performed the service at a health care  
8 facility that is a participating provider. The administrator shall  
9 make a payment required by this subsection directly to the provider  
10 not later than, as applicable:

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

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

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

1 1. Is based on:

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

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

6 2. Is not based on any additional amount determined to be owed  
7 to the provider under Sections 22 through 35 of this act.

8 C. This section does not apply to a nonemergency health care or  
9 medical service:

10 1. That a participant elects to receive in writing in advance  
11 of the service with respect to each out-of-network provider  
12 providing the service; and

13 2. For which an out-of-network provider, before providing the  
14 service, provides a complete written disclosure to the participant  
15 that:

16 a. explains that the provider does not have a contract  
17 with the participant's managed care plan,

18 b. discloses projected amounts for which the participant  
19 may be responsible, and

20 c. discloses the circumstances under which the  
21 participant would be responsible for those amounts.

22 SECTION 13. NEW LAW A new section of law to be codified  
23 in the Oklahoma Statutes as Section 7423 of Title 36, unless there  
24 is created a duplication in numbering, reads as follows:

1           A. Except as provided by subsection C of this section, the  
2 administrator of a managed care plan provided under the group  
3 benefits program shall pay for a covered health care or medical  
4 service performed for or a covered supply related to that service  
5 provided to a participant by an out-of-network provider who is a  
6 diagnostic imaging provider or laboratory service provider at the  
7 usual and customary rate or at an agreed rate if the provider  
8 performed the service in connection with a health care or medical  
9 service performed by a participating provider. The administrator  
10 shall make a payment required by this subsection directly to the  
11 provider not later than, as applicable:

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

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

18           B. Except as provided by subsection C of this section, an out-  
19 of-network provider who is a diagnostic imaging provider or  
20 laboratory service provider or a person asserting a claim as an  
21 agent or assignee of the provider may not bill a participant  
22 receiving a health care or medical service or supply described by  
23 subsection A of this section in, and the participant does not have  
24 financial responsibility for, an amount greater than an applicable

1 copayment, coinsurance, and deductible under the participant's  
2 managed care plan that:

3 1. Is based on:

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

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

8 2. Is not based on any additional amount determined to be owed  
9 to the provider under Sections 22 through 35 of this act.

10 C. This section does not apply to a nonemergency health care or  
11 medical service:

12 1. That a participant elects to receive in writing in advance  
13 of the service with respect to each out-of-network provider  
14 providing the service; and

15 2. For which an out-of-network provider, before providing the  
16 service, provides a complete written disclosure to the participant  
17 that:

18 a. explains that the provider does not have a contract  
19 with the participant's managed care plan,

20 b. discloses projected amounts for which the participant  
21 may be responsible, and

22 C. discloses the circumstances under which the  
23 participant would be responsible for those amounts.  
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1 SECTION 14. NEW LAW A new section of law to be codified  
2 in the Oklahoma Statutes as Section 7424 of Title 36, unless there  
3 is created a duplication in numbering, reads as follows:

4 A. The administrator of a managed care plan provided under the  
5 group program shall provide written notice in accordance with this  
6 section in an explanation of benefits provided to the enrollee and  
7 the physician or health care provider in connection with a health  
8 care or medical service or supply provided by an out-of-network  
9 provider. The notice must include:

10 1. A statement of the billing prohibition under Sections 15,  
11 16, or 17 of this act, as applicable;

12 2. The total amount the physician or provider may bill the  
13 enrollee under the enrollee's managed care plan and an itemization  
14 of copayments, coinsurance, deductibles, and other amounts included  
15 in that total; and

16 3. For an explanation of benefits provided to the physician or  
17 provider, information advising the physician or provider of the  
18 availability of mediation or arbitration pursuant to Sections 25 and  
19 31 of this act.

20 B. The administrator shall provide the explanation of benefits  
21 with the notice required by this section to a physician or health  
22 care provider not later than the date the administrator makes a  
23 payment under this act.

1 SECTION 15. NEW LAW A new section of law to be codified

2 in the Oklahoma Statutes as Section 7425 of Title 36, unless there  
3 is created a duplication in numbering, reads as follows:

4 A. The administrator of a managed care plan provided under the  
5 group program shall pay for covered emergency care performed by or a  
6 covered supply related to that care provided by an out-of-network  
7 provider at the usual and customary rate or at an agreed rate. The  
8 administrator shall make a payment required by this subsection  
9 directly to the provider not later than, as applicable:

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

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

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

23 1. Is based on:  
24  
25



- 1 a. the amount initially determined payable by the  
2 administrator, or  
3 b. if applicable, a modified amount as determined under  
4 the administrator's internal appeal process; and

5 2. Is not based on any additional amount determined to be owed  
6 to the provider under Sections 22 through 35 of this act.

7 SECTION 16. NEW LAW A new section of law to be codified  
8 in the Oklahoma Statutes as Section 7426 of Title 36, unless there  
9 is created a duplication in numbering, reads as follows:

10 A. Except as provided by subsection C of this section, the  
11 administrator of a managed care plan provided under the group  
12 program shall pay for a covered health care or medical service  
13 performed for or a covered supply related to that service provided  
14 to an enrollee by an out-of-network provider who is a facility-based  
15 provider at the usual and customary rate or at an agreed rate if the  
16 provider performed the service at a health care facility that is a  
17 participating provider. The administrator shall make a payment  
18 required by this subsection directly to the provider not later than,  
19 as applicable:

20 1. The thirtieth day after the date the administrator receives  
21 an electronic claim for those services that includes all information  
22 necessary for the administrator to pay the claim; or  
23  
24  
25

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

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

12           1. Is based on:

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

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

17           2. Is not based on any additional amount determined to be owed  
18 to the provider under Sections 22 through 35 of this act.

19           C. This section does not apply to a nonemergency health care or  
20 medical service:

21           1. That an enrollee elects to receive in writing in advance of  
22 the service with respect to each out-of-network provider providing  
23 the service; and

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

- 4           a. explains that the provider does not have a contract  
5                 with the enrollee's managed care plan,
- 6           b. discloses projected amounts for which the enrollee may  
7                 be responsible, and
- 8           c. discloses the circumstances under which the enrollee  
9                 would be responsible for those amounts.

10           SECTION 17.        NEW LAW        A new section of law to be codified  
11 in the Oklahoma Statutes as Section 7427 of Title 36, unless there  
12 is created a duplication in numbering, reads as follows:

13           A. Except as provided by subsection C of this section, the  
14 administrator of a managed care plan provided under the group  
15 program shall pay for a covered health care or medical service  
16 performed for or a covered supply related to that service provided  
17 to an enrollee by an out-of-network provider who is a diagnostic  
18 imaging provider or laboratory service provider at the usual and  
19 customary rate or at an agreed rate if the provider performed the  
20 service in connection with a health care or medical service  
21 performed by a participating provider. The administrator shall make  
22 a payment required by this subsection directly to the provider not  
23 later than, as applicable:

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

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

7 B. Except as provided by subsection C of this section, an out-  
8 of-network provider who is a diagnostic imaging provider or  
9 laboratory service provider or a person asserting a claim as an  
10 agent or assignee of the provider may not bill an enrollee receiving  
11 a health care or medical service or supply described by subsection A  
12 of this section in, and the enrollee does not have financial  
13 responsibility for, an amount greater than an applicable copayment,  
14 coinsurance, and deductible under the enrollee's managed care plan  
15 that:

16 1. Is based on:

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

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

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

23 C. This section does not apply to a nonemergency health care or  
24 medical service:

1 1. That an enrollee elects to receive in writing in advance of  
2 the service with respect to each out-of-network provider providing  
3 the service; and

4 2. For which an out-of-network provider, before providing the  
5 service, provides a complete written disclosure to the enrollee  
6 that:

7 a. explains that the provider does not have a contract  
8 with the enrollee's managed care plan,

9 b. discloses projected amounts for which the enrollee may  
10 be responsible, and

11 c. discloses the circumstances under which the enrollee  
12 would be responsible for those amounts.

13 SECTION 18. NEW LAW A new section of law to be codified  
14 in the Oklahoma Statutes as Section 7428 of Title 36, unless there  
15 is created a duplication in numbering, reads as follows:

16 A. The administrator of a managed care plan provided under this  
17 act shall provide written notice in accordance with this section in  
18 an explanation of benefits provided to the enrollee and the  
19 physician or health care provider in connection with a health care  
20 or medical service or supply provided by an out-of-network provider.  
21 The notice must include:

22 1. A statement of the billing prohibition under Sections 19,  
23 20, or 21 of this act, as applicable;

1           2. The total amount the physician or provider may bill the  
2 enrollee under the enrollee's managed care plan and an itemization  
3 of copayments, coinsurance, deductibles, and other amounts included  
4 in that total; and

5           3. For an explanation of benefits provided to the physician or  
6 provider, information advising the physician or provider of the  
7 availability of mediation or arbitration pursuant to Sections 25 and  
8 31 of this act.

9           B. The administrator shall provide the explanation of benefits  
10 with the notice required by this section to a physician or health  
11 care provider not later than the date the administrator makes a  
12 payment under Sections 19, 20, or 21 of this act, as applicable.

13           SECTION 19.       NEW LAW       A new section of law to be codified  
14 in the Oklahoma Statutes as Section 7429 of Title 36, unless there  
15 is created a duplication in numbering, reads as follows:

16           A. The administrator of a managed care plan provided under this  
17 act shall pay for covered emergency care performed by or a covered  
18 supply related to that care provided by an out-of-network provider  
19 at the usual and customary rate or at an agreed rate. The  
20 administrator shall make a payment required by this subsection  
21 directly to the provider not later than, as applicable:

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

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

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

11           1. Is based on:

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

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

16           2. Is not based on any additional amount determined to be owed  
17 to the provider under Sections 22 through 35 of this act.

18           SECTION 20.       NEW LAW       A new section of law to be codified  
19 in the Oklahoma Statutes as Section 7430 of Title 36, unless there  
20 is created a duplication in numbering, reads as follows:

21           A. Except as provided by subsection C of this section, the  
22 administrator of a managed care plan provided under this chapter  
23 shall pay for a covered health care or medical service performed for  
24 or a covered supply related to that service provided to an enrollee

1 by an out-of-network provider who is a facility-based provider at  
2 the usual and customary rate or at an agreed rate if the provider  
3 performed the service at a health care facility that is a  
4 participating provider. The administrator shall make a payment  
5 required by this subsection directly to the provider not later than,  
6 as applicable:

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

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

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

21 1. Is based on:

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



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

3           2.    Is not based on any additional amount determined to be owed  
4 to the provider under Sections 22 through 35 of this act.

5           C.    This section does not apply to a nonemergency health care or  
6 medical service:

7           1.    That an enrollee elects to receive in writing in advance of  
8 the service with respect to each out-of-network provider providing  
9 the service; and

10          2.    For which an out-of-network provider, before providing the  
11 service, provides a complete written disclosure to the enrollee  
12 that:

13           a.    explains that the provider does not have a contract  
14                   with the enrollee's managed care plan,

15           b.    discloses projected amounts for which the enrollee may  
16                   be responsible, and

17           c.    discloses the circumstances under which the enrollee  
18                   would be responsible for those amounts.

19          SECTION 21.        NEW LAW        A new section of law to be codified  
20 in the Oklahoma Statutes as Section 7431 of Title 36, unless there  
21 is created a duplication in numbering, reads as follows:

22          A.    Except as provided by subsection C of this section, the  
23 administrator of a managed care plan provided under this section  
24 shall pay for a covered health care or medical service performed for  
25

1 or a covered supply related to that service provided to an enrollee  
2 by an out-of-network provider who is a diagnostic imaging provider  
3 or laboratory service provider at the usual and customary rate or at  
4 an agreed rate if the provider performed the service in connection  
5 with a health care or medical service performed by a participating  
6 provider. The administrator shall make a payment required by this  
7 subsection directly to the provider not later than, as applicable:

8 1. The 30th day after the date the administrator receives an  
9 electronic claim for those services that includes all information  
10 necessary for the administrator to pay the claim; or

11 2. The 45th day after the date the administrator receives a  
12 nonelectronic claim for those services that includes all information  
13 necessary for the administrator to pay the claim.

14 B. Except as provided by subsection C of this section, an out-  
15 of-network provider who is a diagnostic imaging provider or  
16 laboratory service provider or a person asserting a claim as an  
17 agent or assignee of the provider may not bill an enrollee receiving  
18 a health care or medical service or supply described by subsection A  
19 of this section in, and the enrollee does not have financial  
20 responsibility for, an amount greater than an applicable copayment,  
21 coinsurance, and deductible under the enrollee's managed care plan  
22 that:

23 1. Is based on:  
24  
25

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

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

5 2. Is not based on any additional amount determined to be owed  
6 to the provider under Sections 22 through 35 of this act.

7 C. This section does not apply to a nonemergency health care or  
8 medical service:

9 1. That an enrollee elects to receive in writing in advance of  
10 the service with respect to each out-of-network provider providing  
11 the service; and

12 2. For which an out-of-network provider, before providing the  
13 service, provides a complete written disclosure to the enrollee  
14 that:

15 a. explains that the provider does not have a contract  
16 with the enrollee's managed care plan,

17 b. discloses projected amounts for which the enrollee may  
18 be responsible, and

19 c. discloses the circumstances under which the enrollee  
20 would be responsible for those amounts.

21 SECTION 22. NEW LAW A new section of law to be codified  
22 in the Oklahoma Statutes as Section 7432 of Title 36, unless there  
23 is created a duplication in numbering, reads as follows:

24 A. Sections 22 through 35 of this act shall only apply to:

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

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

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

8 SECTION 23. NEW LAW A new section of law to be codified  
9 in the Oklahoma Statutes as Section 7433 of Title 36, unless there  
10 is created a duplication in numbering, reads as follows:

11 A. The Insurance Department, State Board of Medical Licensure  
12 and Supervision, and State Board of Osteopathic Examiners shall  
13 promulgate rules as necessary to implement their respective powers  
14 and duties under Sections 22 through 35 of this act.

15 B. Sections 23 through 28 of this act shall not be construed to  
16 prohibit:

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

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

21 SECTION 24. NEW LAW A new section of law to be codified  
22 in the Oklahoma Statutes as Section 7434 of Title 36, unless there  
23 is created a duplication in numbering, reads as follows:

1 A. The Insurance Department shall select an organization to  
2 maintain a benchmarking database in accordance with this section.

3 The organization may not:

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

7 2. Have any other conflict of interest.

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

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

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

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

18 SECTION 25. NEW LAW A new section of law to be codified  
19 in the Oklahoma Statutes as Section 7435 of Title 36, unless there  
20 is created a duplication in numbering, reads as follows:

21 A. Sections 22 through 35 of this act shall apply only with  
22 respect to a health benefit claim submitted by an out-of-network  
23 provider that is a facility and shall not be construed to apply to a  
24

1 health benefit claim for the professional or technical component of  
2 a physician service.

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

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

12 D. An out-of-network provider or a health benefit plan issuer  
13 or administrator may request mediation of a settlement of an out-of-  
14 network health benefit claim through a portal on the Department's  
15 Internet website if:

16 1. There is an amount billed by the provider and unpaid by the  
17 issuer or administrator after copayments, deductibles, and  
18 coinsurance for which an enrollee may not be billed; and

19 2. The health benefit claim is for:

20 a. emergency care,

21 b. an out-of-network laboratory service, or

22 c. an out-of-network diagnostic imaging service.

23 E. If a person requests mediation under this subchapter, the  
24 out-of-network provider or the provider's representative, and the

1 health benefit plan issuer or the administrator, as appropriate,  
2 shall participate in the mediation.

3 SECTION 26. NEW LAW A new section of law to be codified  
4 in the Oklahoma Statutes as Section 7436 of Title 36, unless there  
5 is created a duplication in numbering, reads as follows:

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

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

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

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

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

4 SECTION 27. NEW LAW A new section of law to be codified  
5 in the Oklahoma Statutes as Section 7437 of Title 36, unless there  
6 is created a duplication in numbering, reads as follows:

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

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

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

16 SECTION 28. NEW LAW A new section of law to be codified  
17 in the Oklahoma Statutes as Section 7438 of Title 36, unless there  
18 is created a duplication in numbering, reads as follows:

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

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



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

5 D. On agreement of all parties, any deadline under Sections 22  
6 through 35 of this act may be extended.

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

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

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

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

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

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

- 5 1. The names of the parties to the mediation; and
- 6 2. Whether the parties reached an agreement.

7 SECTION 29. NEW LAW A new section of law to be codified  
8 in the Oklahoma Statutes as Section 7439 of Title 36, unless there  
9 is created a duplication in numbering, reads as follows:

10 Not later than the forty-fifth day after the date that the  
11 mediator's report is provided to the Department under Section 28 of  
12 this act, either party to a mediation for which there was no  
13 agreement may file a civil action to determine the amount due to an  
14 out-of-network provider. A party may not bring a civil action  
15 before the conclusion of the mediation process under this act.

16 SECTION 30. NEW LAW A new section of law to be codified  
17 in the Oklahoma Statutes as Section 7440 of Title 36, unless there  
18 is created a duplication in numbering, reads as follows:

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

22 B. The Department shall:

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

1 including the establishment of a portal on the Department's Internet  
2 website through which a request for arbitration under Section 31 of  
3 this act may be submitted; and

4 2. Shall maintain a list of qualified arbitrators for the  
5 program.

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

10 D. The determination shall take into account:

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

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

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

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

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

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

4 5. Individual enrollee characteristics;

5 6. The 80th percentile of all billed charges for the service or  
6 supply performed by a health care provider in the same or similar  
7 specialty and provided in the same geozip area as reported in a  
8 benchmarking database described by Section 24 of this act;

9 7. The 50th percentile of rates for the service or supply paid  
10 to participating providers in the same or similar specialty and  
11 provided in the same geozip area as reported in a benchmarking  
12 database described by Section 24 of this act;

13 8. The history of network contracting between the parties;

14 9. Historical data for the percentiles described by paragraphs  
15 6 and 7 of this subsection; and

16 10. An offer made during the informal settlement teleconference  
17 required under Section 27 of this act.

18 SECTION 31. NEW LAW A new section of law to be codified  
19 in the Oklahoma Statutes as Section 7441 of Title 36, unless there  
20 is created a duplication in numbering, reads as follows:

21 A. Not later than the ninetieth day after the date an out-of-  
22 network provider receives the initial payment for a health care or  
23 medical service or supply, the out-of-network provider or the health  
24 benefit plan issuer or administrator may request arbitration of a  
25

1 settlement of an out-of-network health benefit claim through a  
2 portal on the Insurance Department's Internet website if:

3 1. There is a charge billed by the provider and unpaid by the  
4 issuer or administrator after copayments, coinsurance, and  
5 deductibles for which an enrollee may not be billed; and

6 2. The health benefit claim is for:

7 a. emergency care,

8 b. a health care or medical service or supply provided by  
9 a facility-based provider in a facility that is a  
10 participating provider,

11 c. an out-of-network laboratory service, or

12 d. an out-of-network diagnostic imaging service;

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

17 C. The person who requests the arbitration shall provide  
18 written notice on the date the arbitration is requested in the form  
19 and manner prescribed by Department rule to the Department and each  
20 other party.

21 D. In an effort to settle the claim before arbitration, all  
22 parties must participate in an informal settlement teleconference  
23 not later than the thirtieth day after the date on which the  
24 arbitration is requested. A health benefit plan issuer or

1 administrator, as applicable, shall make a reasonable effort to  
2 arrange the teleconference.

3 E. The Insurance Department shall adopt rules providing  
4 requirements for submitting multiple claims to arbitration in one  
5 proceeding. The rules must provide that the multiple claims in one  
6 proceeding must be limited to the same out-of-network provider.

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

11 SECTION 32. NEW LAW A new section of law to be codified  
12 in the Oklahoma Statutes as Section 7442 of Title 36, unless there  
13 is created a duplication in numbering, reads as follows:

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

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

23 C. In approving an individual as an arbitrator, the Department  
24 shall ensure that the individual does not have a conflict of  
25

1 interest that would adversely impact the individual's independence  
2 and impartiality in rendering a decision in an arbitration. A  
3 conflict of interest includes current or recent ownership or  
4 employment of the individual or a close family member in any health  
5 benefit plan issuer or administrator or physician, health care  
6 practitioner, or other health care provider.

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

10 SECTION 33. NEW LAW A new section of law to be codified  
11 in the Oklahoma Statutes as Section 7443 of Title 36, unless there  
12 is created a duplication in numbering, reads as follows:

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

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

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

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

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

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

3 SECTION 34. NEW LAW A new section of law to be codified  
4 in the Oklahoma Statutes as Section 7444 of Title 36, unless there  
5 is created a duplication in numbering, reads as follows:

6 A. Not later than the fifty-first day after the date the  
7 arbitration is requested, an arbitrator shall provide the parties  
8 with a written decision in which the arbitrator:

9 1. Determines whether the billed charge or the payment made by  
10 the health benefit plan issuer or administrator, as those amounts  
11 were last modified during the issuer's or administrator's internal  
12 appeal process, if the provider elects to participate, or the  
13 informal settlement teleconference required by subsection D of  
14 Section 31 of this act, as applicable, is the closest to the  
15 reasonable amount for the services or supplies; and

16 2. Selects the amount determined to be closest under paragraph  
17 1 of this subsection as the binding award amount.

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

20 C. An arbitrator shall provide written notice in the form and  
21 manner prescribed by Department rule of the reasonable amount for  
22 the services or supplies and the binding award amount. If the  
23 parties settle before a decision, the parties shall provide written  
24 notice in the form and manner prescribed by Department rule of the



1 amount of the settlement. The Department shall maintain a record of  
2 notices provided under this subsection.

3 D. An arbitrator's decision under this section is binding. Not  
4 later than the forty-fifth day after the date of an arbitrator's  
5 decision under this section, a party not satisfied with the decision  
6 may file an action to determine the payment due to an out-of-network  
7 provider.

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

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

16 SECTION 35. NEW LAW A new section of law to be codified  
17 in the Oklahoma Statutes as Section 7445 of Title 36, unless there  
18 is created a duplication in numbering, reads as follows:

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

- 21 1. Failing to participate in the informal settlement  
22 teleconference under subsection C of Section 27 of this act,  
23 subsection D of Section 31 of this act, or an arbitration or  
24 mediation under this act;

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

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

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

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

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

18           SECTION 36.       NEW LAW       A new section of law to be codified  
19 in the Oklahoma Statutes as Section 7446 of Title 36, unless there  
20 is created a duplication in numbering, reads as follows:

21           A. The Insurance Department, State Board of Medical Licensure  
22 and Supervision, and State Board of Osteopathic Examiners as  
23 appropriate, shall adopt rules regulating the investigation and  
24 review of a complaint filed that relates to the settlement of an  
25

1 out-of-network health benefit claim that is subject to this chapter.

2 The rules adopted under this section shall:

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

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

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

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

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

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

20 5. Any other information about:

21 a. the health benefit plan issuer or administrator that  
22 the Department by rule requires, or  
23  
24  
25

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

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

8           SECTION 37.        NEW LAW        A new section of law to be codified  
9 in the Oklahoma Statutes as Section 7447 of Title 36, unless there  
10 is created a duplication in numbering, reads as follows:

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

14           1.    Trends in billed amounts for health care or medical services  
15 or supplies, especially emergency services, laboratory services,  
16 diagnostic imaging services, and facility-based services;

17           2.    Comparison of the total amount spent on out-of-network  
18 emergency services, laboratory services, diagnostic imaging  
19 services, and facility-based services by calendar year and provider  
20 type or physician specialty;

21           3.    Trends and changes in network participation by providers of  
22 emergency services, laboratory services, diagnostic imaging  
23 services, and facility-based services by provider type or physician  
24

1 specialty, including whether any terminations were initiated by a  
2 health benefit plan issuer, administrator, or provider;

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

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

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

12 7. Trends in the usual and customary rate for health care or  
13 medical services or supplies, especially emergency services,  
14 laboratory services, diagnostic imaging services, and facility-based  
15 services; and

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

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

22 C. The Department may not publish a particular rate paid to a  
23 participating provider in the study described by subsection A of  
24 this section, identifying information of a physician or health care  
25

1 provider, or non-aggregated study results. Information described by  
2 this subsection is confidential and shall not be considered a record  
3 pursuant to Section 24A.3 of Title 51 of the Oklahoma Statutes.

4 D. The Department:

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

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

11 E. Not later than December 1 of each even-numbered year, the  
12 Department shall prepare and submit a written report on the results  
13 of the study under this section, including the Department's  
14 findings, to the legislature.

15 SECTION 38. AMENDATORY 51 O.S. 2021, Section 24A.3, is  
16 amended to read as follows:

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

18 1. "Record" means all documents, including, but not limited to,  
19 any book, paper, photograph, microfilm, data files created by or  
20 used with computer software, computer tape, disk, record, sound  
21 recording, film recording, video record or other material regardless  
22 of physical form or characteristic, created by, received by, under  
23 the authority of, or coming into the custody, control or possession  
24 of public officials, public bodies, or their representatives in

1 connection with the transaction of public business, the expenditure  
2 of public funds or the administering of public property. "Record"  
3 does not mean:

- 4 a. computer software,
- 5 b. nongovernment personal effects,
- 6 c. unless public disclosure is required by other laws or  
7 regulations, vehicle movement records of the Oklahoma  
8 Transportation Authority obtained in connection with  
9 the Authority's electronic toll collection system,
- 10 d. personal financial information, credit reports or  
11 other financial data obtained by or submitted to a  
12 public body for the purpose of evaluating credit  
13 worthiness, obtaining a license, permit, or for the  
14 purpose of becoming qualified to contract with a  
15 public body,
- 16 e. any digital audio/video recordings of the toll  
17 collection and safeguarding activities of the Oklahoma  
18 Transportation Authority,
- 19 f. any personal information provided by a guest at any  
20 facility owned or operated by the Oklahoma Tourism and  
21 Recreation Department or the Board of Trustees of the  
22 Quartz Mountain Arts and Conference Center and Nature  
23 Park to obtain any service at the facility or by a  
24 purchaser of a product sold by or through the Oklahoma

- 1 Tourism and Recreation Department or the Quartz  
2 Mountain Arts and Conference Center and Nature Park,  
3 g. a Department of Defense Form 214 (DD Form 214) filed  
4 with a county clerk, including any DD Form 214 filed  
5 before July 1, 2002, ~~or~~  
6 h. except as provided for in Section 2-110 of Title 47 of  
7 the Oklahoma Statutes,  
8 (1) any record in connection with a Motor Vehicle  
9 Report issued by the Department of Public Safety,  
10 as prescribed in Section 6-117 of Title 47 of the  
11 Oklahoma Statutes, or  
12 (2) personal information within driver records, as  
13 defined by the Driver's Privacy Protection Act,  
14 18 United States Code, Sections 2721 through  
15 2725, which are stored and maintained by the  
16 Department of Public Safety~~,~~  
17 i. information submitted to a mediator by the parties of  
18 a claim dispute pursuant to Section 28 of this act,  
19 j. information submitted to an arbitrator by the parties  
20 of an arbitration pursuant to Section 33 of this act,  
21 or  
22 k. information containing the particular rate paid to a  
23 participating provider, identifying information of a  
24 physician or health care provider, or non-aggregated



1                   study results utilized by the Insurance Department  
2                   pursuant to Section 37 of this act.

3           2. "Public body" shall include, but not be limited to, any  
4 office, department, board, bureau, commission, agency, trusteeship,  
5 authority, council, committee, trust or any entity created by a  
6 trust, county, city, village, town, township, district, school  
7 district, fair board, court, executive office, advisory group, task  
8 force, study group, or any subdivision thereof, supported in whole  
9 or in part by public funds or entrusted with the expenditure of  
10 public funds or administering or operating public property, and all  
11 committees, or subcommittees thereof. Except for the records  
12 required by Section 24A.4 of this title, "public body" does not mean  
13 judges, justices, the Council on Judicial Complaints, the  
14 Legislature, or legislators;

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

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

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

3 SECTION 39. This act shall become effective November 1, 2022.

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