Am. Sub. H.B. 166
As Passed by the Senate
INSCD7

____________________________ moved to amend as follows:

1 In line 166 of the title, delete "3902.53,"
2 In line 167 of the title, delete "3902.54,"
3 In line 343, delete "3902.53,"
4 In line 344, delete "3902.54,"
5 Delete lines 44365 through 44542 and insert:

"Sec. 3902.50. (A) As used in sections 3902.50 to 3902.52
of the Revised Code:

(1) "Cost sharing" means the cost to a covered person under
a health benefit plan according to any coverage limit,
copayment, coinsurance, deductible, or other out-of-pocket
expense requirement.

(2) "Covered person," "health benefit plan," "health care
services," and "health plan issuer" have the same meanings as in
section 3922.01 of the Revised Code.

(3) "Emergency facility" has the same meaning as in section
3701.74 of the Revised Code.

(4) "Emergency services" means all of the following as
described in 42 U.S.C. 1395dd:
(a) Medical screening examinations undertaken to determine whether an emergency medical condition exists;

(b) Treatment necessary to stabilize an emergency medical condition;

(c) Appropriate transfers undertaken prior to an emergency medical condition being stabilized.

(5) "Individual in-network provider," "individual out-of-network provider," and "individual provider" mean a provider who is an individual.

(6) "Unanticipated out-of-network care" means health care services that are covered under a health benefit plan and that are provided by an individual out-of-network provider when either of the following conditions applies:

(a) The covered person did not have the ability to request such services from an individual in-network provider.

(b) The services provided were emergency services.

(B)(1) A health plan issuer shall reimburse an individual out-of-network provider for unanticipated out-of-network care when both of the following apply:

(a) The services are provided to a covered person at a facility that is in the covered person's health benefit plan provider network.
(b) The services would be covered if provided by an individual provider in the covered person's health benefit plan network.

(2) A health plan issuer shall reimburse both of the following for emergency services provided to a covered person at an out-of-network emergency facility:

   (a) An individual out-of-network provider;
   
   (b) The out-of-network emergency facility.

(C)(1) The reimbursement required to be paid an individual provider under division (B)(1) or (2) of this section shall be the greatest of the following amounts:

   (a) The amount negotiated with individual in-network providers for the service in question, excluding any in-network cost sharing imposed under the health benefit plan. If there is more than one amount negotiated with individual in-network providers for the service, the relevant amount shall be the median of those amounts, excluding any in-network cost sharing imposed under the health benefit plan. In determining the median amount, the amount negotiated with each individual in-network provider shall be treated as a separate amount even if the same amount is paid to more than one provider. If there is no per-service amount negotiated with individual in-network providers, such as under a capitation or similar payment arrangement, the
amount described in division (C)(1)(a) of this section shall be disregarded.

(b) The amount for the service calculated using the same method the health benefit plan generally uses to determine payments for out-of-network health care services, such as the usual, customary, and reasonable amount, excluding any in-network cost sharing imposed under the health benefit plan. This amount shall be determined without reduction for cost sharing that generally applies under the health benefit plan with respect to out-of-network health care services.

(c) The amount that would be paid under the medicare program, part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395, as amended, for the service in question, excluding any in-network cost sharing imposed under the health benefit plan.

(2) The reimbursement required to be paid to an out-of-network emergency facility under division (B)(2) of this section shall be the greatest of the following amounts:

(a) The amount negotiated with in-network emergency facilities for the service in question, excluding any in-network cost sharing imposed under the health benefit plan. If there is more than one amount negotiated with in-network emergency facilities for the service, the relevant amount shall be the median of those amounts, excluding any in-network cost sharing
imposed under the health benefit plan. In determining the median amount, the amount negotiated with each in-network emergency facility shall be treated as a separate amount even if the same amount is paid to more than one provider. If there is no per-service amount negotiated with in-network emergency facilities, such as under a capitation or similar payment arrangement, the amount described in division (C)(2)(a) of this section shall be disregarded.

(b) The amount for the service calculated using the same method the health benefit plan generally uses to determine payments for out-of-network health care services, such as the usual, customary, and reasonable amount, excluding any in-network cost sharing imposed under the health benefit plan. This amount shall be determined without reduction for cost sharing that generally applies under the health benefit plan with respect to out-of-network health care services.

(c) The amount that would be paid under the medicare program, part A or part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395, as amended, for the service in question, excluding any in-network cost sharing imposed under the health benefit plan.

(D)(1) For unanticipated out-of-network care provided at an in-network facility in this state, an individual provider shall not bill a covered person for the difference between the health
plan issuer's reimbursement and the individual provider's charge for the services.

(2)(a) For emergency services provided at an out-of-network emergency facility in this state, an individual provider shall not bill a covered person for the difference between the health plan issuer's reimbursement and the individual provider's charge for the services.

(b) For emergency services provided at an out-of-network emergency facility in this state, the emergency facility shall not bill a covered person for the difference between the health plan issuer's reimbursement and the emergency facility's charge for the services.

(E) A health plan issuer shall not require cost sharing for any service described in division (B) of this section from the covered person at a rate higher than if the services were provided by an individual in-network provider or in-network emergency facility.

(F) For health care services, other than those described in division (B) of this section, that are covered under a health benefit plan but are provided by an individual out-of-network provider at an in-network facility, all of the following apply:

(1) For services provided in this state, the individual provider shall not bill the covered person for the difference between the health plan issuer's out-of-network reimbursement
and the provider's charge for the services unless all of the following conditions are met:

(a) The individual provider informs the covered person that
the individual provider is not in the person's health benefit
plan network.

(b) The individual provider provides to the covered person
a good faith estimate of the cost of the services, including the
individual provider's charge, the estimated reimbursement by the
health plan issuer, and the covered person's responsibility. The
estimate shall contain a disclaimer that the covered person is
not required to obtain the health care service at that location
or from that individual provider.

(c) The covered person affirmatively consents to receive
the services.

(2) The health plan issuer may reimburse the individual
provider at either the in-network or out-of-network rate as
described in the covered person's health benefit plan.

(G) A pattern of continuous or repeated violations of this
section is an unfair and deceptive act or practice in the
business of insurance under sections 3901.19 to 3901.26 of the
Revised Code.

(H) Nothing in this section is subject to section 3901.71
of the Revised Code.
Sec. 3902.51. (A) An individual provider or emergency facility may request alternative dispute resolution if both of the following apply:

(1) The individual provider or emergency facility believes that the health plan issuer's offer of reimbursement does not meet the requirements of division (C) of section 3902.50 of the Revised Code.

(2) The billed amount exceeds seven hundred dollars.

(B) Any documents or information submitted by a health plan issuer, individual provider, or emergency facility in the course of alternative dispute resolution are not public records for the purposes of section 149.43 of the Revised Code and shall not be released.

Sec. 3902.52. The superintendent of insurance shall adopt by rule alternative dispute resolution procedures and guidelines for complaints brought by individual providers or emergency facilities against health plan issuers relating to reimbursement under section 3902.50 of the Revised Code. The superintendent shall require that mediation be attempted prior to arbitration."

In line 96545, delete "to"

In line 96546, delete "3902.53" and insert "and 3902.51"

Delete lines 97593 and 97594

The motion was ________ agreed to.
SYNOPSIS

Reimbursement for out-of-network care

R.C. 3902.50 to 3902.54; Sections 739.21 and 812.10

Replaces the Senate-passed version of the out-of-network care provisions with the House-passed version, with the following changes:

1. Applies the provisions to providers who are individuals, rather than health care practitioners, and applies the provisions to facilities, rather than hospitals.

2. Requires an insurer to reimburse an out-of-network provider for covered services at an in-network facility when the covered person could not request an in-network provider or the services were emergency services. The House-passed version was limited to emergency services provided at an in-network hospital.

3. Additionally requires an insurer to reimburse an out-of-network provider and out-of-network emergency facility for emergency services provided at such a facility.

4. Replaces the House's required out-of-network reimbursement amount, instead requiring it to be the highest of (a) a negotiated amount, (b) the plan's usual and customary amount for out-of-network emergency services, or (c) the Medicare amount.

5. Provides that continuous or repeated violations constitute an unfair and deceptive act or practice in the business of insurance.

6. Prohibits balance billing for unanticipated out-of-network care provided at in-network facilities and emergency services provided at in-state facilities.

7. Permits an individual provider or emergency facility to request alternative dispute resolution if (1) the insurer's reimbursement offer does not meet the bill's requirements, rather than if the offer is less than what an in-network provider would receive and (2) the billed amount exceeds $700.

8. Prohibits the disclosure of documents submitted for alternative dispute resolution.
(9) Defers to April 2020 the application of the provisions, instead of having the out-of-network care provisions apply to plans issued, modified, or renewed after the provisions' effective date.