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133rd General Assembly
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Sub. H. B. No. 388

A BILL

To enact sections 3902.50, 3902.51, 3902.52, 3902.53, and 3902.54 of the Revised Code regarding out-of-network care.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 3902.50, 3902.51, 3902.52, 3902.53, and 3902.54 of the Revised Code be enacted to read as follows:

Sec. 3902.50. As used in sections 3902.50 to 3902.54 of the Revised Code:

(A) "Ambulance" has the same meaning as in section 4765.01 of the Revised Code.

(B) "Clinical laboratory services" has the same meaning as in section 4731.65 of the Revised Code.

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

(D) "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.

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

(F) "Emergency services" means all of the following as described in 42 U.S.C. 1395dd:

(1) Medical screening examinations undertaken to determine whether an emergency medical condition exists;

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

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

(G) "Unanticipated out-of-network care" means health care services, including clinical laboratory 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:

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

(2) The services provided were emergency services.

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

Sec. 3902.51. (A)(1)(a) A health plan issuer shall reimburse an individual out-of-network provider for unanticipated out-of-network care when both of the following

apply:

(i) The services are provided to a covered person at an in-network facility.

(ii) The services would be covered if provided by an individual in-network provider.

(b) 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:

(i) An individual out-of-network provider;

(ii) The out-of-network emergency facility.

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

(i) An individual out-of-network provider;

(ii) The out-of-network ambulance.

(2) In the case of clinical laboratory services provided in connection with care described in division (A)(1) of this section, a health plan issuer shall reimburse any individual out-of-network provider and any out-of-network facility that provided the clinical laboratory services.

(B)(1) Unless the individual provider, facility, emergency facility, or ambulance wishes to negotiate reimbursement under division (B)(2) of this section, the reimbursement required to be paid to the individual provider, facility, emergency facility, or ambulance under division (A) of this section shall be the greatest of the following amounts:

(a) The amount negotiated with individual in-network

providers, facilities, emergency facilities, or ambulances for the service in question in that geographic region under that health benefit plan, excluding any in-network cost sharing imposed under the health benefit plan. If there is more than one such amount, 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, facility, emergency facility, or ambulance 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, such as under a capitation or similar payment arrangement, the amount described in division (B)(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) In lieu of accepting reimbursement under division (B)(1) of this section, an individual provider, facility, emergency facility, or ambulance may notify the health plan issuer that the individual provider, facility, emergency facility, or

ambulance wishes to negotiate reimbursement. Upon receipt of such notice, the health plan issuer shall accept the request and notify the requestor. Both parties shall attempt a good faith negotiation.

(C)(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) For emergency services provided at an out-of-network emergency facility in this state, neither the emergency facility nor an individual out-of-network provider shall bill a covered person for the difference between the health plan issuer's reimbursement and the emergency facility's or individual provider's charge for the services.

(3) For emergency services provided by an out-of-network ambulance in this state, neither the ambulance nor an individual out-of-network provider shall bill a covered person for the difference between the health plan issuer's reimbursement and the ambulance's or individual provider's charge for the services.

(4) In the case of clinical laboratory services provided in this state in connection with care described in division (A)(1) of this section, no individual out-of-network provider or out-of-network facility shall bill a covered person for the difference between the health plan issuer's reimbursement and the individual provider's or facility's charge for the clinical laboratory services.

(D) A health plan issuer shall not require cost sharing

for any service described in division (A) of this section from the covered person at a rate higher than if the services were provided in network.

(E) For health care services, other than those described in division (A) of this section, that are covered under a health benefit plan but are provided to a covered person by an individual out-of-network provider at an in-network facility, both 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-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 shall reimburse the individual provider at either the in-network or out-of-network rate as described in the covered person's health benefit plan.

(F) Nothing in this section is subject to section 3901.71 of the Revised Code.

Sec. 3902.52. (A)(1) If a negotiation undertaken pursuant to division (B)(2) of section 3902.51 of the Revised Code has not successfully concluded within thirty days, the individual provider, facility, emergency facility, or ambulance may send a request for arbitration to the superintendent of insurance and shall notify the health plan issuer of its request

if both of the following apply:

(a) The service in question was provided not more than one year prior to the request.

(b) The billed amount exceeds seven hundred fifty dollars, except as provided in division (A)(2)(b) of this section.

(2)(a) In seeking arbitration, an individual provider, facility, emergency facility, or ambulance may bundle up to ten claims with respect to the same health benefit plan that involve the same or similar services provided under similar circumstances.

(b) A claim that is bundled with other claims may be seven hundred fifty dollars or less so long as the sum of the bundled claims is greater than seven hundred fifty dollars.

(B)(1) Each party shall submit its final offer to the arbitrator. The health plan issuer shall submit as its final offer the greatest of the three amounts described in division (B)(1) of section 3902.51 of the Revised Code as applicable.

(2) Each party may submit to the arbitrator supporting documents or information solely to establish or demonstrate any of the following:

(a) The circumstances, complexity, and severity of the particular case, including the time and place of service;

(b) The usual, customary, and reasonable rate for the service in question;

(c) The amount of the reimbursement required under division (B)(1) of section 3902.51 of the Revised Code.

(C) If arbitration does not commence within thirty days of the request described in division (A) of this section, the health plan issuer shall reimburse the individual provider, facility, emergency facility, or ambulance the amount of the provider's, facility's, emergency facility's, or ambulance's final offer.

(D) An arbitrator shall only award either party's final offer submitted under division (B) of this section. In deciding the award, the arbitrator shall consider all documentation submitted under division (B)(2) of this section, as well as all of the following, and may require the parties to submit documents or information pertaining to all of the following in order to determine the accuracy or inaccuracy of the final offers with regard to the reimbursement amount required under division (B)(1) of section 3902.51 of the Revised Code:

(1) The distribution of in-network allowed amounts by the health benefit plan for the service in question in the same geographic area;

(2) The distribution of out-of-network allowed amounts by the health benefit plan for the service in question in the same geographic area;

(3) The medicare reimbursement rate for the service in question in the same geographic area;

(4) The distribution of billed charges and allowed amounts for all health benefit plans for the service in question in the

same geographic area.

(E) The nonprevailing party shall pay all the arbitrator's fees and the costs of arbitration.

(F) The nonprevailing party shall pay all amounts due not later than ten calendar days following the arbitration decision.

(G) A final arbitration decision shall be binding and enforceable in a court of law.

(H) Documentation submitted by the parties in the course of arbitration shall be confidential and privileged, shall not be a public record as defined in section 149.43 of the Revised Code, and shall not be released.

Sec. 3902.53. (A) Sections 3901.38 to 3901.3814 of the Revised Code shall not apply with respect to a claim during a period of negotiation under section 3902.51 of the Revised Code or a period of arbitration under section 3902.52 of the Revised Code.

(B) A pattern of continuous or repeated violations of section 3902.51 or 3902.52 of the Revised Code is an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

(C) An individual provider who violates section 3902.51 or 3902.52 of the Revised Code shall be subject to professional discipline under Title XLVII of the Revised Code as applicable.

Sec. 3902.54. (A)(1) Subject to division (A)(2) of this section, the superintendent of insurance shall contract with a single arbitration entity to perform all arbitrations described in section 3902.52 of the Revised Code. The superintendent shall ensure that the arbitration entity, any arbitrators the

arbitration entity designates to conduct an arbitration, and any officer, director, or employee of the arbitration entity do not have any material, professional, familial, or financial connection with any of the following:

(a) The health plan issuer involved in a dispute;

(b) An officer, director, or employee of the health plan issuer;

(c) An individual provider, facility, emergency facility, ambulance, medical group, or independent practice organization involved with the service in question;

(d) The development or manufacture of any principal drug, device, procedure, or other therapy in dispute;

(e) The covered person who received the service that is the subject of a dispute or the covered person's immediate family.

(2) If a conflict of interest described in division (A)(1) of this section exists with respect to a particular arbitration, the superintendent may utilize another arbitration entity in that particular case.

(3) The superintendent shall require the arbitration entity to do all of the following:

(a) Utilize arbitrators who are knowledgeable and experienced in applicable principles of contract and insurance law and the health care industry to determine the accuracy or inaccuracy of the reimbursement amounts described in division (B)(1) of section 3902.51 of the Revised Code;

(b) Ensure that the arbitrators have access to appropriate specialists including certified coding specialists, physicians,

nurses, other clinicians, and health insurance experts as necessary to render a determination;

(c) Utilize a secure electronic portal for the submission, processing, and management of arbitration applications;

(d) Perform all arbitrations under section 3902.52 of the Revised Code on a flat fee basis.

(B) In selecting the arbitration entity with which to contract, the superintendent shall at minimum require a prospective arbitration entity to submit to the superintendent a disclosure containing all of the following:

(1) The name, telephone number, and address of the applicant;

(2) If the applicant has issued any outstanding shares that are listed on a national securities exchange or are regularly quoted in an over-the-counter market by one or more members of a national or affiliated securities association, the name of each person holding more than five per cent stock or call or put options in the applicant;

(3) The name of each person holding bonds or notes issued by the applicant totaling over one hundred thousand dollars;

(4) The name of each entity the applicant controls and the nature and extent of such control, including the nature of the controlled entity's business;

(5) The name of each entity in which the applicant has more than five per cent ownership interest, including the nature of the entity's business;

(6) The name, contact information, and work history of each director, officer, and executive and any current or

previous relationship each of those persons has or had with a health plan issuer, individual provider, facility, emergency facility, medical group, or independent practice organization;

(7) The percentage of revenue the arbitration entity receives from its arbitration services;

(8) A description of the applicant's arbitration process, including information about how the applicant will meet the superintendent's standards and how the applicant will avoid conflicts of interest;

(9) An application fee prescribed by the superintendent.

(C) The superintendent shall require the contracted arbitration entity to submit to the superintendent on an annual basis the disclosure described in division (B) of this section.

(D) The superintendent shall adopt rules as necessary to implement sections 3902.50 to 3902.54 of the Revised Code. The requirements of section 121.95 of the Revised Code do not apply to rules adopted in accordance with this division.

Section 2. (A) The requirements of sections 3902.50 to 3902.53 of the Revised Code, as enacted in this act, apply beginning nine months following the effective date of this act to the following:

(1) Individual providers, facilities, emergency facilities, and ambulances, except as provided in division (B)(1) of this section;

(2) Health benefit plans delivered, issued for delivery, modified, or renewed on or after the effective date of those sections.

(B) If, beginning nine months following the effective date

of this act, an individual provider, facility, emergency facility, or ambulance sends a claim for unanticipated out-of-network care or emergency services to a health plan issuer for reimbursement under a health benefit plan not described in division (A)(2) of this section, then both of the following apply:

(1) Any provision of sections 3902.50 to 3902.53 of the Revised Code that applies to an individual provider, facility, emergency facility, or ambulance does not apply to that individual provider, facility, emergency facility, or ambulance with respect to the unanticipated out-of-network care or emergency services to which that claim relates.

(2) Upon receiving the claim, the health benefit plan shall inform the individual provider, facility, emergency facility, or ambulance of both of the following:

(a) That the health benefit plan is not subject to the requirements of sections 3902.50 to 3902.53 of the Revised Code with regard to the claim;

(b) That sections 3902.50 to 3902.53 of the Revised Code do not apply to that individual provider, facility, emergency facility, or ambulance with respect to that unanticipated out-of-network care or emergency services, and that the individual provider, facility, emergency facility, or ambulance is not prohibited from billing the covered person for the difference between the health plan issuer's reimbursement and the individual provider's, facility's, emergency facility's, or ambulance's charge for the care.

(C) As used in this section, "ambulance," "covered person," "emergency facility," "emergency services," "health

benefit plan," "individual provider," and "unanticipated out-of-network care" have the same meanings as in section 3902.50 of the Revised Code, as enacted in this act.