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H.B. 388
133rd General Assembly

Bill Analysis

Version: As Introduced

Primary Sponsor: Rep. Holmes

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SUMMARY

- Requires an insurer to reimburse an out-of-network provider for unanticipated out-of-network care provided at an in-network facility.
- Requires an insurer to reimburse an out-of-network provider or emergency facility for emergency services provided at an out-of-network emergency facility.
- Prohibits a provider from balance billing a patient for unanticipated or emergency care as described above when that care is provided in Ohio.
- Establishes negotiation and arbitration procedures for disputes between providers and insurers regarding unanticipated or emergency out-of-network care.
- Requires a provider to disclose certain information to patients regarding the cost of other out-of-network services.

DETAILED ANALYSIS

Unanticipated and emergency out-of-network care

Unanticipated out-of-network care at an in-network facility

The bill requires a health plan issuer to reimburse an individual out-of-network provider for unanticipated out-of-network care when the care is provided to a person at an in-network facility and the services would be covered if provided by an in-network provider.

Under the bill, “**unanticipated out-of-network care**” means health care services that are provided under a health benefit plan and that are provided by an out-of-network provider when either of the following applies:

- The covered person did not have the ability to request such services from an individual in-network provider.
- The services provided were emergency services.

A provider network might include a facility but not certain individual providers at that facility. In certain situations, such as those involving medical emergencies, covered persons are not always able to request only in-network providers give them care. Under existing law, if a person receives such unanticipated or emergency care at an in-network facility by an out-of-network provider, the issuer might not reimburse the provider (some plans allow for such reimbursement, but others do not), meaning the covered person must pay the entire cost of the services. Under the bill, for care provided in Ohio, the provider is prohibited from billing the patient for the difference between the issuer's reimbursement and the provider's charge (balance billing).¹

Emergency care at an out-of-network facility

Similar requirements apply in the case of emergency care received at an out-of-network emergency facility: the issuer must reimburse the facility and any individual out-of-network providers at the facility, and, for care provided in Ohio, neither the facility nor the providers may balance bill a patient.²

Cost sharing

The bill further provides that a covered person's cost-sharing responsibility for the services described above cannot be greater than if the services were provided by an in-network provider or emergency facility.³

Enforcement

A pattern of continuous or repeated violations of these provisions is considered an unfair and deceptive act or practice in the business of insurance, potentially subjecting the violator to penalties including payment of damages, a limitation or suspension of the violator's ability to engage in the business of insurance, and an investigation by the Attorney General.⁴

Amount of reimbursement

Under the bill, unless the provider or emergency facility wishes to negotiate reimbursement (see "**Negotiation**" below), the reimbursement described under "**Unanticipated and emergency out-of-network care**" above must be the greatest of the following three amounts:

- The median amount the health plan issuer negotiated with in-network providers or facilities for the service in question;
- The rate the health plan issuer pays for out-of-network services under the health benefit plan; or

¹ R.C. 3902.50(E) and 3902.51(A)(1) and (D)(1).

² R.C. 3902.51(A)(2) and (D)(2).

³ R.C. 3902.51(E).

⁴ R.C. 3902.51(G); R.C. 3901.19 to 3901.26, not in the bill.

- The rate paid by Medicare for the service in question.⁵

Negotiation

The bill allows the provider or emergency facility, in lieu of accepting the reimbursement described above, to initiate negotiations with the health plan issuer. To do so, the provider must notify the issuer of its desire to negotiate. Upon receiving the notice, the issuer must attempt a good faith negotiation with the provider or facility. During the period of negotiation, the laws that require prompt payments by issuers are suspended with regard to that claim. If negotiations have not concluded within 30 days, the provider or facility may request arbitration (see “**Arbitration**” below).⁶

Arbitration

Under the bill, if arbitration is requested as described under “**Negotiation**” above, each party must submit its final offer to the arbitrator. The issuer must submit as its final offer the greatest of the three amounts described under “**Amount of reimbursement**” above. Each party’s final offer must be based solely on the accuracy or inaccuracy of the reimbursement required under “**Amount of reimbursement**” above.

To be eligible for arbitration, the service in question must have been provided not more than one year prior to the request. In seeking arbitration, a provider or emergency facility may bundle up to 25 claims with respect to the same health benefit plan that involve the same or similar services provided under similar circumstances. During the period of arbitration, the laws that require prompt payments by issuers are suspended with regard to that claim.

The bill provides that if arbitration does not commence within 90 days of the request for arbitration, the issuer must reimburse the provider or facility the amount of the provider’s final offer.

The bill requires an arbitrator to only award either party’s final offer. In deciding the award, the arbitrator must only consider the accuracy or inaccuracy of the reimbursement described in “**Amount of reimbursement**” above. The nonprevailing party must pay 70% of the arbitrator’s fees and the costs of arbitration, and the prevailing party must pay the remaining 30%.

The parties to arbitration may submit, and the arbitrator may consider, any additional documents or information that may assist the arbitrator in determining the amount to award.⁷

⁵ R.C. 3902.51(B)(1) and (C)(1).

⁶ R.C. 3902.51(B)(2) and (C)(2) and 3902.52(A).

⁷ R.C. 3902.52.

Other out-of-network care

If a health care service is covered under a health benefit plan, is not unanticipated or emergency in nature, and is provided by an individual out-of-network provider at an in-network facility, then all of the following apply under the bill:

- For care provided in Ohio, the individual provider may not balance bill the patient unless all of the following conditions are met:
 - The individual provider informs the covered person that the individual provider is not in-network.
 - 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 must contain a disclaimer that the covered person is not required to obtain the health care service at that location or from that individual provider.
 - The covered person affirmatively consents to receive the services.
- The health plan issuer must reimburse the individual provider at either the in-network or out-of-network rate as described in the covered person's health benefit plan.

A pattern of continuous or repeated violations of these provisions is considered an unfair and deceptive act or practice in the business of insurance, potentially subjecting the violator to penalties including payment of damages, a limitation or suspension of the violator's ability to engage in the business of insurance, and an investigation by the Attorney General.⁸

Location of care

The requirements placed on health plan issuers apply regardless of where the unanticipated or emergency out-of-network care is received, while the requirements placed on providers apply only to care received in Ohio. However, an out-of-state provider may seek arbitration in Ohio.

Exemption from review by the Superintendent of Insurance

The bill's provisions requiring reimbursement might be considered a mandated health benefit. Under R.C. 3901.71, if the General Assembly enacts a provision for mandated health benefits, that provision cannot be applied to any health benefit plan until the Superintendent of Insurance determines that the provision can be applied fully and equally in all respects to employee benefit plans subject to regulation by the federal "Employee Retirement Income Security Act of 1974," (ERISA),⁹ and to employee benefit plans established or modified by the

⁸ R.C. 3902.51(F) and (G).

⁹ 29 United States Code (U.S.C.) 1001.

state or any of its political subdivisions. ERISA appears to preempt any state regulation of such plans.¹⁰

The bill contains provisions that exempt its requirements from this restriction.¹¹

Effective date

Article II, Section 28 of the Ohio Constitution prohibits the General Assembly from passing laws “impairing the obligation of contracts.” The bill therefore makes the requirements effective for health benefit plans that are entered into or renewed following the bill’s effective date. Thus, upon the bill’s passage, plans become subject to its requirements only when they renew.

The bill specifies that if a provider sends a claim for unanticipated or emergency care to a health plan issuer that is not yet subject to the bill’s requirements, the health plan issuer must inform the provider that the plan is not subject to the bill’s provisions with regard to that claim and that the provider is therefore not subject to the bill’s provisions with regard to that claim either and may balance bill the patient for that claim.¹²

Definitions

The bill uses the following definitions:

“**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.¹³

“**Emergency services**” means all of the following:

- Medical screening examinations undertaken to determine whether an emergency medical condition exists;
- Treatment necessary to stabilize an emergency medical condition;
- Appropriate transfers undertaken prior to an emergency medical condition being stabilized.¹⁴

“**Emergency facility**” means a hospital emergency department or any other facility that provides emergency medical services.¹⁵

¹⁰ 29 U.S.C. 1144.

¹¹ R.C. 3902.51(H).

¹² Section 2 of the bill.

¹³ R.C. 3902.50(A).

¹⁴ R.C. 3902.50(D); 42 U.S.C. 1395dd.

¹⁵ R.C. 3902.50(C); R.C. 3701.74, not in the bill.

“**Health benefit plan**” means, subject to certain exceptions, a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.¹⁶

“**Health plan issuer**” means an entity subject to the Ohio Insurance Laws and rules, or subject to the jurisdiction of the Superintendent of Insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan. “Health plan issuer” includes health insuring corporations, sickness and accident insurers, public employee benefit plans, self-funded multiple employer welfare arrangements, and third-party administrators such as pharmacy benefit managers.¹⁷

HISTORY

Action	Date
Introduced	11-05-19

H0388-I-133/ts

¹⁶ R. C. 3902.50(B); R.C. 3922.01, not in the bill.

¹⁷ R.C. 3902.50(B); R.C. 3922.01, not in the bill.