CC6069X2

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 life 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:

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

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

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

15 (3) "Emergency facility" has the same meaning as in section
16 3701.74 of the Revised Code.

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

19 (a) Medical screening examinations undertaken to determine
20 whether an emergency medical condition exists;
21 (b) Treatment necessary to stabilize an emergency medical
22 condition;
23 (c) Appropriate transfers undertaken prior to an emergency
24 medical condition being stabilized.
25 (5) "Individual in-network provider," "individual out-of-
26 network provider," and "individual provider" mean a provider who
27 is an individual.
28 (6) "Unanticipated out-of-network care" means health care
29 services that are covered under a health benefit plan and that
30 are provided by an individual out-of-network provider when
31 either of the following conditions applies:
32 (a) The covered person did not have the ability to request
33 such services from an individual in-network provider.
34 (b) The services provided were emergency services.
35 (B)(1) A health plan issuer shall reimburse an individual
36 out-of-network provider for unanticipated out-of-network care
37 when both of the following apply:
38 (a) The services are provided to a covered person at a
39 facility that is in the covered person's health benefit plan
40 provider network.

41 (b) The services would be covered if provided by an
42 individual provider in the covered person's health benefit plan
43 network.
44 (2) A health plan issuer shall reimburse both of the
45 following for emergency services provided to a covered person at
46 an out-of-network emergency facility:
47 (a) An individual out-of-network provider;
48 (b) The out-of-network emergency facility.
49 (C)(1) The reimbursement required to be paid an individual
50 provider under division (B)(1) or (2) of this section shall be
51 the greatest of the following amounts:
52 (a) The amount negotiated with individual in-network
53 providers for the service in question, excluding any in-network
54 cost sharing imposed under the health benefit plan. If there is
55 more than one amount negotiated with individual in-network
56 providers for the service, the relevant amount shall be the
57 median of those amounts, excluding any in-network cost sharing
58 imposed under the health benefit plan. In determining the median
59 amount, the amount negotiated with each individual in-network
60 provider shall be treated as a separate amount even if the same
61 amount is paid to more than one provider. If there is no per-
62 service amount negotiated with individual in-network providers,
63 such as under a capitation or similar payment arrangement, the

64 amount described in division (C)(1)(a) of this section shall be
65 disregarded.
66 (b) The amount for the service calculated using the same
67 method the health benefit plan generally uses to determine
68 payments for out-of-network health care services, such as the
69 usual, customary, and reasonable amount, excluding any in-
70 network cost sharing imposed under the health benefit plan. This
71 amount shall be determined without reduction for cost sharing
72 that generally applies under the health benefit plan with
73 respect to out-of-network health care services.
74 (c) The amount that would be paid under the medicare
75 program, part A or part B of Title XVIII of the Social Security
76 Act, 42 U.S.C. 1395, as amended, for the service in question,
77 excluding any in-network cost sharing imposed under the health
78 benefit plan.
79 (2) The reimbursement required to be paid to an out-of-
80 network emergency facility under division (B)(2) of this section
81 shall be the greatest of the following amounts:
82 (a) The amount negotiated with in-network emergency
83 facilities for the service in question, excluding any in-network
84 cost sharing imposed under the health benefit plan. If there is
85 more than one amount negotiated with in-network emergency
86 facilities for the service, the relevant amount shall be the
87 median of those amounts, excluding any in-network cost sharing

88 imposed under the health benefit plan. In determining the median
89 amount, the amount negotiated with each in-network emergency
90 facility shall be treated as a separate amount even if the same
91 amount is paid to more than one provider. If there is no per-
92 service amount negotiated with in-network emergency facilities,
93 such as under a capitation or similar payment arrangement, the
94 amount described in division (C)(2)(a) of this section shall be
95 disregarded.

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

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

109 (D)(1) For unanticipated out-of-network care provided at an
110 in-network facility in this state, an individual provider shall
111 not bill a covered person for the difference between the health

112 plan issuer's reimbursement and the individual provider's charge
113 for the services.

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

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

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

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

133 (1) For services provided in this state, the individual
134 provider shall not bill the covered person for the difference
135 between the health plan issuer's out-of-network reimbursement

136 and the provider's charge for the services unless all of the
137 following conditions are met:
138 (a) The individual provider informs the covered person that
139 the individual provider is not in the person's health benefit
140 plan network.
141 (b) The individual provider provides to the covered person
142 a good faith estimate of the cost of the services, including the
143 individual provider's charge, the estimated reimbursement by the
144 health plan issuer, and the covered person's responsibility. The
145 estimate shall contain a disclaimer that the covered person is
146 not required to obtain the health care service at that location
147 or from that individual provider.
148 (c) The covered person affirmatively consents to receive
149 the services.
150 (2) The health plan issuer may reimburse the individual
151 provider at either the in-network or out-of-network rate as
152 described in the covered person's health benefit plan.
153 (G) A pattern of continuous or repeated violations of this
154 section is an unfair and deceptive act or practice in the
155 business of insurance under sections 3901.19 to 3901.26 of the
156 Revised Code.
157 (H) Nothing in this section is subject to section 3901.71
158 of the Revised Code.

159 **Sec. 3902.51.** (A) An individual provider or emergency
160 facility may request alternative dispute resolution if both of
161 the following apply:
162 (1) The individual provider or emergency facility believes
163 that the health plan issuer's offer of reimbursement does not
164 meet the requirements of division (C) of section 3902.50 of the
165 Revised Code.
166 (2) The billed amount exceeds seven hundred dollars.
167 (B) Any documents or information submitted by a health plan
168 issuer, individual provider, or emergency facility in the course
169 of alternative dispute resolution are not public records for the
170 purposes of section 149.43 of the Revised Code and shall not be
171 released.
172 **Sec. 3902.52.** The superintendent of insurance shall adopt
173 by rule alternative dispute resolution procedures and guidelines
174 for complaints brought by individual providers or emergency
175 facilities against health plan issuers relating to reimbursement
176 under section 3902.50 of the Revised Code. The superintendent
177 shall require that mediation be attempted prior to arbitration."
178 In line 96545, delete "to"
179 In line 96546, delete "3902.53" and insert "and 3902.51"
180 Delete lines 97593 and 97594

181 The motion was ________ agreed to.

182 SYNOPSIS

183 **Reimbursement for out-of-network care**

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

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

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

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

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

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

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

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

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

216 (8) Prohibits the disclosure of documents submitted for
217 alternative dispute resolution.

218 (9) Defers to April 2020 the application of the provisions,
219 instead of having the out-of-network care provisions apply to
220 plans issued, modified, or renewed after the provisions'
221 effective date.