(133rd General Assembly)
(Substitute House Bill Number 388)

AN ACT

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 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 in-network provider.

(2) The services provided were emergency services.

Sec. 3902.51. (A)(1)(a) A health plan issuer shall reimburse an 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 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 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 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 out-of-network provider and any out-of-network facility that provided the clinical laboratory services.

(3) For purposes of sections 3902.50 to 3902.54 of the Revised Code:

(a) In the request for reimbursement, the provider, facility, emergency facility, or ambulance shall include the proper billing code for the service for which reimbursement is requested.

(b) The health plan issuer shall send the provider, facility, emergency facility, or ambulance its intended reimbursement as described in division (B)(1) of this section.

(c) Within the period of time specified by the superintendent of insurance in rule, the provider, facility, emergency facility, or ambulance shall either notify the health plan issuer of its acceptance of the reimbursement or seek to negotiate reimbursement under division (B)(2) of this section. Failure to timely notify the issuer of an intent to negotiate shall be considered acceptance of the issuer's reimbursement.

(B)(1) Unless the 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 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 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 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 with 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, a provider, facility, emergency facility, or ambulance may notify the health plan issuer that the provider, facility, emergency facility, or ambulance wishes to negotiate reimbursement. Upon receipt of such notice, the health plan issuer shall attempt a good faith negotiation with the provider, facility, emergency facility, or ambulance.

(C)(1) For unanticipated out-of-network care provided at an in-network facility in this state, a provider shall not bill a covered person for the difference between the health plan issuer's reimbursement and the 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 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 the 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 out-of-network provider shall bill a covered person for the difference between the health plan issuer's reimbursement and the ambulance's or 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 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 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 out-of-network provider at an in-network facility, both of the following apply:

(1) For services provided in this state, the 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 provider informs the covered person that the provider is not in the covered person's health benefit plan network.

(b) The provider provides to the covered person a good faith estimate of the cost of the services, including the 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 provider.

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

(2) The health plan issuer may reimburse the 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, or if both parties agree that they are at an impasse, the 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. To be eligible for arbitration, both of the following must 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, a provider, facility, emergency facility, or ambulance may

bundle up to fifteen claims with respect to the same health benefit plan that involve the same or similar services provided under similar circumstances. Any bundled claims shall be for services using the same coding set and providers of the same license type.

(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) If arbitration is requested under division (A) of this section, each party shall submit its final offer to the arbitrator. The parties also may submit, and the arbitrator may consider, evidence that relates to the factors described in division (C) of this section if the evidence is in a form that can be verified and authenticated.

(C) An arbitrator shall consider all of the following factors in rendering a decision:

(1) The in-network rates that other health benefit plans reimburse, and have reimbursed, that particular provider, facility, emergency facility, or ambulance for the service in question, including the factors that went into those rates such as guaranteed patient volume or availability of providers in the provider's, facility's, emergency facility's, or ambulance's geographic area;

(2) The in-network rates that the health benefit plan reimburses, or has reimbursed, other providers, facilities, emergency facilities, or ambulances for the service in question in that particular geographic area, including the factors that went into those rates such as guaranteed patient volume or availability of providers in that particular geographic area;

(3) If the health plan issuer and the provider, facility, emergency facility, or ambulance have had a contractual relationship in the previous six years, any in-network reimbursement rates previously agreed upon between the issuer and the provider, facility, emergency facility, or ambulance;

(4) The results of, or any documents submitted in the course of, a previous arbitration between the parties conducted under this section that the arbitrator considers relevant in rendering a decision.

(D) After considering the evidence submitted by the parties pursuant to division (B) of this section and the criteria described in division (C) of this section, the arbitrator shall issue a decision that awards the final offer of either party that best reflects a fair reimbursement rate based upon the factors considered under division (C) of this section.

(E) The nonprevailing party shall pay seventy per cent of the arbitrator's fees, and the prevailing party shall pay thirty per cent.

(F) A final arbitration decision shall be binding except as to other remedies available at law.

(G) Documents and other evidence submitted to an arbitrator under this section are confidential, not public records for the purposes of section 149.43 of the Revised Code, and shall not be released except as authorized pursuant to this division. If release of the evidence is required pursuant to a court order, the arbitrator shall release the evidence pursuant to the court order but shall redact from the evidence released information that constitutes intellectual property, trade secrets, or information requiring redaction pursuant to a rule adopted by the superintendent of insurance.

(H) As used in this section, "provider" includes a practice of providers to the extent permitted by rules adopted by the superintendent of insurance under division (D) of section 3902.54 of the Revised Code including but not limited to rules adopted regarding the maximum number of providers in a practice.

Sec. 3902.53. (A)(1) Except as provided in division (A)(2) of this section, 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. Sections 3901.38 to 3901.3814 of the Revised Code shall apply upon the completion of a successful negotiation or upon the rendering of an arbitration decision.

(2) The superintendent of insurance may adopt rules pursuant to division (D) of section 3902.54 of the Revised Code specifying situations in which sections 3901.38 to 3901.3814 of the Revised Code apply during periods of negotiation under section 3902.51 of the Revised Code.

(B) A pattern of continuous or repeated violations of section 3902.51 or 3902.52 of the Revised Code by a health plan issuer 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) A 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) 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) A 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) 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;

(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 accompanied by an application fee prescribed by the superintendent:

(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, 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) The fee the applicant would charge for an arbitration.

(C)(1) 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.

(2) The superintendent shall require the contracted arbitration entity to submit to the superintendent on an annual basis, and the superintendent shall issue, a report containing all of the following:

(a) The number of arbitrations conducted under section 3902.52 of the Revised Code;

(b) The provider type, whether individual, practice, facility, emergency facility, or ambulance, that engaged in the arbitrations;

(c) The specialty of the provider engaging in the arbitrations;

(d) The out-of-network situation;

(e) The percentage of times the arbitrator decides in favor of the health plan issuer versus the provider, facility, emergency facility, or ambulance.

(D) The superintendent of insurance shall adopt rules pursuant to Chapter 119. of the Revised Code as necessary to implement sections 3902.50 to 3902.54 of the Revised Code.

Rules adopted by the superintendent may relate to the definitions of "provider," "facility," "emergency facility," and "ambulance." The requirements of section 121.95 of the Revised Code do not apply to rules adopted in accordance with this division.

SECTION 2. 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 section. In particular, the requirements apply to all health benefit plans regardless of a particular plan's date of origination, issuance, delivery, renewal, or modification.

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Speaker _____ of the House of Representatives.

_____

President _____ of the Senate.

Passed _____, 20____

Approved _____, 20____

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Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

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Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the ____ day of _____, A. D. 20____.

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Secretary of State.

File No. _____ Effective Date _____