As Introduced

133rd General Assembly

Regular Session **S. B. No. 198**

2019-2020

Senators Huffman, S., Antonio

Cosponsors: Senators Thomas, Sykes, Williams, Huffman, M., Manning, Kunze, Roegner

A BILL

To enact sections 3902.50, 3902.51, 3902.511, 3902.52, 3902.53, 3902.531, 3902.54, and 3902.55 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, 3902.511, 3902.52, 3902.53, 3902.531, 3902.54, and 3902.55 of the Revised Code be enacted to read as follows:

Sec. 3902.50. As used in sections 3902.50 to 3902.55 of the Revised Code:

(A) "Cost sharing" means the cost to an individual covered under a health benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by a health benefit plan.

(B) "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.

(C) "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.

(D) "Health care contract" has the same meaning as in section 3963.01 of the Revised Code.

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

(F) "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:

(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.

Sec. 3902.51. (A) An individual provider shall file a claim for reimbursement with a covered person's health plan issuer for unanticipated out-of-network care provided at an in-network facility in this state.

(B) Upon receiving a claim made pursuant to division (A) of this section, or upon receiving a claim for reimbursement for other unanticipated out-of-network care provided at an in-

network facility, the health plan issuer shall, within thirty days, either pay the individual provider's claim or attempt to negotiate reimbursement with the individual provider. Sections 3901.38 to 3901.3814 of the Revised Code shall not apply with respect to the claim during a period of negotiation.

(C) 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 reimbursement from the covered person's health plan issuer and the individual provider's charge for the services.

(D) If the claim is not subject to arbitration pursuant to division (A) of section 3902.52 of the Revised Code, the health plan issuer shall, at a minimum, reimburse the individual provider the lesser of the following:

(1) The provider's charge;

(2) The eightieth percentile of all provider charges in the same or similar specialty for the health care service provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent of insurance pursuant to division (A) of section 3902.54 of the Revised Code.

(E) A health plan issuer shall not require cost sharing for unanticipated out-of-network care at a rate higher than if the care were provided by an individual in-network provider.

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

Sec. 3902.511. For health care services, other than unanticipated out-of-network care, that are covered under a health benefit plan but are provided by an individual out-of-

network provider 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 individual 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 provider network.

(B) The individual provider provides the covered person a good faith estimate of the cost of the health care services. This estimate shall contain a disclaimer that the covered person is not required to obtain the services at that location or from that individual provider.

(C) The covered person affirmatively consents to receive the health care services.

Sec. 3902.52. (A)(1) Except as provided in division (A)(2) of this section, if an individual provider files a claim for reimbursement, and the individual provider and the health plan issuer receiving the claim do not agree on a negotiated reimbursement within sixty days of the start of negotiations under division (B) of section 3902.51 of the Revised Code, the health plan issuer or individual provider may file a request with the superintendent of insurance for binding arbitration to determine the reimbursement amount for unanticipated out-of-network care on a per claim basis if either of the following applies:

(a) The claim exceeds seven hundred dollars.

(b) The individual provider has filed two or more claims for which no reimbursement was agreed upon, each of which is

seven hundred dollars or less but together total more than seven hundred dollars. If the requesting party desires to bundle claims as described in division (A)(1)(b) of this section, the party shall do so as part of its initial request.

(2) An individual provider requesting arbitration may bundle similar claims into one arbitration proceeding if the claims together total more than seven hundred dollars. If the requesting party desires to bundle claims as described in division (A)(2) of this section, the party shall do so as part of its initial request. For purposes of this division, "similar claims" means claims that are from the same individual provider, the individual provider's medical group, or the individual provider's independent practice organization, are sent to the same health plan issuer, and are any of the following:

(a) Of a similar medical nature;

(b) Subject to denial by the health plan issuer for similar reasons;

(c) Otherwise materially similar.

(B)(1) The party requesting arbitration shall notify the other party that it has requested arbitration. The notice shall state the party's final offer. If the party is bundling claims under division (A)(1)(b) or (2) of this section, the notice shall state the party's final offer for each claim.

(2) In response to the notice described in division (B)(1) of this section, the nonrequesting party shall inform the requesting party of its final offer before the arbitration commences.

If the requesting party bundled claims, the nonrequesting party shall state its final offer for each claim. The

nonrequesting party may object to the bundling of claims as not meeting the requirements of division (A)(1)(b) or (2) of this section by informing the requesting party and the arbitrator of its objection before the arbitration commences.

(C)(1) A health plan issuer shall not deny coverage of a claim after arbitration on that claim has been initiated pursuant to division (A) of this section.

(2) Sections 3901.38 to 3901.3814 of the Revised Code shall not apply with respect to a claim during the period of arbitration under this section.

Sec. 3902.53. (A) When arbitration is requested under division (A) of section 3902.52 of the Revised Code, the superintendent of insurance shall appoint an arbitrator within ten days of receiving the request.

(B) The arbitration shall consist of a review of the written documentation submitted by both parties to the arbitrator. The parties shall submit to the arbitrator all required documentation as soon as is practicable.

(C)(1) If the requesting party bundled claims and the nonrequesting party timely objected to the bundling pursuant to division (B)(2) of section 3902.52 of the Revised Code, the arbitrator shall promptly decide whether the bundling of claims was proper. If the nonrequesting party does not timely object to the bundling, the arbitrator shall allow the bundling. If the arbitrator decides that the bundling was improper in whole or in part, the arbitrator shall inform the superintendent and the parties, and the superintendent shall appoint additional arbitrators as appropriate. The ten-day period for appointing arbitrators described in division (A) of this section is deemed

to begin when the superintendent receives the arbitrator's decision disallowing the bundling.

(2) The arbitrator shall make a decision and provide that decision in writing to all parties and to the superintendent within thirty days after the appointment of the arbitrator.

(D)(1) An arbitrator may direct both parties to attempt a good faith negotiation if the arbitrator determines either of the following to be true:

(a) A settlement between the parties is reasonably likely.

(b) Both the individual provider's final offer and the health plan issuer's final offer described in division (B) of section 3902.52 of the Revised Code are unreasonable.

(2) Negotiations undertaken pursuant to division (D)(1) of this section shall take not more than ten days, but in any case shall conclude within the thirty-day time period identified in division (C) of this section.

(E)(1) An arbitrator shall only award either the individual provider's final offer or the health plan issuer's final offer described in division (B) of section 3902.52 of the Revised Code, plus the arbitrator's fees, which shall be paid by the nonprevailing party.

(2) If the parties reach a settlement as a result of negotiations undertaken pursuant to division (D) of this section, the arbitrator's fees shall be paid by both parties equally.

(F)(1) In reaching a decision under division (E)(1) of this section, an arbitrator shall consider all of the following factors:

(a) The individual provider's level of training, education, experience, and specialization or sub-specialization;

(b) The acuity level of patients treated by the individual provider;

(c) The individual provider's quality and outcome metrics;

(d) Contracted rates for other providers under other health benefit plans in the same geographic area;

(e) The history of prior contracted rates between the individual provider and health plan issuer;

(f) If terminated by either party within one year prior to the filing of the arbitration request under division (A) of section 3902.52 of the Revised Code, the health care contract in existence at the time of the unanticipated out-of-network care that formed the basis for the dispute, including any valuable consideration received by either party for entering into the health care contract;

(g) Past compliance by each party with the terms of the most recent, if any, health care contract;

(h) The eightieth percentile of all provider charges for the health care service provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the superintendent of insurance pursuant to division (A) of section 3902.54 of the Revised Code;

(i) The circumstances and complexity of the case under dispute, including the place of service as defined by the federal centers for medicare and medicaid services;

(j) The individual provider's usual charges for the services;

(k) Any other relevant economic aspect of the unanticipated out-of-network care.

(2) In reaching a decision under division (E)(1) of this section, an arbitrator shall not consider the rates of other programs including indigent care programs, medicare, medicaid, or tricare.

(G)(1) The determination of the arbitrator shall be binding and shall be admissible in any court proceeding between the health plan issuer and the individual provider, the individual provider's medical group, or the individual provider's independent practice organization.

(2) The determination of the arbitrator shall be binding and shall be admissible in any proceeding between the state and the individual provider, the individual provider's medical group, or the individual provider's independent practice organization.

Sec. 3902.531. Sections 3902.50 to 3902.53 of the Revised Code do not apply to medicaid managed care plans or to health care services, including emergency services, for which individual provider fees are subject to schedules or other monetary limitations under any other law, including Chapters 4121. and 4123. of the Revised Code.

Sec. 3902.54. (A) The superintendent shall specify the benchmarking database described in division (D) of section 3902.51 or division (E)(1)(h) of section 3902.53 of the Revised Code. The superintendent shall not select a nonprofit organization that is affiliated with or receives funding from a health plan issuer.

(B) The superintendent shall adopt rules as necessary to

implement sections 3902.50 to 3902.53 of the Revised Code. The rules shall at minimum address all of the following:

(1) The certification of arbitrators to carry out the arbitration process provided under sections 3902.52 and 3902.53 of the Revised Code;

(2) The payment of an arbitrator's fees under division (E) of section 3902.53 of the Revised Code;

(3) Any other items the superintendent considers necessary to implement sections 3902.50 to 3902.53 of the Revised Code.

Sec. 3902.55. (A) A health plan issuer shall provide a directory of health care providers for each of its health benefit plans on the issuer's web site and in print format in each plan brochure.

(B) The directory shall contain the following information in plain language:

(1) Which directory applies to which health benefit plan;

(2) The criteria the health plan issuer uses to evaluate health care providers that attempt to join the issuer's network;

(3) The criteria the health plan issuer uses to tier health care providers;

(4) The tier on which each health care provider is placed;

(5) A statement that authorization or referral may be required prior to covering a health care provider's services;

(6) A customer service electronic mail address and telephone number or electronic link that any person may use to notify the health plan issuer of inaccurate directory information;

(7) Regarding the version of the directory on the issuer's web site:

(a) In searchable format, the following information relating to each in-network health care provider that is not a health care facility: name, gender, contact information, participating locations, specialties, board certifications, medical group affiliations, health care facility affiliations, participating health care facility affiliations, languages spoken by the provider and the provider's staff, and whether the provider is accepting new patients.

(b) In searchable format, the following information relating to each in-network health care facility: facility name, contact information, facility type, types of services available if a facility is not a hospital, location, and certification or accreditation status if the facility is a hospital.

(8) Regarding the print version of the directory, a disclosure that the directory is accurate as of the date of printing and that covered persons and prospective enrollees should consult the electronic version of the directory on the health plan issuer's web site or contact the health plan issuer via telephone to obtain current directory information.

(C) A health plan issuer shall do all of the following in relation to the directory described in this section:

(1) Update the directory on the issuer's web site at least monthly;

(2) Ensure that the public may view the directory on the issuer's web site via a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number;

(3) Upon a covered person's or a prospective enrollee's request, make available in print format the following directory information for the applicable health benefit plan:

(a) The following information relating to each in-network health care provider: name, contact information, participating locations, specialties, languages spoken, and whether the provider is accepting new patients;

(b) The following information relating to each in-network health care facility: facility name, contact information, facility type, location, and types of services available if a facility is not a hospital.

(D) A health plan issuer shall perform an annual audit of a reasonable sample of its directories for accuracy. A health plan issuer shall retain documentation of the audit's results for a period of five years and provide such documentation to the superintendent of insurance upon request.

Section 2. (A) Section 3902.55 of the Revised Code, as enacted by this act, applies to health benefit plans delivered, issued for delivery, modified, or renewed on or after the effective date of this section.

(B) The requirements of sections 3902.50 to 3902.531 of the Revised Code, as enacted in this act, apply beginning April 1, 2020, to the following:

(1) Individual providers, except as provided in division (C)(1) of this section;

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

(C) If, on or after April 1, 2020, an individual provider sends a claim for unanticipated out-of-network care to a health plan issuer for reimbursement under a health benefit plan not described in division (B)(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 does not apply to that individual provider with respect to the unanticipated out-of-network care to which that claim relates.

(2) Upon receiving the claim, the health benefit plan shall inform the individual provider 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;

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

(D) As used in this section, "covered person," "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.