## As Introduced

## 133rd General Assembly Regular Session 2019-2020

H. B. No. 388

1

## Representative Holmes, A.

To enact sections 3902.50, 3902.51, and 3902.52 of

the Revised Code regarding out-of-network care.

## A BILL

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

Section 1. That sections 3902.50, 3902.51, and 3902.52 of	3
the Revised Code be enacted to read as follows:	4
Sec. 3902.50. As used in sections 3902.50 to 3902.52 of	5
the Revised Code:	6
(A) "Cost sharing" means the cost to a covered person_	7
under a health benefit plan according to any coverage limit,	8
copayment, coinsurance, deductible, or other out-of-pocket	9
expense requirement.	10
(B) "Covered person," "health benefit plan," "health care	11
services," and "health plan issuer" have the same meanings as in	12
section 3922.01 of the Revised Code.	13
(C) "Emergency facility" has the same meaning as in	14
section 3701.74 of the Revised Code.	15
(D) "Emergency services" means all of the following as	16
described in 42 U.S.C. 1395dd:	17

(1) Medical screening examinations undertaken to determine	18
whether an emergency medical condition exists;	19
(2) Treatment necessary to stabilize an emergency medical	20
<pre>condition;</pre>	21
(3) Appropriate transfers undertaken prior to an emergency	22
medical condition being stabilized.	23
	0.4
(E) "Unanticipated out-of-network care" means health care	24
services that are covered under a health benefit plan and that	25
are provided by an individual out-of-network provider when	26
either of the following conditions applies:	27
(1) The covered person did not have the ability to request_	28
such services from an individual in-network provider.	29
(2) The services provided were emergency services.	30
(F) "Individual in-network provider," "individual out-of-	31
network provider," and "individual provider" mean a provider who	32
is an individual.	33
Sec. 3902.51. (A) (1) A health plan issuer shall reimburse	34
an individual out-of-network provider for unanticipated out-of-	35
network care when both of the following apply:	36
(a) The services are provided to a covered person at an	37
in-network facility.	38
(b) The services would be covered if provided by an	39
individual in-network provider.	40
(2) A health plan issuer shall reimburse both of the	41
following for emergency services provided to a covered person at	42
an out-of-network emergency facility:	43
(a) An individual out-of-network provider;	44

(b) The out-of-network emergency facility.	45
(B)(1) Unless the individual provider wishes to negotiate	46
reimbursement under division (B)(2) of this section, the	47
reimbursement required to be paid to an individual provider	48
under division (A)(1) or (2) of this section shall be the	49
greatest of the following amounts:	50
(a) The amount negotiated with individual in-network	51
providers for the service in question, excluding any in-network	52
cost sharing imposed under the health benefit plan. If there is	53
more than one amount negotiated with individual in-network	54
providers for the service, the relevant amount shall be the	55
median of those amounts, excluding any in-network cost sharing	56
imposed under the health benefit plan. In determining the median	57
amount, the amount negotiated with each individual in-network	58
provider shall be treated as a separate amount even if the same	59
amount is paid to more than one provider. If there is no per-	60
service amount negotiated with individual in-network providers,	61
such as under a capitation or similar payment arrangement, the	62
amount described in division (B)(1)(a) of this section shall be	63
disregarded.	64
(b) The amount for the service calculated using the same	65
method the health benefit plan generally uses to determine	66
payments for out-of-network health care services, such as the	67
usual, customary, and reasonable amount, excluding any in-	68
network cost sharing imposed under the health benefit plan. This	69
amount shall be determined without reduction for cost sharing	70
that generally applies under the health benefit plan with	71
respect to out-of-network health care services.	72
(c) The amount that would be paid under the medicare	73
program, part A or part B of Title XVIII of the Social Security	74

Act, 42 U.S.C. 1395, as amended, for the service in question,	75
excluding any in-network cost sharing imposed under the health	76
benefit plan.	77
(2) In lieu of accepting reimbursement under division (B)	78
(1) of this section, an individual provider may notify the	79
health plan issuer that the individual provider wishes to	80
negotiate reimbursement. Upon receipt of such notice, the health	81
plan issuer shall attempt a good faith negotiation with the	82
individual provider. Sections 3901.38 to 3901.3814 of the	83
Revised Code shall not apply with respect to a claim during this_	84
period of negotiation.	85
(C)(1) Unless the out-of-network emergency facility wishes	86
to negotiate reimbursement under division (C)(2) of this	87
section, the reimbursement required to be paid to an out-of-	88
network emergency facility under division (A)(2) of this section	89
shall be the greatest of the following amounts:	90
(a) The amount negotiated with in-network emergency	91
facilities for the service in question, excluding any in-network	92
cost sharing imposed under the health benefit plan. If there is	93
more than one amount negotiated with in-network emergency	94
facilities for the service, the relevant amount shall be the	95
median of those amounts, excluding any in-network cost sharing	96
imposed under the health benefit plan. In determining the median	97
amount, the amount negotiated with each in-network emergency	98
facility shall be treated as a separate amount even if the same	99
amount is paid to more than one provider. If there is no per-	100
service amount negotiated with in-network emergency facilities,	101
such as under a capitation or similar payment arrangement, the	102
amount described in division (C)(1)(a) of this section shall be	103
disregarded.	104

(b) The amount for the service calculated using the same	105
method the health benefit plan generally uses to determine	106
payments for out-of-network health care services, such as the	107
usual, customary, and reasonable amount, excluding any in-	108
network cost sharing imposed under the health benefit plan. This	109
amount shall be determined without reduction for cost sharing	110
that generally applies under the health benefit plan with	111
respect to out-of-network health care services.	112
(c) The amount that would be paid under the medicare	113
program, part A or part B of Title XVIII of the Social Security	114
Act, 42 U.S.C. 1395, as amended, for the service in question,	115
excluding any in-network cost sharing imposed under the health	116
benefit plan.	117
(2) In lieu of accepting reimbursement under division (C)	118
(1) of this section, an out-of-network emergency facility may	119
notify the health plan issuer that the emergency facility wishes	120
to negotiate reimbursement. Upon receipt of such notice, the	121
health plan issuer shall attempt a good faith negotiation with	122
the emergency facility. Sections 3901.38 to 3901.3814 of the	123
Revised Code shall not apply with respect to a claim during this	124
period of negotiation.	125
(D)(1) For unanticipated out-of-network care provided at	126
an in-network facility in this state, an individual provider	127
shall not bill a covered person for the difference between the	128
health plan issuer's reimbursement and the individual provider's	129
charge for the services.	130
(2) (a) For emergency services provided at an out-of-	131
network emergency facility in this state, an individual provider	132
shall not bill a covered person for the difference between the	133
health plan issuer's reimbursement and the individual provider's	134

charge for the services.	135
(b) For emergency services provided at an out-of-network	136
emergency facility in this state, the emergency facility shall	137
not bill a covered person for the difference between the health	138
plan issuer's reimbursement and the emergency facility's charge	139
for the services.	140
(E) A health plan issuer shall not require cost sharing	141
for any service described in division (A) of this section from	142
the covered person at a rate higher than if the services were	143
provided by an individual in-network provider or in-network	144
<pre>emergency facility.</pre>	145
(F) For health care services, other than those described	146
in division (A) of this section, that are covered under a health	147
benefit plan but are provided to a covered person by an	148
individual out-of-network provider at an in-network facility,	149
all of the following apply:	150
(1) For services provided in this state, the individual	151
provider shall not bill the covered person for the difference	152
between the health plan issuer's out-of-network reimbursement	153
and the provider's charge for the services unless all of the	154
<pre>following conditions are met:</pre>	155
(a) The individual provider informs the covered person	156
that the individual provider is not in-network.	157
(b) The individual provider provides to the covered person	158
a good faith estimate of the cost of the services, including the	159
individual provider's charge, the estimated reimbursement by the	160
health plan issuer, and the covered person's responsibility. The	161
estimate shall contain a disclaimer that the covered person is	162
not required to obtain the health care service at that location	163

or from that individual provider.	164
(c) The covered person affirmatively consents to receive	165
the services.	166
(2) The health plan issuer shall reimburse the individual	167
provider at either the in-network or out-of-network rate as	168
described in the covered person's health benefit plan.	169
(G) A pattern of continuous or repeated violations of this	170
section is an unfair and deceptive act or practice in the	171
business of insurance under sections 3901.19 to 3901.26 of the	172
Revised Code.	173
(H) Nothing in this section is subject to section 3901.71	174
of the Revised Code.	175
Sec. 3902.52. (A) If a negotiation undertaken pursuant to	176
division (B)(2) or (C)(2) of section 3902.51 of the Revised Code	177
has not successfully concluded within thirty days, the	178
individual provider or emergency facility may request	179
arbitration and shall notify the health plan issuer of its	180
request. To be eligible for arbitration, the service in question	181
must have been provided not more than one year prior to the	182
request. Sections 3901.38 to 3901.3814 of the Revised Code shall	183
not apply with respect to a claim during a period of arbitration	184
requested pursuant to division (A) of this section.	185
(B) If arbitration is requested under division (A) of this	186
section, each party shall submit its final offer to the	187
arbitrator. The health plan issuer shall submit as its final	188
offer the greatest of the three amounts described in division	189
(B) (1) or (C) (1) of section 3902.51 of the Revised Code as	190
applicable. Each party's final offer shall be based solely on	191
the accuracy or inaccuracy of the reimbursement required under	192

division (B)(1) or (C)(1) of section 3902.51 of the Revised Code	193
as applicable.	194
(C) If arbitration does not commence within ninety days of	195
the request described in division (A) of this section, the	196
health plan issuer shall reimburse the individual provider or	197
<pre>emergency facility the amount of the provider's or facility's</pre>	198
<pre>final offer.</pre>	199
(D) An arbitrator shall only award either party's final	200
offer submitted under division (B) of this section. In deciding	201
the award, the arbitrator shall only consider the accuracy or	202
inaccuracy of the reimbursement required under division (B)(1)	203
or (C)(1) of section 3902.51 of the Revised Code as applicable.	204
(E) The nonprevailing party shall pay seventy per cent of	205
the arbitrator's fees and the costs of arbitration, and the	206
prevailing party shall pay thirty per cent.	207
(F) In seeking arbitration, an individual provider or	208
emergency facility may bundle up to twenty-five claims with	209
respect to the same health benefit plan that involve the same or	210
similar services provided under similar circumstances.	211
(G) The parties to arbitration may submit, and the	212
arbitrator may consider, any additional documents or information	213
that may assist the arbitrator in determining the amount to	214
award.	215
Section 2. (A) The requirements of sections 3902.50 to	216
3902.52 of the Revised Code, as enacted in this act, apply to	217
the following:	217
the refreshing.	210
(1) Individual providers and emergency facilities, except	219
as provided in division (B)(1) of this section;	220

(2) Health benefit plans delivered, issued for delivery,	221
modified, or renewed on or after the effective date of those	222
sections.	223
(B) If, on or after the effective date of this act, an	224
individual provider or emergency facility sends a claim for	225
unanticipated out-of-network care or emergency services to a	226
health plan issuer for reimbursement under a health benefit plan	227
not described in division (A)(2) of this section, then both of	228
the following apply:	229
(1) Any provision of sections 3902.50 to 3902.52 of the	230
Revised Code that applies to an individual provider or emergency	231
facility does not apply to that individual provider or emergency	232
facility with respect to the unanticipated out-of-network care	233
or emergency services to which that claim relates.	234
(2) Upon receiving the claim, the health benefit plan	235
shall inform the individual provider or emergency facility of	236
both of the following:	237
(a) That the health benefit plan is not subject to the	238
requirements of sections 3902.50 to 3902.52 of the Revised Code	239
with regard to the claim;	240
(b) That sections 3902.50 to 3902.52 of the Revised Code	241
do not apply to that individual provider or emergency facility	242
with respect to that unanticipated out-of-network care or	243
emergency services, and that the individual provider or	244
emergency facility is not prohibited from billing the covered	245
person for the difference between the health plan issuer's	246
reimbursement and the individual provider's or emergency	247
facility's charge for the care.	248
(C) As used in this section, "covered person," "emergency	249

H. B. No. 388 As Introduced	Page 10
facility," "emergency services," "health benefit plan,"	250
"individual provider," and "unanticipated out-of-network care"	251
have the same meanings as in section 3902.50 of the Revised	252
Code, as enacted in this act.	253