As Introduced

133rd General Assembly
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H. B. No. 388

Representative Holmes, A.

A BILL

To enact sections 3902.50, 3902.51, and 3902.52 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, and 3902.52 of the Revised Code be enacted to read as follows:

Sec. 3902.50. As used in sections 3902.50 to 3902.52 of the Revised Code:

(A) "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.

(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 facility" has the same meaning as in section 3701.74 of the Revised Code.

(D) "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.

(E) "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.

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

Sec. 3902.51. (A)(1) A health plan issuer shall reimburse an individual out-of-network provider for unanticipated out-of-network care when both of the following apply:

(a) The services are provided to a covered person at an in-network facility.

(b) The services would be covered if provided by an individual in-network provider.

(2) 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:

(a) An individual out-of-network provider;

(b) The out-of-network emergency facility.

(B)(1) Unless the individual provider wishes to negotiate reimbursement under division (B)(2) of this section, the reimbursement required to be paid to an individual provider under division (A)(1) or (2) of this section shall be the greatest of the following amounts:

(a) The amount negotiated with individual in-network providers for the service in question, excluding any in-network cost sharing imposed under the health benefit plan. If there is more than one amount negotiated with individual in-network providers for the service, 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 individual in-network provider 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 negotiated with individual in-network providers, 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 without 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, an individual provider may notify the health plan issuer that the individual provider wishes to negotiate reimbursement. Upon receipt of such notice, the health plan issuer shall attempt a good faith negotiation with the individual provider. Sections 3901.38 to 3901.3814 of the Revised Code shall not apply with respect to a claim during this period of negotiation.

(C)(1) Unless the out-of-network emergency facility wishes to negotiate reimbursement under division (C)(2) of this section, the reimbursement required to be paid to an out-of-network emergency facility under division (A)(2) of this section shall be the greatest of the following amounts:

(a) The amount negotiated with in-network emergency facilities for the service in question, excluding any in-network cost sharing imposed under the health benefit plan. If there is more than one amount negotiated with in-network emergency facilities for the service, 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 emergency facility 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 negotiated with in-network emergency facilities, such as under a capitation or similar payment arrangement, the amount described in division (C)(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 without 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 (C)(1) of this section, an out-of-network emergency facility may notify the health plan issuer that the emergency facility wishes to negotiate reimbursement. Upon receipt of such notice, the health plan issuer shall attempt a good faith negotiation with the emergency facility. Sections 3901.38 to 3901.3814 of the Revised Code shall not apply with respect to a claim during this period of negotiation.

(D)(1) 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 health plan issuer's reimbursement and the individual provider's charge for the services.

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

charge for the services.

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

(E) 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 by an individual in-network provider or in-network emergency facility.

(F) 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 individual out-of-network provider at an in-network facility, all of the following apply:

(1) For services provided 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 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-network.

(b) 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 shall contain a disclaimer that the covered person is not required to obtain the health care service at that location

or from that individual provider.

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

(2) The health plan issuer shall reimburse the individual provider at either the in-network or out-of-network rate as described in the covered person's health benefit plan.

(G) A pattern of continuous or repeated violations of this section is an unfair and deceptive act or practice in the business of insurance under sections 3901.19 to 3901.26 of the Revised Code.

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

Sec. 3902.52. (A) If a negotiation undertaken pursuant to division (B)(2) or (C)(2) of section 3902.51 of the Revised Code has not successfully concluded within thirty days, the individual provider or emergency facility may request arbitration and shall notify the health plan issuer of its request. To be eligible for arbitration, the service in question must have been provided not more than one year prior to the request. Sections 3901.38 to 3901.3814 of the Revised Code shall not apply with respect to a claim during a period of arbitration requested pursuant to division (A) of this section.

(B) If arbitration is requested under division (A) of this section, each party shall submit its final offer to the arbitrator. The health plan issuer shall submit as its final offer the greatest of the three amounts described in division (B)(1) or (C)(1) of section 3902.51 of the Revised Code as applicable. Each party's final offer shall be based solely on the accuracy or inaccuracy of the reimbursement required under

division (B)(1) or (C)(1) of section 3902.51 of the Revised Code as applicable.

(C) If arbitration does not commence within ninety days of the request described in division (A) of this section, the health plan issuer shall reimburse the individual provider or emergency facility the amount of the provider's or facility's final offer.

(D) An arbitrator shall only award either party's final offer submitted under division (B) of this section. In deciding the award, the arbitrator shall only consider the accuracy or inaccuracy of the reimbursement required under division (B)(1) or (C)(1) of section 3902.51 of the Revised Code as applicable.

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

(F) In seeking arbitration, an individual provider or emergency facility may bundle up to twenty-five claims with respect to the same health benefit plan that involve the same or similar services provided under similar circumstances.

(G) 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.

Section 2. (A) The requirements of sections 3902.50 to 3902.52 of the Revised Code, as enacted in this act, apply to the following:

(1) Individual providers and emergency facilities, except as provided in division (B)(1) of this section;

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

(B) If, on or after the effective date of this act, an individual provider or emergency facility sends a claim for unanticipated out-of-network care or emergency services to a health plan issuer for reimbursement under a health benefit plan not described in division (A)(2) of this section, then both of the following apply:

(1) Any provision of sections 3902.50 to 3902.52 of the Revised Code that applies to an individual provider or emergency facility does not apply to that individual provider or emergency facility with respect to the unanticipated out-of-network care or emergency services to which that claim relates.

(2) Upon receiving the claim, the health benefit plan shall inform the individual provider or emergency facility of both of the following:

(a) That the health benefit plan is not subject to the requirements of sections 3902.50 to 3902.52 of the Revised Code with regard to the claim;

(b) That sections 3902.50 to 3902.52 of the Revised Code do not apply to that individual provider or emergency facility with respect to that unanticipated out-of-network care or emergency services, and that the individual provider or emergency facility is not prohibited from billing the covered person for the difference between the health plan issuer's reimbursement and the individual provider's or emergency facility's charge for the care.

(C) As used in this section, "covered person," "emergency

facility," "emergency services," "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.