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Representative Holmes, A.

Cosponsors: Representatives Butler, Edwards, Hambley, Perales, Roemer, Rogers, Romanchuk, West, Abrams, Baldrige, Brown, Carruthers, Cera, Clites, Crossman, DeVitis, Ghanbari, Ginter, Green, Greenspan, Grendell, Hicks-Hudson, Hillyer, Ingram, Jones, Lanese, Lang, LaRe, Leland, Lightbody, Liston, Manning, G., Miller, J., Miranda, O'Brien, Patton, Richardson, Robinson, Seitz, Sheehy, Smith, K., Smith, T., Sobecki, Stein, Sweeney, Upchurch, Weinstein, Wilkin

Senators Hackett, Antonio, Craig, Eklund, Fedor, Hottinger, Lehner, Maharath, Williams

A BILL

To enact sections 3902.50, 3902.51, 3902.52, 1
3902.53, and 3902.54 of the Revised Code 2
regarding out-of-network care. 3

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

Section 1. That sections 3902.50, 3902.51, 3902.52, 4
3902.53, and 3902.54 of the Revised Code be enacted to read as 5
follows: 6

Sec. 3902.50. As used in sections 3902.50 to 3902.54 of 7
the Revised Code: 8

(A) "Ambulance" has the same meaning as in section 4765.01 9
of the Revised Code. 10

(B) "Clinical laboratory services" has the same meaning as 11
in section 4731.65 of the Revised Code. 12

(C) "Cost sharing" means the cost to a covered person 13
under a health benefit plan according to any copayment, 14
coinsurance, deductible, or other out-of-pocket expense 15
requirement. 16

(D) "Covered person," "health benefit plan," "health care 17
services," and "health plan issuer" have the same meanings as in 18
section 3922.01 of the Revised Code. 19

(E) "Emergency facility" has the same meaning as in 20
section 3701.74 of the Revised Code. 21

(F) "Emergency services" means all of the following as 22
described in 42 U.S.C. 1395dd: 23

(1) Medical screening examinations undertaken to determine 24
whether an emergency medical condition exists; 25

(2) Treatment necessary to stabilize an emergency medical 26
condition; 27

(3) Appropriate transfers undertaken prior to an emergency 28
medical condition being stabilized. 29

(G) "Unanticipated out-of-network care" means health care 30
services, including clinical laboratory services, that are 31
covered under a health benefit plan and that are provided by an 32
out-of-network provider when either of the following conditions 33
applies: 34

(1) The covered person did not have the ability to request 35
such services from an in-network provider. 36

(2) The services provided were emergency services. 37

Sec. 3902.51. (A) (1) (a) A health plan issuer shall 38
reimburse an out-of-network provider for unanticipated out-of- 39

network care when both of the following apply: 40

(i) The services are provided to a covered person at an in-network facility. 41
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(ii) The services would be covered if provided by an in-network provider. 43
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(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: 45
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(i) An out-of-network provider; 48

(ii) The out-of-network emergency facility. 49

(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: 50
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(i) An out-of-network provider; 53

(ii) The out-of-network ambulance. 54

(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. 55
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(3) For purposes of sections 3902.50 to 3902.54 of the Revised Code: 60
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(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. 62
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(b) The health plan issuer shall send the provider, 66

facility, emergency facility, or ambulance its intended 67
reimbursement as described in division (B)(1) of this section. 68

(c) Within the period of time specified by the 69
superintendent of insurance in rule, the provider, facility, 70
emergency facility, or ambulance shall either notify the health 71
plan issuer of its acceptance of the reimbursement or seek to 72
negotiate reimbursement under division (B)(2) of this section. 73
Failure to timely notify the issuer of an intent to negotiate 74
shall be considered acceptance of the issuer's reimbursement. 75

(B)(1) Unless the provider, facility, emergency facility, 76
or ambulance wishes to negotiate reimbursement under division 77
(B)(2) of this section, the reimbursement required to be paid to 78
the provider, facility, emergency facility, or ambulance under 79
division (A) of this section shall be the greatest of the 80
following amounts: 81

(a) The amount negotiated with in-network providers, 82
facilities, emergency facilities, or ambulances for the service 83
in question in that geographic region under that health benefit 84
plan, excluding any in-network cost sharing imposed under the 85
health benefit plan. If there is more than one such amount, the 86
relevant amount shall be the median of those amounts, excluding 87
any in-network cost sharing imposed under the health benefit 88
plan. In determining the median amount, the amount negotiated 89
with each in-network provider, facility, emergency facility, or 90
ambulance 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, such as under a capitation or similar payment 93
arrangement, the amount described in division (B)(1)(a) of this 94
section shall be disregarded. 95

(b) The amount for the service calculated using the same 96

method the health benefit plan generally uses to determine 97
payments for out-of-network health care services, such as the 98
usual, customary, and reasonable amount, excluding any in- 99
network cost sharing imposed under the health benefit plan. This 100
amount shall be determined with reduction for cost sharing that 101
generally applies under the health benefit plan with respect to 102
out-of-network health care services. 103

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

(2) In lieu of accepting reimbursement under division (B) 109
(1) of this section, a provider, facility, emergency facility, 110
or ambulance may notify the health plan issuer that the 111
provider, facility, emergency facility, or ambulance wishes to 112
negotiate reimbursement. Upon receipt of such notice, the health 113
plan issuer shall attempt a good faith negotiation with the 114
provider, facility, emergency facility, or ambulance. 115

(C) (1) For unanticipated out-of-network care provided at 116
an in-network facility in this state, a provider shall not bill 117
a covered person for the difference between the health plan 118
issuer's reimbursement and the provider's charge for the 119
services. 120

(2) For emergency services provided at an out-of-network 121
emergency facility in this state, neither the emergency facility 122
nor an out-of-network provider shall bill a covered person for 123
the difference between the health plan issuer's reimbursement 124
and the emergency facility's or the provider's charge for the 125
services. 126

(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. 127
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(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. 132
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(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. 139
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(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: 143
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(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: 148
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(a) The provider informs the covered person that the provider is not in the covered person's health benefit plan network. 153
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(b) The provider provides to the covered person a good 156
faith estimate of the cost of the services, including the 157
provider's charge, the estimated reimbursement by the health 158
plan issuer, and the covered person's responsibility. The 159
estimate shall contain a disclaimer that the covered person is 160
not required to obtain the health care service at that location 161
or from that provider. 162

(c) The covered person affirmatively consents to receive 163
the services. 164

(2) The health plan issuer may reimburse the provider at 165
either the in-network or out-of-network rate as described in the 166
covered person's health benefit plan. 167

(F) Nothing in this section is subject to section 3901.71 168
of the Revised Code. 169

Sec. 3902.52. (A) (1) If a negotiation undertaken pursuant 170
to division (B) (2) of section 3902.51 of the Revised Code has 171
not successfully concluded within thirty days, or if both 172
parties agree that they are at an impasse, the provider, 173
facility, emergency facility, or ambulance may send a request 174
for arbitration to the superintendent of insurance and shall 175
notify the health plan issuer of its request. To be eligible for 176
arbitration, both of the following must apply: 177

(a) The service in question was provided not more than one 178
year prior to the request. 179

(b) The billed amount exceeds seven hundred fifty dollars, 180
except as provided in division (A) (2) (b) of this section. 181

(2) (a) In seeking arbitration, a provider, facility, 182
emergency facility, or ambulance may bundle up to fifteen claims 183
with respect to the same health benefit plan that involve the 184

same or similar services provided under similar circumstances. 185
Any bundled claims shall be for services using the same coding 186
set and providers of the same license type. 187

(b) A claim that is bundled with other claims may be seven 188
hundred fifty dollars or less so long as the sum of the bundled 189
claims is greater than seven hundred fifty dollars. 190

(B) If arbitration is requested under division (A) of this 191
section, each party shall submit its final offer to the 192
arbitrator. The parties also may submit, and the arbitrator may 193
consider, evidence that relates to the factors described in 194
division (C) of this section if the evidence is in a form that 195
can be verified and authenticated. 196

(C) An arbitrator shall consider all of the following 197
factors in rendering a decision: 198

(1) The in-network rates that other health benefit plans 199
reimburse, and have reimbursed, that particular provider, 200
facility, emergency facility, or ambulance for the service in 201
question, including the factors that went into those rates such 202
as guaranteed patient volume or availability of providers in the 203
provider's, facility's, emergency facility's, or ambulance's 204
geographic area; 205

(2) The in-network rates that the health benefit plan 206
reimburses, or has reimbursed, other providers, facilities, 207
emergency facilities, or ambulances for the service in question 208
in that particular geographic area, including the factors that 209
went into those rates such as guaranteed patient volume or 210
availability of providers in that particular geographic area; 211

(3) If the health plan issuer and the provider, facility, 212
emergency facility, or ambulance have had a contractual 213

relationship in the previous six years, any in-network 214
reimbursement rates previously agreed upon between the issuer 215
and the provider, facility, emergency facility, or ambulance; 216

(4) The results of, or any documents submitted in the 217
course of, a previous arbitration between the parties conducted 218
under this section that the arbitrator considers relevant in 219
rendering a decision. 220

(D) After considering the evidence submitted by the 221
parties pursuant to division (B) of this section and the 222
criteria described in division (C) of this section, the 223
arbitrator shall issue a decision that awards the final offer of 224
either party that best reflects a fair reimbursement rate based 225
upon the factors considered under division (C) of this section. 226

(E) The nonprevailing party shall pay seventy per cent of 227
the arbitrator's fees, and the prevailing party shall pay thirty 228
per cent. 229

(F) A final arbitration decision shall be binding except 230
as to other remedies available at law. 231

(G) Documents and other evidence submitted to an 232
arbitrator under this section are confidential, not public 233
records for the purposes of section 149.43 of the Revised Code, 234
and shall not be released except as authorized pursuant to this 235
division. If release of the evidence is required pursuant to a 236
court order, the arbitrator shall release the evidence pursuant 237
to the court order but shall redact from the evidence released 238
information that constitutes intellectual property, trade 239
secrets, or information requiring redaction pursuant to a rule 240
adopted by the superintendent of insurance. 241

(H) As used in this section, "provider" includes a 242

practice of providers to the extent permitted by rules adopted 243
by the superintendent of insurance under division (D) of section 244
3902.54 of the Revised Code including but not limited to rules 245
adopted regarding the maximum number of providers in a practice. 246

Sec. 3902.53. (A) (1) Except as provided in division (A) (2) 247
of this section, sections 3901.38 to 3901.3814 of the Revised 248
Code shall not apply with respect to a claim during a period of 249
negotiation under section 3902.51 of the Revised Code or a 250
period of arbitration under section 3902.52 of the Revised Code. 251
Sections 3901.38 to 3901.3814 of the Revised Code shall apply 252
upon the completion of a successful negotiation or upon the 253
rendering of an arbitration decision. 254

(2) The superintendent of insurance may adopt rules 255
pursuant to division (D) of section 3902.54 of the Revised Code 256
specifying situations in which sections 3901.38 to 3901.3814 of 257
the Revised Code apply during periods of negotiation under 258
section 3902.51 of the Revised Code. 259

(B) A pattern of continuous or repeated violations of 260
section 3902.51 or 3902.52 of the Revised Code by a health plan 261
issuer is an unfair and deceptive act or practice in the 262
business of insurance under sections 3901.19 to 3901.26 of the 263
Revised Code. 264

(C) A provider who violates section 3902.51 or 3902.52 of 265
the Revised Code shall be subject to professional discipline 266
under Title XLVII of the Revised Code as applicable. 267

Sec. 3902.54. (A) (1) The superintendent of insurance shall 268
contract with a single arbitration entity to perform all 269
arbitrations described in section 3902.52 of the Revised Code. 270
The superintendent shall ensure that the arbitration entity, any 271

<u>arbitrators the arbitration entity designates to conduct an</u>	272
<u>arbitration, and any officer, director, or employee of the</u>	273
<u>arbitration entity do not have any material, professional,</u>	274
<u>familial, or financial connection with any of the following:</u>	275
<u>(a) The health plan issuer involved in a dispute;</u>	276
<u>(b) An officer, director, or employee of the health plan</u>	277
<u>issuer;</u>	278
<u>(c) A provider, facility, emergency facility, ambulance,</u>	279
<u>medical group, or independent practice organization involved</u>	280
<u>with the service in question;</u>	281
<u>(d) The development or manufacture of any principal drug,</u>	282
<u>device, procedure, or other therapy in dispute;</u>	283
<u>(e) The covered person who received the service that is</u>	284
<u>the subject of a dispute or the covered person's immediate</u>	285
<u>family.</u>	286
<u>(2) The superintendent shall require the arbitration</u>	287
<u>entity to do all of the following:</u>	288
<u>(a) Utilize arbitrators who are knowledgeable and</u>	289
<u>experienced in applicable principles of contract and insurance</u>	290
<u>law;</u>	291
<u>(b) Ensure that the arbitrators have access to appropriate</u>	292
<u>specialists including certified coding specialists, physicians,</u>	293
<u>nurses, other clinicians, and health insurance experts as</u>	294
<u>necessary to render a determination;</u>	295
<u>(c) Utilize a secure electronic portal for the submission,</u>	296
<u>processing, and management of arbitration applications;</u>	297
<u>(d) Perform all arbitrations under section 3902.52 of the</u>	298

<u>Revised Code on a flat fee basis.</u>	299
<u>(B) In selecting the arbitration entity with which to</u>	300
<u>contract, the superintendent shall at minimum require a</u>	301
<u>prospective arbitration entity to submit to the superintendent a</u>	302
<u>disclosure containing all of the following accompanied by an</u>	303
<u>application fee prescribed by the superintendent:</u>	304
<u>(1) The name, telephone number, and address of the</u>	305
<u>applicant;</u>	306
<u>(2) If the applicant has issued any outstanding shares</u>	307
<u>that are listed on a national securities exchange or are</u>	308
<u>regularly quoted in an over-the-counter market by one or more</u>	309
<u>members of a national or affiliated securities association, the</u>	310
<u>name of each person holding more than five per cent stock or</u>	311
<u>call or put options in the applicant;</u>	312
<u>(3) The name of each person holding bonds or notes issued</u>	313
<u>by the applicant totaling over one hundred thousand dollars;</u>	314
<u>(4) The name of each entity the applicant controls and the</u>	315
<u>nature and extent of such control, including the nature of the</u>	316
<u>controlled entity's business;</u>	317
<u>(5) The name of each entity in which the applicant has</u>	318
<u>more than five per cent ownership interest, including the nature</u>	319
<u>of the entity's business;</u>	320
<u>(6) The name, contact information, and work history of</u>	321
<u>each director, officer, and executive and any current or</u>	322
<u>previous relationship each of those persons has or had with a</u>	323
<u>health plan issuer, provider, facility, emergency facility,</u>	324
<u>medical group, or independent practice organization;</u>	325
<u>(7) The percentage of revenue the arbitration entity</u>	326

<u>receives from its arbitration services;</u>	327
<u>(8) A description of the applicant's arbitration process,</u>	328
<u>including information about how the applicant will meet the</u>	329
<u>superintendent's standards and how the applicant will avoid</u>	330
<u>conflicts of interest;</u>	331
<u>(9) The fee the applicant would charge for an arbitration.</u>	332
<u>(C)(1) The superintendent shall require the contracted</u>	333
<u>arbitration entity to submit to the superintendent on an annual</u>	334
<u>basis the disclosure described in division (B) of this section.</u>	335
<u>(2) The superintendent shall require the contracted</u>	336
<u>arbitration entity to submit to the superintendent on an annual</u>	337
<u>basis, and the superintendent shall issue, a report containing</u>	338
<u>all of the following:</u>	339
<u>(a) The number of arbitrations conducted under section</u>	340
<u>3902.52 of the Revised Code;</u>	341
<u>(b) The provider type, whether individual, practice,</u>	342
<u>facility, emergency facility, or ambulance, that engaged in the</u>	343
<u>arbitrations;</u>	344
<u>(c) The specialty of the provider engaging in the</u>	345
<u>arbitrations;</u>	346
<u>(d) The out-of-network situation;</u>	347
<u>(e) The percentage of times the arbitrator decides in</u>	348
<u>favor of the health plan issuer versus the provider, facility,</u>	349
<u>emergency facility, or ambulance.</u>	350
<u>(D) The superintendent of insurance shall adopt rules</u>	351
<u>pursuant to Chapter 119. of the Revised Code as necessary to</u>	352
<u>implement sections 3902.50 to 3902.54 of the Revised Code.</u>	353

Rules adopted by the superintendent may relate to the 354
definitions of "provider," "facility," "emergency facility," and 355
"ambulance." The requirements of section 121.95 of the Revised 356
Code do not apply to rules adopted in accordance with this 357
division. 358

Section 2. The requirements of sections 3902.50 to 3902.53 359
of the Revised Code, as enacted in this act, apply beginning 360
nine months following the effective date of this section. In 361
particular, the requirements apply to all health benefit plans 362
regardless of a particular plan's date of origination, issuance, 363
delivery, renewal, or modification. 364