

As Introduced

133rd General Assembly

Regular Session

2019-2020

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.

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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:

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

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(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.

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(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.

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

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

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(1) Medical screening examinations undertaken to determine 18
whether an emergency medical condition exists; 19

(2) Treatment necessary to stabilize an emergency medical 20
condition; 21

(3) Appropriate transfers undertaken prior to an emergency 22
medical condition being stabilized. 23

(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.

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(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:

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(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.

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(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.

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(c) The amount that would be paid under the medicare
program, part A or part B of Title XVIII of the Social Security

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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
emergency facility. 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
following conditions are met: 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
emergency facility the amount of the provider's or facility's 198
final offer. 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: 218

(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

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