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Substitute Bill Comparative Synopsis

Sub. H.B. 388

133rd General Assembly

House Finance

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This table summarizes how I_133_1962-10 differs from I_133_1962-15. It addresses only the topics on which the two versions differ substantively. It does not list topics on which the two bills are substantively the same.

Previous Version (I_133_1962-10)	Latest Version (I_133_1962-15)
Providers, scope	
Applies generally to *individual providers*, facilities in which clinical laboratory services are performed, emergency facilities, and ambulances.	Instead applies to *providers* (whether individual or not), facilities in which clinical laboratory services are performed, emergency facilities, and ambulances. Permits the Superintendent of Insurance to adopt rules relating to the definitions of "provider," "facility," "emergency facility," and "ambulance" *(R.C. 3902.54(D))*.
Reimbursement	
No provision.	Requires the provider, facility, emergency facility, or ambulance to include in the request for reimbursement the proper billing code for the service *(R.C. 3902.51(A)(3)(a))*.
No provision.	Requires the health plan issuer to send the provider, facility, emergency facility, or ambulance its intended reimbursement *(R.C. 3902.51(A)(3)(b))*.

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No provision.	Within the period of time specified by the Superintendent of Insurance in rule, requires the provider, facility, emergency facility, or ambulance to either notify the health plan issuer of its acceptance of the reimbursement or seek to negotiate. Considers failure to timely notify the issuer of an intent to negotiate acceptance of the issuer's reimbursement. *(R.C. 3902.51(A)(3)(b).)*
In determining the required reimbursement, requires the standard out-of-network amount to be determined *without* reduction for out-of-network cost sharing *(R.C. 3902.51(B)(1)(b))*.	Requires this amount to be determined *with* reduction for cost sharing *(R.C. 3902.51(B)(1)(b))*.
Negotiation	
Requires both parties to attempt a good faith negotiation if negotiation is requested by the individual provider, facility, emergency facility, or ambulance *(R.C. 3902.51(B)(2))*.	Requires a health plan issuer to attempt a good faith negotiation if negotiation is requested by the provider, facility, emergency facility, or ambulance *(R.C. 3902.51(B)(2))*.
Arbitration	
Permits the individual provider, facility, emergency facility, or ambulance to seek arbitration if the negotiation has not successfully concluded within 30 days *(R.C. 3902.52(A)(1))*.	Additionally permits the provider, facility, emergency facility, or ambulance to seek arbitration if both parties agree that they are at an impasse *(R.C. 3902.52(A)(1))*.
Allows an individual provider, facility, emergency facility, or ambulance to bundle up to 10 claims that involve the same or similar services provided under similar circumstances *(R.C. 3902.52(A)(2)(a))*.	Raises this cap to 15 claims and additionally requires bundled claims to be for services using the same coding set and providers of the same license type *(R.C. 3902.52(A)(2)(a))*.
Requires the health plan issuer's final offer to be the greatest of the in-network, out-of-network, or Medicare rates *(R.C. 3902.52(B)(1))*.	No provision (either party may submit any amount as its final offer).
Allows parties to submit supporting documents or information *solely* to establish or demonstrate any of the following: ▪ The circumstances, complexity, and severity of the particular case, including the time and place of service;	Allows the parties to submit and the arbitrator to consider evidence relating to the mandatory factors described below if the evidence is in a form that can be verified and authenticated: ▪ The in-network rates that other health benefit plans reimburse, and have

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▪ The usual, customary, and reasonable rate for the service in question; ▪ The amount of the reimbursement required under the bill *(R.C. 3902.52(B)(2))*.	reimbursed, that particular provider, facility, emergency facility, or ambulance for the service in question, including the factors that went into those rates; ▪ The in-network rates that the health benefit plan reimburses, or has reimbursed, other providers, facilities, emergency facilities, or ambulances for the service in question in that particular geographic area, including the factors that went into those rates; ▪ If the health plan issuer and the provider, facility, emergency facility, or ambulance have had a contractual relationship in the previous six years, any in-network reimbursement rates previously agreed upon between the issuer and the provider, facility, emergency facility, or ambulance; ▪ The results of, or any documents submitted in the course of, a previous arbitration between the parties conducted under the bill that the arbitrator considers relevant in rendering a decision. *(R.C. 3902.52(C).)*
Requires the arbitrator to only award one of the party's final offers. In deciding which offer to award, requires the arbitrator to consider all submitted documentation. Allows arbitrator to also require the submission of additional documentation pertaining to the following to determine the accuracy or inaccuracy of the required reimbursement: ▪ The distribution of in-network allowed amounts by the health benefit plan for the service in question in the same geographic area; ▪ The distribution of out-of-network allowed amounts by the health benefit plan for the service in question in the same geographic area;	Requires the arbitrator to award the final offer of the party that best reflects a fair reimbursement rate based upon the factors described in the above bulleted list *(R.C. 3902.52(D))*.

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▪ The Medicare reimbursement rate for the service in question in the same geographic area; ▪ The distribution of billed charges and allowed amounts for all health benefit plans for the service in question in the same geographic area *(R.C. 3902.52(D))*.	
Requires, if arbitration does not commence within 30 days of the request, the health plan issuer to reimburse the individual provider, facility, emergency facility, or ambulance in the amount of that party's final offer *(R.C. 3902.52(C))*.	No provision.
Requires the nonprevailing party to pay 100% of the arbitrator's fees and costs of arbitration *(R.C. 3902.52(E))*.	Requires the nonprevailing party to pay 70% of the arbitrator's fees (not costs of arbitration) and requires the prevailing party to pay 30% *(R.C. 3902.52(E))*.
Specifies that a final arbitration decision is binding and enforceable in a court of law *(R.C. 3902.52(G))*.	Specifies that a final arbitration decision is binding except as to other remedies available at law *(R.C. 3902.52(F))*.
States that documentation submitted by the parties in the course of arbitration is confidential and privileged, is not a public record, and must not be released *(R.C. 3902.52(H))*.	States that documents and other evidence submitted to an arbitrator are confidential, not public records, and must not be released except pursuant to a court order. Requires, in such a case, the arbitrator to redact information constituting intellectual property, trade secrets, or information requiring redaction pursuant to a rule adopted by the Superintendent. *(R.C. 3902.52(G).)*
No provision.	For the purposes of the bill's arbitration provisions, defines "provider" to include a practice of providers to the extent permitted by rules adopted by the Superintendent of Insurance including rules adopted regarding the maximum number of providers in a practice *(R.C. 3902.52(H))*.
Requires any reimbursement and any payment of fees or costs to be paid within ten calendar days following the conclusion of arbitration *(R.C. 3902.52(F))*.	No provision (but see "**Prompt Pay Law**" below).

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Prompt Pay Law	
States that the Prompt Pay Law does not apply during a period of negotiation or arbitration *(R.C. 3902.53(A))*.	Same, for arbitration, but allows the Superintendent to adopt rules specifying situations in which the Prompt Pay Law applies during a period of negotiation. Expressly states that the Prompt Pay Law applies upon the completion of a successful negotiation or upon the rendering of an arbitration decision. *(R.C. 3902.53(A).)*
Superintendent of Insurance	
Permits the Superintendent of Insurance, if a conflict of interest exists in a particular arbitration with respect to the arbitration entity selected for arbitrations generally, to use a different arbitration entity in that particular case *(R.C. 3902.54(A)(2))*.	No provision.
Requires the Superintendent of Insurance to require the arbitration entity to utilize arbitrators who are knowledgeable and experienced in applicable principles of contract and insurance law *and the health care industry to determine the accuracy or inaccuracy of the reimbursement amounts required under the bill (R.C. 3902.54(A)(3)(a))*.	Removes the requirement that the Superintendent utilize arbitrators who are knowledgeable and experienced in the health care industry to determine the accuracy or inaccuracy of the reimbursement amounts required under the bill *(R.C. 3902.54(A)(2)(a))*.
No provision.	Requires a prospective arbitration entity to disclose to the Superintendent the fee the entity plans to charge for an arbitration *(R.C. 3902.54(B)(9))*.
No provision.	Requires the Superintendent to require the contracted entity to submit annually, and requires the Superintendent to issue, a report containing all of the following: ▪ The number of arbitrations conducted under the bill; ▪ The provider type, whether individual, practice, facility, emergency facility, or ambulance, that engaged in the arbitrations;

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	▪ The specialty of the provider engaging in the arbitrations; ▪ The out-of-network situation; ▪ The percentage of times the arbitrator decides in favor of the health plan issuer versus the provider, facility, emergency facility, or ambulance *(R.C. 3902.54(C)(2))*.
Effective date	
States that the bill's requirements apply beginning nine months following the bill's effective date to health benefit plans delivered, issued for delivery, modified, or renewed on or after the bill's effective date, thereby applying on a rolling basis as plans renew.	Applies the bill to all persons and contracts beginning nine months following the bill's effective date, including health benefit plans regardless of a particular plan's date of origination, issuance, delivery, renewal, or modification *(Section 2)*.
Requires a health plan issuer to notify a provider, facility, emergency facility, or ambulance if the bill's requirements do not yet apply to the plan and that the provider, facility, emergency facility, or ambulance may balance bill the covered person. *(Section 2.)*	No provision.