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OHIO LEGISLATIVE SERVICE COMMISSION

Office of Research
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Legislative Budget
Office

H.B. 388
(I_133_1962-10)
133rd General Assembly

Fiscal Note & Local Impact Statement

[Click here for H.B. 388's Bill Analysis](#)

Version: In House Finance

Primary Sponsor: Rep. Holmes

Local Impact Statement Procedure Required: Yes

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Highlights

- The Department of Insurance may have increased administrative costs to monitor and enforce the bill's provisions, including arbitration provisions. Under the bill, a health plan issuer that fails to comply with the bill's requirements is deemed to have engaged in an unfair and deceptive act or practice in the business of insurance, which carries civil penalties. Any revenue from the penalties would depend on health issuers' compliance with the requirement. Any revenue from the penalties would be deposited into the Department of Insurance Operating Fund (Fund 5540). Fund 5540 would also be the source of payment for any departmental costs.
- Requirements imposed on health plan issuers are likely to increase health insurance premiums and costs for self-insured health benefit plans subject to those requirements. This would in turn increase costs to the state and local governments to provide health benefits to their employees and beneficiaries. LBO does not have an estimate of the magnitude of any such cost increases.

Detailed Analysis

The bill defines "unanticipated out-of-network care" as health care services, including clinical laboratory services, that are covered under a health benefit plan and that are provided by an individual out-of-network provider when either: (1) the covered person did not have the ability to request such services from an individual in-network provider, or (2) the services provided were emergency services. The bill also defines "emergency services" as all of the following: (1) medical screening examinations undertaken to determine whether an emergency medical condition exists, (2) treatment necessary to stabilize an emergency medical condition, and (3) appropriate transfers undertaken prior to an emergency medical condition being stabilized. Under the bill, an "emergency facility" means a hospital emergency department or any other facility that provides emergency medical services.

Health plan issuers

The bill requires health plan issuers to reimburse an individual out-of-network provider for unanticipated out-of-network care when both of the following apply: (1) the services are provided to a covered person at an in-network facility, and (2) the services would be covered if provided by an individual in-network provider. The bill also requires health plan issuers to reimburse both an individual out-of-network provider and the emergency facility for emergency services provided to a covered person at an out-of-network emergency facility.¹

The bill requires health plan issuers to reimburse an individual provider, facility, emergency facility, or ambulance service the greatest of the following amounts: (1) the amount negotiated with individual in-network providers, facilities, emergency facilities, or ambulance services for the service in question in that geographic region under that health benefit plan, excluding any in-network cost sharing imposed under the health benefit plan,² (2) 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, or (3) the amount that would be paid under the Medicare Program, Part A or Part B of Title XVIII of the Social Security Act, 42 United States Code (U.S.C.) 1395, as amended, for the service in question, excluding any in-network cost sharing imposed under the health benefit plan.

The bill allows an individual provider, out-of-network emergency facility, and ambulance service to negotiate the reimbursement with a plan issuer, instead of accepting the reimbursement above. Upon receipt of a notice advising the health plan issuer that the provider, facility, or ambulance service wishes to negotiate, the issuer must acknowledge receipt of the notice and both parties must attempt a good faith negotiation.

Health plan issuers are prohibited from requiring cost sharing³ from a covered person for any unanticipated out-of-network care or emergency services at a rate higher than if the services were provided by an in-network provider.

Individual providers and out-of-network emergency facilities

The bill prohibits an individual provider who provides unanticipated out-of-network care at an in-network facility in this state from billing a covered person for the difference between

¹ Comparable requirements apply to health insurers in the case of emergency services provided by an out-of-network ambulance service and to both unanticipated out-of-network and emergency clinical laboratory services. When this fiscal note uses the term “provider,” it refers to these two types of provider as well as individual providers and emergency facilities.

² If there is more than one amount negotiated with individual in-network providers, facilities, emergency facilities, or ambulance services for the service, the relevant amount must be the median of those amounts, excluding any in-network cost sharing imposed under the health benefit plan.

³ The bill defines “cost sharing” as the cost to an individual covered under a health benefit plan according to any copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by a health benefit plan.

the health plan issuer's reimbursement and the individual provider's charge for the services (generally known as "surprise billing"). The bill also prohibits surprise billing in the case of an individual provider who provides emergency services at an out-of-network facility.

The bill prohibits an out-of-network individual provider who provides health care services that are covered under a health benefit plan (that are not unanticipated out-of-network care or emergency services) at an in-network facility in this state from surprise billing the covered person, unless certain conditions are met.

The bill prohibits an out-of-network emergency facility or an out-of-network ambulance service from surprise billing a covered person. A similar prohibition applies to clinical laboratories' surprise billing for unanticipated out-of-network or emergency services provided.

Arbitration

The bill specifies eligibility for arbitration. If negotiations mentioned above have not concluded within 30 days, the individual provider, facility, emergency facility, or ambulance service may send a request for arbitration to the Superintendent of Insurance. That provider must notify the health plan issuer of the request if the request meets certain conditions for an arbitration. The bill specifies provisions governing a provider's seeking arbitration to bundle up to ten claims with respect to the same health benefit plan. The provider must submit its final offer to the arbitrator.

The health plan issuer is required to submit as its final offer the greatest of the three reimbursement amounts described above. The bill requires the health plan issuer to reimburse the provider the amount of the provider's final offer, if arbitration does not commence within 30 days of the initial request. An arbitrator is required to only award either party's final offer. The nonprevailing party is required to pay all the arbitrator's fees and the costs of arbitration within ten calendar days of the arbitration decision.

Superintendent of Insurance

The bill requires the Superintendent to contract with a single arbitration entity to perform all arbitrations under the bill. The Superintendent must also ensure that the arbitration entity, any arbitrators the arbitration entity designates to conduct an arbitration, and any officer, director, or employee of the arbitration entity do not have any material, professional, familial, or financial connection with: (1) the health plan issuer involved in a dispute, (2) an officer, director, or employee of the health plan issuer, (3) an individual provider, facility, emergency facility, ambulance, medical group, or independent practice organization involved with the service in question, (4) the development or manufacture of any principal drug, device, procedure, or other therapy in dispute, and (5) the covered person who received the service that is the subject of a dispute or the covered person's immediate family. The bill also requires the Superintendent to adopt rules as necessary to implement the bill's arbitration provisions.

Other provisions

The bill specifies that the existing requirements related to prompt payments to health care providers do not apply with respect to a claim during a period of negotiation or arbitration. The bill specifies that a pattern of continuous or repeated violations of its provisions is considered an unfair and deceptive act or practice in the business of insurance, potentially subjecting the violator to penalties including payment of damages, a limitation or suspension of

the violator's ability to engage in the business of insurance, and an investigation by the Attorney General. An individual provider who violates the bill's requirements is subject to applicable professional discipline under Title XLVII of the Revised Code.

The bill includes a provision that exempts its requirements from the existing requirement related to mandated health benefits. Under current law, no mandated health benefits legislation enacted by the General Assembly after January 14, 1993, may be applied to sickness and accident or other health benefits policies, contracts, plans, or other arrangements until the Superintendent of Insurance determines that the provision can be applied fully and equally in all respects to employee benefit plans subject to regulation by the federal Employee Retirement Income Security Act of 1974 (ERISA) and employee benefit plans established or modified by the state or any political subdivision of the state or by any agency or instrumentality of the state or any political subdivision of the state.

The bill also specifies the effective date of the requirements.

Fiscal effect

The bill may increase the Department of Insurance's administrative costs to ensure that health plan issuers comply with the bill's requirements, including arbitration provisions. However, LBO staff are uncertain about the magnitude of any such increase. Under the bill, a health plan issuer that fails to comply with the bill's requirements is deemed to have engaged in an unfair and deceptive act or practice in the business of insurance, which carries civil penalties; under continuing law, the Department may impose between \$3,500 and \$10,000 for each unfair or deceptive act or practice in the business of insurance in the state. Any revenue from the penalties would depend on health issuers' compliance with the bill's requirements, and could be used to offset the Department's administrative costs. Any revenue from the penalties would be deposited into the Department's Operating Fund (Fund 5540); Fund 5540 also would be the source of funding for any administrative costs.

The requirements imposed on health insurers, especially the required payments and the prohibition against increasing cost sharing by covered individuals, are likely to increase health insurers' costs. In addition, health insurers would likely incur some costs from paying arbitration fees. These cost increases in turn would likely increase health insurance premiums and the costs to the state and local governments to provide health benefits to their employees and beneficiaries. Currently, the state employee health benefit plans (Ohio Med PPO and Ohio Med HDHP) require different in-network and out-of-network costs associated with annual deductibles, copayments, coinsurance, and maximum out-of-pocket expenses, and covered persons under the two plans may be subject to balance billing. LBO staff could not determine the magnitude of the fiscal impact to local governments due to lack of information related to cost sharing under local governments' employee health benefit plans.

Synopsis of Fiscal Effect Changes

The substitute bill (I_133_1962-10) makes various changes that do not significantly change the fiscal effects in the As Introduced version. Some changes do have potentially significant fiscal effects, including: (1) the expansion of the health insurer reimbursement requirements for unanticipated out-of-network care and emergency care provided by clinical laboratory services, (2) the expansion of the health insurer reimbursement requirements to reimburse emergency services provided by an out-of-network ambulance service, (3) the

introduction of a role for the Superintendent of Insurance in arbitrations, and (4) the change from a nonprevailing party to an arbitration paying 70% of the costs of arbitration to paying 100% of those costs. The first two items in this list would tend to increase costs for the state and local governments by an uncertain magnitude as compared with the As Introduced bill, while the last item may increase or decrease such costs, depending on the likelihood of the state and local governments being the prevailing party in an arbitration. The third item would likely increase costs for the Department of Insurance paid from Fund 5540.