OHIO LEGISLATIVE SERVICE COMMISSION

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Office of Research and Drafting

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**H.B. 388**
**133rd General Assembly**

# Bill Analysis

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**Version:** As Passed by the House

**Primary Sponsor:** Rep. Holmes

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## SUMMARY

- Requires an insurer to reimburse:
  - An out-of-network provider for unanticipated out-of-network care provided at an in-network facility;
  - An out-of-network provider or emergency facility for emergency services provided at an out-of-network emergency facility;
  - An out-of-network ambulance for emergency services provided in an out-of-network ambulance;
  - An out-of-network provider or facility for clinical laboratory services provided in connection with unanticipated out-of-network care or emergency services.
- Prohibits a provider, facility, emergency facility, or ambulance from balance billing a patient for unanticipated or emergency care as described above when that care is provided in Ohio.
- Provides that a covered person's cost-sharing responsibility for the services described above cannot be greater than if the services were provided in network.
- Establishes the default reimbursement rate as the greatest of the in-network rate, the out-of-network rate, or the Medicare rate and establishes procedures by which payees (providers, facilities, emergency facilities, and ambulances) may seek to negotiate the reimbursement in lieu of the default reimbursement rate.
- Permits certain payees to seek arbitration if negotiation is unsuccessful, establishes criteria to be eligible for arbitration, and establishes procedures for the conduct of the arbitration.
- Requires the Superintendent of Insurance to select an arbitration entity to conduct arbitrations under the bill using specified criteria.

- Requires a provider to disclose certain information to patients regarding the cost of out-of-network services that are not unanticipated out-of-network care or emergency services.
- Subjects payees and insurers to penalties for failure to comply with the bill's requirements.
- Delays the bill's requirements until nine months following the bill's effective date.

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# DETAILED ANALYSIS

## Unanticipated and emergency out-of-network care

### Unanticipated out-of-network care at an in-network facility

The bill requires a health plan issuer to reimburse an out-of-network provider for unanticipated out-of-network care when the care is provided to a person at an in-network facility and the services would be covered if provided by an in-network provider.

Under the bill, "**unanticipated out-of-network care**" means health care services, including clinical laboratory services, that are provided under a health benefit plan and that are provided by an out-of-network provider when either of the following applies:

- The covered person did not have the ability to request such services from an in-network provider.
- The services provided were emergency services.

A provider network might include a facility but not certain providers at that facility. In certain situations, such as those involving unexpected services that are needed while a person is under general anesthesia or medical emergencies, covered persons are not always able to request only in-network providers give them care. Under existing law, if a person receives such unanticipated or emergency care at an in-network facility by an out-of-network provider, the issuer might not reimburse the provider (some plans allow for such reimbursement, but others do not), meaning the covered person must pay the entire cost of the services. Under the bill, for care provided in Ohio, the provider is prohibited from billing the patient for the difference between the issuer's reimbursement and the provider's charge (balance billing).[1]

### Emergency care at an out-of-network facility or in an out-of-network ambulance

Similar requirements apply in the case of emergency care received at an out-of-network emergency facility or in an out-of-network ambulance: the issuer must reimburse the facility or ambulance and any out-of-network providers at the facility or in the ambulance, and, for care provided in Ohio, neither the facility, ambulance, nor the providers may balance bill a patient.[2]

### Clinical laboratory services

The bill also requires a health plan issuer to reimburse any out-of-network provider and any out-of-network facility for clinical laboratory services that are provided in connection with any unanticipated out-of-network care or any emergency care at an out-of-network facility and prohibits the laboratory from balance billing the patient.[3]

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[1] R.C. 3902.50(G) and 3902.51(A)(1)(a) and (C)(1).

[2] R.C. 3902.51(A)(1)(b) and (c) and (C)(2) and (3).

[3] R.C. 3902.51(A)(2) and (C)(4).

### Cost sharing

The bill further provides that a covered person's cost-sharing responsibility for the services described above cannot be greater than if the services were provided in network.[4]

### Enforcement

A pattern of continuous or repeated violations of these provisions, or the provisions described below under "**Other out-of-network care**," by a health plan issuer 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.[5]

The bill subjects a provider who violates the bill's provisions to professional discipline, which could include suspension of the person's license to practice or other penalties.[6]

## Reimbursement

Under the bill, unless the provider, facility, emergency facility, or ambulance (collectively the "payee") wishes to negotiate reimbursement (see "**Negotiation**" below), the reimbursement described under "**Unanticipated and emergency out-of-network care**" above must be the greatest of the following three amounts:

- The median amount the health plan issuer negotiated with in-network payees for the service in question in that geographic region;
- The rate the health plan issuer pays for out-of-network services under the health benefit plan; or
- The rate paid by Medicare for the service in question.[7]

In a request for reimbursement, the payee must include the proper billing code for the service in question. The bill requires the health plan issuer to send the payee its intended reimbursement. And it further requires the payee, within the period of time specified by the Superintendent of Insurance in rule, to either notify the health plan issuer of its acceptance of the reimbursement or seek to negotiate. Failure to timely notify the issuer of an intent to negotiate is considered acceptance of the issuer's reimbursement.[8]

[4] R.C. 3902.51(D).

[5] R.C. 3902.53(B); R.C. 3901.19 to 3901.26, not in the bill.

[6] R.C. 3902.53(C).

[7] R.C. 3902.51(B)(1).

[8] R.C. 3902.51(A)(3).

# Negotiation

The payee may initiate negotiations with the health plan issuer in lieu of accepting the reimbursement described above. To do so, the payee must notify the issuer of its desire to negotiate. Upon receiving the notice, the issuer must attempt a good faith negotiation. While the laws requiring prompt payments by issuers generally do not apply during a period of negotiation, the Superintendent is permitted to adopt rules specifying situations in which those laws do apply. If negotiations have not concluded within 30 days, or if both parties agree that they are at an impasse, the payee may request arbitration by sending a request to the Superintendent of Insurance and notifying the issuer of the request (see "**Arbitration**" below).[9]

# Arbitration

## Eligibility

To be eligible for arbitration, the service in question must have been provided not more than one year prior to the request. In addition, the billed amount must exceed $750 unless the claim is bundled as described below, in which case an individual claim may be less than $750 so long as all claims together total more than $750. In seeking arbitration, a payee may bundle up to 15 claims with respect to the same health benefit plan that involve the same or similar services provided under similar circumstances (using the same coding set and providers of the same license type). During the period of arbitration, the laws that require prompt payments by issuers are suspended with regard to that claim.

The arbitration provisions apply to a practice of providers to the extent permitted by rules adopted by the Superintendent, including rules adopted regarding the maximum number of providers in a practice.[10]

## Award, factors

The bill requires each party to submit its final offer to the arbitrator. The parties may also submit, and the arbitrator may consider, evidence relating to the factors below if the evidence is in a form that can be verified and authenticated. The arbitrator must consider the following factors:

- The in-network rates that other health benefit plans reimburse, and have reimbursed, that particular payee for the service in question, including the factors that went into those rates such as guaranteed patient volume or availability of providers in the payee's geographic area;
- The in-network rates that the health benefit plan reimburses, or has reimbursed, other payees for the service in question in that particular geographic area, including the

[9] R.C. 3902.51(B)(2), 3902.52(A)(1), and 3902.53(A).

[10] R.C. 3902.52(A) and (H) and 3902.53(A).

factors that went into those rates such as guaranteed patient volume or availability of providers in that particular geographic area;

- If the health plan issuer and the payee have had a contractual relationship in the previous six years, any in-network reimbursement rates previously agreed upon between the issuer and the payee;
- 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.

The arbitrator may only award either party's final offer, specifically, the offer that best reflects a fair reimbursement rate based upon the factors in the above paragraph. A final arbitration decision is binding except as to other remedies available at law.

The nonprevailing party must pay 70% of the arbitrator's fees, and the prevailing party must pay the remaining 30%.[11]

### Confidentiality

Under the bill, documents and other evidence submitted to an arbitrator are confidential, not public records, and must not be released except pursuant to a court order. In that case, the arbitrator must redact information constituting intellectual property, trade secrets, or information requiring redaction pursuant to a rule adopted by the Superintendent.[12]

## Other out-of-network care

If a health care service is covered under a health benefit plan, is not unanticipated or emergency in nature, and is provided by an out-of-network provider at an in-network facility, then all of the following apply under the bill:

- For care provided in Ohio, the provider may not balance bill the patient unless all of the following conditions are met:
  - The provider informs the covered person that the provider is not in-network.
  - The provider provides to the covered person a good faith estimate of the cost of the services, including the provider's charge, the estimated reimbursement by the health plan issuer, and the covered person's responsibility. The estimate must contain a disclaimer that the covered person is not required to obtain the health care service at that location or from that provider.
  - The covered person affirmatively consents to receive the services.

[11] R.C. 3902.52(B) to (F).

[12] R.C. 3902.52(G).

- The health plan issuer must reimburse the provider at either the in-network or out-of-network rate as described in the covered person's health benefit plan.[13]

# Location of care

The requirements placed on health plan issuers and health benefit plans apply regardless of where the unanticipated or emergency out-of-network care is received, while the requirements placed on providers, facilities, emergency facilities, and ambulances apply only to care received in Ohio. However, an out-of-state provider, facility, emergency facility, or ambulance may seek arbitration in Ohio.[14]

# Arbitration entity

## No conflicts of interest

The bill requires the Superintendent of Insurance to contract with a single arbitration entity to perform all arbitrations. The Superintendent must ensure that the arbitration entity, any arbitrators it designates to conduct an arbitration, and any officer, director, or employee do not have any material, professional, familial, or financial connection with any of the following:

- The health plan issuer involved in a dispute;
- An officer, director, or employee of the health plan issuer;
- A provider, facility, emergency facility, ambulance, medical group, or independent practice organization involved with the service in question;
- The development or manufacture of any principal drug, device, procedure, or other therapy in dispute;
- The covered person who received the service that is the subject of a dispute or the covered person's immediate family.[15]

## Features

Under the bill, the Superintendent must require the arbitration entity to do all of the following:

- Utilize arbitrators who are knowledgeable and experienced in applicable principles of contract and insurance law;
- Ensure that the arbitrators have access to appropriate specialists including certified coding specialists, physicians, nurses, other clinicians, and health insurance experts as necessary to render a determination;

[13] R.C. 3902.51(E).

[14] R.C. 3902.51 and 3902.52.

[15] R.C. 3902.54(A)(1).

- Utilize a secure electronic portal for the submission, processing, and management of arbitration applications;
- Perform all arbitrations on a flat fee basis.[16]

## Disclosures and reports

### On application to be the arbitration entity

In selecting the arbitration entity with which to contract, the Superintendent must at minimum require a prospective arbitration entity to submit to the Superintendent a disclosure containing all of the following accompanied by an application fee prescribed by the Superintendent:

- The name, telephone number, and address of the applicant;
- If the applicant has issued any outstanding shares that are listed on a national securities exchange or are regularly quoted in an over-the-counter market by one or more members of a national or affiliated securities association, the name of each person holding more than 5% stock or call or put options in the applicant;
- The name of each person holding bonds or notes issued by the applicant totaling over $100,000;
- The name of each entity the applicant controls and the nature and extent of such control, including the nature of the controlled entity's business;
- The name of each entity in which the applicant has more than 5% ownership interest, including the nature of the entity's business;
- The name, contact information, and work history of each director, officer, and executive and any current or previous relationship each of those persons has or had with a health plan issuer, provider, facility, emergency facility, medical group, or independent practice organization;
- The percentage of revenue the arbitration entity receives from its arbitration services;
- A description of the applicant's arbitration process, including information about how the applicant will meet the Superintendent's standards and how the applicant will avoid conflicts of interest;
- The fee the applicant would charge for an arbitration.[17]

### Annual

After the Superintendent contracts with an arbitration entity, the Superintendent must require it to submit the above disclosure on an annual basis. In addition, the Superintendent

[16] R.C. 3902.54(A)(2).

[17] R.C. 3902.54(B).

must require the contracted entity to submit information as necessary for the Superintendent to issue a report containing all of the following on an annual basis:

- The number of arbitrations conducted;
- The provider type, whether individual, practice, facility, emergency facility, or ambulance, that engaged in the arbitrations;
- 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 payee.[18]

## Superintendent's rules

The Superintendent may adopt rules as necessary to implement the provisions of the bill. These rules may relate to the definitions of "provider," "facility," "emergency facility," and "ambulance." The bill exempts these rules from the continuing requirement that for every new rule, an agency must remove at least two existing rules.[19]

## Exemption from review by the Superintendent of Insurance

The bill's provisions requiring reimbursement might be considered a mandated health benefit. Under R.C. 3901.71, if the General Assembly enacts a provision for mandated health benefits, that provision cannot be applied to any health benefit plan 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),[20] and to employee benefit plans established or modified by the state or any of its political subdivisions. ERISA appears to preempt any state regulation of such plans.[21]

The bill contains provisions that exempt its requirements from this restriction.[22]

## Effective date

The bill's requirements take effect nine months following its effective date. During this period, neither payees nor health plan issuers are subject to its provisions. They become subject to its provisions beginning nine months after the effective date.[23]

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[18] R.C. 3902.54(C).

[19] R.C. 3902.54(D); R.C. 121.95, not in the bill.

[20] 29 United States Code (U.S.C.) 1001.

[21] 29 U.S.C. 1144.

[22] R.C. 3902.51(F).

[23] Section 2 of the bill.

## Definitions

The bill uses the following definitions:

"**Ambulance**" means any motor vehicle that is used, or is intended to be used, for the purpose of responding to emergency medical situations, transporting emergency patients, and administering emergency medical services to patients before, during, or after transportation.[24]

"**Clinical laboratory services**" means either of the following, but does not include the mere collection or preparation of specimens:

- Any examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment or for the assessment of health;
- Procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body.[25]

"**Cost sharing**" means the cost to a covered person under a health benefit plan according to any copayment, coinsurance, deductible, or other out-of-pocket expense requirement.[26]

"**Emergency facility**" means a hospital emergency department or any other facility that provides emergency medical services.[27]

"**Emergency services**" means all of the following:

- Medical screening examinations undertaken to determine whether an emergency medical condition exists;
- Treatment necessary to stabilize an emergency medical condition;
- Appropriate transfers undertaken prior to an emergency medical condition being stabilized.[28]

"**Health benefit plan**" means, subject to certain exceptions, a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.[29]

"**Health plan issuer**" means an entity subject to the Ohio Insurance Laws and rules, or subject to the jurisdiction of the Superintendent of Insurance, that contracts, or offers to

[24] R.C. 3902.50(A); R.C. 4765.01, not in the bill.

[25] R.C. 3902.50(B); R.C. 4731.65, not in the bill.

[26] R.C. 3902.50(C).

[27] R.C. 3902.50(E); R.C. 3701.74, not in the bill.

[28] R.C. 3902.50(F); 42 U.S.C. 1395dd.

[29] R. C. 3902.50(D); R.C. 3922.01, not in the bill.

contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan. "Health plan issuer" includes health insuring corporations, sickness and accident insurers, public employee benefit plans, self-funded multiple employer welfare arrangements, and third-party administrators such as pharmacy benefit managers.[30]

# COMMENT

The application of the bill's provisions to health benefit plans that have not yet been renewed or modified following the bill's effective date raises questions under the Contracts Clauses of the U.S. and Ohio Constitutions, which prohibit the General Assembly from enacting laws that impair existing contractual obligations. These prohibitions are not absolute, however. They do not absolutely prevent a state from abridging contractual obligations when exercising its police power and passing laws for the protection of public health, safety, and welfare.

Rather, they prohibit a "substantial" impairment of existing contractual obligations unless the state can *justify the impairment on the basis of an overriding public interest and the impairing measure is appropriately tailored to serve that interest*. The more substantial the impairment, the more closely a court will scrutinize the law. In looking at whether an impairment is substantial, courts look to (1) the extent to which reasonable expectations in the contract are disrupted and (2) whether a party has relied on an obligation that is impaired by legislation, such as when the legislation impairs the express terms of a contract.[31]

# HISTORY

| Action | Date |
|---|---|
| Introduced | 11-05-19 |
| Reported, H. Finance | 05-20-20 |
| Passed House (95-0) | 05-20-20 |

H0388-PH-133/ar

[30] R.C. 3902.50(D); R.C. 3922.01, not in the bill.

[31] U.S. Constitution, Article I, Section 10; Ohio Constitution, Article II, Section 28; *Westfield Ins. Co. v. Galatis*, 100 Ohio St.3d 216, 2003-Ohio-5849; *City of Middletown v. Ferguson*, 25 Ohio St.3d 71 (1986), *cert. denied, Sticklen v. Middletown*, 479 U.S. 1034 (1987); and *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234 (1978).