



www.lsc.ohio.gov

OHIO LEGISLATIVE SERVICE COMMISSION

Office of Research
and Drafting

Legislative Budget
Office

H.B. 388
133rd General Assembly

Fiscal Note & Local Impact Statement

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

Version: As Passed by the Senate

Primary Sponsor: Rep. Holmes

Local Impact Statement Procedure Required: Yes

Ruhaiza Ridzwan, Senior Economist

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 plan 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 out-of-network provider when either: (1) the covered person did not have the ability to request such services from an 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 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 in-network provider. The bill also requires health plan issuers to reimburse both an 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 send a provider, facility, emergency facility, or ambulance its intended reimbursement, which is the greatest of the following amounts: (1) the amount negotiated with in-network providers, facilities, emergency facilities, or ambulance 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. Within the period of time specified by the Superintendent of Insurance in rule, the provider, emergency facility, and ambulance must either notify the health plan issuer of its acceptance of the reimbursement mentioned above or seek to negotiate the reimbursement with a plan issuer. Upon receipt of such notice, the health plan issuer must attempt a good faith negotiation with the provider, facility, emergency facility, or ambulance.

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.

Providers, facilities, emergency facilities, and ambulance

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

¹ Comparable requirements apply to health insurers in the case of emergency services provided by an out-of-network ambulance and to both unanticipated out-of-network and emergency clinical laboratory services.

² If there is more than one amount negotiated with in-network providers, facilities, emergency facilities, or ambulance 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 a covered person 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 bill prohibits an out-of-network 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 from surprise billing a covered person. A similar prohibition applies to clinical laboratories' surprise billing for unanticipated out-of-network or emergency services provided.

The bill requires the provider, facility, emergency facility, or ambulance to include the proper billing code for the service for which reimbursement is requested from a health plan issuer.

Arbitration

The bill specifies eligibility for arbitration. If negotiations mentioned above have not successfully concluded within 30 days, or if both parties agree that they are at an impasse, the provider, facility, emergency facility, or ambulance may send a request for arbitration to the Superintendent of Insurance. That provider must also notify the health plan issuer of the request, and the request must meet certain conditions to be eligible for an arbitration. The bill specifies provisions governing a provider's seeking arbitration to bundle up to 15 claims with respect to the same health benefit plan that involve the same or similar services provided under similar circumstances. Each party in the arbitration must submit its final offer to the arbitrator. The bill provides that arbitration parties are allowed to submit, and the arbitrator may consider, evidence that relates to certain factors specified under the bill if the evidence is in a form that can be verified and authenticated.

The bill specifies that an arbitrator must consider specified factors under the bill in rendering a decision. An arbitrator is required to award either party's final offer that best reflects a fair reimbursement rate based upon the factors specified under the bill. The nonprevailing party is required to pay 70% of the arbitrator's fees and the prevailing party must pay the remaining 30%.

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 specified parties to the arbitration. The bill specifies requirements related to selection of and contract with an arbitration entity. The bill specifies that the Superintendent must require the contracted arbitration entity to submit to the Superintendent on an annual basis specified information. The bill also requires the Superintendent to issue an annual report containing such information. The bill requires the Superintendent to adopt rules as necessary to implement the bill's 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. However, they apply upon the completion of a successful negotiation or upon the rendering of

an arbitration decision. The bill allows the Superintendent to adopt rules specifying situations in which the existing requirements related to prompt payments to health care providers apply during periods of negotiation. 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 plan 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.

The bill would have little to no fiscal effect on the state or local governments after 2021 because the federal requirements specified under the No Surprises Act, enacted under H.R. 133 of the 116th Congress during December of 2020, would take effect beginning in 2022. After 2021 most, or all, of the costs of the bill would have arisen from the federal legislation with or without H.B. 388.