



www.lsc.ohio.gov

# OHIO LEGISLATIVE SERVICE COMMISSION

Office of Research  
and Drafting

Legislative Budget  
Office

**S.B. 198**  
**133<sup>rd</sup> General Assembly**

## Bill Analysis

**Version:** As Introduced

**Primary Sponsor:** Sen. Huffman

Nick Thomas, Research Associate

### SUMMARY

- Imposes requirements related to billing for unanticipated out-of-network care.
- Prohibits providers that provide unanticipated out-of-network care from billing patients for the difference between the amount charged by the provider and the reimbursement proposed by the health plan issuer.
- Requires a health plan issuer, within 30 days of receiving a claim for unanticipated out-of-network care, to either pay the provider or enter into negotiations regarding the claim.
- Allows, if negotiations are unsuccessful after 60 days, either party to request binding arbitration for claims that exceed \$700 or, under certain circumstances, are \$700 or less but aggregate to exceed \$700.
- Requires health plan issuers to issue a directory of health care providers for each plan issued by the issuer.

### TABLE OF CONTENTS

Overview .....	2
Application of the bill.....	2
Surprise billing prohibited.....	3
Arbitration.....	4
Request for arbitration.....	4
By either party .....	4
Provider bundling of similar claims .....	5
Notice of request, objection to bundling .....	5
Arbitration process.....	5

Negotiations in lieu of arbitration .....	7
Alternative reimbursement.....	7
Intentionally choosing out-of-network care.....	7
Does not apply to Medicaid .....	8
Superintendent of Insurance .....	8
Benchmarking database .....	8
Rules .....	8
Health care provider directory .....	9
Effective dates.....	10
Definitions.....	10

## **DETAILED ANALYSIS**

### **Overview**

The bill enacts new requirements related to billing for unanticipated out-of-network care, commonly referred to as “surprise billing.” Unanticipated out-of-network care, as defined by the bill, is when a person covered by a health benefit plan unwittingly receives medical services from a health care provider that is out-of-network when either of the following applies:

- The patient did not have the ability to request such services from an in-network provider;
- The services provided were emergency services.<sup>1</sup>

To provide an illustrative example of unanticipated out-of-network care, consider a person who undergoes knee replacement surgery. The person chooses to have the operation performed at a health care facility that is in-network under the person’s health benefit plan. The doctor that is going to perform the surgery is also considered in-network. When the operation is actually performed, however, the anesthesiologist that is working at the facility that day does not have a contract with the patient’s health plan issuer and is considered out-of-network. Because the anesthesiologist and the health benefit plan do not have a reimbursement contract, the anesthesiologist bills the patient directly for the services provided. This would be considered unanticipated out-of-network care under the bill.

### **Application of the bill**

Ohio health insuring corporations, sickness and accident insurers, public employee benefit plans, and multiple employer welfare arrangements are required to comply with the bill’s requirements. Also, any person that provides a health care service at a facility in Ohio is

---

<sup>1</sup> R.C. 3902.50(F).

subject to the bill. A “health care service” is any services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.<sup>2</sup>

The following table provides a breakdown of when the bill’s requirements would apply.

Type of service	Required to be covered by bill
Standard services providers that the patient did not knowingly choose at in-network facility	Yes
Emergency services providers at an in-network facility	Yes
Out-of-network standard services providers that the patient <i>knowingly</i> chose at an in-network facility	No
Emergency services provided at an out of-network facility	No

In summary, a patient that knowingly chooses an out-of-network provider at an in-network facility or a patient that receives emergency services at an out-of-network facility would *not* be covered by the bill and could be responsible for the cost of all services received.<sup>3</sup>

Also note that continuing law requires certain health benefit plans to cover emergency services, regardless of whether or not the facility where the services are provided is in-network. Plans issued by sickness and accident insurers are required to cover *all* emergency services. Plans issued by health insuring corporations cover emergency services provided at an out-of-network facility when the patient is unable to knowingly choose that facility. For example, if a person were in a car accident, rendered unconscious, and transported to the nearest hospital, then that person’s health benefit plan is required to cover the services provided to such a person, regardless of whether or not the hospital in question is in-network.<sup>4</sup> Multiple employer welfare arrangements and public employee benefit plans do not appear to be required to provide coverage for *any* emergency services provided at out-of-network facilities.

## Surprise billing prohibited

When a provider provides unanticipated out-of-network care at an in-network facility in Ohio, that provider is required by the bill to file a claim for reimbursement with the covered

<sup>2</sup> R.C. 3902.50(B) and R.C. 3922.01, not in the bill.

<sup>3</sup> R.C. 3902.50(F)(2) and 3902.51(A), (B), and (C).

<sup>4</sup> R.C. 1753.28 and 3923.65, not in the bill.

person's health plan issuer. Upon receiving such a claim, or upon receiving a claim from a provider of out-of-network care at an in-network facility in another state, the health plan issuer must, within 30 days, either pay the claim or attempt to negotiate reimbursement with the provider.<sup>5</sup> Regarding care provided at an Ohio in-network facility, the health care provider is then prohibited from billing the patient for the difference between the amount charged by the provider and the reimbursement offered by the health plan issuer.<sup>6</sup>

The following miscellaneous requirements would also apply to unanticipated out-of-network care:

- Ohio's Prompt Pay requirements do not apply during the negotiation period.<sup>7</sup>
- A health plan issuer is prohibited from requiring cost sharing for unanticipated out-of-network care at a rate higher than if the care were provided by an in-network provider.<sup>8</sup>
- The bill's requirements related to unanticipated out-of-network care are not to be considered a mandate and are not subject to provisions of existing law prohibiting them from being implemented until the Superintendent of Insurance can determine whether or not they apply equally to health benefit plans that are subject to federal oversight.<sup>9</sup>

## **Arbitration**

### **Request for arbitration**

#### **By either party**

If a negotiated reimbursement cannot be reached within 60 days, either the health plan issuer or the provider may file a request with the Superintendent for binding arbitration to determine the reimbursement amount on a per claim basis if either of the following applies:

- The claim exceeds \$700;
- The provider has filed two or more claims for which no reimbursement was agreed upon, each of which is \$700 or less but together total more than \$700. If the requesting party desires to bundle claims in this manner, then the party must do so as part of its initial request.<sup>10</sup>

---

<sup>5</sup> R.C. 3902.51(A) and (B).

<sup>6</sup> R.C. 3902.51(C).

<sup>7</sup> R.C. 3902.51(B) and R.C. 3901.38 to 3901.3814, not in the bill.

<sup>8</sup> R.C. 3902.51(E).

<sup>9</sup> R.C. 3902.51(F) and R.C. 3901.71, not in the bill.

<sup>10</sup> R.C. 3902.52(A)(1).

### **Provider bundling of similar claims**

A provider requesting arbitration may bundle similar claims into one arbitration proceeding if the claims together total more than \$700, but this manner of bundling must be done as a part of the initial request. “Similar claims” means claims that are from the same individual provider, the individual provider’s medical group, or the individual provider’s independent practice organization, that are sent to the same health plan issuer, and are any of the following:

- Of a similar medical nature;
- Subject to denial by the health plan issuer for similar reasons;
- Otherwise materially similar.<sup>11</sup>

### **Notice of request, objection to bundling**

The party requesting arbitration is required to notify the other party that it has requested arbitration. The notice must state the party’s final offer. If the party is bundling claims as described above, the notice is to state the party’s final offer for each claim. In response to this notice, the nonrequesting party is to inform the requesting party of *its* final offer before the arbitration commences. If the requesting party bundled claims, the nonrequesting party must state its final offer for each claim.<sup>12</sup>

The nonrequesting party may object to the bundling of claims as not meeting the requirements described above by informing the requesting party and the arbitrator of its objection before the arbitration commences. If such an objection is timely made, the arbitrator is required to promptly decide whether the bundling of claims was proper. If the nonrequesting party does not timely object to the bundling, the arbitrator is required to allow the bundling. If the arbitrator decides that the bundling was improper in whole or in part, the arbitrator must inform the Superintendent and the parties, and the Superintendent is to appoint additional arbitrators as appropriate. The ten-day period for appointing arbitrators described above is deemed to begin again when the Superintendent receives the arbitrator’s decision disallowing the bundling.<sup>13</sup>

### **Arbitration process**

The bill requires the Superintendent to appoint an arbitrator within ten days of such a request being made, and the arbitrator must make a decision and provide that decision in writing to all parties and to the Superintendent within 30 days after the arbitrator’s appointment.<sup>14</sup>

---

<sup>11</sup> R.C. 3902.52(A)(2).

<sup>12</sup> R.C. 3902.52(B).

<sup>13</sup> R.C. 3902.53(C)(1).

<sup>14</sup> R.C. 3902.53(A) and (C)(2).

Note that the bill prohibits a health plan issuer from denying a claim after arbitration related to that claim has been initiated. Also, the Ohio Prompt Pay Requirements do not apply while arbitration is underway.<sup>15</sup>

The arbitration is to consist of a review of the written documentation submitted by both parties to the arbitrator. The parties are required to submit to the arbitrator all necessary documentation as soon as is practicable.<sup>16</sup>

An arbitrator is to only award either the provider's final offer or the health plan issuer's final offer described above, plus the arbitrator's fees, which are to be paid by the nonprevailing party.<sup>17</sup> In reaching a decision, an arbitrator is to consider all of the following factors:

- The provider's level of training, education, experience, and specialization or sub-specialization;
- The acuity level of patients treated by the provider;
- The provider's quality and outcome metrics;
- Contracted rates for other providers under other health benefit plans in the same geographic area;
- The history of prior contracted rates between the provider and health plan issuer;
- If terminated by either party within one year prior to the filing of the arbitration request, the health care contract in existence at the time of the unanticipated out-of-network care that formed the basis for the dispute, including any valuable consideration received by either party for entering into the health care contract;
- Past compliance by each party with the terms of the most recent, if any, health care contract;
- The 80<sup>th</sup> percentile of all provider charges for the health care service provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the Superintendent (see "**Superintendent of Insurance – Benchmarking database,**" below);
- The circumstances and complexity of the case under dispute, including the place of service as defined by the federal Centers for Medicare and Medicaid Services;
- The provider's usual charges for the services;
- Any other relevant economic aspect of the unanticipated out-of-network care.

---

<sup>15</sup> R.C. 3902.52(C).

<sup>16</sup> R.C. 3902.53(B).

<sup>17</sup> R.C. 3902.53(E)(1).

In reaching a decision, an arbitrator is not to consider the rates of other programs, including indigent care programs, Medicare, Medicaid, or Tricare.<sup>18</sup>

The determination of the arbitrator is binding and is to be admissible in any court proceeding between the health plan issuer and the provider, the provider's medical group, or the provider's independent practice organization. Similarly, the determination of the arbitrator is to be admissible in any proceeding between the state and the provider, the provider's medical group, or the provider's independent practice organization.<sup>19</sup>

### **Negotiations in lieu of arbitration**

As opposed to entering a final decision as described above, an arbitrator may direct both parties to attempt a good faith negotiation if the arbitrator determines either of the following to be true:

- A settlement between the parties is reasonably likely;
- Both the individual provider's final offer and the health plan issuer's final offer are unreasonable.

Such negotiations are not to take more than ten days, but in any case must conclude within the 30-day time period in which the arbitrator is required to make a final decision. If the parties reach a settlement as a result of negotiations, the arbitrator's fees are to be paid by both parties equally.<sup>20</sup>

### **Alternative reimbursement**

If a claim does not meet the \$700 threshold required for arbitration, the health plan issuer is required by the bill to, at a minimum, reimburse the individual provider the lesser of the following:

- The provider's charge;
- The 80<sup>th</sup> percentile of all provider charges in the same or similar specialty for the health care service provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the Superintendent of Insurance (see "**Superintendent of Insurance – Benchmarking database,**" below).<sup>21</sup>

### **Intentionally choosing out-of-network care**

For health care services, other than unanticipated out-of-network care, that are covered under a health benefit plan but are provided by an individual out-of-network provider in Ohio,

---

<sup>18</sup> R.C. 3902.53(F).

<sup>19</sup> R.C. 3902.53(G).

<sup>20</sup> R.C. 3902.53(D) and (E)(2).

<sup>21</sup> R.C. 3901.51(D).

the individual provider must not bill the covered person for the difference between the health plan issuer's out-of-network reimbursement and the individual provider's charge for the services unless all of the following conditions are met:

- The individual provider informs the covered person that the individual provider is not in the person's health benefit plan provider network;
- The individual provider provides the covered person a good faith estimate of the cost of the health care services. This estimate is to contain a disclaimer that the covered person is not required to obtain the services at that location or from that individual provider;
- The covered person affirmatively consents to receive the health care services.<sup>22</sup>

## **Does not apply to Medicaid**

The bill specifies that its requirements related to unanticipated out-of-network care, negotiations, and arbitration do not apply to Medicaid managed care plans or to health care services, including emergency services, for which individual provider fees are subject to schedules or other monetary limitations under any other law.<sup>23</sup>

## **Superintendent of Insurance**

### **Benchmarking database**

The bill requires the Superintendent to specify the benchmarking database described above for purposes of arbitration and alternative reimbursement. The Superintendent is not to select a nonprofit organization that is affiliated with or receives funding from a health plan issuer.<sup>24</sup>

### **Rules**

The Superintendent is required to adopt rules as necessary to implement the bill's requirements. The rules are to address, at minimum, all of the following:

- The certification of arbitrators to carry out the arbitration process;
- The payment of an arbitrator's fees;
- Any other items the Superintendent considers necessary to implement the bill's requirements.<sup>25</sup>

---

<sup>22</sup> R.C. 3902.511.

<sup>23</sup> R.C. 3902.531.

<sup>24</sup> R.C. 3902.54(A).

<sup>25</sup> R.C. 3902.54(B).



## Health care provider directory

The bill requires a health plan issuer to provide a directory of health care providers for each of its health benefit plans on the issuer's website and in print format in each plan brochure. The directory is to contain the following information in plain language:

- Which directory applies to which health benefit plan;
- The criteria the health plan issuer uses to evaluate health care providers that attempt to join the issuer's network;
- The criteria the health plan issuer uses to tier health care providers;
- The tier on which each health care provider is placed;
- A statement that authorization or referral may be required prior to covering a health care provider's services;
- A customer service email address and telephone number or electronic link that any person may use to notify the health plan issuer of inaccurate directory information;
- Regarding the version of the directory on the issuer's website:
  - In searchable format, the following information relating to each in-network health care provider that is not a health care facility: name, gender, contact information, participating locations, specialties, board certifications, medical group affiliations, health care facility affiliations, participating health care facility affiliations, languages spoken by the provider and the provider's staff, and whether the provider is accepting new patients.
  - In searchable format, the following information relating to each in-network health care facility: facility name, contact information, facility type, types of services available if a facility is not a hospital, location, and certification or accreditation status if the facility is a hospital.
- The print version of the directory must disclose that the directory is accurate as of the date of printing and that covered persons and prospective enrollees should consult the electronic version of the directory on the health plan issuer's website or contact the health plan issuer via telephone to obtain current directory information.

A health plan issuer must do all of the following in relation to the directory under the bill:

- Update the directory on the issuer's website at least monthly;
- Ensure that the public may view the directory on the issuer's website via a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number;
- Upon a covered person's or a prospective enrollee's request, make available in print format the following directory information for the applicable health benefit plan:

- The following information relating to each in-network health care provider: name, contact information, participating locations, specialties, languages spoken, and whether the provider is accepting new patients;
- The following information relating to each in-network health care facility: facility name, contact information, facility type, location, and types of services available if a facility is not a hospital.

A health plan issuer is required to perform an annual audit of a reasonable sample of its directories for accuracy, retain documentation of the audit's results for a period of five years, and provide such documentation to the Superintendent upon request.<sup>26</sup>

## Effective dates

The bill's requirements related to health plan issuers and directories would only apply to health benefit plans issued, renewed, or amended on or after the bill's effective date.

The bill's requirements related to unanticipated out-of-network care apply April 1, 2020, to providers for health benefit plans issued, amended, or renewed on or after the bill's effective date. Providers that provide services to individuals covered by plans issued, amended, or renewed prior to the bill's effective date do not have to follow the bill's requirements and are allowed to bill the patient for the difference between the provider's charge and the health plan issuer's reimbursement amount. In such situations, the health plan issuer is required to inform the provider of this fact.<sup>27</sup>

To provide an illustrative example, suppose that the bill were enacted and its effective date was January 1, 2020. Two health benefit plans are issued by a health plan issuer: one on December 31, 2019, and another on January 2, 2020. A health care provider does not have to follow the bill's requirements on unanticipated out-of-network care for either plan until April 1, 2020. After that date, the provider would have to follow the unanticipated out-of-network care requirements for *only* the plan issued in 2020. For the plan issued in 2019, the provider would be able to bill the covered individual as under current law.

## Definitions

The bill makes the following additional definitions not previously discussed in this analysis:

"Cost sharing" means the cost to an individual covered under a health benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by a health benefit plan.

"Covered person" means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan.

---

<sup>26</sup> R.C. 3902.55.

<sup>27</sup> Section 2.

“Health benefit plan” means 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. “Health benefit plan” also means a limited benefit plan, except the term does not mean any of the following types of coverage:

- A policy, contract, certificate, or agreement that covers only a specified accident, accident only, credit, dental, disability income, long-term care, hospital indemnity, supplemental coverage, specified disease, or vision care;
- Coverage issued as a supplement to liability insurance;
- Insurance arising out of workers’ compensation or similar law;
- Automobile medical payment insurance;
- Insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
- A Medicare supplement policy of insurance, coverage under a plan through Medicare, Medicaid, or a federal employees benefit program.

“Health plan issuer” under the bill is an entity subject to Ohio Insurance Laws or the Superintendent of Insurance’s jurisdiction that contracts, or offers to contract, to provide, or pay for, health care services under a health benefit plan. In addition to a sickness and accident insurer, health insuring corporation, fraternal benefit society, self-funded multiple employer welfare arrangement, and nonfederal, government health plan, the bill applies to a third-party administrator to the extent that the benefits that it administers are subject to Ohio Insurance Laws and Rules or the Superintendent’s jurisdiction.

“Emergency services” means all of the following as described in pertinent federal law:

- 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.

“Health care contract” means a contract entered into, materially amended, or renewed between a contracting entity and a participating provider for the delivery of basic health care services, specialty health care services, or supplemental health care services to enrollees.

“Individual in-network provider,” “individual out-of-network provider,” and “individual provider” refer to a health care provider who is an individual.<sup>28</sup>

---

<sup>28</sup> R.C. 3902.50; 3922.01 and 3963.01, not in the bill.

---

## HISTORY

Action	Date
Introduced	09-16-19

---