OHIO LEGISLATIVE SERVICE COMMISSION

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Office of Research and Drafting

Legislative Budget Office

S.B. 198
133rd General Assembly

Fiscal Note & Local Impact Statement

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Version: As Introduced

Primary Sponsors: Sens. S. Huffman and Antonio

Local Impact Statement Procedure Required: Yes

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Highlights

- The requirements that the Superintendent of Insurance appoint arbitrators, specify a benchmarking database, and adopt any necessary rules to implement the bill's requirements would increase the Department of Insurance's administrative costs. Any increase in the Department's administrative costs would be paid from the Department of Insurance Operating Fund (Fund 5540). The magnitude of the cost increase would depend heavily on the number of arbitration cases that the Superintendent is required to manage. LBO economists consider it plausible that these requirements would mean the Department of Insurance would have to hire one or more staff persons to manage the arbitrations.
- 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 that are covered services under a health benefit plan but are provided by an individual out-of-network provider if either (1) the services were emergency services, or (2) the covered person did not have the ability to request an in-network provider. The bill's provisions generally relate to unanticipated out-of-network care.

Health plan issuers

The bill requires health plan issuers, within 30 days of receiving a claim for reimbursement for unanticipated out-of-network care provided at an in-network facility, to

either: (1) pay the individual provider's claim, or (2) attempt to negotiate[1] reimbursement with the individual provider. If the claim is not subject to arbitration under the terms of the bill, the health plan issuer is required, at a minimum, to reimburse the individual provider the lesser of: (1) the provider's charge, or (2) the 80th percentile of all provider charges in the same or similar specialty for the health care service provided in the same geographical area. The 80th percentile of such provider charges would be determined by a benchmarking database maintained by a nonprofit organization designated by the Superintendent of Insurance. Health plan issuers are prohibited from requiring cost sharing[2] for unanticipated out-of-network care at a rate higher than if the care were provided by an individual in-network provider. The bill prohibits a health plan issuer from denying coverage of a claim after arbitration once that claim has been initiated.

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 bill specifies several requirements related to the directory and information that must be included in the directory. The bill requires a health plan issuer 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 of Insurance upon request.

Health plan issuers subject to the bill's requirements generally include sickness and accident insurance companies, health insuring corporations, fraternal benefit societies, self-funded multiple employer welfare arrangements, nonfederal government health plans, and third-party administrators licensed under Chapter 3959 of the Revised Code.[3]

Individual provider

The bill requires an individual provider to file a claim for reimbursement with a covered person's health plan issuer for unanticipated out-of-network care provided at an in-network facility in Ohio, and prohibits an individual provider who provides such unanticipated out-of-network care from billing a covered person for the difference between the reimbursement from the covered person's health plan issuer and the individual provider's charge for the services (generally known as "surprise billing"). The bill also prohibits an individual out-of-network provider who provides health care services other than unanticipated out-of-network care from billing the covered person for the difference between the health plan issuer and the individual provider's charge for the services, unless certain conditions are met.

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[1] The bill specifies that the existing requirements related to prompt payments to health care providers do not apply with respect to the claim during a period of negotiation.

[2] The bill defines "cost sharing" as 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.

[3] More generally, they include any entity subject to the state insurance laws and rule, or subject to the jurisdiction of the Superintendent of Insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan.

Arbitration

The bill specifies that if an individual provider files a claim for reimbursement, and the provider and the health plan issuer receiving the claim do not agree on a negotiated reimbursement within 60 days of the start of negotiations, the health plan issuer or individual provider may file a request with the Superintendent of Insurance for binding arbitration[4] to determine the reimbursement amount if either of the following applies: (1) the claim exceeds $700, or (2) the individual 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.[5] The party requesting arbitration must provide a notice to the other party that it has requested arbitration, including a statement of the party's final offer. In response to the notice, the nonrequesting party must inform the requesting party of its final offer before the arbitration commences. The Superintendent is to appoint an arbitrator within ten days of receiving notice from the requestor.

The bill requires an arbitrator to make a decision and provide that decision in writing to all parties and to the Superintendent of Insurance within 30 days after the appointment of the arbitrator. An arbitrator must award either the individual provider's final offer or the health plan issuer's final offer, plus the arbitrator's fees, which must be paid by the nonprevailing party. An arbitrator may also direct both parties to attempt a good faith negotiation if the arbitrator determines either of the following to be true: (1) a settlement between the parties is reasonably likely, or (2) both the individual provider's final offer and the health plan issuer's final offer are unreasonable. The negotiations must not take more than ten days, but in any case must conclude within 30 days; the 30-day time limitation applies to the arbitrator's decision as well. If the parties reach a settlement as a result of negotiations, the arbitrator's fees would be paid by both parties equally.

Superintendent of Insurance

In addition to the requirement that the Superintendent of Insurance appoint an arbitrator within ten days, the bill requires the Superintendent to specify the benchmarking database. The bill prohibits the Superintendent from selecting a nonprofit organization that is affiliated with or receives funding from a health plan issuer. The bill requires the Superintendent to adopt any necessary rules to implement the bill's requirements, including rules to address the certification of arbitrators to carry out the arbitration process and the payment of an arbitrator's fees.

Other provisions

The bill includes provisions that exempt the requirements related to unanticipated out-of-network care from the existing requirement related to mandated health benefits. Under

[4] The bill specifies that an arbitration must consist of a review of the written documentation submitted by both parties (the health plan issuer and the provider) to the arbitrator. The parties are also required to submit to the arbitrator all required documentation as soon as is practicable.

[5] The bill specifies a number of details governing the bundling of multiple claims in a request for arbitration.

current law, no mandated health benefits legislation enacted by the General Assembly after January 14, 1993, must 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's provisions 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, including under industrial commission and workers' compensation laws.

Fiscal effect

The requirements that the Superintendent of Insurance must appoint an arbitrator upon receiving a request for an arbitration, specify the benchmarking database,[6] and adopt any necessary rules to implement the bill's requirements would increase the Department of Insurance's administrative costs. Any increase in the Department's administrative costs would be paid from the Department of Insurance Operating Fund (Fund 5540). As of this writing, LBO does not have an estimate of the magnitude of any such costs. They would clearly depend on the number of cases of arbitration that were requested, which could plausibly number in the thousands annually. The Department may plausibly have to hire one or more individuals to manage these requirements.

The requirements imposed on health insurers, especially the minimum required payments for unanticipated out-of-network bills combined with the prohibition against increasing cost sharing by covered individuals to defray those costs, 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 plans) require different in-network and out-of-network costs associated with annual deductible, copayment, coinsurance, and maximum out-of-pocket and covered persons under the two plans may be subject to balance billing.[7] 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.

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[6] The bill does not state how the provider of a benchmarking database would be compensated for any costs involved in setting up and maintaining the database, and does not specify what the Superintendent is to do in the event that an acceptable benchmarking database cannot be identified.

[7] A copy of State of Ohio Employee Benefits Guide, July 1, 2019 – June 30, 2020, is available at: https://das.ohio.gov/LinkClick.aspx?fileticket=jpQ-dU6Tsxs%3d&portalid=0.