SUMMARY OF OHIO SENATE BILL 198
(S.B. 198)
Introduced September 16, 2019

A Bill Regarding Out-Of-Network Care

Joint Primary Sponsors: S. Huffman (R) and Antonio (D)
Cosponsors: Thomas (D), V. Sykes (D), Williams (D), M. Huffman (R), Manning (R), Kunze (R), Roegner (R)

Unanticipated OON Care

Payment of OON Claims
A provider shall file a claim with a covered person’s plan for unanticipated OON care provided at an in-network facility. Upon receipt of the claim, the plan has 30 days to pay the provider’s claim or attempt to negotiate reimbursement with the provider.

If the claim is not subject to the bill’s arbitration language the plan shall pay, at a minimum, the lesser of the provider charge or the 80th percentile of all provider charges in the same or similar geographical area as reported in a benchmarking database maintained by a nonprofit specified by the superintendent of insurance.

Balance Billing Prohibition
For unanticipated OON care provided at an in-network facility, the provider shall not bill a covered person for the difference between the reimbursement from the insurer and the provider’s charge.

Patient Cost Sharing
A health plan issuer shall not require cost sharing for unanticipated OON care at a rate higher than if the care were provided by an in-network provider.

Care Other than Unanticipated OON Care

Payments for OON Providers
For health care services, other than unanticipated OON care, that are covered but provided by an OON provider, the provider may not bill the covered person for the difference between the health plan issuer's OON reimbursement and the provider's charge unless the following conditions are met:
• The provider informs the covered person that they are not in the plan’s network
• The provider gives the covered person a good faith estimate of the cost of the services
• This estimate shall 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

**Arbitration**

If a provider and health plan do not agree on a negotiated reimbursement within 60 days of the start of negotiations, the health plan or provider may file a request with the superintendent of insurance for binding arbitration to determine the reimbursement amount. The conditions for arbitration are if the claim exceeds $700 or if there are multiple claims that total more than $700. If the requesting party wishes to bundle similar claims they shall do so at the initial request. The bill defines similar claims as claims that are from the same provider, the provider's medical group, or the provider's independent practice organization, and are sent to the same health plan issuer. Similar claims are also similar in medical nature, subject to denial by the health plan issuer for similar reasons, or otherwise materially similar.

The party requesting arbitration shall notify the other party of the request. The notice shall state the party's final offer for each claim. The non-requesting party shall provide their final offer for each claim before the arbitration commences.

A health plan issuer shall not deny coverage of a claim after arbitration on that claim has been initiated.

The superintendent of insurance shall appoint an arbitrator within 10 days of receiving the request. The arbitration shall consist of a review of the written documentation submitted by both parties to the arbitrator. The parties shall submit to the arbitrator all required documentation as soon as is practicable.

If the requesting party bundled claims and the non-requesting party objected in a timely manner to the bundling, the arbitrator shall promptly decide whether the bundling of claims was proper. If the non-requesting party does not object to the bundling, the arbitrator shall allow the bundling. If the arbitrator decides that the bundling was improper in whole or in part, the arbitrator shall inform the superintendent and the parties, and the superintendent shall appoint additional arbitrators as appropriate.

The arbitrator shall make a decision and provide that decision in writing to all parties and to the superintendent within 30 days after the appointment of the arbitrator. An arbitrator may direct both parties to attempt a good faith negotiation if a settlement between the parties is reasonably likely or both the individual provider's final offer and the health plan issuer's final offer are unreasonable. These negotiations are limited to 10 days.

An arbitrator shall only award the prevailing party its final offer, plus the arbitrator's fees. If a settlement is reached the arbitrator’s fees shall be split equally.
The arbitrator shall 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 plans in the same geographic area
- The history of prior contracted rates between the provider and plan
- 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 OON 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 health care contract
- The 80th percentile of all 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 of insurance
- The circumstances and complexity of the case under dispute, including the place of service as defined by the Centers for Medicare & Medicaid Services
- The individual provider's usual charges for the services
- Any other relevant economic aspect of the unanticipated OON care

An arbitrator shall not consider the rates of other programs including indigent care programs, Medicare, Medicaid, or Tricare.

The determination of the arbitrator shall be binding and shall be admissible in any court proceeding between the health plan issuer and the individual provider, the individual provider's medical group, or the individual provider's independent practice organization.

These 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.

The superintendent shall specify the benchmarking database. The superintendent shall not select a nonprofit organization that is affiliated with or receives funding from a health plan issuer.

The superintendent shall adopt rules as necessary to implement these provisions. The rules shall address:

- 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
**Provider Directories**

A health plan issuer shall provide a directory of providers for each of its plans on its web site and in print format in each plan brochure.

The directory shall contain the following information in plain language:

- Which directory applies to which health benefit plan
- The criteria used to evaluate providers that attempt to join the issuer's network
- The criteria the plan uses to tier providers
- The tier on which each provider is placed
- A statement that authorization or referral may be required
- 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

The insurer web site shall contain information relating to each in-network health care provider that is not a health care facility and each in-network health facility. The print directory should refer covered persons to the online directory for the most current information. The online directory should be updated at least monthly. A plan shall perform an annual audit of a reasonable sample of its directories for accuracy.

**Effective Date**

The effective date of the bill is April 1, 2020.