Ohio | Common Sense Initiative

Mike DeWine, Governor
Jon Husted, Lt. Governor

Sean McCullough, Director

MEMORANDUM

TO: Loretta Medved and George McNab, Ohio Department of Insurance

FROM: Joseph Baker, Business Advocate

DATE: October 15, 2021

RE: **CSI Review – No Surprise Billing - Reimbursement for Unanticipated Out-of-Network Care (OAC 3901-8-17)**

On behalf of Lt. Governor Jon Husted, and pursuant to the authority granted to the Common Sense Initiative (CSI) Office under Ohio Revised Code (ORC) section 107.54, the CSI Office has reviewed the abovementioned administrative rule package and associated Business Impact Analysis (BIA). This memo represents the CSI Office's comments to the Department as provided for in ORC 107.54.

Analysis

This rule package consists of one new rule proposed by the Ohio Department of Insurance (Department). This rule package was submitted to the CSI Office on August 5, 2021, and the public comment period was held open through August 19, 2021. The Department shared its response to comments with CSI on October 7, 2021. Unless otherwise noted below, this recommendation reflects the version of the proposed rule filed with the CSI Office on August 5, 2021.

The rule in this package establishes requirements for health insurers and providers relating to cost reimbursement for insured customers receiving unanticipated out-of-network healthcare. The Department notes in the BIA that the proposed rule implements House Bill 388 (133rd General Assembly).

OAC 3901-17 states that a health plan issuer shall not require cost sharing for unanticipated out-of-network healthcare that exceeds the in-network rate if the care meets certain statutory conditions, such as being provided to a covered person at an in-network facility or being provided by an out-of-network provider as an emergency service. The rule allows providers who receive reimbursement for

unanticipated out-of-network care to negotiate reimbursement with the health insurer by contacting the insurer with 30 days of receiving the reimbursement. Additionally, the rule allows providers to request arbitration for claims that exceed $750 and occurred within a year of the request and establishes processes and procedures related to requesting arbitration, including potential bundling of arbitration claims should negotiations prove unsuccessful. The rule also requires arbitrators to perform arbitration on a flat fee basis with no additional costs for bundled claims with the non-prevailing party paying 70% of the costs and the remainder paid by the prevailing party.

During early stakeholder outreach, the Department engaged numerous stakeholders over the course of several months, including the American College of Emergency Physicians, Cleveland Clinic, CareSource, Ohio Association of Health Plans, Ohio Ambulance and Medical Transportation Association, Ohio Hospital Association, Ohio State Medical Association, and numerous other parties. The Department launched a special website dedicated to providing information regarding the rule and emailed stakeholders requesting feedback for initial rule framework. The Department also held meetings with health plans, medical providers before publishing the draft rule on the website. Subsequently, the Department held additional meetings and revised the draft rule based on stakeholder feedback to reflect negotiated agreements between interested parties and recent federal rule changes. During the public comment period, CSI received comments from the Ohio Chapter of the American College of Emergency Physicians (ACEP), the Ohio Society of Pathologists (OSP), Medical Mutual of Ohio (MMO), the Ohio Ambulance and Medical Transportation Association, the Cleveland Clinic, the Ohio Hospital Association (OHA), Bon Secours Mercy Health, the Ohio State Medical Association (OSMA), Quest Diagnostics, AMR Global Medical Response (AMR), and the Ohio Emergency Medicine Physician Alliance (OEMPA). Several groups, including OHA and OSMA raised concerns regarding the Department's use of geographic regions for purposes of determining appropriate regional payment amounts. In response to the comments, the Department clarified the proposed rule to explicitly state that the payer must use the geographic region where the service is performed in determining the appropriate payment amount.

The OSMA, ACEP, OEMPA, Bon Secours Mercy Health, and Quest Diagnostics raised concerns over the requirement that providers submit "sufficient" information to the payer regarding the claim, noting that some information regarding network coverage status is more readily available to payers than providers. In response, the Department stated to CSI that the requirement was necessary to ensure that providers and plans communicate the necessary information to execute out-of-network reimbursement claims. However, the Department did determine to remove a provision that previously required providers to note whether the provider was prohibited from balance billing the covered person on a request for reimbursement. Several comments also suggested that the Department implement an extended timeframe for providers to determine whether to proceed to arbitration regarding a claim. The Department did not adopt the suggestion to expand the timeframe from 30 to 90 days to remain aligned

with federal standards; however, the Department has stated to CSI that it intends to utilize business days rather than calendar days for this purpose, which will increase the time providers have to determine whether to proceed to arbitration. Groups representing medical transportation providers commented to state that the rule will result in medical transportation providers receiving decreased payments from commercial insurers and that the federal law excluded ground ambulances from the federal surprise billing law due to special considerations and concerns that are specific to the industry. The Department acknowledged the comment but stated that the statute specifically prescribes the payment methodology for these providers and that the rule conforms directly with the statute.

Finally, the OEMPA raised several concerns regarding the calculation of payment amounts for providers, such as that no fixed reference date and inflationary adjustment is prescribed for determining a "median" payment amount, that the "greatest of three" methodology prescribed by the rule is based on an outdated federal statute, and that the "usual, customary, and reasonable" amount specified in the rule requires additional clarification and specificity to ensure that providers receive appropriate payment amounts. The Department stated in response to these comments that the terms used in the rule are identical to the statute and that further changes to the rule to address these concerns would result in the Department exceeding its statutory authority.

According to the BIA, the business community impacted by the rules includes health insurers and healthcare providers when insured individuals receive healthcare from an out-of-network provider or at an out-of-network facility. The adverse impacts to business include potential loss of revenue for providers who may otherwise receive higher rates, costs associated with properly complying with the rule and identifying, documenting, and negotiating such claims either independently or through arbitration, potential costs and administrative effort associated with healthcare providers reviewing out-of-network business relationships, and expenses connected to insurers modifying identification cards to indicate that insurance plans are subject to Ohio surprise billing regulations. The Department states in the BIA that the adverse impact to business is necessary to ensure that consumers are not harmed by surprise medical bills and that insurers and providers can work through negotiation or arbitration to resolve claims and cost issues.

Recommendations

Based on the information above, the CSI Office has no recommendations on this rule package.

Conclusion

The CSI Office concludes that the Ohio Department of Insurance should proceed in filing the proposed rules with the Joint Committee on Agency Rule Review.