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OHIO LEGISLATIVE SERVICE
COMMISSION
DOCUMENT #226342

Ohio Revised Code

Section 3902.51 Out-of-network care reimbursement requirement, negotiations.

Effective: April 12, 2021
Legislation: House Bill 388 - 133rd General Assembly

(A)(1)(a) A health plan issuer shall reimburse an out-of-network provider for unanticipated out-of-network care when both of the following apply:

(i) The services are provided to a covered person at an in-network facility.

(ii) The services would be covered if provided by an in-network provider.

(b) A health plan issuer shall reimburse both of the following for emergency services provided to a covered person at an out-of-network emergency facility:

(i) An out-of-network provider;

(ii) The out-of-network emergency facility.

(c) A health plan issuer shall reimburse both of the following for emergency services provided to a covered person by an out-of-network ambulance:

(i) An out-of-network provider;

(ii) The out-of-network ambulance.

(2) In the case of clinical laboratory services provided in connection with care described in division (A)(1) of this section, a health plan issuer shall reimburse any out-of-network provider and any out-of-network facility that provided the clinical laboratory services.

(3) For purposes of sections 3902.50 to 3902.54 of the Revised Code:

(a) In the request for reimbursement, the provider, facility, emergency facility, or ambulance shall

include the proper billing code for the service for which reimbursement is requested.

(b) The health plan issuer shall send the provider, facility, emergency facility, or ambulance its intended reimbursement as described in division (B)(1) of this section.

(c) Within the period of time specified by the superintendent of insurance in rule, the provider, facility, emergency facility, or ambulance shall either notify the health plan issuer of its acceptance of the reimbursement or seek to negotiate reimbursement under division (B)(2) of this section. Failure to timely notify the issuer of an intent to negotiate shall be considered acceptance of the issuer's reimbursement.

(B)(1) Unless the provider, facility, emergency facility, or ambulance wishes to negotiate reimbursement under division (B)(2) of this section, the reimbursement required to be paid to the provider, facility, emergency facility, or ambulance under division (A) of this section shall be the greatest of the following amounts:

(a) The amount negotiated with in-network providers, facilities, emergency facilities, or ambulances 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. If there is more than one such amount, the relevant amount shall be the median of those amounts, excluding any in-network cost sharing imposed under the health benefit plan. In determining the median amount, the amount negotiated with each in-network provider, facility, emergency facility, or ambulance shall be treated as a separate amount even if the same amount is paid to more than one provider. If there is no per-service amount, such as under a capitation or similar payment arrangement, the amount described in division (B)(1)(a) of this section shall be disregarded.

(b) 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. This amount shall be determined with reduction for cost sharing that generally applies under the health benefit plan with respect to out-of-network health care services.

(c) The amount that would be paid under the medicare program, part A or part B of Title XVIII of

the Social Security Act, 42 U.S.C. 1395, as amended, for the service in question, excluding any in-network cost sharing imposed under the health benefit plan.

(2) In lieu of accepting reimbursement under division (B)(1) of this section, a provider, facility, emergency facility, or ambulance may notify the health plan issuer that the provider, facility, emergency facility, or ambulance wishes to negotiate reimbursement. Upon receipt of such notice, the health plan issuer shall attempt a good faith negotiation with the provider, facility, emergency facility, or ambulance.

(C)(1) For unanticipated out-of-network care provided at an in-network facility in this state, a provider shall not bill a covered person for the difference between the health plan issuer's reimbursement and the provider's charge for the services.

(2) For emergency services provided at an out-of-network emergency facility in this state, neither the emergency facility nor an out-of-network provider shall bill a covered person for the difference between the health plan issuer's reimbursement and the emergency facility's or the provider's charge for the services.

(3) For emergency services provided by an out-of-network ambulance in this state, neither the ambulance nor an out-of-network provider shall bill a covered person for the difference between the health plan issuer's reimbursement and the ambulance's or provider's charge for the services.

(4) In the case of clinical laboratory services provided in this state in connection with care described in division (A)(1) of this section, no out-of-network provider or out-of-network facility shall bill a covered person for the difference between the health plan issuer's reimbursement and the provider's or facility's charge for the clinical laboratory services.

(D) A health plan issuer shall not require cost sharing for any service described in division (A) of this section from the covered person at a rate higher than if the services were provided in network.

(E) For health care services, other than those described in division (A) of this section, that are covered under a health benefit plan but are provided to a covered person by an out-of-network provider at an in-network facility, both of the following apply:

(1) For services provided in this state, the provider shall not bill the covered person for the difference between the health plan issuer's out-of-network reimbursement and the provider's charge for the services unless all of the following conditions are met:

(a) The provider informs the covered person that the provider is not in the covered person's health benefit plan network.

(b) The provider provides to the covered person a good faith estimate of the cost of the services, including the provider's charge, the estimated reimbursement by the health plan issuer, and the covered person's responsibility. The estimate shall contain a disclaimer that the covered person is not required to obtain the health care service at that location or from that provider.

(c) The covered person affirmatively consents to receive the services.

(2) The health plan issuer may reimburse the provider at either the in-network or out-of-network rate as described in the covered person's health benefit plan.

(F) Nothing in this section is subject to section 3901.71 of the Revised Code.