Ohio Revised Code

Section 3902.54 Out-of-network care arbitrator requirements.

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

(A)(1) The superintendent of insurance shall contract with a single arbitration entity to perform all arbitrations described in section 3902.52 of the Revised Code. The superintendent shall ensure that the arbitration entity, any arbitrators the arbitration entity designates to conduct an arbitration, and any officer, director, or employee of the arbitration entity do not have any material, professional, familial, or financial connection with any of the following:

(a) The health plan issuer involved in a dispute;

(b) An officer, director, or employee of the health plan issuer;

(c) A provider, facility, emergency facility, ambulance, medical group, or independent practice organization involved with the service in question;

(d) The development or manufacture of any principal drug, device, procedure, or other therapy in dispute;

(e) The covered person who received the service that is the subject of a dispute or the covered person's immediate family.

(2) The superintendent shall require the arbitration entity to do all of the following:

(a) Utilize arbitrators who are knowledgeable and experienced in applicable principles of contract and insurance law;

(b) Ensure that the arbitrators have access to appropriate specialists including certified coding specialists, physicians, nurses, other clinicians, and health insurance experts as necessary to render a determination;

(c) Utilize a secure electronic portal for the submission, processing, and management of arbitration applications;

(d) Perform all arbitrations under section 3902.52 of the Revised Code on a flat fee basis.

(B) In selecting the arbitration entity with which to contract, the superintendent shall at minimum require a prospective arbitration entity to submit to the superintendent a disclosure containing all of the following accompanied by an application fee prescribed by the superintendent:

(1) The name, telephone number, and address of the applicant;

(2) If the applicant has issued any outstanding shares that are listed on a national securities exchange or are regularly quoted in an over-the-counter market by one or more members of a national or affiliated securities association, the name of each person holding more than five per cent stock or call or put options in the applicant;

(3) The name of each person holding bonds or notes issued by the applicant totaling over one hundred thousand dollars;

(4) The name of each entity the applicant controls and the nature and extent of such control, including the nature of the controlled entity's business;

(5) The name of each entity in which the applicant has more than five per cent ownership interest, including the nature of the entity's business;

(6) The name, contact information, and work history of each director, officer, and executive and any current or previous relationship each of those persons has or had with a health plan issuer, provider, facility, emergency facility, medical group, or independent practice organization;

(7) The percentage of revenue the arbitration entity receives from its arbitration services;

(8) A description of the applicant's arbitration process, including information about how the applicant will meet the superintendent's standards and how the applicant will avoid conflicts of

interest;

(9) The fee the applicant would charge for an arbitration.

(C)(1) The superintendent shall require the contracted arbitration entity to submit to the superintendent on an annual basis the disclosure described in division (B) of this section.

(2) The superintendent shall require the contracted arbitration entity to submit to the superintendent on an annual basis, and the superintendent shall issue, a report containing all of the following:

(a) The number of arbitrations conducted under section 3902.52 of the Revised Code;

(b) The provider type, whether individual, practice, facility, emergency facility, or ambulance, that engaged in the arbitrations;

(c) The specialty of the provider engaging in the arbitrations;

(d) The out-of-network situation;

(e) The percentage of times the arbitrator decides in favor of the health plan issuer versus the provider, facility, emergency facility, or ambulance.

(D) The superintendent of insurance shall adopt rules pursuant to Chapter 119. of the Revised Code as necessary to implement sections 3902.50 to 3902.54 of the Revised Code.

Rules adopted by the superintendent may relate to the definitions of "provider," "facility," "emergency facility," and "ambulance." The requirements of section 121.95 of the Revised Code do not apply to rules adopted in accordance with this division.