DEPARTMENT OF INSURANCE

Reimbursement for out-of-network care

- Requires an insurer to reimburse an out-of-network provider for unanticipated out-of-network care provided at an in-network hospital.
- Prohibits an out-of-network provider from balance billing a patient for out-of-network services when those services are performed at an in-network facility unless certain conditions are met.
- Establishes arbitration and negotiation procedures for disputes between providers and insurers regarding unanticipated out-of-network care.

Telemedicine services

- Requires a health benefit plan to provide coverage for telemedicine services on the same basis and to the same extent as in-person services.
- Prohibits a health benefit plan from excluding telemedicine services from coverage solely because they are telemedicine services.
- Prohibits a provider from charging a health plan issuer any facility, origination, or equipment fees for a covered telemedicine service.
- Applies to all health benefit plans issued, offered, or renewed on or after January 1, 2020.

Pharmacy copayments

- Prohibits health plan issuers and third party administrators from requiring or directing pharmacies to collect cost-sharing beyond a certain amount from individuals purchasing prescription drugs.
- Prohibits issuers and administrators from retroactively adjusting pharmacy claims other than as a result of a technical billing error or a pharmacy audit.
- Prohibits issuers and administrators from charging claim-related fees unless those fees can be determined at the time of claim adjudication.
- Requires pharmacists, pharmacy interns, and terminal distributors of dangerous drugs to inform patients if the cost-sharing required by the patient's plan exceeds the amount that may otherwise be charged and prohibits those persons from charging patients the higher amount.
- Provides for license or certificate of authority suspension or revocation and monetary penalties for failure to comply with the bill.
- Requires the Department of Insurance to create a web form for consumers to submit complaints relating to violations of the bill.

Direct primary care agreements not insurance

- Provides that certain agreements to provide health care do not constitute insurance.

Health care price transparency

- Requires a hospital to provide a patient or the patient's representative with a written or verbal cost estimate for a service or procedure scheduled at least seven days in advance.
- Requires a hospital to publish on its website the standard list of health care items and services it must annually prepare and make public under federal law.
- Specifies that both requirements take effect January 1, 2020.
- Requires a health plan issuer to provide to its covered persons estimates of the costs of health care services and procedures to at least the same extent it is required to do so by federal law.
- Prohibits the Superintendent of Insurance from enforcing the health plan issuer cost estimate requirement.

Release of insurance claims data

- Requires a health plan issuer, beginning in July 2020, to release the following to a requesting group policyholder: net claims data paid or incurred by month, monthly enrollment data, monthly prescription claims information, and, for paid claims over $30,000, the amount paid toward each claim and claimant health condition.
- Defines a group policyholder as being a policyholder for a health insurance policy covering 50 or more full-time employees who work an average of at least 30 hours per week during a calendar month, or at least 130 hours during the calendar month.
- Applies the disclosure requirement to claims data for the current, or immediately preceding, policy period, as requested by the policyholder.
- Provides protections from civil liability to the health plan issuer in relation to the disclosure of the claims data.
- Makes a series of violations of the bill's release of claims data requirements that, taken together, constitute a pattern or practice, an unfair or deceptive practice in the business of insurance.

Ohio Assigned Risk Insurance Plan

- Allows the Ohio Assigned Risk Insurance Plan (OARP) to directly issue automobile insurance policies to persons unable to meet the financial responsibility requirements through ordinary methods.
- Requires OARP to file its policies and related items with the Superintendent of Insurance as if it were any other insurer.

- Provides that policies issued by OARP are to be treated like any policy issued by any other insurer.
- Requires OARP to provide audited reports and its books and records to the Superintendent of Insurance.

Reimbursement for out-of-network care

(R.C. 3902.50, 3902.51, 3902.52, 3902.53, and 3902.54; Section 739.10)

Unanticipated out-of-network care

The bill requires a health plan issuer to reimburse an out-of-network health care practitioner for unanticipated out-of-network care when the care is provided to a person covered by a health benefit plan at a hospital that is in the health benefit plan's provider network. A provider network might include a hospital but not certain individual practitioners at that hospital. In certain situations, such as those involving medical emergencies, covered persons are not always able to request only in-network practitioners give them care. Under existing law, if a person receives such unanticipated or emergency care at an in-network hospital by an out-of-network practitioner, the issuer might not reimburse the practitioner (some plans allow for such reimbursement, but others do not), meaning the covered person must pay the entire cost of the services. Under the bill, the practitioner must bill the issuer and the issuer must reimburse the practitioner. The practitioner is prohibited from billing the patient for the difference between the issuer's out-of-network reimbursement and the practitioner's charge (balance billing).

The bill further provides that a covered person's cost-sharing amount for the services described above cannot be greater than if the services were provided by an in-network practitioner.

When the out-of-network practitioner bills the issuer, the bill requires the issuer to, within 30 days, either pay the billed amount or attempt to negotiate a new amount. The bill suspends the Prompt Payment Law deadlines, which require payment to be made within certain periods of time, during this period. If the practitioner and issuer cannot agree on a reimbursement amount within 60 days of the start of negotiations, either party may initiate binding arbitration to determine the amount as described in "**Arbitration**" below, if certain criteria are met.

As used in this provision, "**unanticipated out-of-network care**" means health care services that are provided under a health benefit plan and that are provided by an out-of-network practitioner when either of the following applies:

- The covered person did not have the ability to request such services from an in-network practitioner; or
- The services provided were emergency services.

"**Emergency services**" means all of the following:

- Medical screening examinations undertaken to determine whether an emergency medical condition exists;
- Treatment necessary to stabilize an emergency medical condition;
- Appropriate transfers undertaken prior to an emergency medical condition being stabilized.

Other services

The bill prohibits an out-of-network health care practitioner from balance billing a covered person for the difference between the health plan issuer's out-of-network reimbursement and the practitioner's charge for care, other than unanticipated out-of-network care provided at an in-network hospital, unless all of the following conditions are met:

- The practitioner informs the person that the practitioner is not in the person's plan network.
- The practitioner provides the person a good faith estimate of the cost of the services. This estimate must contain a disclaimer that the covered person is not required to obtain the health care service at that location or from that practitioner.
- The person affirmatively consents to receive the services.

Arbitration

If a health care practitioner and health plan issuer do not agree on a reimbursement amount within 60 days of the start of negotiations as described in "**Unanticipated out-of-network care**" above, the bill allows either party to initiate binding arbitration to determine the amount as long as the billed amount exceeds both $700 and 120% of the usual and customary amount for the service in question. As used in this provision, the "**usual and customary amount**" means the 80th percentile of all charges for the service in question by other practitioners in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database selected by the Superintendent of Insurance.

To initiate arbitration, the bill requires the practitioner or issuer to file a request with the Superintendent and notify the other party of the request and of its final offer. In response to this notice, the nonrequesting party must inform the requesting party of its final offer before the arbitration occurs. Once arbitration is initiated, application of the Prompt Payment Law to the services in question is suspended, and the issuer cannot deny coverage for those services.

The bill requires the Superintendent to appoint an arbitrator within ten days of the request. The arbitration will consist of a review of written documentation, which must be submitted by the parties as soon as is practicable.

The bill requires an arbitrator, within 30 days of the arbitrator's appointment, to reach a decision and provide that decision in writing to the parties and the Superintendent. The arbitrator must award either the issuer's reimbursement offer or the practitioner's billed amount. This decision is binding and is admissible in any court proceeding between the issuer

and the practitioner or in any proceeding between the state and the practitioner. In reaching the decision, the arbitrator must consider all of the following factors:

- Whether there is a gross disparity between the practitioner's billed amount and either of the following:
  - Payments made to the practitioner for the same health care services rendered in other recent instances in which the practitioner was out-of-network;
  - Recent fees paid by the issuer to reimburse similarly qualified out-of-network practitioners for the same services in the same geographic region.
- The level of training, education, and experience of the practitioner;
- The practitioner's usual charge for comparable services when the practitioner is out-of-network;
- The circumstances and complexity of the particular case, including the time and place of the service;
- Individual patient characteristics;
- Rates, including historical rates, between the 50th percentile of contracted rates and the 80th percentile of billed charges in the practitioner's geographical area using the first three numbers in the practitioner's zip code (the GEOZIP) according to the benchmarking database selected by the Superintendent;
- The history of network contracting between the parties; and
- Any additional criteria as determined by the arbitrator.

The bill requires the arbitrator's fees to be paid by the nonprevailing party or by both parties equally if negotiations are completed as described in "**Negotiation**" below.

Negotiation

The bill allows an arbitrator to direct the parties to attempt a good faith negotiation instead of arbitration if the arbitrator determines either of the following to be true:

- A settlement is reasonably likely; or
- Both the practitioner's charge and the issuer's reimbursement offer are unreasonable.

The bill requires any such negotiation to be completed within ten days or within 30 days of the arbitrator's appointment, whichever is sooner.

Rules

The bill requires the Superintendent to adopt, at minimum, rules addressing the following:

- The certification of arbitrators;
- The payment of an arbitrator's fees; and

- Any other items the Superintendent considers necessary.

Exemptions

The bill exempts the following from its provisions:

- Medicaid managed care plans;
- Health care services, including emergency services, for which health care practitioner fees are subject to schedules or other monetary limitations under any other law, including the Workers' Compensation Law.

Effective date

The bill specifies that the above requirements apply beginning on April 1, 2020, to health benefit plans that are entered into or renewed on or after the provisions' effective date.

Telemedicine services

(R.C. 3902.30, 4723.94, and 4731.2910)

The bill requires a health benefit plan to provide coverage for telemedicine services on the same basis and to the same extent that the plan provides coverage for in-person health care services. "Telemedicine service" is defined as a health care service provided through synchronous or asynchronous information and communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where the recipient is located.

The bill prohibits a health benefit plan from excluding coverage for a service solely because it is provided as a telemedicine service. It also prohibits a health benefit plan from imposing any annual or lifetime benefit maximum in relation to telemedicine services other than a benefit maximum imposed on all benefits offered under the plan.

Under the bill, a health benefit plan may assess cost-sharing requirements to a covered individual for telemedicine services as long as these requirements are not greater than those for comparable in-person health care services. Also, the bill does not require a health plan issuer to reimburse a physician for any costs or fees associated with the provision of telemedicine services that would be in addition to or greater than the standard reimbursement for comparable in-person health care services.

The bill prohibits a physician, physician's assistant, or advanced practice registered nurse from charging a health plan issuer a facility fee, origination fee, or any fee associated with the cost of equipment used to provide telemedicine services with regard to a covered telemedicine service.

The above telemedicine provisions apply to all health benefit plans issued, offered, or renewed on or after January 1, 2021.

Pharmacy copayments

(R.C. 1739.05, 1751.92, 3923.87, 3959.12, 3959.20, and 4729.48)

The bill prohibits a health plan issuer, a term that includes pharmacy benefit managers and other third-party administrators, from requiring cost-sharing in an amount greater than the lesser of the following from an individual purchasing a prescription drug:

- The amount an individual would pay if the drug were purchased without coverage under a health benefit plan;
- The net reimbursement paid to the pharmacy by the health plan issuer.

Under the bill, a health plan issuer also is prohibited from directing a pharmacy to collect cost-sharing in an amount greater than the lesser of those amounts in relation to prescription drugs.

The following table describes how this requirement might work in practice for a health benefit plan having default cost-sharing in the form of a copay of $10 (amounts are for illustrative purposes only):

Health benefit plan default contractual copay	Pharmacy's net reimbursement for drug	"Without insurance" price for drug	Maximum amount patient would be required to pay for drug
$10	$200	$300	$10
$10	$8	$2	$2
$10	$4	$6	$4

Prohibited adjustments and fees

The bill prohibits a health plan issuer from retroactively adjusting a pharmacy claim for reimbursement for a prescription drug unless the adjustment resulted from either a technical billing error or a pharmacy audit.

Also, under the bill, a health plan issuer is prohibited from charging a fee related to a claim unless the amount of the fee can be determined at the time of claim adjudication.

Duties of pharmacists, interns, and terminal distributors

When filling a prescription, if a pharmacist, pharmacy intern, or terminal distributor of dangerous drugs has information indicating that the cost-sharing amount required by the patient's health benefit plan exceeds the amount that may otherwise be charged for the same drug, this person must inform the patient of this fact and the patient must not be charged the higher amount.

Enforcement

Health plan issuers

The bill provides that if a pharmacy benefit manager or other administrator knowingly violates its pharmacy copayment provisions, its license may be suspended for a period not to exceed two years, revoked, or not renewed by the Superintendent.

If a health insuring corporation or a multiple employer welfare arrangement fails to comply with the bill's provisions, the Superintendent may suspend or revoke its certificate of authority.

It appears that if a sickness and accident insurer or, possibly, public employee benefit plan, fails to comply with the bill, the insurer or plan would be subject to a forfeiture of $1,000 to $10,000.

The Insurance Law contains a catchall penalty that requires, in the absence of any other penalty, an association, company, or corporation to forfeit and pay not less than $1,000 nor more than $10,000 to the Superintendent of Insurance for violating any law relating to the Superintendent or any Insurance Law. It appears that R.C. 3923.87, enacted by the bill, would constitute an Insurance Law. But, it is uncertain whether this provision applies to public employee benefit plans.

Pharmacists, interns, and terminal distributors

If a pharmacist or pharmacy intern violates the bill's pharmacy copayment provisions, the State Board of Pharmacy may take any of the following actions against that individual:

- Revoke, suspend, restrict, limit, or refuse to grant or renew a license;
- Reprimand or place the license holder on probation; or
- Impose a monetary penalty or forfeiture not to exceed $500.

If a terminal distributor of dangerous drugs violates the bill's pharmacy copayment provisions, the State Board of Pharmacy may take any of the same actions against the distributor as it may take against a pharmacist or pharmacy intern, except that a monetary penalty or forfeiture may not exceed $1,000.

Web-based complaint form

The Department of Insurance must create a web form that consumers can use to submit complaints relating to violations of the pharmacy copayment provisions.

Affected plans

The bill's pharmacy copayment requirements apply to contracts for pharmacy services and to health benefit plans entered into or amended on or after the bill's effective date.

Direct primary care agreements not insurance

(R.C. 3901.95)

The bill provides that an agreement that meets all of the following conditions is not insurance and is not subject to the insurance laws of Ohio:

- The agreement is in writing.
- It is between a patient, or that patient's legal representative, and a health care provider and is related to services to be provided in exchange for the payment of a fee to be paid on a periodic basis.
- It allows either party to terminate the agreement, as specified in the agreement, through written notification.
- It permits termination to take effect immediately upon the other party's receipt of the notification or not more than 60 days after receipt.
- It does not impose a termination penalty or require payment of a termination fee.
- It describes the health care services to be provided under the agreement and the basis on which the periodic fee is to be paid.
- It specifies the periodic fee required and any additional fees that may be charged and authorizes those fees to be paid by a third party.
- It prohibits the health services provider from charging or receiving any fee other than the fees prescribed in the agreement for the services prescribed in the agreement.
- It conspicuously and prominently states that the agreement is not health insurance and does not meet any individual health insurance mandate that may be required under federal law.

Health care price transparency

Cost estimates from hospitals

(R.C. 3727.46; R.C. 5162.80, repealed)

The bill repeals law that requires specified health care facilities and professionals to provide a reasonable, good faith estimate of various costs before products, services, or procedures are provided. These requirements have been the subject of ongoing litigation and, as of February 13, 2019, have been permanently enjoined from going into effect.[97]

[97] The Ohio Attorney General filed an appeal of the injunction on March 14, 2019. See Kaitlyn Schroeder, "State Appeals Judge's Decision to Block Health Price Law," *Dayton Daily News* (March 18, 2019), available at https://www.daytondailynews.com/news/state-appeals-judge-decision-block-health-price-law/rmm2FzohEvSZpXTcS37ELK/.

The bill replaces the repealed provisions with a requirement that only hospitals, on the request of a patient or the patient representative, provide to that individual a reasonable, good faith cost estimate for a health care service or procedure. The requirement applies only when a service or procedure has been scheduled at least seven days before it is to occur.

The estimate that hospitals must give under the bill may be written or verbal. A written estimate may be given in electronic form. The following apply with respect to the estimate's components of:

--The estimate must specify the amount that the patient or party responsible for paying for the patient's care will be required to pay to the hospital for the service;

--If applicable, the estimate must include a notice that the professional services of physicians or other health care providers will be billed separately;

--The estimate must include a disclaimer that the information provided is only an estimate based on facts available at the time the estimate was prepared and that other required health care items, services, or procedures could change the estimate; and

--If applicable and known to the hospital at the time the estimate is given, the estimate must include a notification that the hospital or a health care provider who will treat the patient is out-of-network for the patient.

The estimate must be based on information available at the time the estimate is provided and need not take into account any information that subsequently arises, such as unexpected additional services or procedures. Also, a hospital may state the estimate as a range rather than an actual dollar amount.

The cost estimate requirement on hospitals does not apply if the patient is insured and the patient's health plan issuer fails to supply the necessary information to the hospital within 48 hours of the hospital's request to the health plan issuer for that information.

The bill's provisions on hospital cost estimates take effect on January 1, 2020.

Patient responsibility for payment

(R.C. 3727.461)

The bill specifies that a patient or party responsible for paying for the patient's care is responsible for payment of hospital services provided even if the patient does not receive a cost estimate in accordance with the bill before the services are provided.

Standard charges list

(R.C. 3727.462)

The bill requires a hospital to publish on its website the list, required by federal law,[98] of the hospital's standard charges for items and services provided by the hospital. The hospital

[98] Section 2718(e) of the Public Health Service Act, 42 U.S.C. 300gg-18(e).

must update the list on the website immediately after an updated list is prepared. Each estimate required by the bill must contain a website address where the list is available.

Cost estimates from health plan issuers

(R.C. 3902.60)

The bill requires a health plan issuer to provide to its covered persons and their representatives estimates of the costs of health care services and procedures to at least the same extent it is required to do so by federal law. The Superintendent of Insurance is prohibited, however, from enforcing this requirement.

Under the bill, a health plan issuer is an entity subject to Ohio's insurance laws, 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. Examples include sickness and accident insurers, health insuring corporations, self-funded multiple employer welfare arrangements, and nonfederal, government health plans.

Release of insurance claims data

(R.C. 3901.89 and 3904.13; Section 812.10)

Duty to disclose

The bill requires a health plan issuer (see "**Scope**," below), upon request but not more than once per calendar year per group policyholder, to release to each group policyholder (including the authorized representative of a group policyholder) monthly claims data relating to the policy within 30 business days after receiving the request. The data released must include all of the following:

1. The net claims paid or incurred by month;

2. If the group policyholder is an employer, the monthly enrollment data by employee only, employee and spouse, and employee and family. Otherwise, the monthly enrollment data must be provided and organized in a relevant manner.

3. Monthly prescription claims information; and

4. Paid claims over $30,000, including a claim identifier other than the name and date of the occurrence, the amount paid toward each claim, and claimant health condition or diagnosis.

The claims data must be for the current, or immediately preceding, policy period, as requested by the policyholder.

Protections of the health plan issuer

A health plan issuer that discloses claims data under the bill may condition disclosure on an agreement that releases the health plan issuer from civil liability regarding the use of the data. Furthermore, the bill stipulates that a health plan issuer is also absolved of civil liability relating to subsequent use of the data. By authorizing disclosure of data, the bill does not

authorize disclosure of the identity of a particular covered individual or any particular health insurance claim, condition, or diagnosis in violation of federal or state law.

The bill entitles a group policyholder to receive protected information only after an authorized representative of the group policyholder certifies that (1) the health plan documents comply with federal laws and regulations relating to disclosures[99] and (2) the policyholder will safeguard and limit the disclosure of protected health information (individually identifiable health information). A group policyholder that fails to provide the appropriate certification is not entitled to receive protected health information described in (4) above, but may receive a report of claim information described in (1), (2), and (3), above.

Enforcement

A health plan issuer that commits a series of violations of these requirements that, taken together, constitute a practice or pattern is deemed to have engaged in an unfair and deceptive act or practice in the business of insurance and is subject to sanctions under Ohio Insurance Law.

Disclosure of other information

The bill specifies that it does not prohibit a health plan issuer from disclosing additional claims information beyond what the bill requires.

The bill exempts disclosures made in accordance with the bill to a group policyholder from the prohibition against an insurance institution, agent, or insurance support organization disclosing personal or privileged information.

Scope

A "health plan issuer," for the purpose of these provisions, is an entity subject to Ohio Insurance Laws or the Superintendent of Insurance's jurisdiction that contracts, or offers to contract, to provide, or pay for, health care services under a health benefit plan. In addition to a sickness and accident insurer, health insuring corporation, fraternal benefit society, self-funded

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[99] These provisions raise questions with regard to its interaction with the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA's privacy rule prohibits covered entities from disclosing protected health information. Generally speaking, HIPAA prohibits disclosures of protected health information to third parties unless those disclosures are made in relation to treatment, payment, or health care operations. It is unclear whether the disclosures made to an employer required by the bill would fall under any of these categories. Furthermore, federal rules prescribe only two situations in which the disclosure of protected health information from a health plan issuer to a plan sponsor is explicitly authorized:

- To obtain premium bids from health plans for providing health insurance;
- To modify, amend, or terminate the group health plan.

Note, however, that the HIPAA privacy rule does not apply to information that does not identify or provide a reasonable basis to identify an individual. Accordingly, if a health plan issuer could disclose information in a way that was sufficiently anonymous, it would likely not be in conflict with HIPAA.

multiple employer welfare arrangement, and nonfederal, government health plan, the bill applies to a third party administrator to the extent that the benefits that it administers are subject to Ohio Insurance Laws and Rules or the Superintendent's jurisdiction.

Additionally, a "group policyholder" is a policyholder for a health insurance policy covering 50 or more full-time employees. A "full-time employee" is an employee working an average of at least 30 hours per week during a calendar month, or at least 130 hours during a calendar month.

Effective date

The release of claims data provisions take effect July 1, 2020.

Ohio Assigned Risk Insurance Plan

(R.C. 4509.70)

The bill allows the Ohio Assigned Risk Insurance Plan (OARP) to directly issue automobile insurance policies. Under continuing law, the OARP is a program through which drivers who are unable to obtain automobile insurance through ordinary methods may obtain coverage. Such applicants are often unable to obtain coverage because they are deemed "high risk" by insurers. Coverage under the OARP is available from automobile insurers as provided in a plan approved by the Superintendent of Insurance that fairly apportions applicants among Ohio automobile insurers. The bill expands the availability of such coverage by explicitly authorizing the OARP to directly issue policies as if it were an automobile insurer.

The bill requires that every form of a policy, endorsement, rider, manual of classifications, rules, and rates, every rating plan, and every modification of any of them proposed to be used by the OARP be filed with the Superintendent as if the OARP were any other insurer. The bill requires any policy issued by the OARP to be recognized as if it were issued by any other insurer. The bill requires any policy issued by the OARP to meet all requirements of the Proof of Financial Responsibility Laws. If the policy meets the proof of financial responsibility requirements, the bill requires that it be recognized as if it were issued by any other insurer for purposes of demonstrating proof of financial responsibility.

The bill requires the OARP to make annual audited financial reports and its books and records available to the Superintendent.