OHIO HOSPITAL ASSOCIATION

OHA exists to collaborate with member hospitals and health systems to ensure a healthy Ohio.

Winter 2022

Fast Facts

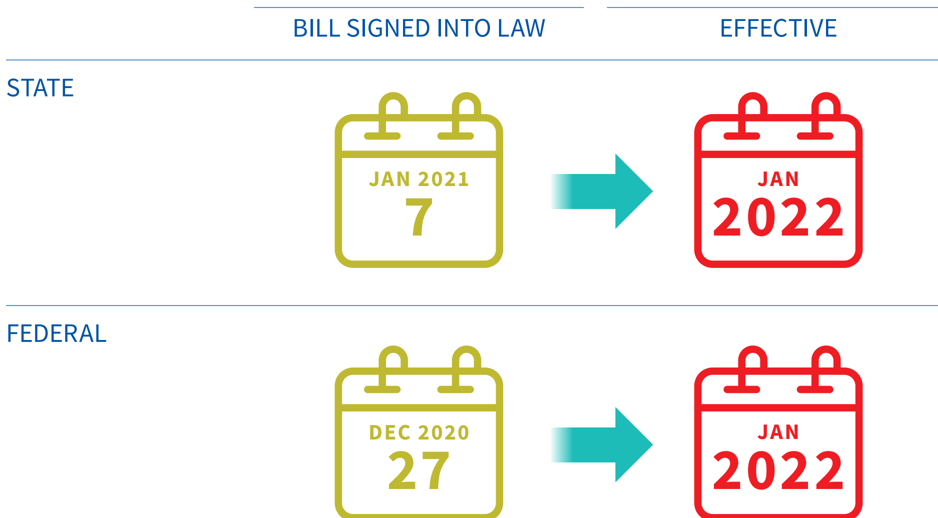
OHA MEMBER SURPRISE BILLING REFERENCE GUIDE

THE ISSUE

Federal, State Balance Billing Policies in Effect

Ohio's surprise billing law protects patients from receiving surprise medical bills for emergency care or, in certain circumstances, unanticipated out-of-network care.

TIMELINE



Primarily, the law prohibits the practice of balance billing patients in these instances, leaving any price negotiation to be handled between the health care provider and the health plan.

The law originated from House Bill 388 of the 133rd General Assembly, which passed in December 2020 and was signed into law by Gov. Mike DeWine Jan. 7, 2021. The Ohio Department of Insurance (ODI) is responsible for administering and enforcing many provisions of this law beginning January 2022. Ohio Administrative Code (OAC) 3901-8-17, Reimbursement for Unanticipated Out-of-Network Care, has been finalized by ODI to implement the law, effective Jan. 1, 2022.

Under the federal No Surprises Act, health care providers, including professionals and facilities, are not permitted to bill out-of-network patients for more than their in-network cost-sharing amount for certain services. The No Surprises Act was signed into law Dec. 27, 2020 as part of the Consolidated Appropriations Act of 2021. Many NSA regulations became effective Jan 1, 2022.

Legislation

Federal No Surprises Act, included as a part of the Consolidated Appropriations Act of 2021

Ohio Surprise Billing Law (House Bill 388, 133rd General Assembly)

Provider Resources/Toolkits

Federal "No Surprises Act" Resources

Ohio Surprise Billing Toolkit

Rules Implementing Laws

Federal No Surprises Act Interim Final Rule

- Requirements Related to Surprise Billing, Part 1
- Requirements Related to Surprise Billing, Part 2
- Prescription Drug and Health Care Spending
- CMS Overview of Rules &Fact Sheets

Ohio Surprise Billing Rule (Ohio Administrative Code 3901-8-17)

CMS Surprise Billing Enforcement Letter

Q&AQ&AQ&AQ&AQ&AQ&AQ&A

Q: How Do The Laws Approach Balance Billing Patients?

A: Under both state and federal laws, health care providers are prohibited from billing out-of-network patients for more than their in-network cost-sharing amount, or balance billing, for certain services. This includes health care professionals, facilities and ground ambulances.

THE PROVISIONS APPLY IN THESE SCENARIOS:

1. A covered person receives **emergency services** (using the prudent layperson standard for seeking such services) from an out-of-network provider at either an out-of-network or in-network facility.
2. A covered person receives **non-emergency services** from an out-of-network provider at an in-network facility.
3. **Clinical laboratory** services are provided by an out-of-network provider, but were ordered by an in-network provider, shall be considered protected under Ohio's surprise billing law, unless the provider rendering the laboratory services discloses its network status in writing to the covered person before the services are provided.
4. Under federal regulations, individuals covered under Medicaid and Medicare plans are already protected from balance billing.
5. For health plans that do not have networks (e.g., reference-based plans), the laws only apply for emergency services as there would never be out-of-network providers providing services at in-network facilities because these plans do not have any in-network providers or facilities.

THE PROVISIONS DO NOT APPLY IN THESE SCENARIOS:

1. The covered person receives non-emergency services from an out-of-network provider at an out-of-network facility (i.e., usually scheduled services)
2. Federal and state regulations permit patients to waive balance billing protections if the out-of-network provider obtains the patient's consent for certain scheduled services provided by an out-of-network provider at an in-network facility.
3. Federal regulation permits patients to waive balance billing protections for post-stabilization services.

Expect Updates

This document will be updated and shared with members as we gather additional guidance and gain experience on how the provisions of the state and federal surprise billing regulations operate. Questions remain around implementation requirements for both state and federal regulations. Members are encouraged to put forth their best effort to abide by the regulations. It is understood that there will be immense growing pains as all parties determine how to implement these requirements appropriately.

OHA will continue our engagement with the relevant regulatory agencies as needed to address issues with implementation.

Q: Which Law is Primary—Federal or State?

A: In general, the No Surprises Act will supersede state laws. If the state law is less protective than the federal law, the federal law may wrap around the state law to provide comprehensive protection.

EXAMPLE: When a patient receives both emergency and post-stabilization services and the state law only provides protections for the emergency services, the state law protections apply for the emergency services, and the federal law applies to the remainder of the care (up to the limits in federal law and regulations).

Q: What Are Limits of Notice and Consent?

A: The federal law prohibits the use of notice and consent for certain services, including:

1. Emergency services (with the exception of some services provided post-stabilization)
2. Items or services that are delivered as a result of an unforeseen urgent medical need that arises during a procedure for which notice and consent was received
3. Items and services for which no in-network provider is available in the facility
4. Certain ancillary services

Providers do not need to use the notice and consent process in instances where the NSA patient protections do not apply, such as when both the provider and facility are out-of-network, for non-emergency care.

Q: How Do Providers Secure Payment For Unanticipated Out-Of-Network Care?

A: Under state law, a request for reimbursement for unanticipated out-of-network care by the provider must include:

1. Sufficient information for the health plan issuer to identify the facility where a health care service was provided, and
2. Sufficient information for the health plan issuer to identify a request for reimbursement where the provider has met the good faith estimate requirement and affirmative consent conditions contained in division (E)(1) of section 3902.51 of the Revised Code.

Federal legislation defers to state law or policy for reimbursement for out-of-network services. Under federal and state regulations, health plan issuers are required to make an initial payment for unanticipated out-of-network care directly to providers within 30 calendar days of the date the claim is received.

Q: What If The Provider Disagrees With The Payer's Reimbursement Rate?

A: Providers must notify the health plan issuer of their intent to negotiate reimbursement within 30 business days of receiving reimbursement for unanticipated out-of-network care. Failure to notify the health plan issuer of an intent to negotiate with 30 business days is considered acceptance of the health plan issuer's reimbursement.

Q: What Reimbursement Rates Apply For Unanticipated Out-Of-Network Care?

A: House Bill 388 established the default reimbursement rate for unanticipated out-of-network care as the greatest of the in-network rate, the out-of-network rate or the Medicare rate.

State regulation requires the health plan issuers to include remark codes on the remittance advice to identify that the payment is "the greatest of three" potential amounts. Providers are encouraged to use the remittance advice remark codes to flag eligible claims for immediate review to determine whether negotiation is necessary.

Q: When Are Third Parties Involved?

A: If a provider and health plan cannot agree on reimbursement within 30 days of the initial payment from the health plan issuer to the provider, either party may pursue the independent dispute resolution, or IDR, process or arbitration process to use an independent contracted arbitration entity to determine payment.

Each party will then provide a final offer for reimbursement and any supporting documentation to the IDR/arbitration entity for review. The IDR/arbitration entity must render a decision within 30 days. The non-prevailing party must then remit the difference in payment to the prevailing party within 30 days.

QUICK VIEW

Comparing the State and Federal Laws

	FEDERAL REGULATION	STATE REGULATION
Applicable Health Plans	Health plans regulated by the federal government generally will include: • Self-insured group plans (i.e., ERISA), including ACA grandfathered health plans • Federal Employees Health Benefits Program	Health plans regulated by state government generally will include: • Fully insured individual and group market plans • Health plans regulated by the state of Ohio should have the letters "ODI" clearly denoted on member's insurance identification card, as required by OAC 3901-8-17
Applicable Providers	• Hospitals, critical access hospitals, freestanding emergency departments, ambulatory surgical centers • Providers furnishing services at a facility • Air ambulances	• Hospitals, critical access hospitals, freestanding emergency departments • Providers furnishing services at a facility • Ground ambulances

	Federal Regulation	State Regulation
Covered Services	• Emergency services • Post-stabilization services until the patient is discharged or transferred [1] • Scheduled professional services when provided at an in-network facility, unless the provider obtains the patient's consent to out-of-network services	• Emergency services • Clinical lab services provided by an out-of-network provider but ordered by an in-network provider[2] • Scheduled professional services when provided at an in-network facility, unless the provider obtains the patient's consent to out-of-network services

Disclosure Notice Requirements	• Must be publicly available and posted on facility's public website
	• One-page notice that includes information on:
	  ◦ The restrictions on providers and facilities regarding balance billing in certain circumstances
	  ◦ Any applicable state law protections against balance billing, and
	  ◦ Information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing
	• CMS model disclosure form
		• The Ohio Department of Insurance encourages the use of the CMS model disclosure form.
		• Providers can use the following language for the description of Ohio's surprise billing law:
		Ohioans who get health insurance through plans regulated by the Ohio Department of Insurance are also protected from receiving surprise medical bills under Ohio law. Ohio law provides the following protections when you receive unanticipated out-of-network care:
		  ◦ No balance billing for emergency services, including emergency services provided by an ambulance, even if they're provided out-of-network.
		  ◦ No balance billing by out-of-network providers at an in-network facility when you're unable to choose an in-network provider.
		  ◦ Your cost-sharing amounts, such as copayments, coinsurance, and deductibles, are limited to the amount you would pay for in-network services.
		You can find additional information at Surprise Billing | Department of Insurance (ohio.gov)

1 Patients can waive balance billing protections for post-stabilization services.
2 Patients can be balance billed if the provider rendering the lab services discloses its network status in writing to the covered person before the services are provided.

	Federal Regulation	State Regulation

Notice and Consent Requirement

Federal Regulation

- A patient must receive the notice with the request for their consent to be balance billed at least 72 hours before the service or treatment is to be delivered.
- For same-day services, the notice must be provided at least three hours prior to receiving the service or treatment.
- CMS model notice and consent form
  - These documents may not be modified by providers or facilities, except as indicated in brackets or as may be necessary to reflect applicable state law.
- The notice and consent documents must be provided in the top 15 languages in a state or geographic region in which the applicable facility is located.
- The standard notice and consent documents must be given physically separate from and not attached to or incorporated into any other documents.
- The documents must not be hidden or included among other forms, and a representative of the provider or facility must be physically present or available by phone to explain the documents and estimates to the individual, and answer any questions, as necessary.

State Regulation

- The Ohio Department of Insurance encourages the use of the CMS model notice and consent form.

Good Faith Estimate of Charges

Federal Regulation

- Providers are required to provide good faith estimates of all expected charges for scheduled services prior to care.
- For insured patients, the providers will transmit the good faith estimates to the patient's health plan[3]; the health plan will use that information to create an advanced explanation of benefits for the patient.
- For uninsured patients, the provider will send the estimates directly to the patient[4].
  - The notice and consent form must include a good faith estimate of the out-of-network charges.
- The good faith estimate reflects the amount the provider or facility expects to charge for furnishing such items or services, even if the provider or facility intends to first bill the health plan/issuer.

State Regulation

- If the provider intends to balance bill the patient, they are required to provide 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 and the patient must affirmatively consent to receive the services.

3 Effective date for good faith estimates for insured patients and advanced EOBs is TBD.
4 Effective date for good faith estimates for uninsured patients is Jan. 1, 2022.

	Federal Regulation	State Regulation
Independent Dispute Resolution/Arbitration Process	• If a provider and health plan cannot come to agreement on reimbursement within 30 days of the initial payment from the plan to the provider, either party may trigger the IDR process (referred to as "notifying") within four days of the conclusion of the 30-day open negotiation period. • The plan and provider then have three business days to jointly select the IDR entity to oversee the case; should that fail, the secretary of the U.S. Department of Health & Human Services has up to three business days to select one on their behalf. • Within 10 days of the selection of the IDR entity, each party must submit an offer for reimbursement, as well as any supporting materials • The IDR entity must select one of the offers without modification as the final reimbursement determination within 30 days of the IDR entity having been selected • Once a determination has been reached in a case, the payer must remit reimbursement to the provider within 30 days	• Requests for arbitration must be s ubmitted to the Ohio Department of Insurance superintendent. A form will be made available on ODI's website. • Maximus Federal Services is the state's single arbitration entity. • An arbitrator will be assigned by ODI's contracted arbitration entity within 10 business days • Within 10 business days after an arbitrator is assigned, each party must submit its final offer and supporting evidence ◦ Billed charges and public payer rates may not be submitted as evidence • The arbitrator must render a decision within 30 business days • If the arbitrator determines the provider's final offer best reflects a fair reimbursement, the health plan issuer must pay the difference to the provider within 30 calendar days of the arbitrator's decision • If the arbitrator determines the health plan issuer's final offer best reflects a fair reimbursement, the provider must pay the difference to the health plan issuer within 30 calendar days of the arbitrator's decision
Batching/Claims Bundling for Arbitration	• Providers may batch together like claims attributable to the same health plan that occur during a 30-day period.	• If negotiation is unsuccessful, the provider may choose to arbitrate that claim as a bundle of up to 15 claims at a later date[5]
Payment for IDR/ Arbitration Process	• The party that submits the losing bid is responsible for the costs of the IDR process • If the dispute is resolved between the two parties prior to the conclusion of the process, the parties must split whatever costs have been incurred by the IDR entity to that point	• Each arbitration will be a flat fee. • There will be no additional costs for an arbitration case of up to 15 bundled claims. • The non-prevailing party must pay 70% of the arbitrator's fees. • The prevailing party must pay 30% of the arbitrator's fees. • If multiple claims are bundled in a single arbitration case and the arbitrator selects a final offer from each party the same number of times, then there is no prevailing party, and each party shall pay 50% of the arbitrator's fees.

FOR MORE INFORMATION, CONTACT:

Quyen Weaver
Director, Health Economics & Policy

Stephanie Gilligan
Senior Director, Advocacy

[5] All claims in the bundle must meet the requirements of division (A)(1) of section 3902.52 of the Revised Code.