What Ohio's 'Surprise Billing' Ban Means For Providers

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Ohio's H.B. 388, passed on Jan. 1 and codified in Ohio Revised Code Sections 3902.50-.54, prohibits certain out-of-network providers, facilities, emergency facilities and ambulances from balance billing patients for services.

Out-of-network providers are now required to seek full reimbursement for their services from the patient's health plan. H.B. 388 created a required procedure to facilitate these payments to out-of-network providers.

Health plans are required to make an initial payment equal to the greatest of three amounts they are required to calculate. Out-of-network providers can either accept the payment as full reimbursement or initiate a negotiation and arbitration process.

The negotiation process is generally informal, excluding certain statutory deadlines, but the arbitration process requires the use of an arbitrator contracted by the Ohio Department of Insurance, and delineates the factors to be considered in the decision-making process.

The ODI was tasked with promulgating rules to clarify several key aspects of the law. The ODI finalized Rule 3901-8-17, Reimbursement for Unanticipated Out-of-Network Care on Dec. 20, 2021, and the rule became effective in January and applies to care received on or after Jan. 12.

On Feb. 24, the U.S. District Court for the Eastern District of Texas granted the Texas Medical Association's motion for summary judgement, vacating portions of the interim final rules implementing the federal No Surprises Act.[1]

There are still at least five other pending lawsuits challenging aspects of the No Surprises Act. Given the activity and challenges to the No Surprises Act, the ODI's new rule could experience similar uncertainty.

Determination of Reimbursement Rate

The ODI's new rule clarifies a couple elements of this greater-of-three rate calculation standard. Perhaps most importantly, the new rule clarifies that the geographic region for determining the in-network rate will be tied to Ohio's metropolitan statistical areas, as defined by the U.S. Office of Management and Budget and the U.S. Census Bureau.

All other regions of Ohio that are not within a metropolitan statistical area will be aggregated to form their own geographic region. Further, the new rule requires reimbursement claims to be submitted with the proper billing code, sufficient information to identify the facility where the services were provided, and sufficient information for the health plan to identify an exempt claim.

Negotiating Reimbursement Rate

The ODI's new rule establishes a timeline for rate negotiations and a limited right for out-of-network providers to request information. Out-of-network provider's have 30 business days, after the initial payment, to notify the health plan that it wants to negotiate the rate otherwise the payment is deemed accepted.

During negotiations health plans must, upon an out-of-network provider's request, disclose the three reimbursement rates used in its greatest-of-three calculation.[2] Note, the plan is only required to disclose the value, not the formula used to reach the rate. The new rule also requires parties to engage in good faith negotiations to settle the claim for at least 30 business days. After which, the out-of-network provider may escalate to arbitration.

Arbitrating Reimbursement Rate

The ODI's new rule established the arbitration timeline, bundling requirements, costs and evidentiary limitations for reimbursement disputes. Out-of-network providers may bundle up to 15 claims for arbitration provided the claims are under the same health benefit plan, involve the same or similar services provided under similar circumstances, use the same coding set and are delivered by out-of-network providers of the same license type.

Only claims in excess of $750 that were provided within the year prior to the request are eligible for arbitration. Further, only evidence and supporting information that relates to the factors in Revised Code 3902.52(C) may be submitted, and it must be in a form that can be verified and authenticated. Parties are prohibited from submitting billed charges or the applicable Medicare or Medicaid reimbursement rates as supporting evidence.

Assessment

There are a number of issues providers will need to navigate in connection with out-of-network services as a result of federal and state law. For starters, health care providers will need to identify out-of-network claims, assess the reimbursement rate, determine whether to negotiate or arbitrate, identify which negotiation or arbitration rules apply,[3] and initiate the appropriate process.

Under the new rule, out-of-network providers will have to do this, for all out-of-network claims, within 30 business days of receiving payment or risk losing their rights. This arduous process will likely result in inconsistent reimbursement rates and add considerable administrative costs to the provision of health care services in Ohio.

Providers will also have to navigate difficulties associated with determining whether the reimbursement rate they are being paid is adequate and equitable. Health plans are required to pay the greatest of three rates for out-of-network services calculated based on the statutory formulas.

For two of the formulas, out-of-network providers will have no insight into how the values are calculated as each health plan is permitted to use its own methods and interpretations so long as they are consistent with the new rule's ambiguous requirements.

Further, health plans can use different methods for different providers when calculating the rates. Providers will only see the amount they are reimbursed when the payment is received and cannot review the three rates derived from the formulas or the interpretations used or their interpretations and there appears to be little administrative oversight built into H.B. 388 or the new rule.

Finally, the calculation methods are loosely defined and significantly vary from the greatest-of-three calculation methods in the No Surprises Act. As a result, health plans could use these ambiguities and inconsistencies to forum shop or manipulate reimbursement rates among providers, geographic regions or as they otherwise see fit.

The geographic regions defined by the new rule may also create significant problems for providers, particularly rural providers, and could form the basis for an administrative challenge. Ohio's metropolitan statistical areas primarily cover each of Ohio's major cities, including Columbus, Cincinnati, Cleveland, Dayton, Toledo, Akron, Mansfield, Youngstown and Lima.[4]

By aggregating all nonmetropolitan statistical areas into one geographic region for purposes of calculating the in-network reimbursement rate, the ODI has functionally separated the reimbursement rate from the locality where the service was provided. This separation could form the basis for an administrative challenge because the statute requires insurers to tie the calculation of its reimbursement rate to "that geographic region under the health benefit plan."[5]

For example, a health care provider in Hancock County, Ohio, could have its out-of-network reimbursement rate calculated, in part or in whole, by the health plan's in-network rates for providers in Ashtabula or Athens County, Ohio, and vice versa.

Since rural providers already tend to receive less from health plans for similar services, this effect could be compounded by aggregating them together. A health plan calculating a reasonable, usual and customary rate, despite its historical practices, would be able to selectively choose the applicable rural locality within this catch-all geographic region resulting in a race to the bottom for usual and customary rates.

Additionally, rural providers are generally lean organizations that cannot afford the additional administrative burden of negotiating or arbitrating every out-of-network service claim. This could result in the majority of providers in rural Ohio receiving Medicare rates for their out-of-network services since the other two methods of calculating reimbursement rates can be driven down.

Aside from these problematic issues, there are numerous others that the new federal and state no surprise billing laws do not consider such as the interaction of these requirements with mental health parity and telemedicine laws. Over the course of 2022, health care providers will likely have their hands full as they attempt to implement and navigate these requirements.

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[1] Texas Medical Association v. U.S. Department of Health and Human Services, No. 6:21-cv-425 (E.D. Tex., Oct. 28, 2021).

[2] See R.C. 3902.51(B)(1).

[3] Generally, providers will be required to comply with the federal No Surprises Act. There are, however, numerous exceptions. For instance, state law will govern if it is more protective that the requirements under the No Surprises Act and state law will likely govern for state-regulated plans. The No Surprises Act does not apply to ground ambulances and state law may not apply to ERISA or other federally regulated benefit plans.

[4] The U.S. Census Bureau's most recent map is available here.

[5] R.C. 3902.51(B)(1)(a).