
DEPARTMENT OF INSURANCE

Reimbursement for out-of-network care (VETOED)

- Would have required an insurer to reimburse an out-of-network provider for unanticipated out-of-network care provided at an in-network facility and for emergency care provided at any facility (VETOED).
- Would have prohibited a provider from balance billing a patient (1) for unanticipated or emergency out-of-network care provided at the above facilities and (2) for any other out-of-network care unless certain conditions were met (VETOED).
- Would have established alternative dispute resolution procedures for disputes between providers and insurers regarding unanticipated or emergency out-of-network care (VETOED).

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, but specifies that a health plan issuer is not required to reimburse for telemedicine services at the same rate 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, 2021.

Minimum charges for health services

- Declares void any provision in a contract that requires health care providers to charge minimum amounts for health care services or that prohibits providers from advertising their rates.

Pharmacy copayments

- Prohibits health plan issuers and third party administrators from (1) requiring or directing pharmacies to collect cost-sharing beyond a certain amount from individuals purchasing prescription drugs, (2) retroactively adjusting pharmacy claims other than as a result of a technical billing error or a pharmacy audit, and (3) 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 pharmacy copayment provisions.
- Requires the Department of Insurance to create a web form for consumers to submit complaints relating to violations of the pharmacy copayment provisions.

Direct primary care agreements

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

Health care price transparency (VETOED)

- Would have added to preexisting health care price transparency requirements that apply to health care products, services, and procedures (VETOED).
- Would have required that certain health care providers, health plan issuers, and Medicaid to provide to patients or their representatives, within specified time limits, a cost estimate for nonemergency products, services, or procedures before each is provided (VETOED).
- Would have required the Department of Insurance to create or procure a connector portal that health care providers may use to transmit information to health plan issuers for their use in generating cost estimates (VETOED).
- Would have authorized any member of the General Assembly to intervene in litigation challenging either the preexisting or additional health care price transparency provisions (VETOED).

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.
- Requires policies issued by OARP 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 (VETOED)

(R.C. 3902.50, 3902.51, and 3902.52; Section 739.31)

Unanticipated out-of-network care in network facility

The Governor vetoed provisions that would have required a health plan issuer to reimburse an individual out-of-network provider for unanticipated out-of-network care when

the care was provided to a covered person at a facility that was in the health benefit plan's provider network. The provider would have been required to charge the health plan issuer, and the issuer would have been required to reimburse the provider.

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

- The covered person did not have the ability to request such services from an in-network provider; 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.

Emergency out-of-network care at out-of-network facility

The above reimbursement provisions would also have applied in the context of emergency care provided at an out-of-network facility. In addition, a health plan issuer would have needed to reimburse the out-of-network emergency facility, not just the individual provider.

Amount of reimbursement

The reimbursement described above would have been required to be the greatest of the following three amounts:

- The median amount the health plan issuer negotiated with in-network providers for the service in question;
- The rate the health plan issuer pays for out-of-network services; or
- The rate paid by Medicare for the service in question.

Prohibition on balance billing

In addition to requiring a health plan issuer to reimburse a provider or facility, the act also would have prohibited a provider or facility from billing a covered person for the difference between the issuer's out-of-network reimbursement and the provider's or facility's charge (balance billing), so long as the care had been provided in Ohio.

Cost sharing

The act would have prohibited a health plan issuer from requiring cost sharing from a covered person at a rate higher than if the unanticipated or emergency care had been provided on an in-network basis.

Price transparency

The Governor also vetoed provisions relating to health care services, other than unanticipated or emergency services, provided by an individual out-of-network provider at an in-network facility. These provisions would have required such a provider to do the following in order to charge a covered person:

- Inform the person that the provider is not in the person's health benefit plan network;
- Provide the person a good faith estimate for the cost of the services, the estimated reimbursement, and the person's individual responsibility; and
- Obtain the person's affirmative consent to receive the services.

The act would have allowed the health plan issuer to reimburse the provider at either the health plan's in-network or out-of-network rate.

Penalties

A pattern of continuous or repeated violations of any of the above provisions would have constituted an unfair or deceptive act or practice in the business of insurance, potentially subjecting the violator to penalties including payment of damages, a limitation or suspension of the violator's ability to engage in the business of insurance, and an investigation by the Attorney General.

Alternative dispute resolution

The act would have allowed a provider to request alternative dispute resolution from the Superintendent of Insurance to resolve a billing dispute for unanticipated or emergency out-of-network care if both of the following applied:

- The provider believed that the health plan issuer's offer of reimbursement did not meet the requirements in "**Amount of reimbursement**" above; and
- The billed amount exceeded \$700.

Additionally, the Superintendent of Insurance would have been required to adopt alternate dispute resolution procedures. It would have specifically required mediation to be attempted before arbitration.

Effective date

The requirements would have begun to apply beginning April 1, 2020, to health benefit plans entered into or renewed on or after October 17, 2019.

Telemedicine services

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

The act 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. A "**telemedicine service**" is a health care service provided through synchronous

or asynchronous information and communication technology by a health care professional who is located at a site other than where the recipient is located.

A health benefit plan may not exclude coverage for a service solely because it is provided as a telemedicine service. The act 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.

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 act does not require a health plan issuer to reimburse a health care provider (1) at the same rate as in-person services or (2) 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.

A physician, physician assistant, or advanced practice registered nurse may not charge 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 telemedicine provisions apply to all health benefit plans issued, offered, or renewed on or after January 1, 2021.

Minimum charges for health services

(R.C. 3902.31)

The act declares void any provision in a contract between a third-party payer (any person that reimburses another for covered health services, such as an insurer or third-party administrator) and a provider (a facility or individual that provides health care services) that does either of the following:

- Establishes a minimum amount that the provider is required to charge an individual for a health service when that individual pays in full for the service; or
- Prohibits a provider from advertising the provider's rates for a service.

Such a contract may, however, prohibit a provider from disclosing or advertising contractually agreed upon reimbursement rates.

These requirements apply to all new contracts between a third-party payer and a provider entered into on or after October 17, 2019 (the section's effective date). For contracts in existence prior to and continuing through that date, the requirements apply three years after that date or at the expiration or renewal of the contract, whichever occurs first.

Pharmacy copayments

(R.C. 1739.05, 1751.92, 3923.87, 3959.12, 3959.20, and 4729.48; Section 739.20)

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

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

A health plan issuer also is prohibited from directing a pharmacy to collect cost-sharing in such a prohibited amount.

Prohibited adjustments and fees

A health plan issuer may not retroactively adjust a pharmacy claim for reimbursement for a prescription drug unless the adjustment resulted from either a technical billing error or a pharmacy audit.

Also, 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

If a pharmacy benefit manager or other administrator knowingly violates the act's pharmacy copayment provisions, its license may be suspended for up to two years, revoked, or not renewed by the Superintendent of Insurance.

If a health insuring corporation or a multiple employer welfare arrangement fails to comply with the pharmacy copayment 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 pharmacy copayment, 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 for violating the law. It appears that R.C. 3923.87, enacted by the act, 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 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 pharmacy copayment provisions, the Board 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 pharmacy copayment requirements apply to contracts for pharmacy services and to health benefit plans entered into or amended on or after October 17, 2019.

Direct primary care agreements

(R.C. 3901.95)

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

- 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 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, or up to 60 days after, the other party's receives the notification.
- It does not impose a termination penalty or 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 (VETOED)

(R.C. 3962.01 to 3962.15 and 5164.65; Section 751.15)

The Governor vetoed provisions that would have added to existing health price transparency requirements, which apply to health care products, services, and procedures, but have not been implemented due to ongoing litigation.⁶⁸ The vetoed provisions generally would have required certain health care providers and health plan issuers to provide to patients or their representatives a cost estimate, within specified time limits, for nonemergency health care products, services, or procedures before each was provided. They also would have required the Department of Insurance to have a connector portal that health care providers could have used to transmit information to health plan issuers for their use in generating cost estimates. A detailed description of the vetoed provisions is available on pages 240 to 252 of LSC's analysis of H.B. 166, As Passed by the House. The analysis is available online at <https://www.legislature.ohio.gov/download?key=12043&format=pdf>.

Ohio Assigned Risk Insurance Plan

(R.C. 4509.70)

The act 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 act expands the availability of such coverage by explicitly authorizing the OARP to directly issue policies as if it were an automobile insurer.

Every form of a policy, endorsement, rider, rules, and rates, etc., proposed to be used by the OARP must be filed with the Superintendent as if the OARP were any other insurer. The act requires any policy issued by the OARP to be recognized as if it were issued by any other insurer. Any policy issued by the OARP must meet all requirements of the Proof of Financial Responsibility Laws. If the policy meets those requirements, the policy will be recognized to demonstrate proof of financial responsibility.

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

⁶⁸ See R.C. 5162.80, not in the act.