

*Sent via e-mail*

May 28, 2021

Ohio Department of Insurance  
50 W. Town Street, Suite 300  
Columbus, OH 43215

Re: Ohio Hospital Association comments on draft rule 3901-8-17: Reimbursement for Unanticipated Out-of-Network Care

To Whom it May Concern:

On behalf of the Ohio Hospital Association's 243 hospitals and 15 health systems, we appreciate the opportunity to provide feedback on the Ohio Department of Insurance's proposed language for rule 3901-8-17, which addresses reimbursement for unanticipated out-of-network care.

When House Bill 388 of the 133<sup>rd</sup> General Assembly was working its way through the legislative process, we provided testimony affirming that the hospital community shares the legislature's goal of protecting patients from surprise medical bills. We agree that patients should not be balance billed for emergency services or for out-of-network services obtained in any in-network facility when they reasonably could have assumed that the providers were in-network with their health plan.

As the Ohio Department of Insurance works to draft rules to implement the legislation, we appreciate the robust stakeholder engagement process that is being conducted. In order to share the hospital community's perspective, OHA also shared the proposed language with our member hospitals.

We received many comments highlighting the timeframes outlined in 3901-8-17(H), the section of the rule that addresses negotiation in lieu of accepting issuer reimbursement. This section directs the provider, facility, emergency facility, or ambulance to notify the health plan issuer of their acceptance of reimbursement or their intent to negotiate within thirty days. We heard overwhelmingly from hospitals that this timeframe is too short. We suggest providing 90 days for this process to occur. This length of time will better accommodate the high volume of claims some providers experience as well as allow facilities to adjust their workflow.

Another area of interest is 3901-8-17(F), the section of the rule that outlines health plan issuer reimbursement for unanticipated out of network care. This section details the use of geographic regions in the calculation of health plan issuer reimbursement amounts. We suggest ensuring that the comparison provided by the issuer is as "like" as possible and reflects the actual payment rate for services provided. Since plans utilize different payment methodologies and rating areas in Ohio are broad, there could be significant variability in how reimbursement rates are determined and how appropriate they are. For example, in counties where there is only one hospital, perhaps the rate comparison should be to other counties where there is only one hospital.

There are also several terms we'd like to see clarified. For example, when "days" is used, does that mean calendar days or business days? We would recommend business days.

When "timely" is used (in section 3901-8-17(H)), we suggest clarifying that it means 60 days from payment. Further, we suggest considering when the notification of the intent to negotiate must occur. For example: is the

notification required after a claim is adjudicated, after receipt of payment, or after acceptance of reimbursement? Providers oftentimes do not know how the claim is going to be adjudicated until the payment is received into their accounts, so we suggest the “clock begins to run” when the provider receives payment.

A related issue that has been raised is ongoing challenges with identifying patients who are truly “out-of-network.” For example, there are some payers that don’t engage in traditional contracts with providers but tell their enrollees that they are “in-network” everywhere and will pay a certain percentage of Medicare. Providers do not consider themselves to be “in-network” in such scenarios because they do not have contracts with such payers. These situations will cause confusion for both patients and providers in terms of understanding what scenarios fall under these new guidelines.

It is also difficult to determine which plans are ERISA plans, a problem we have previously raised with the Department. We suggest requiring issuers to more clearly identify whether they are a self-insured or fully-insured plan, potentially on the member ID card.

These issues with identifying what type of plan a patient has will contribute to challenges with implementing the new requirements. Providers will have to sort through each case, manually “touch” each one to validate coverage status, and then notify the patient in the appropriate timeframe. More clearly distinguishing the type of coverage the patient has would help alleviate this burden and potential delays.

Finally, it is worth noting that the federal government also passed a surprise billing law around the same time Ohio did. On December 27, 2020, the No Surprises Act was signed into law as part of the Consolidated Appropriations Act of 2021. Most sections of the No Surprises Act go into effect on January 1, 2022 and several federal agencies are currently working to promulgate rules implementing a number of the provisions. Ohio’s law goes into effect January 12, 2022, with the new requirements taking effect nine months after. Given the overlapping subject matter and timelines of these bills, we continue to urge the Department to align provisions and terms as much as possible to ease the administrative burden on providers and reduce confusion for patients.

We appreciate the attention on this important issue, and we look forward to continuing to work together to achieve a workable solution.

Sincerely,



Stephanie Gilligan  
Senior Director of Advocacy