OHIO HOSPITAL ASSOCIATION

Collaborating to
Ensure a Healthy Ohio

August 19, 2021 *Sent via e-mail*

Sean McCullough, Director
Ohio Common Sense Initiative
77 S. High Street, 30th Floor
Columbus, OH 43215

Re: Ohio Hospital Association Comments on Ohio Department of Insurance Proposed Rule 3901-8-17: Reimbursement for Unanticipated Out-of-Network Care

Dear Director McCullough:

On behalf of the Ohio Hospital Association's 245 hospitals and 15 health systems, we appreciate the opportunity to provide feedback on the Ohio Department of Insurance's proposed rule 3901-8-17, which addresses reimbursement for unanticipated out-of-network care.

We understand that the mission of the Common Sense Initiative is to reform Ohio's regulatory policies to help make Ohio a jobs and business-friendly state by eliminating excessive and duplicative rules and regulations. Notably, the CSI program has focused on four goals, two of which are particularly relevant to our comments on ODI rule 3901-8-17:

(1) Compliance should be easy and inexpensive; and
(2) Regulations should be fair and consistent.

OHA is concerned the proposed rule poses significant compliance challenges for hospitals and will be impossible to implement in some cases.

The hospital community shares ODI's goal of ensuring patients are protected from surprise medical bills. Hospitals agree that patients should not be balance billed for emergency services or for out-of-network services obtained in an in-network facility when they reasonably could have assumed that the providers were in-network with their health plan. However, aspects of the proposed rule make compliance challenging and expensive, and disproportionately place regulatory burden on providers.

OHA has submitted two previous comment letters to ODI, outlining concerns with earlier drafts of the rule. While we appreciate the stakeholder engagement process conducted by the Department, we are disappointed that some of the concerns we shared have not been addressed. Additionally, the version of the rule filed with CSI introduced new language that poses additional questions and concerns.

We have continued to stress our concerns with the timeframes outlined in 3901-8-17(I), the section of the rule that establishes timelines and conditions for negotiations before proceeding to arbitration. The current timeframe of 30 days is too short and is unworkable, as it often takes weeks for hospitals to be able to identify claims that are eligible for arbitration. Our concerns with the 30-day timeframe were not addressed in previous versions of the rule. This is a significant area of concern for the hospital industry, and we urge ODI to modify the language to allow 90 days for the provider, facility, emergency facility, or ambulance to notify the health plan issuer of their intent to negotiate. A 90-day period will better accommodate the high volume of claims many hospitals experience (thousands daily in some hospitals) as well as allow facilities to

adjust their workflow to identify claims for which negotiation is necessary. It is also important to note that some hospitals and payers may negotiate "notice of intent to negotiate" periods that are longer than 30 or 90 days. To reflect this contractual right, we ask ODI to allow for these arrangements and give preference to a longer negotiation period when contractually agreed to between providers and payers. Finally, we understand that ODI has maintained the 30-day time frame in order to align with proposed federal rules. However, the federal rule is not finalized, and hospital stakeholders are also submitting feedback to the relevant federal agencies involved in the rule-making process asking for this time period to be extended.

The most significant new area of concern in the proposed rule is section (F), which establishes the parameters for reimbursement by requiring providers to include sufficient information on a request for reimbursement in order to facilitate health plan issuers' processing of claims for unanticipated out-of-network care. More specifically, proposed section (F)(4)(c), which requires a request for reimbursement of a healthcare service to include "whether the provider, facility, emergency facility, or ambulance is prohibited from billing the covered person for the difference, if any, between the health plan issuer's reimbursement and the provider's charge for the service," places the new regulatory burden solely on the provider. Often the provider does not have access to all information necessary to determine whether the healthcare service was provided in an in-network or out-of-network situation. This is information traditionally maintained by payers, who are in the best position to know this information because it is the payer that adjudicates a claim as in-network or out-of-network based on the patient's specific benefit plan.

Here is a very common, sample fact pattern to illustrate this point:

- Patient maintains insurance coverage with Payer;
- Provider is contracted with Payer;
    - As a contracted provider, Provider expects contracted reimbursement;
- Payer has a summary plan description between Payer and Patient;
    - Provider does not know the terms of this plan;
    - In the plan, Patient's specific group coverage restricts network access and Provider is considered out-of-network or not a covered location/entity for Patient to receive services;
- Patient receives health care services from Provider
    - Again, as a contracted provider, Provider expects contracted reimbursement;
    - However, Payer processes the claim and denies it, or applies out-of-network benefits based on Patient's contract with Payer;
    - Patient's contract with Payer is not visible to Provider, so there is no way for Provider to know it is not in Patient's network until Payer tells Provider;
- Note that when Provider verified Patient's coverage at the time of benefit verification (perhaps before services were rendered), Patient would have appeared as an "active" insured (because Provider has a contract with Payer).
    - The plan details as between Payer and Patient are not visible to Provider at the point of benefit verification and are not provided by Payer to Provider at any point in the process.
    - The direct contract between Payer and Patient restricting network access is only visible between Payer and Patient.
- Accordingly, Payer is the only source of Patient's network status under the very common facts outlined in this example.

In situations like the one detailed above, and many others, providers rely on the health plan to provide a patient's eligibility status as there is no way a provider can obtain this network status information on their own. Providers' inability to make this network determination at the time the provider confirms the patient's coverage and benefits places the provider at risk of being non-complaint with this rule. However, if health plans provided more information at the time the provider verifies a patient's insurance coverage and benefits, providers may be able to better comply with the proposed rule.

We believe there is sufficient information on the claim form that the payers can use to determine whether the service provided to the patient was rendered by an out-of-network healthcare provider at an in-network facility. Based on discussions with our members, claim forms for physician services delivered at a hospital include the physician's identifying information; the name, location, and NPI of the hospital where services are delivered; and the name, location, and NPI of the billing provider group that delivers the services. This information should make it possible for the payer to identify a service as provided by an out-of-network provider at an in-network facility. However, in the interest of seeking a workable solution to this issue, we look forward to ODI convening a small group of providers and payers to better understand each party's perspective and work together to resolve this issue.

Another area of importance is giving providers the ability to determine whether a patient's plan is governed by state or federal regulation. We appreciate the Department's efforts to address this issue by requiring health plan issuer identification cards to denote the letters "ODI" or "DOI" if they are subject to Ohio Department of Insurance regulation. We would recommend, however, that the cards be required to just indicate "ODI" on the card, rather than providing multiple options for payers, which will cause confusion to providers, who already have to decipher numerous codes on insurance cards. In addition, patients frequently present for services without their insurance card. For this reason, this identifier requirement on insurance cards does not alleviate the challenges of identifying a patient's specific benefit plan. Therefore, we would encourage the rule to require health plans to share this information with providers during the insurance and benefits verification process.

Another provision of concern is the language in proposed subsection (F)(1) regarding geographic regions. OHA's concern is that this section captures geographic regions of the state that are unrelated to the location where the patient received the health care service. Geographic considerations play an important role in establishing in-network rates, so we are concerned that including rates that are not geographically related to where the patient receives services could inappropriately skew such rates.

There is still much work to do before rule 3901-8-17 is finalized. Although the statutory effective date of this rule is January 2022, we ask ODI to consider a delayed enforcement date for these requirements. Given the administrative complexities that also require adjustments to current processes and the need to establish new processes, providers and health plans need more time to ensure that a workable solution has been achieved and that the patient is fully protected against surprise billing, as intended by this regulation. A delayed enforcement date may also allow for alignment with federal rules regarding this issue, which have not been finalized yet.

We urge the Common Sense Initiative to recognize that the current version of this rule raises serious concerns about the ability of hospitals and other providers to comply. OHA is committed to continuing to

work together to achieve a workable solution and looks forward to working with ODI and the payer community to further discuss provisions of concern.

Thank you for your consideration.

Sincerely,

Stephanie Gilligan
Senior Director of Advocacy