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Ohio Department of Insurance
50 West St, Suite 300
Columbus, Ohio 43214

Re: Comments on Draft Rule 3901-8-17 Reimbursement for Unanticipated Out-of-Network Care

On behalf of the Ohio Society of Pathologists (OSP), I am submitting the following comments on the above captioned draft rule.

I. Purview of the Proposed Rule In Application to Clinical Laboratories Does Not Conform to the Act

The proposed rule 3901-8-17 at E 7 (a)(i), with respect to clinical laboratory services, does not fundamentally conform to the law. Specifically, the ORC § 3902.51 (A) (1) limits the application of the law to the following scenario applicable to clinical laboratory services: "when **both** (emphasis added) of the following apply: (i) The services are provided to a covered person at an in-network facility; (ii) The services would be covered if provided by an in-network provider." The unequivocal language of the law as it applies to clinical laboratories is abundantly clear at ORS § 3902 (A) (2):

> **(2)** In the case of clinical laboratory services **provided in connection with care described in division (A)(1) of this section,** a health plan issuer shall reimburse any out-of-network provider and any out-of-network facility that provided the clinical laboratory services.

The fact that the law singularly and explicitly specifies the application of ORC § 3902.51 (A) (1) provision to clinical laboratory services was designed to serve a manifest purpose that should not be considered superfluous. This provision clearly limits the application of the law to clinical laboratories services when two statutory conditions conjunctively apply in the context of such services. The first condition, expressly states that such services are **"provided to covered persons at an in-network facility."** The second condition expressly stipulates that such services to be subject to the law, must be **"covered if provided in-network."** However, contrary to the law, the language of the proposed rule, at E 7(a)(i), states that "unanticipated out-of-network care" includes:

> "Clinical laboratory services provided by an out-of-network provider, but that are ordered by an in-network provider, shall be considered to have met the condition prescribed in paragraph (E)(7)(a) unless

the provider rendering the laboratory services discloses its network status in writing to the covered person before the services are provided."

Additionally, the proposed language is contrary to ORC § 3902.50 (G), which defines "unanticipated out-of-network care" as health care services, **including clinical laboratory services**, that are covered under a health benefit plan and that are provided by an out-of-network provider when either: (1) the covered person did not have the ability to request such services from an in-network provider, or (2) the services provided were emergency services.

Clearly, the rule does not conform to the law by omitting the explicit statutory predicate that the service is provided to a covered person at an "in-network facility" and, furthermore, that the service must be covered if it were to be rendered by an in-network provider. Clarification is essential in that the application of the law is limited to out-of-network clinical laboratory services at in-network facilities, as is the case with the federal "No Surprises Act." Thus, to conform to the Ohio law, the proposed regulation should be revised as follows:

> E (7)(a)(i) "Clinical laboratory services provided by an out-of-network provider, ~~but that are ordered by an in-network provider,~~ at an in-network facility, when covered by a health plan issuer in-network, shall be considered to have met the condition prescribed in paragraph (E)(7)(a) ~~unless the provider rendering the laboratory services discloses its network status in writing to the covered person before the services are provided.~~ provided the covered person did not have the ability to request such services from an in-network clinical laboratory provider at such facility."

It should also be noted that the verbiage in the proposed rule, predicating application to clinical laboratory services, when "ordered by an in-network provider" appears entirely improvised and has no basis in the language of the law. Indeed, upon its face, the law makes no reference to "ordering" providers, either in-network or out-of-network, and the language of the law does not imply such a scenario should be a basis for statutory applicability.

While certain policy stakeholders might aspire to have the Department expand the sweep and purview of the law, the regulation cannot lawfully transcend the clear language of the statute and defy the intention of the legislature as manifested by statutory language. Failure to remedy the application of the proposed rule regarding clinical laboratory services to the expressed conditions of the statute is not legally tenable.

II. The Proposed Rule Fails to Require Health Plan Transparency or Disclosure of Critical Information to Make Implementation Practical

The proposed rule at (F), "Health plan issuer reimbursement for unanticipated out of network care" does not require the health plan issuer to communicate to the out-of-network provider the calculated basis for the payment. The rule minimally requires: "(3) A health plan issuer shall pay all reimbursement amounts for unanticipated out-of-network care directly to the provider, facility, emergency facility, or ambulance."

For the rule to fully operationalize the statute, the rule must require the health plan issuer to disclose to the out-of-network provider which of the greatest of the three prescribed statutory methodologies is used as basis for payment. pursuant to ORC § 3902.51(B)(1)(a), (b), (c) as follows: the "amount negotiated with in-network providers.. for the service in question in that geographic region," or "same method the health plan generally uses to determine payments for out-of-network health care services" or the amount that would be paid under the Medicare program for the service.

Mandated communication and transparency of this payment methodology from the health plan issuer to the out-of-network provider is essential for several reasons: 1) the out-of-network provider must be cognizant whether the plan is subject to the state law or otherwise exempt and subject to federal law, as would be the case for ERISA plans that will be subject to the federal "No Surprises Act," effective January 1, 2002; and 2) the out-of-network provider must have such requisite knowledge regarding the plan's payment methodology to make an informed

decision on availing arbitration, pursuant to ORC § 3902.52; 3) the out-of-network provider in a good faith negotiation with the health plan issuer, or in formal arbitration, must have such information to formulate the argument to challenge the veracity, accuracy or validity of the payment.

Accordingly, the proposed rule should be amended to include a mandate on the health plan issuer as follows:

> (F) (4) A health plan issuer shall communicate on the explanation of benefits transmitted to an out-of network provider the methdology used to caluate the payment when subject to Revised Code 3902.51

III. The Rule should Specify Payment Violations by Health Plan Issuers

ORC § 3902.53 (B) specifies a violation constituting an unfair and deceptive act or practice in the business of insurance is committed by a health plan issuer for "continued violations of 3902.51 or 3902.52." Accordingly, the rule should elaborate that a violation is committed when a health plan issuer willfully provides on an ongoing basis falsely calculated out-of-network payment amounts to providers that are not in accordance with ORC § 3902.51(B)(1)(a),(b),(c).

> K) Violations of by Health Plan Issuers: A health plan issuer who, as determined through arbitration or through administrative enforcement, is found to have engaged in an ongoing and deliberate payment practice to out-of-network providers not in accordance with Revised Code 3902.51(B)(1)(a), (b),(c) shall be subject to sanctions and penalties for unfair or deceptive acts or practices in the business of insurance.

Thank you for consideration of these comments submitted on behalf of physician pathology providers in the State of Ohio.

Sincerely,

Sean Kirby, MD
President , Ohio Society of Pathologists

cc Monica Hueckel, Ohio State Medical Association
Barry Ziman, College of American Pathologists