Ohio Revised Code

Section 3963.02 Prohibited contract terms; termination; arbitration.

Effective: October 24, 2024
Legislation: Senate Bill 40 - 135th General Assembly

(A)(1) No contracting entity shall sell, rent, or give a third party the contracting entity's rights to a participating provider's services pursuant to the contracting entity's health care contract with the participating provider unless one of the following applies:

(a) The third party accessing the participating provider's services under the health care contract is an employer or other entity providing coverage for health care services to its employees or members, and that employer or entity has a contract with the contracting entity or its affiliate for the administration or processing of claims for payment for services provided pursuant to the health care contract with the participating provider.

(b) The third party accessing the participating provider's services under the health care contract either is an affiliate or subsidiary of the contracting entity or is providing administrative services to, or receiving administrative services from, the contracting entity or an affiliate or subsidiary of the contracting entity.

(c) The health care contract specifically provides that it applies to network rental arrangements and states that one purpose of the contract is selling, renting, or giving the contracting entity's rights to the services of the participating provider, including other preferred provider organizations, and the third party accessing the participating provider's services is any of the following:

(i) A payer or a third-party administrator or other entity responsible for administering claims on behalf of the payer;

(ii) A preferred provider organization or preferred provider network that receives access to the participating provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the participating provider that is in compliance with division (A)(1)(c) of this section, and is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is

bound under its contract with the participating provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.

(iii) An entity that is engaged in the business of providing electronic claims transport between the contracting entity and the payer or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of the contracting entity's contract with the participating provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.

(2) The contracting entity that sells, rents, or gives the contracting entity's rights to the participating provider's services pursuant to the contracting entity's health care contract with the participating provider as provided in division (A)(1) of this section shall do both of the following:

(a) Maintain a web page that contains a listing of third parties described in divisions (A)(1)(b) and (c) of this section with whom a contracting entity contracts for the purpose of selling, renting, or giving the contracting entity's rights to the services of participating providers that is updated at least every six months and is accessible to all participating providers, or maintain a toll-free telephone number accessible to all participating providers by means of which participating providers may access the same listing of third parties;

(b) Require that the third party accessing the participating provider's services through the participating provider's health care contract is obligated to comply with all of the applicable terms and conditions of the contract, including, but not limited to, the products for which the participating provider has agreed to provide services, except that a payer receiving administrative services from the contracting entity or its affiliate shall be solely responsible for payment to the participating provider.

(3) Any information disclosed to a participating provider under this section shall be considered proprietary and shall not be distributed by the participating provider.

(4) Except as provided in division (A)(1) of this section, no entity shall sell, rent, or give a contracting entity's rights to the participating provider's services pursuant to a health care contract.

(B)(1) No contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider provide services for all of the products offered by the contracting entity.

(2) Division (B)(1) of this section shall not be construed to do any of the following:

(a) Prohibit any participating provider from voluntarily accepting an offer by a contracting entity to provide health care services under all of the contracting entity's products;

(b) Prohibit any contracting entity from offering any financial incentive or other form of consideration specified in the health care contract for a participating provider to provide health care services under all of the contracting entity's products;

(c) Require any contracting entity to contract with a participating provider to provide health care services for less than all of the contracting entity's products if the contracting entity does not wish to do so.

(3)(a) Notwithstanding division (B)(2) of this section, no contracting entity shall require, as a condition of contracting with the contracting entity, that the participating provider accept any future product offering that the contracting entity makes.

(b) If a participating provider refuses to accept any future product offering that the contracting entity makes, the contracting entity may terminate the health care contract based on the participating provider's refusal upon written notice to the participating provider no sooner than one hundred eighty days after the refusal.

(4) Once the contracting entity and the participating provider have signed the health care contract, it is presumed that the financial incentive or other form of consideration that is specified in the health care contract pursuant to division (B)(2)(b) of this section is the financial incentive or other form of consideration that was offered by the contracting entity to induce the participating provider to enter into the contract.

(C) No contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider waive or forgo any right or benefit expressly conferred upon a participating

provider by state or federal law. However, this division does not prohibit a contracting entity from restricting a participating provider's scope of practice for the services to be provided under the contract.

(D) No health care contract shall do any of the following:

(1) Prohibit any participating provider from entering into a health care contract with any other contracting entity;

(2) Prohibit any contracting entity from entering into a health care contract with any other provider;

(3) Preclude its use or disclosure for the purpose of enforcing this chapter or other state or federal law, except that a health care contract may require that appropriate measures be taken to preserve the confidentiality of any proprietary or trade-secret information.

(E)(1) No contract or agreement between a contracting entity and a vision care provider shall do any of the following:

(a) Require that a vision care provider accept as payment an amount set by the contracting entity for vision care services or vision care materials provided to an enrollee unless the services or materials are covered vision services.

(i) Notwithstanding division (E)(1)(a) of this section, a vision care provider may, in a contract with a contracting entity, choose to accept as payment an amount set by the contracting entity for vision care services or vision care materials provided to an enrollee that are not covered vision services.

(ii) No contract between a vision care provider and a contracting entity to provide covered vision services or vision care materials shall be contingent on whether the vision care provider has entered into an agreement addressing noncovered vision services pursuant to division (E)(1)(a)(i) of this section.

(iii) A contracting entity may communicate to its enrollees which vision care providers choose to accept as payment an amount set by the contracting entity for vision care services or vision care

materials provided to an enrollee that are not covered vision services pursuant to division (E)(1)(a)(i) of this section. Any communication to this effect shall treat all vision care providers equally in provider directories, provider locators, and other marketing materials as participating, in-network providers, annotated only as to their decision to accept payment pursuant to division (E)(1)(a)(i) of this section.

(b) Require that a vision care provider contract with a plan offering supplemental or specialty health care services as a condition of contracting with a plan offering basic health care services;

(c) Directly limit a vision care provider's choice of sources and suppliers of vision care materials;

(d) Include a provision that prohibits a vision care provider from describing out-of-network options to an enrollee in accordance with division (E)(2) of this section.

The provisions of divisions (E)(1)(a) to (d) of this section shall be effective for contracts entered into, amended, or renewed on or after January 1, 2019.

(2) A vision care provider recommending an out-of-network source or supplier of vision care materials to an enrollee shall notify the enrollee in writing that the source or supplier is out-of-network and shall inform the enrollee of the cost of those materials. The vision care provider shall also disclose in writing to an enrollee any business interest the provider has in a recommended out-of-network source or supplier utilized by the enrollee.

(3) A vision care provider who chooses not to accept as payment an amount set by a contracting entity for vision care services or vision care materials that are not covered vision services shall do both of the following:

(a) Upon the request of an enrollee seeking vision care services or vision care materials that are not covered vision services, provide to the enrollee pricing and reimbursement information, including all of the following:

(i) The estimated fee or discounted price suggested by the contracting entity for the noncovered service or material;

(ii) The estimated fee charged by the vision care provider for the noncovered service or material;

(iii) The amount the vision care provider expects to be reimbursed by the contracting entity for the noncovered service or material;

(iv) The estimated pricing and reimbursement information for any covered services or materials that are also expected to be provided during the enrollee's visit.

(b) Post, in a conspicuous place, a notice stating the following:

"IMPORTANT: This vision care provider does not accept the fee schedule set by your insurer for vision care services and vision care materials that are not covered benefits under your plan and instead charges his or her normal fee for those services and materials. This vision care provider will provide you with an estimated cost for each non-covered service or material upon your request."

(4) Nothing in division (E) of this section shall do any of the following:

(a) Restrict or limit a contracting entity's determination of specific amounts of coverage or reimbursement for the use of network or out-of-network sources or suppliers of vision care materials as set forth in an enrollee's benefit plan;

(b) Restrict or limit a contracting entity's ability to enter into an agreement with another contracting entity or an affiliate of another contracting entity;

(c) Restrict or limit a health care plan's ability to enter into an agreement with a vision care plan to deliver routine vision care services that are covered under an enrollee's plan;

(d) Restrict or limit a vision care plan network from acting as a network for a health care plan;

(e) Prohibit a contracting entity from requiring participating vision care providers to offer network sources or suppliers of vision care materials to enrollees;

(f) Prohibit an enrollee from utilizing a network source or supplier of vision care materials as set forth in an enrollee's plan;

(g) Prohibit a participating vision care provider from accepting as payment an amount that is the same as the amount set by the contracting entity for vision care services or vision care materials that are not covered vision services.

(F)(1) No contract or agreement between a contracting entity and a dental care provider shall do any of the following:

(a) Require that a dental care provider accept as payment an amount set by the contracting entity for dental care services provided to an enrollee unless the services are covered dental services.

(i) Notwithstanding division (F)(1)(a) of this section, a dental care provider may, in a contract with a contracting entity, choose to accept as payment an amount set by the contracting entity for dental care services provided to an enrollee that are not covered dental services.

(ii) No contract between a dental care provider and a contracting entity to provide covered dental services shall be contingent on whether the dental care provider has entered into an agreement addressing noncovered dental services pursuant to division (F)(1)(a)(i) of this section.

(iii) A contracting entity may communicate to its enrollees which dental care providers choose to accept as payment an amount set by the contracting entity for dental care services provided to an enrollee that are not covered dental services pursuant to division (F)(1)(a)(i) of this section. Any communication to this effect shall treat all dental care providers equally in provider directories, provider locators, and other marketing materials as participating, in-network providers, annotated only as to their decision to accept payment pursuant to division (F)(1)(a)(i) of this section.

(b) Require that a dental care provider contract with a plan offering supplemental or specialty health care services as a condition of contracting with a plan offering basic health care services.

The provisions of divisions (F)(1)(a) and (b) of this section apply to contracts entered into, amended, or renewed on or after January 1, 2025.

(2) A dental care provider who chooses not to accept as payment an amount set by a contracting entity for dental care services that are not covered dental services shall do both of the following:

(a) Provide to an enrollee seeking dental care services that are not covered dental services pricing and reimbursement information, including all of the following:

(i) The estimated fee or discounted price suggested by the contracting entity for the noncovered service;

(ii) The estimated fee charged by the dental care provider for the noncovered service;

(iii) The amount the dental care provider expects to be reimbursed by the contracting entity for the noncovered service;

(iv) The estimated pricing and reimbursement information for any covered services that are also expected to be provided during the enrollee's visit.

(b) Post, in a conspicuous place, a notice stating the following:

"IMPORTANT: This dental care provider does not accept the fee schedule set by your insurer for dental care services that are not covered benefits under your plan and instead charges his or her normal fee for those services. This dental care provider will provide you with an estimated cost for each noncovered service."

(3) Nothing in division (F) of this section shall do any of the following:

(a) Restrict or limit a contracting entity's ability to enter into an agreement with another contracting entity or an affiliate of another contracting entity;

(b) Restrict or limit a health care plan's ability to enter into an agreement with a dental care plan to deliver routine dental care services that are covered under an enrollee's plan;

(c) Restrict or limit a dental care plan network from acting as a network for a health care plan;

(d) Prohibit a participating dental care provider from accepting as payment an amount that is the same as the amount set by the contracting entity for dental care services that are not covered dental services.

(G)(1) In addition to any other lawful reasons for terminating a health care contract, a health care contract may only be terminated under the circumstances described in division (A)(3) of section 3963.04 of the Revised Code.

(2) If the health care contract provides for termination for cause by either party, the health care contract shall state the reasons that may be used for termination for cause, which terms shall be reasonable. Once the contracting entity and the participating provider have signed the health care contract, it is presumed that the reasons stated in the health care contract for termination for cause by either party are reasonable. Subject to division (G)(3) of this section, the health care contract shall state the time by which the parties must provide notice of termination for cause and to whom the parties shall give the notice.

(3) Nothing in divisions (G)(1) and (2) of this section shall be construed as prohibiting any health insuring corporation from terminating a participating provider's contract for any of the causes described in divisions (A), (D), and (F)(1) and (2) of section 1753.09 of the Revised Code. Notwithstanding any provision in a health care contract pursuant to division (G)(2) of this section, section 1753.09 of the Revised Code applies to the termination of a participating provider's contract for any of the causes described in divisions (A), (D), and (F)(1) and (2) of section 1753.09 of the Revised Code.

(4) Subject to sections 3963.01 to 3963.11 of the Revised Code, nothing in this section prohibits the termination of a health care contract without cause if the health care contract otherwise provides for termination without cause.

(5) Nothing in division (G) of this section shall be construed to expand the regulatory authority of the superintendent to vision care providers or dental care providers.

(H)(1) Disputes among parties to a health care contract that only concern the enforcement of the contract rights conferred by section 3963.02, divisions (A) and (D) of section 3963.03, and section 3963.04 of the Revised Code are subject to a mutually agreed upon arbitration mechanism that is binding on all parties. The arbitrator may award reasonable attorney's fees and costs for arbitration relating to the enforcement of this section to the prevailing party.

(2) The arbitrator shall make the arbitrator's decision in an arbitration proceeding having due regard for any applicable rules, bulletins, rulings, or decisions issued by the department of insurance or any court concerning the enforcement of the contract rights conferred by section 3963.02, divisions (A) and (D) of section 3963.03, and section 3963.04 of the Revised Code.

(3) A party shall not simultaneously maintain an arbitration proceeding as described in division (H)(1) of this section and pursue a complaint with the superintendent of insurance to investigate the subject matter of the arbitration proceeding. However, if a complaint is filed with the department of insurance, the superintendent may choose to investigate the complaint or, after reviewing the complaint, advise the complainant to proceed with arbitration to resolve the complaint. The superintendent may request to receive a copy of the results of the arbitration. If the superintendent of insurance notifies an insurer or a health insuring corporation in writing that the superintendent has initiated a market conduct examination into the specific subject matter of the arbitration proceeding pending against that insurer or health insuring corporation, the arbitration proceeding shall be stayed at the request of the insurer or health insuring corporation pending the outcome of the market conduct investigation by the superintendent.