As Introduced

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A B I L L

To amend sections 1739.05, 1739.14, 3901.38, and 3902.11, to enact new section 3901.381 and sections 3901.382, 3901.383, 3901.384, 3901.385, 3901.386, and 3901.387, and to repeal section 3901.381 of the Revised Code to revise the "prompt pay" statutes applicable to third-party payers.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 1739.05, 1739.14, 3901.38, and 3902.11 be amended and new section 3901.381 and sections 3901.382, 3901.383, 3901.384, 3901.385, 3901.386, and 3901.387 of the Revised Code be enacted to read as follows:

Sec. 1739.05. (A) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program may be established only if any of the following applies:

(1) The arrangement has and maintains a minimum enrollment of three hundred employees of two or more employers.

(2) The arrangement has and maintains a minimum enrollment of three hundred self-employed individuals.

(3) The arrangement has and maintains a minimum enrollment of three hundred employees or self-employed individuals in any combination of divisions (A)(1) and (2) of this section.

(B) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program shall comply with all laws applicable to self-funded programs in this state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38 to 3901.387, 3901.40, 3901.45, 3901.46, 3902.01 to 3902.14, 3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3924.031, 3924.032, and 3924.27 of the Revised Code.

(C) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall solicit enrollments only through agents or solicitors licensed pursuant to Chapter 3905. of the Revised Code to sell or solicit sickness and accident insurance.

(D) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall provide benefits only to individuals who are members, employees of members, or the dependents of members or employees, or are eligible for continuation of coverage under section 1751.53 or 3923.38 of the Revised Code or under Title X of the "Consolidated Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 U.S.C.A. 1161, as amended.

Sec. 1739.14. (A) Each member shall pay to the multiple employer welfare arrangement operating a group self-insurance program a premium equal to its share of the arrangement's projected obligation for employee welfare benefit liability, administrative expenses, and other costs incurred by the arrangement as determined by the board of the arrangement or by a third-party administrator and approved by the board of the

arrangement. This amount may be adjusted by the board according to the claims experience of each participating member in accordance with criteria set forth in the articles or bylaws of the arrangement.

(B) Each member shall pay a premium for each year at the beginning of each fiscal year unless otherwise provided for under the agreement.

(C) A multiple employer welfare arrangement operating a group self-insurance program shall make payments, or arrange to have payments made, to the employees of the members out of the fund for employee welfare benefits in accordance with ~~section~~ sections 3901.38 to 3901.387 of the Revised Code.

(D) A board of the multiple employer welfare arrangement operating a group self-insurance program shall determine whether any dividends or assessments shall be paid to or levied against participating members.

Sec. 3901.38. ~~(A)~~ As used in ~~this section and section 3901.381~~ sections 3901.38 to 3901.387 of the Revised Code:

~~(1)~~(A) "Beneficiary" means any policyholder, subscriber, member, employee, or other person who is eligible for benefits under a benefits contract.

~~(2)~~(B) "Benefits contract" means a sickness and accident insurance policy providing hospital, surgical, or medical expense coverage, or a health insuring corporation contract or other policy or agreement under which a third-party payer agrees to reimburse for covered health care or dental services rendered to beneficiaries, up to the limits and exclusions contained in the benefits contract.

~~(3)~~(C) "Completed claim" means a proof of loss or a claim for payment for health care services ~~which~~ that uses the standard

proof of loss or claim form prescribed in rules adopted by the superintendent of insurance under section 3902.22 of the Revised Code and that has been submitted to the appropriate claims processing office of the third-party payer ~~accompanied by sufficient documentation for~~. A proof of loss or claim for payment that meets the requirements of such rules shall be considered a "completed claim," unless the third-party payer ~~to determine~~ notifies the provider, in accordance with division (B)(1) of section 3901.381 of the Revised Code, of material deficiencies in the proof of loss ~~and reasonably required by the third-party payer to accept~~ or ~~reject~~ the claim for payment.

~~(4)~~(D) "Hospital" has the same meaning set forth in section 3727.01 of the Revised Code.

~~(5)~~(E) "Proof of loss" ~~means a claim for payment for health care services which has been submitted to the appropriate claims processing office of the third-party payer accompanied by sufficient documentation for the third-party payer to determine benefits payable under the benefits contract and reasonably required by the third-party payer to accept or reject~~ has the ~~claim~~ same meaning as in section 3902.21 of the Revised Code.

~~(6)~~(F) "Provider" means a hospital, nursing home, physician, podiatrist, dentist, pharmacist, chiropractor, or other licensed health care provider entitled to reimbursement by a third-party payer for services rendered to a beneficiary under a benefits contract.

~~(7)~~(G) "Reimburse" means indemnify, make payment, or otherwise accept responsibility for payment for health care services rendered to a beneficiary, or arrange for the provision of health care services to a beneficiary.

~~(8)~~(H) "Third-party payer" means any of the following:

~~(a)~~(1) An insurance company;

~~(b)~~(2) A health insuring corporation;

~~(c)~~(3) A labor organization;

~~(d)~~(4) An employer;

~~(e)~~(5) An intermediary organization, as defined in section 1751.01 of the Revised Code, that is not a health delivery network contracting solely with self-insured employers;

~~(f)~~(6) An administrator subject to sections 3959.01 to 3959.16 of the Revised Code;

~~(g)~~(7) A health delivery network, as defined in section 1751.01 of the Revised Code;

~~(h)~~(8) Any other person that is obligated pursuant to a benefits contract to reimburse for covered health care services rendered to beneficiaries under such contract.

~~(B)(1) Except as provided in division (B)(2) of this section and in section 3901.381 of the Revised Code, within twenty-four days of the receipt of a completed claim from a provider or a beneficiary for reimbursement for health care services rendered by the provider to a beneficiary, a third-party payer shall, in accordance with division (D) of this section, make payment of any amount due on such claim.~~

~~(2) A third-party payer and a provider may, in negotiating a reimbursement contract, agree to any time period by which a third-party payer shall, subject to division (D) of this section, make payment of any amount due on a completed claim. Nothing in this division shall be construed as limiting in any manner the application of the requirements of this section to any benefits or reimbursement contract.~~

~~(3) Any provider or beneficiary aggrieved with respect to any act of a third-party payer that such provider or beneficiary believes to be a violation of division (B)(1) or (2) of this~~

~~section may file a written complaint with the superintendent of insurance. If a series of such complaints is received by the superintendent with respect to a particular third-party payer and if, after investigation, the superintendent finds that such third-party payer has engaged in a series of such violations which, taken together, constitute a consistent pattern or a practice of such third-party payer to violate division (B)(1) or (2) of this section, the superintendent shall issue an order requiring such third-party payer to cease and desist from engaging in such violations and to pay a late payment penalty as specified in divisions (B)(4) and (5) of this section with respect to the claims the superintendent finds were not timely paid. In the order, the superintendent shall specify the reasons for the superintendent's finding and order and state that a hearing conducted pursuant to Chapter 119. of the Revised Code shall be held within fifteen days after requested in writing by the third-party payer. The provisions of division (B)(3) of this section are in addition to, and not in lieu of, such other remedies as providers and beneficiaries may otherwise have by law.~~

~~(4)(a) The late payment penalty shall be computed based upon the number of days that have elapsed between the date payment is due in accordance with division (B)(1) or (2) of this section and the date payment is actually sent.~~

~~(b) The interest rate for determining the amount of the late payment penalty shall be the rate agreed to by the provider and the third-party payer or the rate specified by and determined in accordance with division (A) of section 1343.01 of the Revised Code.~~

~~(5) A provider and a third-party payer may enter into a contractual agreement in which the timing of payments by the third-party payer is not directly related to the receipt of a completed claim. Such contractual arrangement may include periodic~~

~~interim payment arrangements, capitation payment arrangements, or other payment arrangements acceptable to the provider and the third-party payer. Except as agreed to under such contract, this section does not apply to such payment arrangements.~~

~~(6) Any late payment penalty due and payable by a third-party payer in accordance with this section shall not be used to reduce benefits or payments otherwise payable under a benefits contract.~~

~~(C) No third-party payer shall refuse to process or pay within the time period required under division (B)(1) or (2) of this section a completed claim submitted by a provider on the ground the beneficiary has not been discharged from the hospital or the treatment has not been completed, if the submitted claim covers services actually rendered and charges actually incurred over at least a thirty-day period.~~

~~(D)(1) Notwithstanding section 1751.13 or division (I)(2) of section 3923.04 of the Revised Code, a reimbursement contract entered into or renewed on or after June 29, 1988, between a third-party payer and a hospital shall provide that reimbursement for any service provided by a hospital pursuant to a reimbursement contract and covered under a benefits contract shall be made directly to the hospital.~~

~~(2) If the third-party payer and the hospital have not entered into a contract regarding the provision and reimbursement for covered services, the third-party payer shall accept and honor a completed and validly executed assignment of benefits with a hospital by a beneficiary, except when the third-party payer has notified the hospital in writing of the conditions under which the third-party payer will not accept and honor an assignment of benefits. Such notice shall be made annually.~~

~~(3) A third-party payer may not refuse to accept and honor a~~

~~validly executed assignment of benefits with a hospital pursuant to division (D)(2) of this section for medically necessary hospital services provided on an emergency basis.~~

~~(E) A series of violations which taken together, constitute a consistent pattern or a practice of violation of any of the provisions of this section is an unfair and deceptive act pursuant to sections 3901.19 to 3901.23 of the Revised Code and is subject to proceedings pursuant to those sections.~~

Sec. 3901.381. (A)(1) Except as provided in divisions (A)(2) and (B)(2) of this section, a third-party payer shall make payment of any amount due on a completed claim from a provider or a beneficiary for reimbursement for health care services rendered by the provider to a beneficiary, within thirty days after receipt of the claim.

(2) If a third-party payer determines it is not responsible for paying a claim, it shall notify the provider and beneficiary within thirty days after receipt of the claim. The notice shall be in writing and shall state, with specificity, the reasons why the third-party payer is not obligated to pay the claim.

(B)(1) If a claim received by a third-party payer is not a completed claim, the third-party payer shall notify the provider within fifteen days after receipt of the claim. The notice shall be in writing and shall state, with specificity, the information needed to correct all material deficiencies. The third-party payer shall make payment of any amount due on the claim within thirty days after the third-party payer receives the information requested.

(2) If a claim received by a third-party payer is a completed claim, but the responsibility of the third-party payer to make payment is unclear due to a good faith dispute regarding the eligibility of a beneficiary, the liability of another payer for

all or part of the claim, the amount of the claim, the benefits covered, or the manner in which health care services were accessed or provided, the third-party payer shall do both of the following:

(a) Within fifteen days after receipt of the claim, notify the provider and beneficiary that additional information is needed to establish the responsibility of the third-party payer to make payment. The notice shall be in writing and shall state, with specificity, the portion of the claim that is in dispute and the information needed to establish the third-party payer's responsibility to make payment. If any of that information is under the control of the beneficiary, the beneficiary shall provide the information to the third-party payer. The third-party payer shall make payment of any amount due on the claim within thirty days after the third-party payer receives the information requested.

If the third-party payer is the secondary payer, the beneficiary shall submit to the third-party payer an explanation of benefits or other evidence of payment by the primary payer within thirty days after payment by the primary payer. The third-party payer shall make payment of the amount due on the claim that it is responsible for paying within thirty days after it receives such evidence of payment by the primary payer.

(b) Pay any undisputed portion of the claim in accordance with this section.

(C) No third-party payer shall refuse to process or pay within the time period required under division (A)(1) of this section a completed claim submitted by a provider on the ground the beneficiary has not been discharged from the hospital or the treatment has not been completed, if the submitted claim covers services actually rendered and charges actually incurred over at least a thirty-day period.

(D) For purposes of this section, if a dispute exists between a provider and a third-party payer as to the day a claim was received by the third-party payer, both of the following apply:

(1) If the provider submits a claim by mail, there exists a rebuttable presumption that the claim was received by the third-party payer on the third business day after the day the claim was mailed, unless it can be proven otherwise.

(2) If the provider submits a claim electronically, there exists a rebuttable presumption that the claim was received by the third-party payer twenty-four hours after the claim was submitted, unless it can be proven otherwise.

Sec. 3901.382. Notwithstanding section 3901.381 of the Revised Code, a provider and a third-party payer may do either of the following:

(A) Enter into a contractual agreement in which payment of any amount due on a completed claim is to be made by the third-party payer within a time period shorter than that set forth in division (A)(1) of section 3901.381 of the Revised Code;

(B) Enter into a contractual agreement in which the timing of payments by the third-party payer is not directly related to the receipt of a completed claim. Such contractual arrangement may include periodic interim payment arrangements, capitation payment arrangements, or other periodic payment arrangements acceptable to the provider and the third-party payer.

Under a capitation payment arrangement, the third-party payer shall begin paying the capitated amounts to the beneficiary's primary care provider, calculated from the date of enrollment, within sixty days after the date the beneficiary selects or is assigned to the provider. If the selection or assignment does not

occur at the time of enrollment, the capitated amounts for that beneficiary shall be reserved for payment to the primary care provider the beneficiary selects or is assigned to.

Under any other contractual periodic payment arrangement, the contractual agreement shall state, with specificity, the timing of payments by the third-party payer.

Sec. 3901.383. (A) Notwithstanding section 1751.13 or division (I)(2) of section 3923.04 of the Revised Code, a reimbursement contract entered into or renewed on or after June 29, 1988, between a third-party payer and a hospital shall provide that reimbursement for any service provided by a hospital pursuant to a reimbursement contract and covered under a benefits contract shall be made directly to the hospital.

(B) If the third-party payer and the hospital have not entered into a contract regarding the provision and reimbursement of covered services, the third-party payer shall accept and honor a completed and validly executed assignment of benefits with a hospital by a beneficiary, except when the third-party payer has notified the hospital in writing of the conditions under which the third-party payer will not accept and honor an assignment of benefits. Such notice shall be made annually.

(C) A third-party payer may not refuse to accept and honor a validly executed assignment of benefits with a hospital pursuant to division (B) of this section for medically necessary hospital services provided on an emergency basis.

Sec. 3901.384. A payment made by a third-party payer to a provider in accordance with sections 3901.38 to 3901.383 of the Revised Code shall be considered final one year after payment was made. After that date, both of the following apply:

(A) The amount of the payment is not subject to adjustment,

except in the case of fraud by the provider.

(B) The third-party payer shall not deduct any overpayment made to the provider from any other payment it owes the provider.

Sec. 3901.385. (A) Any third-party payer that fails to comply with section 3901.381 of the Revised Code or any contractual payment arrangement entered into under section 3901.382 of the Revised Code, shall pay interest in accordance with this section.

(B)(1) Interest shall be computed based upon the number of days that have elapsed between the date payment is due in accordance with section 3901.381 of the Revised Code or the contractual payment arrangement entered into under section 3901.382 of the Revised Code, and the date payment is made. If a dispute exists between a provider and a third-party payer as to the date a payment is made, both of the following apply:

(a) If the payment is submitted by mail, there exists a rebuttable presumption that the payment was made by the third-party payer three business days before the date the payment was received by the provider, unless it can be proven otherwise.

(b) If the payment is submitted electronically, there exists a rebuttable presumption that the payment was made by the third-party payer twenty-four hours before the date the payment was received by the provider, unless it can be proven otherwise.

(2) The interest rate for determining the amount of interest due shall be eighteen per cent per year. Interest shall be compounded on a daily basis.

(C) Interest due in accordance with this section shall be paid directly to the provider at the time payment of the claim is made and shall not be used to reduce benefits or payments otherwise payable under a benefits contract.

Sec. 3901.386. (A) No third-party payer shall fail to comply with sections 3901.38 to 3901.387 of the Revised Code.

(B) Any provider or beneficiary aggrieved with respect to any act of a third-party payer that the provider or beneficiary believes to be a violation of division (A) of this section may file a written complaint with the superintendent of insurance. If a series of such complaints is received by the superintendent with respect to a particular third-party payer and if, after investigation, the superintendent finds that the third-party payer has engaged in a series of such violations which, taken together, constitute a consistent pattern or a practice of the third-party payer to violate division (A) of this section, the superintendent shall issue an order requiring the third-party payer to cease and desist from engaging in the violations, to pay interest in accordance with section 3901.385 of the Revised Code, and to pay a fine of at least one thousand dollars but not more than ten thousand dollars per violation. In the order, the superintendent shall specify the reasons for the superintendent's finding and order and state that a hearing conducted pursuant to Chapter 119. of the Revised Code shall be held within fifteen days after requested in writing by the third-party payer. The provisions of this division are in addition to, and not in lieu of, such other remedies as providers and beneficiaries may otherwise have by law.

(C) If the superintendent finds that a third-party payer has engaged in a violation of division (A) of this section, the party that filed the complaint with the superintendent shall be entitled to recover reasonable attorney's fees.

(D) Any fine collected under this section shall be paid into the state treasury to the credit of the department of insurance operating fund created by section 3901.021 of the Revised Code.

Sec. 3901.387. No third-party payer shall retaliate against any provider that files a complaint against the third-party payer under division (B) of section 3901.386 of the Revised Code.

Sec. 3902.11. As used in sections 3902.11 to 3902.14 of the Revised Code:

(A) "Beneficiary," ~~has~~ "provider," and "third-party payer" have the same ~~meaning~~ meanings as in ~~division (A)(1) of~~ section 3901.38 of the Revised Code.

(B) "Plan of health coverage" means any of the following if the policy, contract, or agreement contains a coordination of benefits provision:

(1) An individual or group sickness and accident insurance policy, which policy provides for hospital, dental, surgical, or medical services;

(2) Any individual or group contract of a health insuring corporation, which contract provides for hospital, dental, surgical, or medical services;

(3) Any other individual or group policy or agreement under which a third-party payer provides for hospital, dental, surgical, or medical services.

~~(C) "Provider" has the same meaning as in division (A)(6) of section 3901.38 of the Revised Code.~~

~~(D) "Third-party payer" has the same meaning as in division (A)(8) of section 3901.38 of the Revised Code.~~

Section 2. That existing sections 1739.05, 1739.14, 3901.38, and 3902.11 and section 3901.381 of the Revised Code are hereby repealed.

Section 3. Sections 3901.38, 3901.381, 3901.382, 3901.383, 3901.384, 3901.385, 3901.386, and 3901.387 of the Revised Code, as amended, enacted, or repealed and reenacted by this act, apply to any proof of loss or claim for payment for health care services that is submitted to a third-party payer on or after the effective date of this act.