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SENATORS Mumper, Armbruster, Blessing, Spada, Hottinger, Jacobson, Jordan, Oelslager, Mead, Amstutz, Robert Gardner, Harris, DiDonato, Herington, Ryan, Mallory, Shoemaker, Hagan, Randy Gardner, Austria, Coughlin, Espy, Wachtmann

REPRESENTATIVES Stapleton, G. Smith, Britton, Cirelli, DePiero, Evans, Faber, Fessler, Goodman, Husted, Jolivette, Krupinski, Latell, Metelsky, Olman, Salerno, Schaffer, Sullivan, Wolpert, Woodard, Hoops, Schmidt, Grendell, Clancy, Flowers, Carey, Damschroder, D. Miller, Manning, Lendrum, Allen, Ogg, Womer Benjamin, Sulzer, Hollister, Schneider, Barnes, Perry, Barrett, Seaver, Jones, Rhine, Coates, Latta, Carmichael, Niehaus, Hartnett, Hagan, Willamowski, White, Core, Reinhard, Young, Schuring, Peterson, Otterman, Aslanides, Collier, Gilb, Widowfield, DeWine, Roman, Buehrer, Seitz, Driehaus, Distel, Jerse, Fedor, Webster, Boccieri, Beatty, Hughes, Sferra, Setzer, Kearns

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A B I L L

To amend sections 1349.01, 1739.05, 1739.14, 3901.38, 3902.11, 3902.21, 3902.22, 3902.23, and 3924.21, to enact new section 3901.381 and sections 3901.382, 3901.383, 3901.384, 3901.385, 3901.386, 3901.387, 3901.388, 3901.389, 3901.3810, 3901.3811, 3901.3812, 3901.3813, and 3901.3814 and to repeal section 3901.381 of the Revised Code to revise the "prompt pay" requirements applicable to insurance companies, health insuring corporations, and other third-party payers of health care services.

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

Section 1. That sections 1349.01, 1739.05, 1739.14, 3901.38, 3902.11, 3902.21, 3902.22, 3902.23, and 3924.21 be amended and new section 3901.381 and sections 3901.382, 3901.383, 3901.384, 3901.385, 3901.386, 3901.387, 3901.388, 3901.389, 3901.3810, 3901.3811, 3901.3812, 3901.3813, and 3901.3814 of the Revised Code be enacted to read as follows:

Sec. 1349.01. (A) As used in this section:

(1) "Consumer reporting agency" has the same meaning as in the "Fair Credit Reporting Act," 84 Stat. 1128, 15 U.S.C.A. 1681a.

(2) "Court" means the division of the court of common pleas having jurisdiction over actions for divorce, annulment, dissolution of marriage, legal separation, child support, or spousal support.

(3) "Health insurance coverage" means hospital, surgical, or medical expense coverage provided under any health insurance or health care policy, contract, or plan or any other health benefits arrangement.

(4) "Provider" has the same meaning as in section ~~3901.38~~ 3902.11 of the Revised Code.

(B) If, pursuant to an action for divorce, annulment, dissolution of marriage, or legal separation, the court determines that a party who is a resident of this state is responsible for obtaining health insurance coverage for the party's former spouse or children or if, pursuant to a child support order issued in accordance with sections 3119.30 to 3119.58 of the Revised Code, the court requires a party who is a resident of this state to obtain health insurance coverage for the children who are the

subject of the child support order, and the party fails to obtain such coverage, no provider or collection agency shall collect or attempt to collect from the former spouse, children, or person responsible for the children, any reimbursement of any hospital, surgical, or medical expenses incurred by the provider for services rendered to the former spouse or children, which expenses would have been covered but for the failure of the party to obtain the coverage, if the former spouse, any of the children, or a person responsible for the children, provides the following to the provider or collection agency:

(1) A copy of the court order requiring the party to obtain health insurance coverage for the former spouse or children.

(2) Reasonable assistance in locating the party and obtaining information about the party's health insurance coverage.

(C) If the requirements of divisions (B)(1) and (2) of this section are not met, the provider or collection agency may collect the hospital, surgical, or medical expenses both from the former spouse or person responsible for the children and from the party who failed to obtain the coverage. If the requirements of divisions (B)(1) and (2) are met, the provider or collection agency may collect or attempt to collect the expenses only from the party.

A party required to obtain health insurance coverage for a former spouse or children who fails to obtain the coverage is liable to the provider for the hospital, surgical, or medical expenses incurred by the provider as a result of the failure to obtain the coverage. This section does not prohibit a former spouse or person responsible for the children from initiating an action to enforce the order requiring the party to obtain health insurance for the former spouse or children or to collect any amounts the former spouse or person responsible for the children pays for hospital, surgical, or medical expenses for which the

party is responsible under the order requiring the party to obtain health insurance for the former spouse or children.

(D)(1) If the requirements of divisions (B)(1) and (2) of this section are met, both of the following restrictions shall apply:

(a) No collection agency or provider of hospital, surgical, or medical services may report to a consumer reporting agency, for inclusion in the credit file or credit report of the former spouse or person responsible for the children, any information relative to the nonpayment of expenses for the services incurred by the provider, if the nonpayment is the result of the failure of the party responsible for obtaining health insurance coverage to obtain health insurance coverage.

(b) No consumer reporting agency shall include in the credit file or credit report of the former spouse or person responsible for the children, any information relative to the nonpayment of any hospital, surgical, or medical expenses incurred by a provider as a result of the party's failure to obtain the coverage.

(2) If the requirements of divisions (B)(1) and (2) of this section are not met, both of the following provisions shall apply:

(a) A provider of hospital, surgical, or medical services, or a collection agency, may report to a consumer reporting agency, for inclusion in the credit file or credit report of the former spouse or person responsible for the children, any information relative to the nonpayment of expenses for the services incurred by the provider, if the nonpayment is the result of the failure of the party responsible for obtaining health insurance coverage to obtain such coverage.

(b) A consumer reporting agency may include in the credit file or credit report of the former spouse or person responsible for the children, any information relative to the nonpayment of

any hospital, surgical, or medical expenses incurred by the provider, if the nonpayment is the result of the failure of the party responsible for obtaining health insurance coverage to obtain such coverage.

(3)(a) A provider of hospital, surgical, or medical services, or a collection agency, may report to a consumer reporting agency, for inclusion in the credit file or credit report of that party, any information relative to the nonpayment of expenses for the services incurred by the provider, if the nonpayment is the result of the failure of the party responsible for obtaining health insurance coverage to obtain such coverage.

(b) A consumer reporting agency may include in the credit file or credit report of the party responsible for obtaining health insurance coverage, any information relative to the nonpayment of any hospital, surgical, or medical expenses incurred by a provider, if the nonpayment is the result of the failure of that party to obtain health insurance coverage.

(4) If any information described in division (D)(2) of this section is placed in the credit file or credit report of the former spouse or person responsible for the children, the consumer reporting agency shall remove the information from the credit file and credit report if the former spouse or person responsible for the children provides the agency with the information required in divisions (B)(1) and (2) of this section. If the agency fails to remove the information from the credit file or credit report pursuant to the terms of the "Fair Credit Reporting Act," 84 Stat. 1128, 15 U.S.C. 1681a, within a reasonable time after receiving the information required by divisions (B)(1) and (2) of this section, the former spouse may initiate an action to require the agency to remove the information.

If any information described in division (D)(3) of this section is placed in the party's credit file or credit report, the

party has the burden of proving that the party is not responsible for obtaining the health insurance coverage or, if responsible, that the expenses incurred are not covered expenses. If the party meets that burden, the agency shall remove the information from the party's credit file and credit report immediately. If the agency fails to remove the information from the credit file or credit report immediately after the party meets the burden, the party may initiate an action to require the agency to remove the information.

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, 3901.381 to 3901.3814, 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 3901.38 and sections 3901.381 to 3901.3814 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~~ sections 3901.381 to 3901.3814 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) "Completed claim" means a proof of loss or 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 proof of loss and reasonably required by the third-party payer to accept or reject the claim.~~

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

~~(5) "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 the claim.~~

~~(6)~~(D) "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)~~(E) "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)~~(F) "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) Except as provided in sections 3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.

(B)(1) Unless division (B)(2) or (3) of this section applies, when a third-party payer receives from a provider or beneficiary a claim on the standard claim form prescribed in rules adopted by the superintendent of insurance under section 3902.22 of the Revised Code, the third-party payer shall pay or deny the claim not later than thirty days after receipt of the claim. When a third-party payer denies a claim, the third-party payer shall

notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim.

(2)(a) Unless division (B)(3) of this section applies, when a provider or beneficiary has used the standard claim form, but the third-party payer determines that reasonable supporting documentation is needed to establish the third-party payer's responsibility to make payment, the third-party payer shall pay or deny the claim not later than forty-five days after receipt of the claim. Supporting documentation includes the verification of employer and beneficiary coverage under a benefits contract, confirmation of premium payment, medical information regarding the beneficiary and the services provided, information on the responsibility of another third-party payer to make payment or confirmation of the amount of payment by another third-party payer, and information that is needed to correct material deficiencies in the claim related to a diagnosis or treatment or the provider's identification.

Not later than thirty days after receipt of the claim, the third-party payer shall notify all relevant external sources that the supporting documentation is needed. All such notices shall state, with specificity, the supporting documentation needed. If the notice was not provided in writing, the provider, beneficiary, or third-party payer may request the third-party payer to provide the notice in writing, and the third-party payer shall then provide the notice in writing. If any of the supporting documentation is under the control of the beneficiary, the beneficiary shall provide the supporting documentation to the third-party payer.

The number of days that elapse between the third-party payer's last request for supporting documentation within the thirty-day period and the third-party payer's receipt of all of the supporting documentation that was requested shall not be

counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days for payment or denial of a claim. Except as provided in division (B)(2)(b) of this section, if the third-party payer requests additional supporting documentation after receiving the initially requested documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days.

(b) If a third-party payer determines, after receiving initially requested documentation, that it needs additional supporting documentation pertaining to a beneficiary's preexisting condition, which condition was unknown to the third-party payer and about which it was reasonable for the third-party payer to have no knowledge at the time of its initial request for documentation, and the third-party payer subsequently requests this additional supporting documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall not be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days.

(c) When a third-party payer denies a claim, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim.

(d) If a third-party payer determines that supporting documentation related to medical information is routinely necessary to process a claim for payment of a particular health care service, the third-party payer shall establish a description of the supporting documentation that is routinely necessary and make the description available to providers in a readily

accessible format.

Third-party payers and providers shall, in connection with a claim, use the most current CPT code in effect, as published by the American medical association, the most current ICD-9 code in effect, as published by the United States department of health and human services, the most current CDT code in effect, as published by the American dental association, or the most current HCPCS code in effect, as published by the United States health care financing administration.

(3) When a provider or beneficiary submits a claim by using the standard claim form prescribed in the superintendent's rules, but the information provided in the claim is materially deficient, the third-party payer shall notify the provider or beneficiary not later than fifteen days after receipt of the claim. The notice shall state, with specificity, the information needed to correct all material deficiencies. Once the material deficiencies are corrected, the third-party payer shall proceed in accordance with division (B)(1) or (2) of this section.

It is not a violation of the notification time period of not more than fifteen days if a third-party payer fails to notify a provider or beneficiary of material deficiencies in the claim related to a diagnosis or treatment or the provider's identification. A third-party payer may request the information necessary to correct these deficiencies after the end of the notification time period. Requests for such information shall be made as requests for supporting documentation under division (B)(2) of this section, and payment or denial of the claim is subject to the time periods specified in that division.

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

(1) If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer by mail and retains a record of the day the claim was mailed, there exists a rebuttable presumption that the claim was received by the third-party payer on the fifth business day after the day the claim was mailed, unless it can be proven otherwise.

(2) If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer 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.

(D) Nothing in this section requires a third-party payer to provide more than one notice to an employer whose premium for coverage of employees under a benefits contract has not been received by the third-party payer.

(E) Compliance with the provisions of division (B)(3) of this section shall be determined separately from compliance with the provisions of divisions (B)(1) and (2) of this section.

Sec. 3901.382. Beginning six months after the date specified in section 262 of the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 2027, 42 U.S.C.A. 1320d-4, on which a third-party payer is initially required to comply with a standard or implementation specification for the electronic exchange of health information, as adopted or established by the United States secretary of health and human services pursuant to that act, sections 3901.381, 3901.384, 3901.385, 3901.389, 3901.3810, 3901.3811, 3901.3812, and 3901.3813 of the Revised Code apply to a claim submitted to a third-party payer for payment for health care services only if the claim is submitted electronically. A provider and third-party payer may enter into a contractual arrangement under which the third-party payer agrees

to process claims that are not submitted electronically because of the financial hardship that electronic submission of claims would create for the provider or any other extenuating circumstance.

Sec. 3901.383. 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 for rendering health care services is to be made by the third-party payer within time periods shorter than those set forth in 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 claim form. The 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 not later than sixty days after the date the beneficiary selects or is assigned to the provider. Under any other contractual periodic payment arrangement, the contractual agreement shall state, with specificity, the timing of payments by the third-party payer.

Sec. 3901.384. (A) Subject to division (B) of this section, a third-party payer that requires timely submission of claims for payment for health care services shall process a claim that is not submitted in a timely manner if a claim for the same services was initially submitted to a different third-party payer or state or federal program that offers health care benefits and that payer or program has determined that it is not responsible for the cost of the health care services. When a claim is submitted later than one year after the last date of service for which reimbursement is

sought under the claim, the third-party payer shall pay or deny the claim not later than ninety days after receipt of the claim or, alternatively, pursuant to the requirements of sections 3901.381 to 3901.388 of the Revised Code. The third-party payer must make an election to process such claims either within the ninety-day period or under section 3901.381 of the Revised Code. If the claim is denied, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim.

(B) The third-party payer may refuse to process a claim submitted by a provider if the provider submits the claim later than forty-five days after receiving notice from the different third-party payer or a state or federal program that that payer or program is not responsible for the cost of the health care services, or if the provider does not submit the notice of denial from the different third-party payer or program with the claim. The failure of a provider to submit a notice of denial in accordance with this division shall not affect the terms of a benefits contract.

(C) For purposes of this section, both of the following apply:

(1) A determination that a third-party payer or state or federal program is not responsible for the cost of health care services includes a determination regarding coordination of benefits, preexisting health conditions, ineligibility for coverage at the time services were provided, subrogation provisions, and similar findings;

(2) State and federal programs that offer health care benefits include medicare, medicaid, workers' compensation, the civilian health and medical program of the uniformed services and other elements of the tricare program offered by the United States department of defense, and similar state or federal programs.

(D) Any provision of a contractual arrangement entered into between a third-party payer and a provider or beneficiary that is contrary to divisions (A) to (C) of this section is unenforceable.

Sec. 3901.385. A third-party payer shall not do either of the following:

(A) Engage in any business practice that unfairly or unnecessarily delays the processing of a claim or the payment of any amount due for health care services rendered by a provider to a beneficiary;

(B) Refuse to process or pay within the time periods specified in section 3901.381 of the Revised Code a claim submitted by a provider on the grounds 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.

Sec. 3901.386. (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. 3901.387. (A) When a provider or beneficiary submits a duplicative claim for payment for health care services before the time periods specified in section 3901.381 of the Revised Code have elapsed for the original claim submitted, the third-party payer may deny the duplicative claim. Denials of claims determined to be duplicative by the department of insurance shall not be considered by the department in a market conduct examination of a third-party payer's compliance with section 3901.381 of the Revised Code. The superintendent of insurance shall have the discretion to exclude an original claim in determining a violation under section 3901.381 of the Revised Code.

(B)(1) A third-party payer shall establish a system whereby a provider and a beneficiary may obtain information regarding the status of a claim for payment for health care services, provided the claim is not materially deficient. A third-party payer shall inform providers and beneficiaries of the mechanisms that may be used to gain access to the system.

(2) If a third-party payer delegates the processing of payments to another entity, the third-party payer shall require the entity to comply with division (B)(1) of this section on behalf of the third-party payer.

Sec. 3901.388. (A) A payment made by a third-party payer to a provider in accordance with sections 3901.381 to 3901.386 of the Revised Code shall be considered final two years after payment is

made. After that date, the amount of the payment is not subject to adjustment, except in the case of fraud by the provider.

(B) A third-party payer may recover the amount of any part of a payment that the third-party payer determines to be an overpayment if the recovery process is initiated not later than two years after the payment was made to the provider. The third-party payer shall inform the provider of its determination of overpayment by providing notice in accordance with division (C) of this section. The third-party payer shall give the provider an opportunity to appeal the determination. If the provider fails to respond to the notice sooner than thirty days after the notice is made, elects not to appeal the determination, or appeals the determination but the appeal is not upheld, the third-party payer may initiate recovery of the overpayment.

When a provider has failed to make a timely response to the notice of the third-party payer's determination of overpayment, the third-party payer may recover the overpayment by deducting the amount of the overpayment from other payments the third-party payer owes the provider or by taking action pursuant to any other remedy available under the Revised Code. When a provider elects not to appeal a determination of overpayment or appeals the determination but the appeal is not upheld, the third-party payer shall permit a provider to repay the amount by making one or more direct payments to the third-party payer or by having the amount deducted from other payments the third-party payer owes the provider.

(C) The notice of overpayment a third-party payer is required to give a provider under division (B) of this section shall be made in writing and shall specify all of the following:

(1) The full name of the beneficiary who received the health care services for which overpayment was made;

(2) The date or dates the services were provided;

(3) The amount of the overpayment;

(4) The claim number or other pertinent numbers;

(5) A detailed explanation of basis for the third-party payer's determination of overpayment;

(6) The method in which payment was made, including, for tracking purposes, the date of payment and, if applicable, the check number;

(7) That the provider may appeal the third-party payer's determination of overpayment, if the provider responds to the notice within thirty days;

(8) The method by which recovery of the overpayment would be made, if recovery proceeds under division (B) of this section.

(D) Any provision of a contractual arrangement entered into between a third-party payer and a provider or beneficiary that is contrary to divisions (A) to (C) of this section is unenforceable.

Sec. 3901.389. (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 3901.383 of the Revised Code, shall pay interest in accordance with this section.

(B) 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 3901.383 of the Revised Code, and the date payment is made. The interest rate for determining the amount of interest due shall be equal to an annual percentage rate of eighteen per cent.

(C) For purposes of this section, if a dispute exists between

a provider and a third-party payer as to the day a payment was made by the third-party payer, both of the following apply:

(1) If the third-party payer or a person acting on behalf of the third-party payer submits a payment directly to a provider by mail and retains a record of the day the payment was mailed, there exists a rebuttable presumption that the payment was made five business days before the day the payment was received by the provider, unless it can be proven otherwise.

(2) If the third-party payer or a person acting on behalf of the third-party payer submits a payment directly to a provider electronically, there exists a rebuttable presumption that the payment was made twenty-four hours before the date the payment was received by the provider, unless it can be proven otherwise.

(D) 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. 3901.3810. (A) A 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 sections 3901.381 to 3901.388 of the Revised Code may file a written complaint with the superintendent of insurance regarding the violation.

(B) A third-party payer shall not retaliate against a provider or beneficiary who files a complaint under division (A) of this section. If a provider or beneficiary is aggrieved with respect to any act of the third-party payer that the provider or beneficiary believes to be retaliation for filing a complaint under division (A) of this section, the provider or beneficiary may file a written complaint with the superintendent regarding the alleged retaliation.

Sec. 3901.3811. (A) No third-party payer shall fail to comply with sections 3901.381 and 3901.384 to 3901.3810 of the Revised Code.

(B) The superintendent of insurance may require third-party payers to submit reports of their compliance with division (A) of this section. If reports are required, the superintendent shall prescribe the content, format, and frequency of the reports in consultation with third-party payers. The superintendent shall not require reports to be submitted more frequently than once every three months.

The superintendent shall not use findings from reports submitted by a third-party payer under this division as the basis of a finding of a violation of division (A) of this section or the imposition of penalties under section 3901.3812 of the Revised Code. However, the information contained in the reports may cause the superintendent to conduct a market conduct examination of the third-party payer. During this examination, the superintendent may examine data collected from the same time period as covered by these reports and the superintendent's examination findings may be used as the basis for finding a violation of division (A) of this section.

Sec. 3901.3812. (A) If, after completion of an examination involving information collected from a six-month period, the superintendent finds that a third-party payer has committed a series of violations that, taken together, constitutes a consistent pattern or practice of violating division (A) of section 3901.3811 of the Revised Code, the superintendent may impose on the third-party payer any of the administrative remedies specified in division (B) of this section. In making a finding under this division, the superintendent shall apply the error tolerance standards for claims processing contained in the market

conduct examiners handbook issued by the national association of insurance commissioners in effect at the time the claims were processed.

Before imposing an administrative remedy, the superintendent shall provide written notice to the third-party payer informing the third-party payer of the reasons for the superintendent's finding, the administrative remedy the superintendent proposes to impose, and the opportunity to submit a written request for an administrative hearing regarding the finding and proposed remedy. If the third-party payer requests a hearing, the superintendent shall conduct the hearing in accordance with Chapter 119. of the Revised Code not later than fifteen days after receipt of the request.

(B)(1) In imposing administrative remedies under division (A) of this section for violations of section 3901.381 of the Revised Code, the superintendent may do any of the following:

(a) Levy a monetary penalty in an amount determined in accordance with division (B)(3) of this section;

(b) Order the payment of interest directly to the provider in accordance with section 3901.389 of the Revised Code;

(c) Order the third-party payer to cease and desist from engaging in the violations;

(d) If a monetary penalty is not levied under division (B)(1)(a) of this section, impose any of the administrative remedies provided for in section 3901.22 of the Revised Code, other than those specified in divisions (D)(4) and (5) and (G) of that section.

(2) In imposing administrative remedies under division (A) of this section for violations of sections 3901.384 to 3901.3810 of the Revised Code, the superintendent may do any of the following:

(a) Levy a monetary penalty in an amount determined in accordance with division (B)(3) of this section;

(b) Order the payment of interest directly to the provider in accordance with section 3901.38 of the Revised Code;

(c) Order the third-party payer to cease and desist from engaging in the violations;

(d) If a monetary penalty is not levied under division (B)(2)(a) of this section, impose any of the administrative remedies provided for in section 3901.22 of the Revised Code, other than those specified in divisions (D)(4) and (5) and (G) of that section. For violations of sections 3901.384 to 3901.3810 of the Revised Code that did not comply with section 3901.381 of the Revised Code, the superintendent may also use section 3901.22 of the Revised Code except divisions (D)(4) and (5) of that section.

(3) A finding by the superintendent that a third-party payer has committed a series of violations that, taken together, constitutes a consistent pattern or practice of violating division (A) of section 3901.3811 of the Revised Code, shall constitute a single offense for purposes of levying a fine under division (B)(1)(a) and (B)(2)(a) of this section. For a first offense, the superintendent may levy a fine of not more than one hundred thousand dollars. For a second offense that occurs on or earlier than four years from the first offense, the superintendent may levy a fine of not more than one hundred fifty thousand dollars. For a third or additional offense that occurs on or earlier than seven years after a first offense, the superintendent may levy a fine of not more than three hundred thousand dollars. In determining the amount of a fine to be levied within the specified limits, the superintendent shall consider the following factors:

(a) The extent and frequency of the violations;

(b) Whether the violations were due to circumstances beyond the third-party payer's control;

(c) Any remedial actions taken by the third-party payer to prevent future violations;

(d) The actual or potential harm to others resulting from the violations;

(e) If the third-party payer knowingly and willingly committed the violations;

(f) The third-party payer's financial condition;

(g) Any other factors the superintendent considers appropriate.

(C) The remedies imposed by the superintendent under this section are in addition to, and not in lieu of, such other remedies as providers and beneficiaries may otherwise have by law.

(D) Any fine collected under this section shall be paid into the state treasury as follows:

(1) Twenty-five per cent of the total to the credit of the department of insurance operating fund created by section 3901.021 of the Revised Code;

(2) Sixty-five per cent of the total to the credit of the general revenue fund;

(3) Ten per cent of the total to the credit of claims processing education fund, which is hereby created.

All money credited to the claims processing education fund shall be used by the department of insurance to make technical assistance available to third-party payers, providers, and beneficiaries for effective implementation of the provisions of sections 3901.38 and 3901.381 to 3901.3814 of the Revised Code.

Sec. 3901.3813. The superintendent of insurance may adopt rules as the superintendent considers necessary to carry out the purposes of section 3901.38 and sections 3901.381 to 3901.3812 of the Revised Code. The rules shall be adopted in accordance with Chapter 119. of the Revised Code.

Sec. 3901.3814. Sections 3901.38 and 3901.381 to 3901.3813 of the Revised Code do not apply to the following:

(A) Policies offering coverage that is regulated under Chapters 3935. and 3937. of the Revised Code;

(B) An employer's self-insurance plan and any of its administrators, as defined in section 3959.01 of the Revised Code, to the extent that federal law supersedes, preempts, prohibits, or otherwise precludes the application of any provisions of those sections to the plan and its administrators;

(C) A third-party payer for coverage provided under the medicare plus choice or medicaid programs operated under Title XVIII and XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended;

(D) A third-party payer for coverage provided under the tricare program offered by the United States department of defense.

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

(A) "Beneficiary" ~~has~~ 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~~ 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.

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

Sec. 3902.21. As used in sections ~~3902.21 to~~ 3902.22 and 3902.23 of the Revised Code~~:~~

~~(A) "Proof of loss" means the documentation and procedures required and the criteria employed by third-party payers to accept or reject and to determine benefits payable under a claim for reimbursement of health services or supplies, including documentation, procedures, and criteria to determine the medical necessity of health services or supplies.~~

~~(B) "Third-party payers~~, "third-party payer" has the same meaning as in section 3901.38 of the Revised Code.

Sec. 3902.22. The superintendent of insurance shall develop a standard claim form ~~and standard proof of loss~~ to be used by all

third-party payers and providers for reimbursement of health care services and supplies, taking into consideration the special needs of, and differences between, third-party payers. The standard claim form ~~and standard proof of loss~~ shall be prescribed in rules the superintendent shall adopt in accordance with Chapter 119. of the Revised Code. The superintendent may prescribe a separate claim form for each third-party payer. If a national standard claim form ~~and standard proof of loss~~ is established by the sickness and accident insurance industry, the superintendent shall amend the rules to comply with the national standards. The standard claim form shall include a method to specify the license numbers of physical therapists and other health care professionals rendering services designated as physical therapy, as required under section 4755.56 of the Revised Code.

Sec. 3902.23. Beginning one hundred eighty days after rules adopted under section 3902.22 of the Revised Code take effect, no third-party payer shall fail to use the standard claim form ~~and proof of loss~~ prescribed in those rules.

Sec. 3924.21. (A) As used in this section:

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

(2) "Overcharged" means charged more than the usual and customary charge, rate, or fee that is charged by the provider or hospital for a particular item or service.

(3) "Provider" has the same meaning as in section 3902.11 of the Revised Code.

(B) If a beneficiary identifies on the billing statement of a provider or hospital any item or service for which the beneficiary was overcharged by more than five hundred dollars and the

beneficiary notifies the third-party payer of the error at any time after the thirty-day period immediately following the date on which the third-party payer makes payment to the provider or hospital for the item or service, the provider or hospital shall refund to the beneficiary an amount equal to fifteen per cent of the amount overcharged.

(C) A provider or hospital shall not be required to comply with division (B) of this section if, at the time the third-party payer receives notice of the overcharge from the beneficiary, the provider, hospital, or third-party payer is in the process of correcting the error and such process can be documented.

Section 2. That existing sections 1349.01, 1739.05, 1739.14, 3901.38, 3902.11, 3902.21, 3902.22, 3902.23, and 3924.21 and section 3901.381 of the Revised Code are hereby repealed.

Section 3. Sections 1 and 2 of this act shall take effect one year after the act is signed by the Governor or otherwise becomes law.

Section 4. Sections 3901.38, 3901.381, 3901.382, 3901.383, 3901.384, 3901.385, 3901.386, 3901.387, 3901.388, 3901.389, 3901.3810, 3901.3811, 3901.3812, 3901.3813, 3901.3814, 3902.21, 3902.22, and 3902.23 of the Revised Code, as amended, enacted, or repealed and reenacted by this act, apply to any claim for payment for health care services that is submitted to a third-party payer on or after the effective date of this act.