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Sub. S. B. No. 4

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A BILL

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. 1 2 3 4 5 6 7 8 9 10

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 11 12 13 14 15

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: 46 47

(1) A copy of the court order requiring the party to obtain health insurance coverage for the former spouse or children. 48 49

(2) Reasonable assistance in locating the party and obtaining information about the party's health insurance coverage. 50 51

(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. 52 53 54 55 56 57 58 59

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. 60 61 62 63 64 65 66 67 68 69 70 71

(D)(1) If the requirements of divisions (B)(1) and (2) of this section are met, both of the following restrictions shall apply: 72 73 74

(a) No collection agency or provider of hospital, surgical, or medical services may report to a consumer reporting agency, for 75 76

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. 77 78 79 80 81 82

(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. 83 84 85 86 87

(2) If the requirements of divisions (B)(1) and (2) of this section are not met, both of the following provisions shall apply: 88 89

(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. 90 91 92 93 94 95 96 97

(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. 98 99 100 101 102 103 104

(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, 105 106 107

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. 108 109 110 111

(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. 112 113 114 115 116 117

(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. 118 119 120 121 122 123 124 125 126 127 128 129 130

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 131 132 133 134 135 136 137 138 139

party may initiate an action to require the agency to remove the 140
information. 141

Sec. 1739.05. (A) A multiple employer welfare arrangement 142
that is created pursuant to sections 1739.01 to 1739.22 of the 143
Revised Code and that operates a group self-insurance program may 144
be established only if any of the following applies: 145

(1) The arrangement has and maintains a minimum enrollment of 146
three hundred employees of two or more employers. 147

(2) The arrangement has and maintains a minimum enrollment of 148
three hundred self-employed individuals. 149

(3) The arrangement has and maintains a minimum enrollment of 150
three hundred employees or self-employed individuals in any 151
combination of divisions (A)(1) and (2) of this section. 152

(B) A multiple employer welfare arrangement that is created 153
pursuant to sections 1739.01 to 1739.22 of the Revised Code and 154
that operates a group self-insurance program shall comply with all 155
laws applicable to self-funded programs in this state, including 156
sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.381 157
to 3901.3814, 3901.40, 3901.45, 3901.46, 3902.01 to 3902.14, 158
3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3924.031, 3924.032, 159
and 3924.27 of the Revised Code. 160

(C) A multiple employer welfare arrangement created pursuant 161
to sections 1739.01 to 1739.22 of the Revised Code shall solicit 162
enrollments only through agents or solicitors licensed pursuant to 163
Chapter 3905. of the Revised Code to sell or solicit sickness and 164
accident insurance. 165

(D) A multiple employer welfare arrangement created pursuant 166
to sections 1739.01 to 1739.22 of the Revised Code shall provide 167
benefits only to individuals who are members, employees of 168
members, or the dependents of members or employees, or are 169

eligible for continuation of coverage under section 1751.53 or 170
3923.38 of the Revised Code or under Title X of the "Consolidated 171
Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 172
U.S.C.A. 1161, as amended. 173

Sec. 1739.14. (A) Each member shall pay to the multiple 174
employer welfare arrangement operating a group self-insurance 175
program a premium equal to its share of the arrangement's 176
projected obligation for employee welfare benefit liability, 177
administrative expenses, and other costs incurred by the 178
arrangement as determined by the board of the arrangement or by a 179
third-party administrator and approved by the board of the 180
arrangement. This amount may be adjusted by the board according to 181
the claims experience of each participating member in accordance 182
with criteria set forth in the articles or bylaws of the 183
arrangement. 184

(B) Each member shall pay a premium for each year at the 185
beginning of each fiscal year unless otherwise provided for under 186
the agreement. 187

(C) A multiple employer welfare arrangement operating a group 188
self-insurance program shall make payments, or arrange to have 189
payments made, to the employees of the members out of the fund for 190
employee welfare benefits in accordance with section 3901.38 <u>and</u> 191
<u>sections 3901.381 to 3901.3814</u> of the Revised Code. 192

(D) A board of the multiple employer welfare arrangement 193
operating a group self-insurance program shall determine whether 194
any dividends or assessments shall be paid to or levied against 195
participating members. 196

Sec. 3901.38. ~~(A)~~ As used in this section and ~~section~~ 197
<u>sections</u> 3901.381 <u>to 3901.3814</u> of the Revised Code: 198

~~(1)~~<u>(A)</u> "Beneficiary" means any policyholder, subscriber, 199

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.~~ 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282

~~(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.~~ 283 284 285 286

~~(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.~~ 287 288 289 290 291

~~(5) A provider and a third-party payer may enter into a~~ 292

~~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. 356 357 358 359 360 361 362 363 364

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. 365 366 367 368 369 370 371 372 373 374 375

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 376 377 378 379 380 381 382 383 384 385 386 387

third-party payer's compliance with the time period of not more than forty-five days. 388 389

(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. 390 391 392 393 394 395 396 397 398 399 400 401

(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. 402 403 404 405

(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. 406 407 408 409 410 411 412

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 413 414 415 416 417 418 419

administration. 420

(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. 421 422 423 424 425 426 427 428 429

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. 430 431 432 433 434 435 436 437 438 439

(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: 440 441 442 443

(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. 444 445 446 447 448 449

(2) If the provider or a person acting on behalf of the 450

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. 451 452 453 454

(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. 455 456 457 458

(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. 459 460 461

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. 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477

Sec. 3901.383. A provider and a third-party payer may do either of the following: 478 479

(A) Enter into a contractual agreement in which payment of 480

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; 481 482 483

(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. 484 485 486 487 488 489 490 491 492 493 494 495

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 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512

specificity, why the third-party payer denied the claim. 513

(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. 514 515 516 517 518 519 520 521 522 523

(C) For purposes of this section, both of the following apply: 524 525

(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; 526 527 528 529 530 531

(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. 532 533 534 535 536

(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. 537 538 539

Sec. 3901.385. A third-party payer shall not do either of the following: 540 541

(A) Engage in any business practice that unfairly or 542

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; 543 544 545

(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. 546 547 548 549 550 551 552

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. 553 554 555 556 557 558 559

(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. 560 561 562 563 564 565 566 567

(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. 568 569 570 571

Sec. 3901.387. (A) When a provider or beneficiary submits a 572

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. 573 574 575 576 577 578 579 580 581 582

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(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. 584 585 586 587 588 589

(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. 590 591 592 593

Sec. 3901.388. 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. 594 595 596 597 598

(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 599 600 601 602 603

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. 604 605 606 607 608 609 610

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. 611 612 613 614 615 616 617 618 619 620 621 622

(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: 623 624 625

(1) The full name of the beneficiary who received the health care services for which overpayment was made; 626 627

(2) The date or dates the services were provided; 628

(3) The amount of the overpayment; 629

(4) The claim number or other pertinent numbers; 630

(5) A detailed explanation of basis for the third-party payer's determination of overpayment; 631 632

(6) The method in which payment was made, including, for 633

tracking purposes, the date of payment and, if applicable, the check number; 634 635

(7) That the provider may appeal the third-party payer's determination of overpayment, if the provider responds to the notice within thirty days; 636 637 638

(8) The method by which recovery of the overpayment would be made, if recovery proceeds under division (B) of this section. 639 640

(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. 641 642 643

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. 644 645 646 647 648

(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. 649 650 651 652 653 654 655

(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: 656 657 658

(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 659 660 661 662 663

provider, unless it can be proven otherwise. 664

(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. 665 666 667 668 669

(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. 670 671 672 673

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. 674 675 676 677 678

(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. 679 680 681 682 683 684 685 686

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. 687 688 689

(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 690 691 692 693

consultation with third-party payers. The superintendent shall not require reports to be submitted more frequently than once every three months. 694 695 696

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. 697 698 699 700 701 702 703 704 705 706 707

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. 708 709 710 711 712 713 714 715 716 717 718 719 720

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 721 722 723 724

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. 725 726 727 728 729 730

(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: 731 732 733

(a) Levy a monetary penalty in an amount determined in accordance with division (B)(3) of this section; 734 735

(b) Order the payment of interest directly to the provider in accordance with section 3901.389 of the Revised Code; 736 737

(c) Order the third-party payer to cease and desist from engaging in the violations; 738 739

(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. 740 741 742 743 744

(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: 745 746 747 748

(a) Levy a monetary penalty in an amount determined in accordance with division (B)(3) of this section; 749 750

(b) Order the payment of interest directly to the provider in accordance with section 3901.38 of the Revised Code; 751 752

(c) Order the third-party payer to cease and desist from engaging in the violations; 753 754

(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. 755 756 757 758 759 760 761 762

(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: 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777

(a) The extent and frequency of the violations; 778

(b) Whether the violations were due to circumstances beyond the third-party payer's control; 779 780

(c) Any remedial actions taken by the third-party payer to prevent future violations; 781 782

(d) The actual or potential harm to others resulting from the violations; 783 784

(e) If the third-party payer knowingly and willingly 785

committed the violations; 786

(f) The third-party payer's financial condition; 787

(g) Any other factors the superintendent considers appropriate. 788 789

(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. 790 791 792

(D) Any fine collected under this section shall be paid into the state treasury as follows: 793 794

(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; 795 796 797

(2) Sixty-five per cent of the total to the credit of the general revenue fund; 798 799

(3) Ten per cent of the total to the credit of claims processing education fund, which is hereby created. 800 801

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. 802 803 804 805 806

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. 807 808 809 810 811

Sec. 3901.3814. Sections 3901.38 and 3901.381 to 3901.3813 of the Revised Code do not apply to the following: 812 813

(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, except as provided in section 3729.15 of the Revised Code.

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. 903 904 905 906

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. 907 908 909

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. 910 911 912

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. 913 914 915 916 917 918 919