



**S.B. 4**

124th General Assembly  
(As Introduced)

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**BILL SUMMARY**

- Revises the statutes that require third-party payers of health services to make prompt payments to health care providers.
- Provides for automatic interest on late payments.
- Prohibits a third-party payer from retaliating against a provider that files a complaint.
- Provides that payments properly made by a third-party payer are final after one year.

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**CONTENT AND OPERATION**

**Overview**

Current law provides for the "prompt payment" of health care providers by third-party payers. Providers include hospitals, physicians, dentists, pharmacists, and other licensed health care providers entitled to reimbursement for services rendered to a beneficiary covered under a health care benefits contract. Third-party payers include insurance companies, health insuring corporations, labor organizations, employers, and other entities contractually obligated to pay charges for covered health care services.

The bill revises the prompt pay law, both in its substance and its organization in the Revised Code. Among its substantive changes, the bill does the following: (1) revises provisions governing the timing of reimbursement payments and contractual exceptions to the timing requirements, (2) provides for automatic interest on overdue payments, (3) revises the penalties imposed for violations, (4) prohibits a third-party payer from retaliating against a provider that

files a complaint against the third-party payer, and (5) provides that payments made in accordance with the prompt pay law are considered final after one year.

### **Definitional changes**

(secs. 3901.38 and 3901.381 (repealed))

The prompt pay law currently defines a "completed claim" as "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." Specified information must be included in a completed claim in order for a beneficiary or provider, other than a hospital or nursing home, to obtain reimbursement.

The bill amends the definition of a "completed claim," defining it as "a proof of loss or a claim for payment for health care services that uses the standard proof of loss or claim form prescribed in rules adopted by the Superintendent of Insurance . . . and that has been submitted to the appropriate claims processing office of the third-party payer." The bill further provides that "[a] proof of loss or claim for payment that meets the requirements of such rules shall be considered a 'completed claim' unless the third-party payer notifies the provider . . . of material deficiencies in the proof of loss or the claim for payment." Having acknowledged the use of the Superintendent's standard proof of loss or claim form, the bill repeals the statute specifying information that must be included in a completed claim for reimbursement.

The prompt pay law currently defines "proof of loss" as "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" (sec. 3901.38(A)(5)).

The bill amends the definition of "proof of loss," defining it as "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."

### **Timing of reimbursement payments**

(secs. 3901.38(B)(1) and 3901.381(A)(1))

The prompt pay law currently requires a third-party payer to make payment on a completed claim from a provider or a beneficiary within 24 days of receipt of the claim. Under the bill, a third-party payer is required to make payment of any amount due on a completed claim for reimbursement for services rendered by a provider to a beneficiary, within 30 days after receipt of the claim.

The prompt pay deadline does not apply if a third-party payer determines that it is not responsible for paying a claim. In this event, the bill requires the third-party payer to notify the provider and beneficiary within 30 days after receipt of the claim. The notice must be in writing and must state, with specificity, the reasons why the third-party payer is not obligated to pay the claim.

### **Unclear payment responsibility**

(sec. 3901.381(B)(2))

If the responsibility of a third-party payer to make payment is unclear due to a good faith dispute regarding the eligibility of a beneficiary, the liability of another payer for all or part of the claim, the amount of the claim, the benefits covered, or the manner in which health care services were accessed or provided, the bill requires the third-party payer to pay any undisputed portion of the completed claim in accordance with the bill's prompt payment provisions. As for the disputed portion of the claim, the bill requires the third-party payer to notify the provider and beneficiary, within 15 days after receipt of the claim, that additional information is needed to establish the responsibility of the third-party payer to make payment. This notice must be in writing and must state, with specificity, the portion of the claim in dispute and the information needed to establish the third-party payer's responsibility to make payment. If any information is under the control of the beneficiary, the beneficiary is required to provide the information to the third-party payer. The third-party payer must make payment of any amount due on the claim within 30 days after receiving the information requested. If the third-party payer is the secondary payer, the beneficiary is required to submit to the third-party payer an explanation of benefits or other evidence of payment by the primary payer within 30 days after payment by the primary payer. Then the third-party payer must make payment of the amount due on the claim that it is responsible for paying within 30 days after it receives notice of the amount that the primary payer is responsible for paying.

### **Incomplete claims**

(sec. 3901.381(B)(1))

If a claim received by a third-party payer is not a completed claim, the bill requires the third-party payer to notify the provider within 15 days after receipt of the claim. The notice must be in writing and must state, with specificity, the information needed to correct all material deficiencies. The third-party payer must make payment of any amount due within 30 days after the third-party payer receives the information requested.

### **Date of receipt**

(sec. 3901.381(D))

For purposes of settling a dispute between a provider and a third-party payer as to the day a claim was received by the third-party payer, the bill provides the following:

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

(2) If the provider submits a claim electronically, there is a presumption that the claim was received by the third-party payer 24 hours after the claim was submitted, unless it can be proven otherwise.

### **Contractual variations to the timing requirements**

(secs. 3901.38(B)(2) and (5) and 3901.382)

The prompt pay law currently provides that 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 . . . make payment of any amount due on a completed claim." The bill instead permits a third-party payer and a provider to enter into a contractual agreement in which payment is to be made within a time period *shorter* than that otherwise required.

The current prompt pay law also permits a third-party payer and a provider to 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." The law then proceeds to note that such contractual arrangements may include "periodic interim arrangements, capitation payment arrangements, or other payment arrangements acceptable to the provider and the third-party payer."

The bill maintains this contractual exception to the prompt pay law's time requirements, but adds a provision regulating capitation payment arrangements. The bill requires a third-party payer, under a capitation payment arrangement, to begin paying the capitated amounts to the beneficiary's primary care provider, calculated from the date of enrollment, within 60 days after the date the beneficiary selects or is assigned to the provider. The bill requires that capitated amounts be reserved for payment to the primary care provider if the selection or assignment of a provider does not occur at the time of enrollment. The bill also requires that the contract for any other contractual periodic payment arrangement state the timing of payments by the third-party payer with specificity.

**Automatic interest**

(sec. 3901.385)

The bill requires any third-party payer that fails to pay a claim in accordance with the prompt pay law's time requirements or any contractual payment arrangement entered into under the law, to pay interest. The interest is to be computed based upon the number of days that have elapsed between the date payment is due and the date payment is made. If a dispute exists between a provider and a third-party payer as to the date a payment is made, both of the following apply:

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

(2) If the payment is submitted electronically, there is a presumption that the payment was made by the third-party payer 24 hours before the date the payment was received by the provider, unless it can be proven otherwise.

Under the bill, the interest rate is 18% per year. Interest is to be compounded on a daily basis. Interest due must be paid directly to the provider at the time payment of the claim is made and cannot be used to reduce benefits or payments otherwise payable under a benefits contract.

**Complaint process, retaliation prohibited; penalties and attorney's fees**

(secs. 3901.38(B)(3) and (4), 3901.386, and 3901.387)

Current law permits providers and beneficiaries who believe they have been harmed by a third-party payer's violation of the prompt pay law to file a written complaint with the Superintendent of Insurance. The Superintendent may issue an order requiring the third-party payer to cease and desist from violations and to pay a late payment penalty, but only if the Superintendent has received a series of

complaints against a particular third-party payer and the Superintendent finds that the third-party payer has engaged in a series of violations, which, taken together, constitute a consistent pattern or a practice of the third-party payer to violate the prompt pay time requirements. The interest rate used in determining the amount of the late payment penalty is the "rate agreed to by the provider and the third-party payer" or a rate determined in accordance with the Commercial Transactions Law generally setting 8% per year as the maximum interest rate on certain transactions.

The bill adds a fine of at least \$1,000 but not more than \$10,000 per violation and requires the payment of interest in accordance with its automatic interest provisions (see above). Also, the bill provides that the party that filed a complaint is entitled to recover reasonable attorney's fees. Fines collected under the bill are paid to the state treasury to the credit of the Department of Insurance Operating Fund.

The bill creates a prohibition against retaliation, stating "No third-party payer shall retaliate against any provider that files a [prompt pay] complaint against the third-party payer . . . ."

**Payment considered final after one year**

(sec. 3901.384)

Under the bill, a payment made by a third-party payer to a provider in accordance with the bill's prompt pay provisions is to be considered final one year after the 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. Also, after that date, the third-party payer is prohibited from deducting any overpayment made to a provider from any other payment the third-party payer owes the provider.

**Unfair and deceptive act or practice**

(sec. 3901.38(E))

The prompt pay law currently states that a *series* of violations "which taken together, constitute a consistent pattern or practice of violation of any of the provisions of [the prompt pay law]" is an unfair and deceptive act or practice in the business of insurance, subject to proceedings and penalties under Chapter 3901. of the Insurance Law. The bill removes this provision.

**Payments subject to the bill**

(Section 3)

The bill specifies that its provisions apply to any proof of loss or claim for payment that is submitted to a third-party payer on or after the bill's effective date.

**Reorganization**

Organizationally, the bill removes all substantive provisions from section 3901.38 of the Revised Code, relocating these provisions, as amended, through sections 3901.381 to 3901.387 of the Revised Code. Definitions applicable to the prompt pay law remain in section 3901.38 of the Revised Code. Divisions (C) and (D) of existing section 3901.38 of the Revised Code are recodified as section 3901.383 and division (C) of section 3901.381. Conforming changes are made to cross references in two sections related to multiple employer welfare arrangements (secs. 1739.05 and 1739.14), and in a section related to plans of health coverage (sec. 3902.11).

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**HISTORY**

ACTION	DATE	JOURNAL ENTRY
Introduced	01-30-01	p. 90

S0004-I.124/jc