Greg Schwab *Legislative Service Commission*

Sub. S.B. 4

124th General Assembly
(As Passed by the Senate)

Sens. 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

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.
- Provides that payments properly made by a third-party payer are final after two years.

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 unfairly or unnecessarily delaying the processing of a claim and 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 two years.

Time periods for prompt processing of claims

(secs. 3901.38, 3901.381, and 3902.22)

Current law requires a third-party payer to make payments for health care services rendered by a provider to a beneficiary for services covered under a benefits contract. The payment must be made within 24 days after receiving a complete claim. A claim is considered complete if it has been submitted to the appropriate claims processing office and is accompanied by sufficient documentation for the third-party payer to determine its responsibility for paying the claim. Specified information must be included for a beneficiary or provider, other than a hospital or nursing home, to obtain reimbursement.

The bill requires a claim to be processed when it is submitted by the provider or beneficiary on the standard claim form prescribed in rules adopted by the Superintendent of Insurance under existing law.

30-day time period

In general, the bill requires a claim to be paid or denied not later than 30 days after receipt of the claim. When a claim is denied, the bill requires that the third-party payer notify the provider and beneficiary. The notice must be in writing and state, with specificity, why the claim was denied.

45-day time period

When the third-party payer determines that reasonable supporting documentation is needed to establish the third-party payer's responsibility to make payment, the claim must be paid or denied not later than 45 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 services provided, information on the responsibility of another third-party payer to make payment, and information that is needed to correct material deficiencies in the claim related to the identification of a diagnosis, treatment, or provider.

Not later than 30 days after receipt of the claim, the third-party payer must notify the provider, beneficiary, or another third-party payer that the supporting documentation is needed. The notice must state, with specificity, what documentation is needed. If any of the documentation is under the control of the beneficiary, the bill requires the beneficiary to provide it.

The number of days that elapse between the third-party payer's request for supporting documentation and receipt of the requested documentation is not counted for purposes of determining compliance with the 45-day time period. If the third-party payer requests additional supporting documentation after receiving the initially requested documentation, however, the time it takes to receive that documentation is counted.

When a claim is denied, the third-party payer must notify the provider and beneficiary. The notice must state, with specificity, why the claim was denied. If a claim is denied because the provider failed to submit supporting documentation, and the provider in any manner charges the beneficiary for the cost of the services, the provider must notify the beneficiary that the charge is the result of a denied claim and must notify the third-party payer that the beneficiary has been billed. The notices must be made in writing and sent simultaneously. Each notice must include the number assigned by the third-party payer to the claim that was denied.

If a third-party payer determines that supporting documentation is routinely necessary to process a claim for a particular health service, the bill requires the third-party payer to establish a description of the needed documentation. The description must be made available to providers in a readily accessible format.

15-day time period for notice of material deficiencies

When the information provided in the claim is materially deficient, the third-party payer must notify the provider or beneficiary not later than 15 days after receipt of the claim. The notice must state, with specificity, the information needed to correct the claim. Once the material deficiencies are corrected, the third-party payer is required to proceed with processing the claim in accordance with the time periods specified in the bill.

The bill specifies that the 15-day limit for providing notice is not violated if a third-party payer finds after the end of that period that it is necessary to request information related to the identification of a diagnosis, treatment, or provider. Requests for such information are to be made as requests for supporting documentation, and the processing of the claim is subject to the 45-day time period described above.

30-day time period for payment by secondary payers

When a third-party payer is the secondary payer, the bill requires the beneficiary to submit an "explanation of benefits" or other evidence of payment or denial by the primary payer within 30 days. The third-party payer must pay or deny the claim within 30 days. If the claim is denied, the beneficiary must be notified. The notice must state, with specificity, why the claim was denied.

Prompt processing of claims submitted by unlicensed providers

(sec. 3901.38(D))

Current law requires a third-party payer to make prompt payments to hospitals, nursing homes, licensed health practitioners, and other licensed providers. The bill extends its provisions for prompt processing of claims to any unlicensed health care provider, as long as the provider is entitled to reimbursement by the third-party payer under a benefits contract.

Presumed date of payment received

(sec. 3901.381(C))

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

(1) If the provider submits a claim by mail and retains a record of the day it was mailed, there is a 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 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 time periods for processing claims

(sec. 3901.383(A))

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 time periods *shorter* than those otherwise required by the bill.

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." Such contractual arrangements include "periodic interim payment 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 not later than 60 days after the date the beneficiary selects or is assigned to the provider. 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. 3901.389)

The bill requires any third-party payer that fails to process 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 at an annual percentage rate of 18%. The interest is to be computed based on 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 day a payment is made, both of the following apply:

(1) If the third-party payer submits a payment by mail and retains a record of the day it was mailed, there is a 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 payment is submitted electronically, there is a presumption that the payment was made 24 hours before the date the payment was received by the provider, unless it can be proven otherwise.

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.

Denial of duplicative claims

(sec. 3901.387(A))

The bill specifies that when a provider or beneficiary submits a duplicative claim before the time periods for processing the original claim have elapsed, the third-party payer may deny the duplicative claim.

Information systems on status of claims

(sec. 3901.387(B))

The bill requires a third-party payer to establish a system whereby a provider and beneficiary may obtain information regarding the status of a claim. The third-party payer must inform providers and beneficiaries of the mechanisms that may be used to gain access to the system. If a third-party payer delegates the processing of claims to another entity, the third-party payer must require the entity to comply with the requirements for establishing an information system on the status of claims.

Electronic claims

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all third-party payers to become capable of accepting claims submitted electronically by providers. Federal regulations establishing standards for these transactions are now in final form, but the requirement that electronic claims be accepted is delayed for two to three years depending on the type of insurer involved.

Beginning six months after the HIPAA requirements become effective for a third-party payer, the bill provides that the time periods in the bill for processing claims apply only to claims submitted electronically. The bill permits a provider and third-party payer to 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.

Processing of late claims

(sec. 3901.384)

Under the bill, if a third-party payer requires timely submission of claims for payment for health services, the third-party payer must 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 health program and that payer or program determines that it is not responsible for the cost of the services. Examples include determinations regarding coordination of benefits, preexisting health conditions, ineligibility for coverage at the time services were provided, and subrogation provisions. Some of the state and federal health programs that may be involved are Medicare, Medicaid, workers' compensation, and certain programs offered by the United States Department of Defense.

When a claim is submitted later than one year after the last date of service, the bill requires the third-party payer to process the claim in not more than 90 days. If the claim is denied, written notice must be given to the provider and beneficiary. The notice must state, with specificity, why the claim was denied.

The bill authorizes a third-party payer to refuse to process a claim if it is submitted later than 30 days after receiving notice from a different third-party payer or state or federal health program that the payer or program is not responsible for the cost of the health care services. This provision applies to claims submitted by providers, but not to claims submitted by beneficiaries.

The bill specifies that any provision of a contractual arrangement entered into between a third-party payer and a provider or beneficiary that is contrary to the bill's provisions regarding the processing of late claims is unenforceable.

Payment considered final after two years

(sec. 3901.388)

Under the bill, a payment made by a third-party payer to a provider in accordance with the bill is to be considered final two years after the payment is made. After that date, the amount is not subject to adjustment, except in the case of fraud by the provider.

Recovery of overpayments

The bill permits a third-party payer to 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. The third-party payer must notify the provider of its determination and give the provider an opportunity to appeal. If the provider fails to respond to the notice within 30 days, elects not to appeal the determination, or appeals the determination but the appeal is not upheld, the bill permits the third-party payer to initiate recovery of the overpayment.

Notice of overpayment

The bill requires the third-party payer to make the notice of overpayment in writing. The notice must 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;

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

Method of recovery

When a provider fails to make a timely response to the notice of overpayment, the third-party payer is authorized to recover the overpayment by deducting the amount from other payments the third-party payer owes the provider or by taking action pursuant to any other remedy available under Ohio's statutes. When a provider elects not to appeal or loses when an appeal is made, the third-party payer is required to permit the provider to repay the amount by making direct payments or having the amount deducted from other payments the third-party payer owes the provider.

Unenforceable contract provisions

The bill specifies that any provision of a contractual arrangement entered into between a third-party payer and a provider or beneficiary that is contrary to the bill's provisions regarding final payments and recovery of overpayments is unenforceable.

Unfair or unnecessary delays in processing claims

(sec. 3901.385)

The bill prohibits a third-party payer from engaging 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.

Complaint process; retaliation prohibited

(sec. 3901.3810)

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 bill prohibits a third-party payer from retaliating against a provider or beneficiary for filing a complaint. If a provider or beneficiary believes retaliation has occurred, the provider or beneficiary is permitted to file a written complaint regarding the retaliation.

Penalties

(sec. 3901.3812)

Under current law, 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 through an investigation that the third-party payer has engaged in a series of violations, which, taken together, constitutes 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 provides for the imposition of penalties against a third-party payer after the Superintendent completes an examination involving information collected from a six-month period. If the Superintendent finds that the third-party payer has committed a series of violations that, taken together, constitutes a consistent pattern or practice of violating the bill, the Superintendent is authorized to impose administrative remedies. In making such a finding, the bill requires that the Superintendent use the compliance standards recommended by the National Association of Insurance Commissioners.

Before imposing an administrative remedy, the Superintendent must provide written notice to the third-party payer informing the payer of the reasons for the Superintendent's finding, the proposed administrative remedy, and the opportunity to request an administrative hearing. If a hearing is requested, it must be conducted not later than 15 days after receipt of the request and in accordance with the Administrative Procedure Act (R.C. Chapter 119.).

Remedies available

In imposing administrative remedies, the Superintendent may do any of the following:

(1) Levy a monetary penalty;

(2) Order the payment of interest directly to the provider;

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

(4) If a monetary penalty is not imposed, impose any of the administrative remedies otherwise available to the Superintendent when an insurer engages in an unfair and deceptive act or practice in the business of insurance, except for the remedies involving payment of interest and penalties.

Monetary penalties

For purposes of levying a monetary penalty, the bill specifies that a finding by the Superintendent that a series of violations have been committed constitutes a single offense. The bill establishes the amount of a fine that may be imposed according to the following:

(1) For a first offense, not more than $100,000;

(2) For a second offense that occurs on or earlier than six years from the first offense, not less than $50,000 nor more than $200,000;

(3) For a third offense that occurs on or earlier than six years after a first offense, not less than $100,000 nor more than $300,000.

In determining the amount to be imposed, the Superintendent must consider the following factors:

--The extent and frequency of the violations;

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

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

--The actual or potential harm to others resulting from the violations;

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

--The third-party payer's financial condition;

--Any other factors the Superintendent considers appropriate.

Disposition of fines

Any fine collected under the bill must be paid into the state treasury as follows:

(1) 25% to the existing Department of Insurance Operating Fund;

(2) 65% to the General Revenue Fund;

(3) 10% to the Claims Processing Education Fund, which the bill creates for use by the Department in making technical assistance available to third-party payers, providers, and beneficiaries for effective implementation of the bill.

Reports

(sec. 3901.3811)

The Superintendent of Insurance is permitted under the bill to require third-party payers to submit reports of their compliance with the bill. If reports are required, the Superintendent must prescribe the content, format, and frequency of the reports in consultation with third-party payers. The Superintendent cannot require reports to be submitted more frequently than once every three months. Under the bill, the Superintendent cannot use findings from the reports as the basis for finding a violation of the bill or imposing penalties against the third-party payer.

Rules

(sec. 3901.3813)

The bill authorizes the Superintendent of Insurance to adopt rules as the Superintendent considers necessary to carry out the bill's purposes. The rules must be adopted in accordance with the Administrative Procedure Act (Chapter 119.).

Proof of loss

(secs. 3901.38, 3902.21, 3902.22, and 3902.23)

Current law requires the Superintendent of Insurance to develop a standard "proof of loss" to be used by all third-party payers for reimbursement of health care services and supplies. A proof of loss is defined 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.

The bill eliminates the duty of the Superintendent to develop a standard proof of loss. Corresponding references in the existing prompt pay statutes are eliminated.

Exclusions from the bill

(sec. 3901.3814)

The bill specifies that it does not apply to any of the following:

(1) Insurance polices regulated as commercial property, homeowners, casualty, or motor vehicle insurance;

(2) An employer's self-insurance plan and any of its administrators, to the extent that federal law supercedes, preempts, prohibits, or otherwise precludes the application of the bill to the plan and its administrators;

(3) A third-party payer for coverage provided under the Medicare+Choice or Medicaid programs;

(4) A third-party payer for coverage provided under the TRICARE program, which is a health benefits program offered by the United States Department of Defense.

Claims subject to the bill

(Section 3)

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

Technical changes

(secs. 1349.01, 1739.05, 1739.14, 3902.11, and 3924.21)

Cross-reference changes and other nonsubstantive changes are made to conform certain sections of the Revised Code with the bill.

HISTORY

ACTION	DATE	JOURNAL ENTRY	
Introduced	01-30-01	p.	90
Reported, S. Health, Human Services and Aging	05-15-01	p.	369
Passed Senate (32-0)	05-16-01	p.	377

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