



H.B. 686

126th General Assembly
(As Introduced)

Rep. Daniels

BILL SUMMARY

- Requires insurers and other third-party payers to accept and honor assignment-of-benefit agreements entered into between beneficiaries and health care providers or pay beneficiaries directly with a check made payable to both the beneficiary and the provider.

CONTENT AND OPERATION

Assignment-of-benefit agreements

Under existing law, if a third-party payer and a hospital have not entered into an agreement regarding the provision and reimbursement of covered services, a third-party payer must accept and honor a completed and validly executed assignment of benefits with a hospital, unless the hospital notifies the third-party payer in writing otherwise. The notification must be renewed annually. A third-party payer may not refuse a validly executed assignment of benefits with the hospital for medically necessary hospital services on an emergency basis. (R.C. 3901.386.)

The bill creates two options for third-party payers who have not entered into agreements regarding the provision and reimbursement of covered services. As the first option, the bill retains the requirement that a third-party payer accept and honor a completed and validly executed assignment of benefits. The bill also presents the third-party payer the option of paying the beneficiary directly. Under the bill, if the third-party payer chooses to pay the beneficiary directly, the check that the third-party payer remits must be payable to both the beneficiary and the provider. The bill requires the beneficiary to endorse the check and remit it to the provider as payment for the health care services rendered by the provider. Whereas existing law requiring a third-party payer to accept and honor an assignment of benefits contract applies only to hospitals, the bill expands the application of the law to various other providers in addition to hospitals. The bill

removes the provisions in existing law that allow a third-party payer, annually, to give prior notification to a hospital of conditions under which it will not accept an assignment of benefits and regarding emergency services described above. (*Id.*)

Under the bill, a claim under a benefits contract is not settled until the third-party payer makes payment to the provider or beneficiary for the health care services rendered to the beneficiary that are covered under the benefits contract. However, both the beneficiary executing the assignment of benefits and the third-party payer accepting the assignment of benefits are liable for the amount due to the provider for services rendered to the beneficiary. (*Id.*)

Definitions under the bill

The bill adds several definitions to existing law concerning assignment of benefits. "Patient" is defined as any individual who meets one of the following criteria: (1) as a result of illness or injury, one who needs medical attention, (2) one whose physical or mental condition is such that there is imminent danger of loss of life or significant health impairment, (3) one who may be otherwise incapacitated or helpless as a result of a physical or mental condition. (R.C. 3901.386.)

"Provider" means a hospital, long-term care facility, nursing home, physician, podiatrist, dentist, pharmacist, chiropractor, or other licensed health care provider, provider partnership, or provider professional corporation. "Provider" also includes any person licensed or otherwise authorized to transport patients, including but not limited to emergency victims, to, from, or between providers. (*Id.*)

"Third-party payer" means a sickness and accident insurer, health insuring corporation, intermediary organization that contracts with health insuring corporations or self-insured employers to provide health care services, or any other person obligated pursuant to a benefits contract to reimburse for covered health services rendered to beneficiaries. (R.C. 1751.01, not in the bill, and 3901.386.)

HISTORY

| ACTION | DATE |
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| Introduced | 11-21-06 |

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