(131st General Assembly)
(Substitute House Bill Number 259)

AN ACT

To amend section 3901.381, to enact sections 3938.01, 3938.02, 3938.03, 3938.04, 3938.05, 3938.06, 3938.07, 3938.08, 3938.09, and 4123.324, to enact new section 2323.44, and to repeal section 2323.44 of the Revised Code to regulate certificates of insurance prepared or issued to verify the existence of property or casualty insurance coverage, to update prompt payment requirements, and to require the administrator of Workers' Compensation to reduce the transfer of negative experience to a successor employer under certain circumstances.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That section 3901.381 be amended and sections 3938.01, 3938.02, 3938.03, 3938.04, 3938.05, 3938.06, 3938.07, 3938.08, 3938.09, and 4123.324 and new section 2323.44 of the Revised Code be enacted to read as follows:

Sec. 2323.44. (A) As used in this section:

(1) "Health care provider-sponsored organization" means an entity that is sponsored by hospitals, physician groups, other licensed health care providers, or any combination of hospitals, physician groups, or other licensed health care providers that are affiliated through common ownership or control and share financial risk for the purpose of delivering health care services.

(2) "Injured party" means any person who claims any injury, death, or loss to person in a tort action or an estate that makes a survivorship claim due to injury, death, or loss to person, but not including a derivative claim, a claim made by a beneficiary in a wrongful death action pursuant to section 2125.02 of the Revised Code, or a claim for punitive damages arising from a person's claim of injury, death, or loss to person.

(3) "Recovery" means the amount obtained from a third party in a tort action or the amount obtained for a claim in connection with uninsured or underinsured motorist coverage.

(4) "Third party" means any individual, automobile insurance company, or public or private entity against which a person or estate has a tort action.

(5) "Subrogee" means any of the following:

(a) An insurance company doing business in this state;

(b) A self-funded plan providing health, sickness, or disability benefits;

(c) A health care provider-sponsored organization;

(d) Any person or entity that claims a right of subrogation by contract or common law.

(6) "Tort action" means a civil action for injury, death, or loss to person. "Tort action" includes any claim for damages for injury, death, or loss to person, whether or not a lawsuit is pending, or a claim in connection with uninsured or underinsured motorist coverage, but does not include a civil action for breach of contract or another agreement between persons.

(B) Notwithstanding any contract or statutory provision to the contrary, the rights of a subrogee or any other person or entity that asserts a contractual, statutory, or common law subrogation claim against a third party or an injured party in a tort action shall be subject to both of the following:

(1) If less than the full value of the tort action is recovered for comparative negligence, diminishment due to a party's liability under sections 2307.22 to 2307.28 of the Revised Code, or by reason of the collectability of the full value of the claim for injury, death, or loss to person resulting from limited liability insurance or any other cause, the subrogee's or other person's or entity's claim shall be diminished in the same proportion as the injured party's interest is diminished.

(2) If a dispute regarding the distribution of the recovery in the tort action arises, either party may file an action under Chapter 2721. of the Revised Code to resolve the issue of the distribution of the recovery.

Sec. 3901.381. (A) Except as provided in sections 3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.

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

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

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

The number of days that elapse between the third-party payer's last request for supporting documentation within the thirty-day period and the third-party payer's receipt of all of the supporting documentation that was requested shall not be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days for payment or denial of a

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

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

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

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

Third-party payers and providers shall, in connection with a claim, use the most current CPT code in effect, as published by the American medical association, the most current ICD-~~9~~10 code in effect, as published by the United States department of health and human services, the most current CDT code in effect, as published by the American dental association, or the most current HCPCS code in effect, as published by the United States health care financing administration.

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

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

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

(1) If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer by mail and retains a record of the day the claim was mailed, there exists a

rebuttable presumption that the claim was received by the third-party payer on the fifth business day after the day the claim was mailed, unless it can be proven otherwise.

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

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

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

(F) A third party payer shall transmit electronically any payment with respect to claims that the third party payer receives electronically and pays to a contracted provider under this section and under sections 3901.383, 3901.384, and 3901.386 of the Revised Code. A provider shall not refuse to accept a payment made under this section or sections 3901.383, 3901.384, and 3901.386 of the Revised Code on the basis that the payment was transmitted electronically.

Sec. 3938.01. (A) This chapter may be cited as the "Certificates of Insurance Act."

(B) As used in this chapter:

(1) "Certificate of insurance" means a document or instrument, regardless of how titled or described, that is prepared or issued by an insurer or insurance agent licensed under Chapter 3905. of the Revised Code to verify the existence of property or casualty insurance coverage. "Certificate of insurance" includes a document issued to a person as verification of the existence of coverage under a master policy. "Certificate of insurance" does not include a policy of insurance, insurance binder, policy endorsement, or automobile identification card, or any document used to provide proof of financial responsibility for purposes of Chapter 4509. of the Revised Code.

(2) "Certificate holder" means any person, other than a policyholder, that requests, obtains, or possesses a certificate of insurance.

(3) "Person" has the same meaning as in section 1.59 of the Revised Code and includes a limited liability company, the state, and all political subdivisions, authorities, agencies, boards, and commissions of the state.

Sec. 3938.02. A certificate of insurance is not a policy of insurance and does not affirmatively or negatively amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance refers. A certificate of insurance shall not confer to any person new or additional rights beyond what the referenced policy of insurance expressly provides.

Sec. 3938.03. (A) A certificate of insurance shall not include language that does either of the following:

(1) Is unfair, misleading, or deceptive or that violates public policy;

(2) Violates any law or any rule adopted by the superintendent of insurance.

(B) A certificate of insurance shall not guarantee that the policy of insurance referenced in the certificate complies with the requirements for a policy of property or casualty insurance under Title XXXIX of the Revised Code. The inclusion of a contract number or policy description in a certificate of insurance is not proof of such a guarantee.

Sec. 3938.04. No person shall do either of the following:

(A) Prepare, issue, request, or require a certificate of insurance that contains any false or misleading information concerning the policy of insurance referenced in the certificate of insurance;

(B) Prepare, issue, request, or require a certificate of insurance that affirmatively or negatively alters, amends, or extends the coverage provided by the policy of insurance referenced in the certificate of insurance.

Sec. 3938.05. A certificate holder shall be entitled to notice of cancellation or nonrenewal or any similar notice concerning a policy of insurance only if the certificate holder is named within the policy or any endorsement to the policy and the policy or endorsement requires notice to be provided to the certificate holder. The terms and conditions of the notice, including the required timing of the notice, are governed by the policy of insurance and cannot be altered by a certificate of insurance.

Sec. 3938.06. The provisions of this chapter shall apply to all certificates of insurance issued in connection with property and casualty risks located in this state, regardless of where the policyholder, insurer, insurance agent, or person requesting the certificate of insurance is located.

Sec. 3938.07. A certificate of insurance that is issued in violation of this chapter shall be void.

Sec. 3938.08. (A) No person shall fail to comply with sections 3938.01 to 3938.07 of the Revised Code. If the superintendent of insurance determines that any person has violated sections 3938.01 to 3938.07 of the Revised Code, the superintendent may take one or more of the following actions:

(1) Issue an order requiring the person to cease and desist from the actions constituting the violation;

(2) Assess a civil penalty not to exceed one thousand dollars per violation.

(B) The superintendent may investigate the activities of any person the superintendent reasonably believes has engaged in or is engaging in an act or practice prohibited by this chapter.

(C) Before imposing a penalty under division (A) of this section, the superintendent shall give the person notice and opportunity for a hearing as described in Chapter 119. of the Revised Code.

(D) The superintendent shall deposit any penalties assessed under division (A) of this section into the state treasury to the credit of the department of insurance operating fund created in section 3901.021 of the Revised Code.

Sec. 3938.09. The superintendent of insurance may adopt rules in accordance with Chapter 119. of the Revised Code as necessary to implement this chapter.

Sec. 4123.324. (A) The administrator of workers' compensation shall adopt rules, for the purpose of encouraging economic development, that establish conditions under which any negative experience to be transferred to the account of an employer who is successor in interest under division (B) of section 4123.32 of the Revised Code may be reduced or waived.

(B) The administrator, in adopting rules under division (A) of this section, may not permit a waiver or reduction in experience transfer if the succession transaction is entered into for the purpose of escaping obligations under this chapter or Chapter 4121., 4127., or 4131. of the Revised Code.

Section 2. That section 2323.44 and existing section 3901.381 of the Revised Code are hereby repealed.

Speaker _____ of the House of Representatives.

President _____ of the Senate.

Passed _____, 20____

Approved _____, 20____

Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

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Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the ____ day of _____, A. D. 20____.

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Secretary of State.

File No. _____ Effective Date _____