Rep. Plummer Sponsor Testimony HB 691

Chairman Brinkman, Vice-Chair Antani, Ranking Member Boyd, and members of the House Insurance Committee, thank you for allowing myself and Representative Manchester the time this morning to provide sponsor testimony on HB 691. Providers and payers play vital roles in our health care system. Our health care professionals have dedicated their lives to providing quality care to Ohioans, and health insurance companies provide coverage for Ohioans and ensure health care bills are filed correctly and the charges within the claims are valid. However, this adjudication practice is delayed for months on end due to requests for additional information. HB 691 intends to standardize the documentation claims process, establish strong guardrails on the review process, incentivize compliance, and incorporate Managed Care Organizations into the code.

This bill can be divided into three sections: timeline reform, supporting documentation reform, and incentives to comply with the law.

Under current law, a third party payer (TPP) has thirty days to approve or deny a claim if no supporting documentation is required. If supporting documentation is requested, the TPP has an additional 15 days from the time the documentation is received by the payer to approve or deny a claim. Under HB 691, the thirty day timeline is not changed. If no supporting documentation is requested, a decision must be made on a claim within thirty days of receipt. The bill would, however, reform the timeline for claims that the TPP request additional information. This reform would require the payer to request additional documentation within ten days of receiving the claim. The request, under the bill, must be made through the 835 file utilized to communicate between the provider and the TPP. Upon receiving the request for additional documentation, the provider must collect the documents and send the request, also in the 835 file, to the payer. Under our proposal, there is no time limit for the provider to send this information to the payer. We did not

include a timeline for this portion of the sequence for three reasons: 1. it is in the financial interest of the provider to send this information to the payer in a timely fashion, 2. providers vary in size throughout the state, and 3. Current law does not have a timeline established for providers to provide this information to the payers. Large health systems may be able to turn this information over in a very expeditious manner, but smaller, more rural providers may not have the staffing or the capacity to meet a deadline set in this bill.

The second, component of this bill is the supporting documentation reform. The intent of the current prompt pay law is to ensure supporting documentation requests are utilized to collect necessary information to adjudicate a claim. Although some requests for supporting documentation are valid and necessary for the insurance companies to determine the eligibility of benefits, health care providers in my district and throughout the state have brought it to my attention that many requests for information are not relevant to the adjudication of a claim. Current law enumerates documents that are considered supporting documentation. For your reference, these documents can be found on page three of the bill analysis. HB 691 seeks to expand the permitted supporting documentation by including a determination of eligibility for benefits. The bill also lists documentation that is not permitted to be requested prior to the payment of the claim. This list is based on the experience gained from providers that have stated these requests are used for prepayment audits instead of validating the legitimacy of a claim. Proponents to this bill will share specific examples of these documentation requests and will expand on their experience based on these requests.