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H.B. 429
136th General Assembly

Bill Analysis

Version: As Introduced

Primary Sponsor: Rep. Hoops

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SUMMARY

- Prohibits a third-party payer of health care services (including a health insurer, pharmacy benefit manager, or other person obligated to reimburse for covered health care services) from reducing the reimbursement made to a health care provider for a covered health care service, based on any of the following:
  - The third-party payer's own description of what is included in the service outside of the current diagnostic code for the service;
  - The third-party payer's own description of what is included in the diagnosis code submitted on the claim outside of the applicable guidelines for the code set;
  - That the provider billed for additional health services on the same date as the covered service.

DETAILED ANALYSIS

Prohibitions on third-party payers

The bill imposes requirements on third-party payers regarding payments to health care providers. Under continuing law, a third-party payer is:

- An insurance company;
- A health insuring corporation;
- A health delivery network;
- A labor organization;
- An employer;
- An intermediary organization, that is not a health delivery network contracting solely with self-insured employers;

- An administrator, including a pharmacy benefit manager;
- Any other person obligated to reimburse for covered health care services rendered to beneficiaries under a benefits contract.[1]

The bill prohibits a third-party payer of health care services from reducing the reimbursement made to a provider for the provision of a covered health care service based on any of the following:

- The third-party payer's own description of what is included in that **service**, outside of the most current CPT code in effect (as published by the American Medical Association), the most current ICD-10 code in effect (as published by the U.S. 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 U.S. Centers for Medicare and Medicaid Services);
- The third-party payer's own description of what is included in the **diagnosis code** submitted on the claim, outside of guidelines established by entities responsible for the code set, including the Centers for Disease Control and Prevention's (CDC's) National Center for Health Statistics;
- That the provider billed for additional health services, including outpatient surgery, on the same date as the covered service.

Under continuing law, a third-party payer is also prohibited from the following:

- 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 the provider.
- Refusing to process or pay a claim within the time requirements under continuing law on the grounds that a beneficiary has not been discharged from a hospital or that a treatment has not been completed, if the claim covers services rendered and charges incurred over at least a 30-day period.[2]

HISTORY

Action	Date
Introduced	08-28-25

ANHB0429IN-136/ts

[1] R.C. 3901.38, not in the bill.

[2] R.C. 3901.385.