OHIO LEGISLATIVE SERVICE COMMISSION

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Office of Research and Drafting

Legislative Budget Office

H.B. 691
133rd General Assembly

Fiscal Note & Local Impact Statement

Click here for H.B. 691's Bill Analysis

Version: As Introduced

Primary Sponsors: Reps. Manchester and Plummer

Local Impact Statement Procedure Required: No

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Highlights

- The bill would likely increase the Department of Insurance's administrative costs related to prompt pay regulation. Any increase in such costs would be paid from the Department of Insurance Operating Fund (Fund 5540). Penalties assessed for violations of the Prompt Pay Law may offset, in whole or in part, any increase in costs.
- The Ohio Department of Medicaid (ODM) could realize an increase in administrative costs to regulate the Prompt Pay Law, including to investigate any provider complaints.
- The bill may indirectly increase the costs of providing managed care services to Medicaid enrollees, if managed care organizations realize increased costs and capitated rates are adjusted as a result.
- No direct fiscal effect on political subdivisions.

Detailed Analysis

Prompt payment to health care providers

The bill modifies the definition of a third-party payer (TPP) for purposes of Ohio's Prompt Pay Law to include managed care organizations (MCOs) and Medicaid managed care organizations (Medicaid MCOs), thereby requiring such MCOs to comply with that law. The bill also revises other provisions applicable to the current Prompt Pay Law, generally related to (1) the timing of a TPP to pay or deny a claim,[1] and (2) the timing and the method for issuing

[1] Under the bill, a TPP that does not request supporting claim documentation would continue to have 30 days to either pay or deny a claim, same as under the existing law.

required notices. Most such provisions have little or no fiscal effect. The provisions described in this fiscal note are those with potentially significant fiscal effects; please see the LSC bill analysis for a complete description of the bill's provisions.

The bill specifies that if a TPP does not approve, request supporting documentation, or deny a claim within the timelines established under the bill, the TPP is required to immediately remit full payment of the claim. The bill shortens the timing to ten days after receipt of a claim, instead of 30 days under existing law, for the required notice that supporting documentation is needed, and specifies that the notice must be provided in writing. A TPP that requests supporting claim documentation is required to either pay or deny the claim by not later than five days after receipt of the supporting documentation from the provider. The bill prohibits a TPP from denying a claim solely on the basis of a lack of supporting documentation. The bill specifies that all claim denials and requests for information must be returned to the provider in the 835 file.[2]

Department of Insurance

The bill allows a provider to notify the Superintendent of Insurance of one or more violations of section 3901.381 of the Revised Code in either of the following situations: (1) 20% or more of the claims submitted by the provider to the TPP are in violation during a calendar month, and (2) an individual claim is in violation and the claim cannot be resolved through a claim dispute process. The bill requires the Superintendent to investigate such claims by providers within 15 days of receipt. The bill allows the Superintendent to establish rules prescribing the means by which the fines are paid to the provider and other necessary rules to carry out the bill's requirements. These are the only fines paid to providers; other fines collected by the Superintendent are to be allocated as described below, unchanged from current law.

The bill would likely increase the Department of Insurance's administrative costs related to monitoring and enforcing the Prompt Pay Law, primarily due to the extension to MCOs of the law's requirements. Any increase in such cost would be paid from the Department of Insurance Operating Fund (Fund 5540). Any such increase would be offset, in whole or in part, by penalties collected by the Department under existing law and deposited into Fund 5540. Under continuing law, the Superintendent is authorized to levy a fine against a TPP that has committed a series of violations that, taken together, constitutes a consistent pattern or practice of violating the Prompt Pay Law. The following are the current limits for fines for engaging in such a pattern or practice: (1) for the first offense, a fine of not more than $100,000, (2) for a second offense that occurs within four years of the first offense, a fine of not more than $150,000, and (3) for a third or additional offense that occurs within seven years of a first offense, a fine of not more than $300,000. Fines collected by the Superintendent, other than those for violations reported by providers under the terms described above, are paid to the following funds: (1) 25% of the total to Fund 5540, (2) 65% of the total to the General Revenue Fund (GRF), and (3) 10% of the total to the credit of the claims processing education account, which is within Fund 5540 and must be used by the Department to make technical assistance available to TPPs, providers, and beneficiaries for effective implementation of provisions applicable to the Prompt Pay Law.

[2] The bill defines an "835 file" as an electronic transaction that is compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), as defined in section 3965.01 of the Revised Code, and is used by providers to record and document claim payment information.

As noted above, the Superintendent is authorized to impose monetary penalties for certain violations of the TPP claims processing law reported by medical providers. The bill specifies that such monetary penalties must be paid to the affected provider. The amount of revenue collected and paid to providers would depend on the value of claims and TPPs' compliance with the bill's requirements.

The bill has no direct fiscal effect on political subdivisions.

Medicaid

The bill amends the Ohio Prompt Pay Law to include Medicaid MCOs as TPPs subject to that law. Under current law, Medicaid MCOs are exempt from the Prompt Pay Law and are instead regulated under federal Medicaid law and regulations. The bill specifies that TPPs providing coverage under the fee-for-service component of Medicaid remain exempt from the Prompt Pay Law. The inclusion of Medicaid MCOs as parties covered by the Prompt Pay Law may indirectly increase the cost to Ohio Medicaid of providing managed care services to Medicaid enrollees. The bill allows a provider to notify the Medicaid Director of an MCO's failure to comply with certain situations. The bill requires the Medicaid Director to investigate claims. The bill specifies that the Director of Medicaid may collect fees from Medicaid MCOs who commit a series of violations which constitute a consistent pattern or practice of violating the terms of the bill. Fines resulting from violations of the Prompt Pay Law can be credited to the provider, while all other fines for other violations go to the GRF. The Ohio Department of Medicaid (ODM) may realize an increase in administrative costs to regulate the law, including investigating complaints regarding an MCO's failure to comply.

A Medicaid MCO is a capitated at-risk plan in which the managed care provider is paid a fixed monthly premium per beneficiary for any health care included in the benefit package, regardless of the amount of services actually used. Thus, any costs incurred under the Prompt Pay Law would initially be incurred by the Medicaid MCOs, and not the state Medicaid Program. However, Medicaid MCO rates paid by ODM are legally required to be actuarially sound. It is possible that if Medicaid MCOs realize increased costs as a result of the bill, these costs might eventually lead to increased capitated rates.