AUTHENTICATED,
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COMMISSION
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Ohio Administrative Code

Rule 3901-8-02 Provider discounts.

Effective: November 16, 2023

(A) Purpose

The purpose of this rule is to set the requirements that third party payers shall follow if the third party payer receives any discount from billed charges from a health care provider.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent of insurance under sections 3901.041 and 3901.19 to 3901.22 of the Revised Code.

(C) Definitions

(1) "Discount" means any negotiated reduction or variation from the schedule of billed charges (including capitation) that a health care provider otherwise would require a patient and/or the patient's third party payer to pay to that health care provider.

(2) "Billed charges" means the non-discounted schedule of charges for services that the health care provider would use to invoice a patient for services rendered.

(3) "Third party payer" means any of the following:

(a) An insurance company;

(b) A preferred provider organization;

(c) A labor organization;

(d) An employer;

(e) An administrator subject to sections 3959.01 to 3959.16 of the Revised Code;

(f) A multiple employer welfare arrangement subject to sections 1739.01 to 1739.99 of the Revised Code.

(g) Any other person that is obligated pursuant to a benefits contract to reimburse for covered health care services to beneficiaries under such contract, except that "third party payer" does not include a health insuring corporation licensed pursuant to Chapter 1751. of the Revised Code.

(4) "Reasonable cash value" means the amount the third party payer would reimburse the patient or health care provider in the absence of a capitation agreement.

(D) Prohibited activity

No third party payer that has a negotiated discount with a health care provider, shall do the following:

(1) Fail to disclose the existence of such discount to any policy holder, certificate holder, subscriber or enrollee who has purchased health care coverage from the third party payer. Such disclosure shall be contained in the body of the insurance contract, and the certificate if the contract is a group insurance program. Only disclosure of the existence of such discount is required, disclosure of the extent of the discount is not required.

(2) Fail to calculate any annual or lifetime maximums only on the basis of actual payments made to non-capitated health care providers. For capitated health care providers the reasonable cash value of the services provided shall be used to calculate annual or lifetime maximums.

(3) Fail to maintain adequate records of the compliance with this rule.

(E) Penalties

Failure to comply with the requirements of paragraph (D) of this rule is an unfair and deceptive

practice within the meaning of section 3901.21 of the Revised Code.

(F) Severability

If any portion of this rule or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the rule or related rules which can be given effect without the invalid portion or application, and to this end the provisions of this rule are severable.