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Representative Huffman

Cosponsors: Representatives DeGeeter, Seitz, McGregor, J., Schneider, Latta, Adams, Gibbs, Setzer, Oelslager, Uecker, McGregor, R., Stewart, J., Stebelton, Fessler, Barrett, Wagoner, Celeste, Reinhard, Widener, Blessing, Book, Carmichael, Lundy, Hughes, Core, Dodd, Batchelder, Boyd, Budish, Chandler, Collier, Distel, Driehaus, Dyer, Evans, Flowers, Goyal, Hagan, J., Healy, Koziura, Letson, Luckie, Otterman, Patton, Yuko

A B I L L

To amend sections 1751.13, 1753.01, 1753.07, 1753.09, and 5111.17, to enact sections 3963.01 to 3963.10, and to repeal sections 1753.03, 1753.04, 1753.05, and 1753.08 of the Revised Code to establish certain uniform contract provisions between health care providers and contracting entities, to establish standardized credentialing, to require contracting entities to provide to health care providers specified information concerning enrollees, to require the Department of Job and Family Services to allow managed care plans to use providers to render care, and to create a Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That sections 1751.13, 1753.01, 1753.07, 1753.09, and 5111.17 be amended and sections 3963.01, 3963.02, 3963.03, 3963.04, 3963.05, 3963.06, 3963.07, 3963.08, 3963.09, and 3963.10 of the Revised Code be enacted to read as follows:

Sec. 1751.13. (A)(1)(a) A health insuring corporation shall, either directly or indirectly, enter into contracts for the provision of health care services with a sufficient number and types of providers and health care facilities to ensure that all covered health care services will be accessible to enrollees from a contracted provider or health care facility.

(b) A health insuring corporation shall not refuse to contract with a physician for the provision of health care services or refuse to recognize a physician as a specialist on the basis that the physician attended an educational program or a residency program approved or certified by the American osteopathic association. A health insuring corporation shall not refuse to contract with a health care facility for the provision of health care services on the basis that the health care facility is certified or accredited by the American osteopathic association or that the health care facility is an osteopathic hospital as defined in section 3702.51 of the Revised Code.

(c) Nothing in division (A)(1)(b) of this section shall be construed to require a health insuring corporation to make a benefit payment under a closed panel plan to a physician or health care facility with which the health insuring corporation does not have a contract, provided that none of the bases set forth in that division are used as a reason for failing to make a benefit payment.

(2) When a health insuring corporation is unable to provide a covered health care service from a contracted provider or health

care facility, the health insuring corporation must provide that health care service from a noncontracted provider or health care facility consistent with the terms of the enrollee's policy, contract, certificate, or agreement. The health insuring corporation shall either ensure that the health care service be provided at no greater cost to the enrollee than if the enrollee had obtained the health care service from a contracted provider or health care facility, or make other arrangements acceptable to the superintendent of insurance.

(3) Nothing in this section shall prohibit a health insuring corporation from entering into contracts with out-of-state providers or health care facilities that are licensed, certified, accredited, or otherwise authorized in that state.

(B)(1) A health insuring corporation shall, either directly or indirectly, enter into contracts with all providers and health care facilities through which health care services are provided to its enrollees.

(2) A health insuring corporation, upon written request, shall assist its contracted providers in finding stop-loss or reinsurance carriers.

(C) A health insuring corporation shall file an annual certificate with the superintendent certifying that all provider contracts and contracts with health care facilities through which health care services are being provided contain the following:

(1) A description of the method by which the provider or health care facility will be notified of the specific health care services for which the provider or health care facility will be responsible, including any limitations or conditions on such services;

(2) The specific hold harmless provision specifying protection of enrollees set forth as follows:

"[Provider/Health Care Facility] agrees that in no event, including but not limited to nonpayment by the health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall [Provider/Health Care Facility] bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, person to whom health care services have been provided, or person acting on behalf of the covered enrollee, for health care services provided pursuant to this agreement. This does not prohibit [Provider/Health Care Facility] from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor."

(3) Provisions requiring the provider or health care facility to continue to provide covered health care services to enrollees in the event of the health insuring corporation's insolvency or discontinuance of operations. The provisions shall require the provider or health care facility to continue to provide covered health care services to enrollees as needed to complete any medically necessary procedures commenced but unfinished at the time of the health insuring corporation's insolvency or discontinuance of operations. The completion of a medically necessary procedure shall include the rendering of all covered health care services that constitute medically necessary follow-up care for that procedure. If an enrollee is receiving necessary inpatient care at a hospital, the provisions may limit the required provision of covered health care services relating to that inpatient care in accordance with division (D)(3) of section 1751.11 of the Revised Code, and may also limit such required provision of covered health care services to the period ending thirty days after the health insuring corporation's insolvency or

discontinuance of operations.

The provisions required by division (C)(3) of this section shall not require any provider or health care facility to continue to provide any covered health care service after the occurrence of any of the following:

(a) The end of the thirty-day period following the entry of a liquidation order under Chapter 3903. of the Revised Code;

(b) The end of the enrollee's period of coverage for a contractual prepayment or premium;

(c) The enrollee obtains equivalent coverage with another health insuring corporation or insurer, or the enrollee's employer obtains such coverage for the enrollee;

(d) The enrollee or the enrollee's employer terminates coverage under the contract;

(e) A liquidator effects a transfer of the health insuring corporation's obligations under the contract under division (A)(8) of section 3903.21 of the Revised Code.

(4) A provision clearly stating the rights and responsibilities of the health insuring corporation, and of the contracted providers and health care facilities, with respect to administrative policies and programs, including, but not limited to, payments systems, utilization review, quality assurance, assessment, and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs;

(5) A provision regarding the availability and confidentiality of those health records maintained by providers and health care facilities to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and

appropriateness of health care services provided to enrollees. The provision shall include terms requiring the provider or health care facility to make these health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of enrollees, and requiring the provider or health care facility to comply with applicable state and federal laws related to the confidentiality of medical or health records.

(6) A provision that states that contractual rights and responsibilities may not be assigned or delegated by the provider or health care facility without the prior written consent of the health insuring corporation;

(7) A provision requiring the provider or health care facility to maintain adequate professional liability and malpractice insurance. The provision shall also require the provider or health care facility to notify the health insuring corporation not more than ten days after the provider's or health care facility's receipt of notice of any reduction or cancellation of such coverage.

(8) A provision requiring the provider or health care facility to observe, protect, and promote the rights of enrollees as patients;

(9) A provision requiring the provider or health care facility to provide health care services without discrimination on the basis of a patient's participation in the health care plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the provider or health care facility appropriately does not render services due to limitations arising from the provider's or health care facility's lack of training, experience, or skill, or due to licensing restrictions.

(10) A provision containing the specifics of any obligation on the primary care provider to provide, or to arrange for the provision of, covered health care services twenty-four hours per day, seven days per week;

(11) A provision setting forth procedures for the resolution of disputes arising out of the contract;

(12) A provision stating that the hold harmless provision required by division (C)(2) of this section shall survive the termination of the contract with respect to services covered and provided under the contract during the time the contract was in effect, regardless of the reason for the termination, including the insolvency of the health insuring corporation;

(13) A provision requiring those terms that are used in the contract and that are defined by this chapter, be used in the contract in a manner consistent with those definitions.

This division does not apply to the coverage of beneficiaries enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant to a medicare risk contract or medicare cost contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage of beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or medicaid, provided by the department of job and family services under Chapter 5111. of the Revised Code, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the department of administrative services.

(D)(1) No health insuring corporation contract with a

provider or health care facility shall contain any of the following:

(a) A provision that directly or indirectly offers an inducement to the provider or health care facility to reduce or limit medically necessary health care services to a covered enrollee;

(b) A provision that penalizes a provider or health care facility that assists an enrollee to seek a reconsideration of the health insuring corporation's decision to deny or limit benefits to the enrollee;

(c) A provision that limits or otherwise restricts the provider's or health care facility's ethical and legal responsibility to fully advise enrollees about their medical condition and about medically appropriate treatment options;

(d) A provision that penalizes a provider or health care facility for principally advocating for medically necessary health care services;

(e) A provision that penalizes a provider or health care facility for providing information or testimony to a legislative or regulatory body or agency. This shall not be construed to prohibit a health insuring corporation from penalizing a provider or health care facility that provides information or testimony that is libelous or slanderous or that discloses trade secrets which the provider or health care facility has no privilege or permission to disclose.

<u>(f) A provision that violates Chapter 3963. of the Revised Code.</u>

(2) Nothing in this division shall be construed to prohibit a health insuring corporation from doing either of the following:

(a) Making a determination not to reimburse or pay for a

particular medical treatment or other health care service;

(b) Enforcing reasonable peer review or utilization review protocols, or determining whether a particular provider or health care facility has complied with these protocols.

(E) Any contract between a health insuring corporation and an intermediary organization shall clearly specify that the health insuring corporation must approve or disapprove the participation of any provider or health care facility with which the intermediary organization contracts.

(F) If an intermediary organization that is not a health delivery network contracting solely with self-insured employers subcontracts with a provider or health care facility, the subcontract with the provider or health care facility shall do all of the following:

(1) Contain the provisions required by divisions (C) and (G) of this section, as made applicable to an intermediary organization, without the inclusion of inducements or penalties described in division (D) of this section;

(2) Acknowledge that the health insuring corporation is a third-party beneficiary to the agreement;

(3) Acknowledge the health insuring corporation's role in approving the participation of the provider or health care facility, pursuant to division (E) of this section.

(G) Any provider contract or contract with a health care facility shall clearly specify the health insuring corporation's statutory responsibility to monitor and oversee the offering of covered health care services to its enrollees.

(H)(1) A health insuring corporation shall maintain its provider contracts and its contracts with health care facilities at one or more of its places of business in this state, and shall

provide copies of these contracts to facilitate regulatory review upon written notice by the superintendent of insurance.

(2) Any contract with an intermediary organization that accepts compensation shall include provisions requiring the intermediary organization to provide the superintendent with regulatory access to all books, records, financial information, and documents related to the provision of health care services to subscribers and enrollees under the contract. The contract shall require the intermediary organization to maintain such books, records, financial information, and documents at its principal place of business in this state and to preserve them for at least three years in a manner that facilitates regulatory review.

(I)(1) A health insuring corporation shall notify its affected enrollees of the termination of a contract for the provision of health care services between the health insuring corporation and a primary care physician or hospital, by mail, within thirty days after the termination of the contract.

(a) Notice shall be given to subscribers of the termination of a contract with a primary care physician if the subscriber, or a dependent covered under the subscriber's health care coverage, has received health care services from the primary care physician within the previous twelve months or if the subscriber or dependent has selected the physician as the subscriber's or dependent's primary care physician within the previous twelve months.

(b) Notice shall be given to subscribers of the termination of a contract with a hospital if the subscriber, or a dependent covered under the subscriber's health care coverage, has received health care services from that hospital within the previous twelve months.

(2) The health insuring corporation shall pay, in accordance

with the terms of the contract, for all covered health care services rendered to an enrollee by a primary care physician or hospital between the date of the termination of the contract and five days after the notification of the contract termination is mailed to a subscriber at the subscriber's last known address.

(J) Divisions (A) and (B) of this section do not apply to any health insuring corporation that, on June 4, 1997, holds a certificate of authority or license to operate under Chapter 1740. of the Revised Code.

(K) Nothing in this section shall restrict the governing body of a hospital from exercising the authority granted it pursuant to section 3701.351 of the Revised Code.

Sec. 1753.01. As used in this chapter~~:~~

~~(A) "Economic profiling" means a health insuring corporation's use of economic performance data and economic information in determining whether to contract with a provider for the provision of covered health care services to enrollees as a participating provider.~~

~~(B) "Basic~~, "basic health care services," "enrollee," "health care facility," "health care services," "health insuring corporation," "medical record," "person," "primary care provider," "provider," "subscriber," and "supplemental health care services" have the same meanings as in section 1751.01 of the Revised Code.

Sec. 1753.07. (A)(1) Prior to entering into a participation contract with a provider under section 1751.13 of the Revised Code, a health insuring corporation shall disclose basic information regarding its programs and procedures to the provider~~, upon the provider's request~~. The information shall include all of the following:

~~(1)~~(a) How a participating provider is reimbursed for the

participating provider's services, including the range and structure of any financial risk sharing arrangements, a description of any incentive plans, and, if reimbursed according to a type of fee-for-service arrangement, the level of reimbursement for the participating provider's services;

~~(2)~~(b) Insofar as division (A)(1) of section 3963.03 of the Revised Code is applicable, all of the information that is described in that division and is not included in division (A)(1)(a) of this section.

(2) Prior to entering into a participation contract with a provider under section 1751.13 of the Revised Code, a health insuring corporation shall disclose the following information upon the provider's request:

(a) How referrals to other participating providers or to nonparticipating providers are made;

~~(3)~~(b) The availability of dispute resolution procedures and the potential for cost to be incurred;

~~(4)~~(c) How a participating provider's name and address will be used in marketing materials.

(B) A health insuring corporation shall provide all of the following to a participating provider:

(1) Any material incorporated by reference into the participation contract, that is not otherwise available as a public record, if such material affects the participating provider;

(2) Administrative manuals related to provider participation, if any;

(3) Insofar as division (B) of section 3963.03 of the Revised Code is applicable, the summary disclosure form with the disclosures required under that division;

(4) A signed and dated copy of the final participation contract.

Sec. 1753.09. (A) Except as provided in division (D) of this section, prior to terminating the participation of a provider on the basis of the participating provider's failure to meet the health insuring corporation's standards for quality or utilization in the delivery of health care services, a health insuring corporation shall give the participating provider notice of the reason or reasons for its decision to terminate the provider's participation and an opportunity to take corrective action. The health insuring corporation shall develop a performance improvement plan in conjunction with the participating provider. If after being afforded the opportunity to comply with the performance improvement plan, the participating provider fails to do so, the health insuring corporation may terminate the participation of the provider.

(B)(1) A participating provider whose participation has been terminated under division (A) of this section may appeal the termination to the appropriate medical director of the health insuring corporation. The medical director shall give the participating provider an opportunity to discuss with the medical director the reason or reasons for the termination.

(2) If a satisfactory resolution of a participating provider's appeal cannot be reached under division (B)(1) of this section, the participating provider may appeal the termination to a panel composed of participating providers who have comparable or higher levels of education and training than the participating provider making the appeal. A representative of the participating provider's specialty shall be a member of the panel, if possible. This panel shall hold a hearing, and shall render its recommendation in the appeal within thirty days after holding the

hearing. The recommendation shall be presented to the medical director and to the participating provider.

(3) The medical director shall review and consider the panel's recommendation before making a decision. The decision rendered by the medical director shall be final.

(C) A provider's status as a participating provider shall remain in effect during the appeal process set forth in division (B) of this section unless the termination was based on any of the reasons listed in division (D) of this section.

(D) Notwithstanding division (A) of this section, a provider's participation may be immediately terminated if the participating provider's conduct presents an imminent risk of harm to an enrollee or enrollees; or if there has occurred unacceptable quality of care, fraud, patient abuse, loss of clinical privileges, loss of professional liability coverage, incompetence, or loss of authority to practice in the participating provider's field; or if a governmental action has impaired the participating provider's ability to practice.

(E) Divisions (A) to (D) of this section apply only to providers who are natural persons.

(F)(1) Nothing in this section prohibits a health insuring corporation from rejecting a provider's application for participation, or from terminating a participating provider's contract, if the health insuring corporation determines that the health care needs of its enrollees are being met and no need exists for the provider's or participating provider's services.

(2) Nothing in this section shall be construed as prohibiting a health insuring corporation from terminating a participating provider who does not meet the terms and conditions of the participating provider's contract.

<u>(3) Nothing in this section shall be construed as prohibiting</u>

a health insuring corporation from terminating a participating provider's contract pursuant to any provision of the contract described in division (E)(2) of section 3963.02 of the Revised Code, except that, notwithstanding any provision of a contract described in that division, this section applies to the termination of a participating provider's contract for any of the causes described in divisions (A), (D), and (F)(1) and (2) of this section.

(G) The superintendent of insurance may adopt rules as necessary to implement and enforce sections ~~1753.04 to~~ 1753.06, 1753.07, and 1753.09 of the Revised Code. Such rules shall be adopted in accordance with Chapter 119. of the Revised Code. The director of health may make recommendations to the superintendent for rules necessary to implement and enforce sections ~~1753.04 to~~ 1753.06, 1753.07, and 1753.09 of the Revised Code. In adopting any rules pursuant to this division, the superintendent shall consider the recommendations of the director.

Sec. 3963.01. As used in this chapter:

(A) "Affiliate" means any person or entity that has ownership or control of a contracting entity, is owned or controlled by a contracting entity, or is under common ownership or control with a contracting entity.

(B) "Basic health care services" has the same meaning as in division (A) of section 1751.01 of the Revised Code, except that it does not include any services listed in that division that are provided by a pharmacist or nursing home.

(C) "Contracting entity" means any person that has a primary business purpose of contracting with participating providers for the delivery of health care services.

(D) "Credentialing" means the process of assessing and

validating the qualifications of a provider applying to be approved by a contracting entity to provide basic or supplemental health care services to enrollees.

(E) "Edit" means adjusting one or more procedure codes billed by a participating provider on a claim for payment or a practice that results in any of the following:

(1) Payment for some, but not all of the procedure codes originally billed by a participating provider;

(2) Payment for a different procedure code than the procedure code originally billed by a participating provider;

(3) A reduced payment as a result of services provided to an enrollee that are claimed under more than one procedure code on the same service date.

(F) "Enrollee" means any person eligible for health care benefits under a health benefit plan and includes all of the following terms:

(1) "Enrollee" and "subscriber" as defined by section 1751.01 of the Revised Code;

(2) "Member" as defined by section 1739.01 of the Revised Code;

(3) "Insured" and "plan member" pursuant to Chapter 3923. of the Revised Code;

(4) "Beneficiary" as defined by section 3901.38 of the Revised Code.

(G) "Health care contract" means a contract entered into, modified, or renewed between a contracting entity and a participating provider for the delivery of basic or supplemental health care services to enrollees.

(H) "Health care services" means basic health care services and supplemental health care services.

(I) "Participating provider" means a provider that has a health care contract with a contracting entity and is entitled to reimbursement for health care services rendered to an enrollee under the health care contract.

(J) "Payer" means any person that assumes the financial risk for the payment of claims under a health care contract or the reimbursement for health care services provided to enrollees by participating providers pursuant to a health care contract.

(K) "Primary enrollee" means a person who is responsible for making payments for participation in a health care plan or an enrollee whose employment or other status is the basis of eligibility for enrollment in a health care plan.

(L) "Procedure codes" includes the American medical association's current procedural terminology code, the American dental association's current dental terminology, and the centers for medicare and medicaid services health care common procedure coding system.

(M) "Product" means a product line for health care services, including, but not limited to a health insuring corporation product or a medicaid product for which the participating provider may be obligated to provide health care services pursuant to a health care contract.

(N) "Provider" means a physician, podiatrist, dentist, chiropractor, optometrist, psychologist, advanced practice nurse, occupational therapist, massage therapist, physical therapist, professional counselor, professional clinical counselor, hearing aid dealer, orthotist, prosthetist, home medical equipment services provider, hospital, ambulatory surgery center, or medical transportation company. "Provider" does not mean a pharmacist or nursing home.

(O) "Supplemental health care services" has the same meaning

as in division (B) of section 1751.01 of the Revised Code, except that it does not include any services listed in that division that are provided by a pharmacist or nursing home.

Sec. 3963.02. (A)(1) No contracting entity shall sell, rent, or give the contracting entity's rights to a participating provider's services pursuant to the contracting entity's health care contract with the participating provider unless one of the following applies:

(a) The third party accessing the participating provider's services under the health care contract is an employer or other entity providing coverage for health care services to its employees or members, and that employer or entity has a contract with the contracting entity or its affiliate for the administration or processing of claims for payment or service provided pursuant to the health care contract with the participating provider.

(b) The third party accessing the participating provider's services under the health care contract is either of the following:

(i) An affiliate or subsidiary of the contracting entity;

(ii) Providing administrative services to, or receiving administrative services from, the contracting entity or an affiliate or subsidiary of the contracting entity.

(c) The health care contract specifically provides that it applies to network rental arrangements and states that one purpose of the contract is selling, renting, or giving the contracting entity's rights to the services of the participating provider, including other preferred provider organizations, and the third party accessing the participating provider's services is either of the following:

(i) A payer or a third-party administrator or other entity responsible for administering claims on behalf of the payer;

(ii) A preferred provider organization or preferred provider network that receives access to the participating provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the participating provider that is in compliance with division (A)(1)(c) of this section, and is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is bound under its contract with the participating provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.

(2) The contracting entity that sells, rents, or gives the contracting entity's rights to the participating provider's services pursuant to the contracting entity's health care contract with the participating provider as provided in division (A)(1) of this section shall do both of the following:

(a) Maintain a web page that contains a listing of third parties described in divisions (A)(1)(b)(i) and (c) of this section with whom a contracting entity contracts for the purpose of selling, renting, or giving the contracting entity's rights to the services of participating providers that is updated at least every six months and is accessible to all participating providers, or maintain a toll-free telephone number accessible to all participating providers by means of which participating providers may access the same listing of third parties;

(b) Require that the third party accessing the participating provider's services through the participating provider's health care contract is obligated to comply with all of the applicable terms and conditions of the contract, including, but not limited to, the products for which the participating provider has agreed

to provide services, except that a payer receiving administrative services from the contracting entity or its affiliate shall be solely responsible for payment to the participating provider.

(3) Any information disclosed to a participating provider under this section shall be considered proprietary and shall not be distributed by the participating provider.

(4) Except as provided in division (A)(1) of this section, no entity other than a contracting entity shall sell, rent, or give a contracting entity's rights to the participating provider's services pursuant to a health care contract.

(B)(1) No contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider provide services for more than one product offered by the contracting entity.

(2) Division (B)(1) of this section shall not be construed to do any of the following:

(a) Prohibit any participating provider from voluntarily accepting an offer by a contracting entity to provide health care services under more than one of the contracting entity's products;

(b) Prohibit any contracting entity from offering any financial incentive or other form of consideration specified in the health care contract for a participating provider to provide health care services under more than one of the contracting entity's products;

(c) Require any contracting entity to contract with a participating provider to provide health care services under only one of the contracting entity's products if the contracting entity does not wish to do so.

(3) Notwithstanding division (B)(2) of this section, no contracting entity shall require, as a condition of contracting

with the contracting entity, that the participating provider accept any future product offering that the contracting entity makes.

(C) No contracting entity shall require, as a condition of contracting with the contracting entity, that a participating provider waive or forego any right or benefit to which the participating provider may be entitled under state or federal law. However, a contracting entity may restrict a participating provider's scope of practice for the services to be provided under the contract.

(D) No health care contract shall do either of the following:

(1) Prohibit any participating provider from entering into a health care contract with any other contracting entity;

(2) Preclude its use or disclosure for the purpose of enforcing this chapter or other state or federal law, except that a health care contract may require that appropriate measures be taken to preserve the confidentiality of any proprietary or trade-secret information.

(E)(1) In addition to any other lawful reasons for terminating a health care contract, a health care contract may be terminated under the circumstances described in division (A)(2) of section 3963.04 of the Revised Code.

(2) If the health care contract provides for termination for cause by either party, the health care contract shall state the reasons that may be used for termination for cause, which terms shall be reasonable. Subject to division (E)(3) of this section, the health care contract shall state the time by which the parties must provide notice of termination for cause and to whom the parties shall give the notice.

(3) Nothing in divisions (E)(1) and (2) of this section shall be construed as prohibiting any health insuring corporation from

terminating a participating provider's contract for any of the causes described in divisions (A), (D), and (F)(1) and (2) of section 1753.09 of the Revised Code. Notwithstanding any provision in a health care contract pursuant to division (E)(2) of this section, section 1753.09 of the Revised Code applies to the termination of a participating provider's contract for any of the causes described in divisions (A), (D), and (F)(1) and (2) of section 1753.09 of the Revised Code.

(F)(1) Disputes among parties that only concern the enforcement of the contract rights conferred by sections 3963.02 and 3963.04, utilizing the applicable definitions in section 3963.01, of the Revised Code are subject to a mutually agreed upon arbitration mechanism that is binding on all parties. The arbitrator may award reasonable attorney's fees and costs for arbitration relating to the enforcement of this section to the prevailing party.

(2) A party shall not simultaneously maintain an arbitration proceeding as described in division (F)(1) of this section and pursue a complaint with the superintendent of insurance to investigate the subject matter of the arbitration proceeding. If the superintendent of insurance initiates an investigation into the subject matter of a pending arbitration proceeding, the arbitration proceeding shall be stayed at the request of any party pending the outcome of the investigation by the superintendent. The arbitrator shall make the arbitrator's decision in an arbitration proceeding having due regard for any applicable rules, bulletins, rulings, or decisions theretofore issued by the department of insurance or any court concerning the enforcement of the contract rights conferred by sections 3963.02 and 3963.04, utilizing the applicable definitions in section 3963.01, of the Revised Code.

Sec. 3963.03. (A) Each health care contract shall include all of the following information:

(1)(a) Information sufficient for the participating provider to determine the compensation or payment terms for health care services, including all of the following, subject to division (A)(1)(b) of this section:

(i) The manner of payment, such as fee-for-service, capitation, or risk;

(ii) The fee schedule of procedure codes reasonably expected to be billed by a participating provider's specialty for services provided pursuant to the health care contract and the associated payment or compensation for each procedure code. A fee schedule may be provided electronically. Upon request, a contracting entity shall provide a participating provider with the fee schedule for any other procedure codes requested and a written fee schedule, that shall not be required more frequently than twice per year excluding when it is provided in connection with any change to the schedule. The effect, if any, on payment or compensation if more than one procedure code applies to the service also shall be stated. This requirement may be satisfied by providing a clearly understandable, readily available mechanism, such as a specific web site address, that allows a participating provider to determine the effect of procedure codes on payment or compensation before a service is provided or a claim is submitted.

(b) If the contracting entity is unable to include the information described in division (A)(1)(a)(ii) of this section, the contracting entity shall include both of the following types of information instead:

(i) The methodology used to calculate any fee schedule, such as relative value unit system and conversion factor or percentage

of billed charges. If applicable, the methodology disclosure shall include the name of any relative value unit system, its version, edition, or publication date, any applicable conversion or geographic factor, and any date by which compensation or fee schedules may be changed by the methodology as anticipated at the time of contract.

(ii) The identity of any internal processing edits , including the publisher, product name, version, and version update of any editing software.

(2) Any product or network for which the participating provider is to provide services;

(3) The term of the health care contract;

(4) A specific web site address that contains the identity of the contracting entity or payer responsible for the processing of the participating provider's compensation or payment;

(5) Any internal mechanism provided by the contracting entity to resolve disputes concerning the interpretation or application of the terms and conditions of the contract. A contracting entity may satisfy this requirement by providing a clearly understandable, readily available mechanism, such as a specific web site address or an appendix, that allows a participating provider to determine the procedures for the internal mechanism to resolve those disputes.

(6) A list of addenda, if any, to the contract.

(B)(1) Each contracting entity shall include a summary disclosure form with a health care contract that includes all of the information specified in division (A) of this section. The information in the summary disclosure form shall refer to the location in the health care contract, whether a page number, section of the contract, appendix, or other identifiable location, that specifies the provisions in the contract to which the

information in the form refers.

(2) The summary disclosure form shall include all of the following statements:

(a) That the form is a guide to the health care contract and that the terms and conditions of the health care contract constitute the contract rights of the parties;

(b) That reading the form is not a substitute for reading the entire health care contract;

(c) That by signing the health care contract, the participating provider will be bound by the contract's terms and conditions;

(d) That the terms and conditions of the health care contract may be amended pursuant to section 3963.04 of the Revised Code and the participating provider is encouraged to carefully read any proposed amendments sent after execution of the contract;

(e) That nothing in the summary disclosure form creates any additional rights or causes of action in favor of either party.

(3) No contracting entity that includes any information in the summary disclosure form with the reasonable belief that the information is truthful or accurate shall be subject to a civil action for damages or to binding arbitration based on the summary disclosure form. Division (B)(3) of this section does not impair or affect any power of the department of insurance to enforce any applicable law.

(4) The summary disclosure form described in divisions (B)(1) and (2) of this section shall be in substantially the following form:

"SUMMARY DISCLOSURE FORM

(1) Compensation terms

(a) Manner of payment

[ ] Fee for service 753

[ ] Capitation 754

[ ] Risk 755

[ ] Other ..... See 756

(b) Fee schedule available at 757

(c) Fee calculation schedule available at 758

(d) Identity of internal processing edits available at 759
..... 760

(e) Information in (c) and (d) is not required if information 761
in (b) is provided. 762

(2) List of products or networks covered by this contract 763

[ ] 764

[ ] 765

[ ] 766

[ ] 767

[ ] 768

(3) Term of this contract 769

(4) Contracting entity or payer responsible for processing 770
payment available at 771

(5) Internal mechanism for resolving disputes regarding 772
contract terms available at 773

(6) Addenda to contract 774

Title Subject 775

(a) 776

(b) 777

(c) 778

(d)

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section 3963.01(G) of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract constitute the contract rights of the parties.

Reading this Summary Disclosure Form is not a substitute for reading the entire Health Care Contract. When you sign the Health Care Contract, you will be bound by its terms and conditions. These terms and conditions may be amended over time pursuant to section 3963.04 of the Ohio Revised Code. You are encouraged to read any proposed amendments that are sent to you after execution of the Health Care Contract.

Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party."

(C) When a contracting entity presents a proposed health care contract for consideration by a participating provider, the contracting entity shall provide in writing or make reasonably available the information required in division (A)(1) of this section. If the information is not disclosed in writing, it shall be disclosed in a manner that allows the participating provider to evaluate the participating provider's payment or compensation for services under the health care contract. The contracting entity need not provide such information to the participating provider in written format more than twice a year.

(D) The contracting entity shall identify any utilization management, quality improvement, or a similar program that the contracting entity uses to review, monitor, evaluate, or assess the services provided pursuant to a health care contract. The contracting entity shall disclose the policies, procedures, or

guidelines of such a program applicable to a participating provider upon request by the participating provider within fourteen days after the date of the request.

(E) Nothing in this section shall be construed as preventing or affecting the application of section 1753.07 of the Revised Code that would otherwise apply to a contract with a participating provider.

Sec. 3963.04. (A)(1) An amendment of a health care contract shall occur only if the contracting entity provides to the participating provider the proposed amendment in writing and notice of the proposed amendment not later than sixty days prior to the effective date of the amendment. The notice shall be conspicuously entitled "Notice of Material Change to Contract" and shall specify the effective date of the proposed amendment.

(2) Subject to division (A)(4) of this section, if within thirty days after receiving the proposed amendment and notice described in division (A)(1) of this section the participating provider objects in writing to the proposed amendment, and there is no resolution of the objection, either party may terminate the health care contract upon written notice of termination provided to the other party not later than thirty days prior to the effective date of the proposed amendment.

(3) If the participating provider does not object to the proposed amendment in the manner described in division (A)(2) of this section, the amendment shall be effective as specified in the notice described in division (A)(1) of this section.

(4) If a proposed amendment is the addition of a new category of coverage under the health care contract, the participating provider objects to that proposed amendment in the manner described in division (A)(2) of this section, and there is no resolution of the objection, the amendment shall not be effective

as to the participating provider, and the objection shall not be a basis upon which the contracting entity may terminate the contract under that division.

(B)(1) Division (A) of this section does not apply if the delay caused by compliance with that division could result in imminent harm to an enrollee or if the amendment of a health care contract is required by state or federal law, rule, or regulation.

(2) This section does not apply under any of the following circumstances:

(a) The participating provider's payment or compensation is based on the current medicaid or medicare physician fee schedule, and the change in payment or compensation results solely from a change in that physician fee schedule.

(b) A routine change or update of the health care contract is made in response to any addition, deletion, or revision of any service code, procedure code, or reporting code, or a pricing change is made by any third party source.

For purposes of division (B)(2)(b) of this section:

(i) "Service code, procedure code, or reporting code" means the current procedural terminology (CPT), the healthcare common procedure coding system (HCPCS), the international classification of diseases (ICD), or the drug topics redbook average wholesale price (AWP).

(ii) "Third party source" means the American medical association, the centers for medicare and medicaid services, the national center for health statistics, the department of health and human services office of the inspector general, the Ohio department of insurance, or the Ohio department of job and family services.

(C) Notwithstanding divisions (A) and (B) of this section, a

health care contract may be modified, without the need for an amendment pursuant to division (A) of this section, by operation of law as required by any applicable state or federal law, rule, or regulation. Nothing in this section shall be construed to require the renegotiation of a health care contract that is in existence before the effective date of this section, until the time that the contract is renewed or modified.

Sec. 3963.05. (A) The department of insurance shall prepare and adopt a form, in electronic or paper format, that is substantially similar to the credentialing form used by the council for affordable quality healthcare (CAQH), and that form shall be the standard credentialing form for physicians. The department of insurance also shall prepare the standard credentialing form for all other providers.

(B) No contracting entity shall fail to use the applicable standard credentialing form described in division (A) of this section when initially credentialing or recredentialing providers in connection with policies, health care contracts, and agreements providing basic or supplemental health care services.

(C) No contracting entity shall require a provider to provide any information in addition to the information required by the applicable standard credentialing form described in division (A) of this section in connection with policies, health care contracts, and agreements providing basic or supplemental health care services.

Sec. 3963.06. (A) If a provider, upon the oral or written request of a contracting entity to submit a credentialing form, submits a credentialing form that is not complete, the contracting entity that receives the form shall notify the provider of the deficiency electronically or by certified mail, return receipt

requested, not later than twenty-one days after the contracting entity receives the form.

(B) If a contracting entity receives any information that is inconsistent with the information given by the provider in the credentialing form, the contracting entity may request the provider to submit a written clarification of the inconsistency. The contracting entity shall send the request described in this division electronically or by certified mail, return receipt requested.

(C)(1) The credentialing process under this section starts when a provider initially submits a credentialing form upon the oral or written request of a contracting entity. Subject to division (C)(2) of this section, a contracting entity shall complete the credentialing process not later than ninety days after the contracting entity receives that credentialing form from the provider. A contracting entity that does not complete the credentialing process within the ninety-day period specified in this division is liable for a civil penalty payable to the provider in the amount of five hundred dollars per day, including weekend days, starting at the expiration of that ninety-day period until the provider's application for the health care contract is granted or denied.

(2) The requirement that the credentialing process be completed within the ninety-day period specified in division (C)(1) of this section does not apply to a contracting entity if a provider that submits a credentialing form to the contracting entity under that division is a home medical equipment services provider, hospital, ambulatory surgery center, or medical transportation company.

Sec. 3963.07. (A)(1) Upon a participating provider's submission of an enrollee's name, the enrollee's relationship to

the primary enrollee, the enrollee's birth date, or the enrollee's social security number, each contracting entity shall make available information maintained in the ordinary course of business that is sufficient for the participating provider to determine at the time of the enrollee's visit all of the following:

(a) The enrollee's identification number assigned by the contracting entity;

(b) The birth date and gender of the primary enrollee;

(c) The names, birth dates, and gender of all covered dependents;

(d) The current enrollment and eligibility status of the enrollee;

(e) Whether a specific type or category of service is a covered benefit for the enrollee;

(f) The enrollee's excluded benefits or limitations, whether group or individual;

(g) The enrollee's copayment requirements;

(h) The unmet amount of the enrollee's deductible or the enrollee's financial responsibility.

(2) A contracting entity that maintains enrollee information in the ordinary course of business shall make available the information required by division (A)(1) of this section electronically or by an internet portal and shall maintain the flexibility to determine the manner described in division (A)(1) of this section by which the participating provider shall accesses the information specified in that division. The information required by division (A)(1) of this section shall include a statement to the effect that the information made available is not necessarily the final indication of the eligibility status of the

enrollee due to changes that may have occurred prior to or after that date of which the contracting entity is unaware, and that the information was obtained from sources that the contracting entity reasonably believes to be accurate. Any information specified in division (A)(1) of this section that is provided in good faith by the contracting entity shall not be used in any enforcement action under this chapter.

(3) Notwithstanding division (A)(1) of this section, no contracting entity shall make the information required by that division available to any person except to a participating provider or the participating provider's agent or to any person or governmental entity that is authorized under state and federal law to receive personally identifiable information concerning an enrollee or an enrollee's dependent.

(4) No contracting entity directly or indirectly shall charge a participating provider any fee for the information the contracting entity makes available pursuant to division (A) of this section.

(5) A contracting entity is considered as having complied with division (A) of this section if the information specified in division (A)(1) of this section is updated once a month and the date on which the information is updated is included with the information that is made available electronically or by internet portal pursuant to division (A)(2) of this section.

(B) All remittance notices sent by a payer, whether written or electronic, shall include both of the following:

(1) The name of the payer issuing the payment to the participating provider;

(2) The name of the contracting entity through which the payment rate and any discount are claimed, if the contracting entity is different from the payer.

(C) Division (A) of this section takes effect January 1, 2009.

Sec. 3963.08. The superintendent of insurance shall adopt any rules necessary for the implementation of this chapter.

Sec. 3963.09. (A) A series of violations of this chapter by any person regulated by the department of insurance under Title XVII or Title XXXIX of the Revised Code that, taken together, constitute a pattern or practice of violating this chapter may be defined as an unfair and deceptive insurance practice under sections 3901.19 to 3901.26 of the Revised Code.

(B) The superintendent of insurance may conduct a market conduct examination of any person regulated by the department of insurance under Title XVII or Title XXXIX of the Revised Code to determine whether any violation of this chapter has occurred. When conducting that type of examination, the superintendent of insurance may assess the costs of the examination against the person examined. The superintendent may enter into a consent agreement to impose any administrative assessment or fine for conduct discovered that may be a violation of this chapter. All costs, assessments, and fines collected under this section shall be deposited to the credit of the department of insurance operating fund.

Sec. 3963.10. This chapter does not apply with respect to any of the following:

(A) Payments made to providers for rendering health care services to medicaid recipients pursuant to the reimbursement system referred to by the department of job and family services as the fee-for-service system;

(B) Payments made to providers for rendering health care

services to claimants pursuant to claims made under Chapter 4121., 4123., 4127., or 4131. of the Revised Code;

(C) Payments made to providers for rendering health care services to beneficiaries of the medicare program established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended;

(D) An exclusive contract between a health insuring corporation and a single group of providers in a specific geographic area to provide or arrange for the provision of health care services.

Sec. 5111.17. (A) The department of job and family services may enter into contracts with managed care organizations, including health insuring corporations, under which the organizations are authorized to provide, or arrange for the provision of, health care services to medical assistance recipients who are required or permitted to obtain health care services through managed care organizations as part of the care management system established under section 5111.16 of the Revised Code.

(B) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.

(C) The department of job and family services shall allow managed care plans to use providers to render care upon completion of the managed care plan's credentialing process.

Section 2. That existing sections 1751.13, 1753.01, 1753.07, 1753.09, and 5111.17 and sections 1753.03, 1753.04, 1753.05, and 1753.08 of the Revised Code are hereby repealed.

Section 3. Sections 3963.01 to 3963.10 of the Revised Code,

as enacted by this act, shall apply only to contracts that are delivered, issued for delivery, or renewed or modified in this state on or after the effective date of this act. A health insuring corporation having fewer than fifteen thousand enrollees shall comply with the provisions of this section within twelve months after the effective date of this act.

Section 4. Division (A) of section 3963.07 of the Revised Code, as enacted by this act, takes effect January 1, 2009.

Section 5. (A) As used in this section and Section 6 of this act:

(1) "Most favored nation clause" means a provision in a health care contract that does any of the following:

(a) Prohibits, or grants a contracting entity an option to prohibit, the participating provider from contracting with another contracting entity to provide health care services at a lower price than the payment specified in the contract;

(b) Requires, or grants a contracting entity an option to require, the participating provider to accept a lower payment in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price;

(c) Requires, or grants a contracting entity an option to require, termination or renegotiation of the existing health care contract in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price;

(d) Requires the participating provider to disclose the participating provider's contractual reimbursement rates with other contracting entities.

(2) "Contracting entity," "health care contract," "health

care services," "participating provider," and "provider" have the same meanings as in section 3963.01 of the Revised Code, as enacted by this act.

(B) No health care contract that includes a most favored nation clause shall be entered into, and no health care contract at the instance of a contracting entity shall be amended, modified, or renewed to include a most favored nation clause, for a period of two years after the effective date of this act, subject to extension as provided in Section 6 of this act.

Section 6. (A) There is hereby created the Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts consisting of fifteen members as follows:

(1) The Superintendent of Insurance;

(2) Two members of the House of Representatives, one representing the majority party and one representing the minority party;

(3) Two members of the Senate, one representing the majority party and one representing the minority party;

(4) Three providers who are individuals;

(5) Two representatives of hospitals;

(6) Two representatives of contracting entities regulated by the Department of Insurance under Title XVII of the Revised Code;

(7) Two representatives of contracting entities regulated by the Department of Insurance under Title XXXIX of the Revised Code;

(8) One representative of an employer that pays for the health insurance coverage of its employees.

(B) The members of the Commission shall be appointed as follows:

(1) The Speaker of the House of Representatives shall appoint

the two members of the House specified in division (A)(2) of this section.

(2) The President of the Senate shall appoint the two members of the Senate specified in division (A)(3) of this section.

(3) The Speaker of the House of Representatives and the President of the Senate jointly shall appoint the remaining members specified in divisions (A)(4) to (8) of this section.

(C) Initial appointments to the Commission shall be made within thirty days after the effective date of this act. The appointments shall be for the term of the Commission as provided in division (F)(2) of this section. Vacancies shall be filled in the same manner provided for original appointments.

(D)(1) The Superintendent of Insurance shall be the Chairperson of the Commission. Meetings of the Commission shall be at the call of the Chairperson. All of the members of the Commission shall be voting members. Meetings of the Commission shall be held pursuant to section 121.22 of the Revised Code.

(2) The Department of Insurance shall provide office space or other facilities, any administrative or other technical, professional, or clerical employees, and any necessary supplies for the work of the Commission.

(3) The Chairperson of the Commission shall keep the records of the Commission. Upon submission of the Commission's final report to the General Assembly under division (F) of this section, the Chairperson shall deliver all of the Commission's records to the General Assembly.

(E)(1) The Commission shall study the following areas pertaining to health care contracts:

(a) The procompetitive and anticompetitive aspects of most favored nation clauses;

(b) The impact of most favored nation clauses on health care costs and on the availability of and accessibility to quality health care;

(c) The costs associated with the enforcement of most favored nation clauses;

(d) Other state laws and rules pertaining to most favored nation clauses in their health care contracts;

(e) Matters determined by the Department of Insurance as relevant to the study of most favored nation clauses;

(f) Any other matters that the Commission considers appropriate to determine the effectiveness of most favored nation clauses.

(2) The Commission may take testimony from experts or interested parties on the areas of its study as described in division (E)(1) of this section.

(F)(1) Not less than ninety days prior to the expiration of the two-year period specified in Section 5 of this act, the Commission shall report its preliminary findings to the General Assembly and a recommendation of whether to extend that two-year period for one additional year. If the General Assembly does not grant the extension, the Commission shall submit its final report to the General Assembly not later than three months after the expiration of the two-year period specified in Section 5 of this act. If the General Assembly grants the extension, the extension shall be for not more than one year after the expiration of the two-year period specified in Section 5 of this act, and the Commission shall submit its final report to the General Assembly not later than six months prior to the expiration of the one-year extension.

(2) The final report of the Commission shall include its findings and recommendations on whether state law should prohibit

or restrict most favored nation clauses in health care contracts. 1170
The Commission shall cease to exist upon the submission of its 1171
final report to the General Assembly. 1172