Bill Analysis

Lisa Sandberg *Legislative Service Commission*

Sub. H.B. 125

127th General Assembly
(As Reported by S. Judiciary - Civil Justice)

Reps. **Huffman, DeGeeter, Seitz, J. McGregor, Schneider, Latta, Adams, Gibbs, Setzer, Oelslager, Uecker, R. McGregor, J. Stewart, 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, J. Hagan, Healy, Koziura, Letson, Luckie, Otterman, Patton, Yuko**

Sens. **Goodman, Seitz**

BILL SUMMARY

- Prohibits a contracting entity from selling, renting, or giving a third party the entity's rights to a participating provider's services pursuant to the entity's health care contract with the participating provider unless any of specified conditions pertaining to the third party accessing the participating provider's services under the contract applies and requires the contracting entity to provide participating providers access to the listing of certain of those third parties.

- Prohibits a contracting entity from requiring, as a condition of contracting with the entity, that a participating provider provide services for all offered by the entity, specifies that the prohibition is not to be construed to do any of specified actions, and prohibits a contracting entity from requiring, as a condition of contracting with the entity, that the participating provider accept any future product offering that the entity makes.

- Allows a contracting entity, if a participating provider refuses to accept any future product offering that the contracting entity makes, to terminate the health care contract based on the participating provider's refusal upon written notice to the participating provider no sooner than 180 days after the refusal.

- Prohibits a contracting entity from requiring, as a condition of contracting with the entity, that a participating provider waive or forego any right or benefit expressly conferred upon a participating provider by state or federal law but permits a contracting entity to restrict a participating provider's scope of practice for the services to be provided under the contract.

- Prohibits any health care contract from prohibiting any participating provider from entering into a health care contract with any other contracting entity, from prohibiting any contracting entity from entering into a health care contract with any other provider, or generally precluding the contract's use or disclosure for purposes of enforcing the bill's provisions or state or federal law.

- Requires that, if a health care contract provides for termination of the contract for cause by either party, the contract must state the reasons for termination for cause, which terms must be reasonable.

- Provides that once the contracting entity and the participating provider have signed the health care contract, it is presumed that the reasons stated in the health care contract for termination for cause by either party are reasonable.

- Specifies that disputes that only concern the enforcement of the contract rights conferred by certain provisions in the bill are subject to a mutually agreed upon arbitration mechanism that is binding on all parties, authorizes an arbitrator to award to the prevailing party reasonable attorney's fees and arbitration costs, and prohibits a party from simultaneously maintaining an arbitration proceeding and pursuing a complaint with the Superintendent of Insurance to investigate the subject matter of the arbitration proceeding.

- Requires a contracting entity, upon presentation of a proposed health care contract for a participating provider's consideration, to make available to the participating provider specified information regarding compensation or payment terms for health care services.

- Requires each health care contract to include, and requires each contracting party to include a summary disclosure form with a health care contract that includes, the compensation or payment terms and other specified information and to identify any utilization management, quality

improvement, or similar program to be used to review, monitor, evaluate, or assess the services provided under the contract, and specifies certain statements to be included in the summary disclosure form and other requirements for the form.

- Requires that the health care contract and the summary disclosure form provide that if the contracting entity is not the payer and is unable to include the information listed in the preceding dot point, then the contracting entity must provide by telephone a readily available mechanism, such as a specific web site address, that allows the participating provider to obtain that information from the payer.

- Replaces existing law's procedures for amending a health care contract with new procedures that, among other requirements, require a contracting entity to provide to the participating provider the material amendment in writing and notice of the material amendment not later than 90 days prior to the effective date of the material amendment and specifies the circumstances under which the amendment procedures do not apply.

- Provides that if an amendment to a health care contract is not a material amendment, the contracting entity must provide the participating provider notice of the amendment at least 15 days prior to the effective date of the amendment and requires that the contracting entity provide all other notices to the participating provider pursuant to the health care contract.

- Requires the Department of Insurance to prescribe the credentialing application form used by the Council on Affordable Quality Healthcare (CAQH) in electronic or paper format for physicians, requires the Department to also prepare the standard credentialing form for all other providers, requires that the Department of Insurance make the standard credentialing form as simple, straightforward, and easy to use as possible, having due regard for those credentialing forms that are widely in use in the state by contracting entities and that best serve these goals, provides that except for a Medicaid managed care plan the credentialing process starts when a provider initially submits a credentialing form upon the oral or written request of a contracting entity, generally requires a contracting entity to complete the credentialing process within 90 days after receiving that form, and subjects a contracting entity that does not complete the credentialing process within that period to a civil penalty or

to retroactive reimbursement to the provider according to the terms of the contract starting at the expiration of that 90-day period until the provider's credentialing application is granted or denied, and provides that when the credentialing process exceeds the 90-day period, the contracting entity must select the liability to which the contracting entity is subject and must inform the provider of the contracting entity's selection.

- Requires remittance notices sent by a payer to include the payer's name and the name of the contracting entity through which the payment rate and any discount are claimed if different from the payer, and provides that this provision takes effect March 31, 2009.

- Prohibits any health insuring corporation contract with a provider or health care facility from containing any provision that violates the bill's provisions.

- Provides that a series of violations of the bill's provisions (new R.C. Chapter 3963.) by any person regulated by the Department of Insurance under R.C. Title XVII or XXXIX that, taken together, constitute a pattern or practice of violation of that Chapter may be defined as an unfair and deceptive insurance practice under the Insurance Law and authorizes the Superintendent of the Department to conduct a market conduct examination of any person so regulated to determine whether any violation of the Chapter has occurred.

- Requires the Superintendent of Insurance to adopt rules necessary to implement the bill's provisions.

- Specifies certain exclusions from the bill's provisions.

- Applies its provisions only to contracts that are delivered, issued for delivery, or renewed or materially modified in Ohio on or after the act's effective date.

- Requires the Department of Job and Family Services to allow managed care plans to use providers to render care.

- Prohibits a contracting entity from offering to a provider other than a hospital a health care contract that includes a most favored nation clause, entering into a health care contract with a provider other than a hospital

that includes a most favored nation clause, or amending an existing health care contract previously entered into with a provider other than a hospital to include a most favored nation clause and provides that this prohibition goes into effect three years after the effective date of the provision.

- Provides that the parent of the parent's minor child or an adult whom the parent of the minor child has given written authorization to consent to a surgical or medical procedure or course of procedures for the parent's minor child has legal authority to consent on behalf of the patient who is a minor for a surgical or medical procedure or course of procedures.

- Increases the total costs for copies for certain medical records to reflect the consumer price index, includes records with data recorded electronically and x-rays, magnetic resonance imaging (MRI), or computed axial tomography (CAT) scans that are recorded on paper or film, and requires that a health care provider or medical records company provide one copy of a patient's medical record and one copy of any records regarding treatment performed subsequent to the original request, not including a copy of records already provided, without charge, to certain specified entities for certain specified reasons.

- Exempts a nursing home that is a converted county or district home from administrative rules regarding the toilet rooms and dining and recreational areas of nursing homes if certain other requirements are met.

- Precludes any health care contract that includes a most favored nation clause from being entered into, and precludes any health care contract from being amended or renewed at the instance of a contracting entity to include a most favored nation clause, for a two-year period after the effective date of the act, subject to extension but provides that this prohibition does not apply to and does not prohibit the continued use of a most favored nation clause in a health care contract that is between a contracting entity and a hospital and that is in existence on the effective date of the act under certain specified circumstances.

- Creates a 17-member Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts, chaired by the Superintendent of Insurance, and charged with studying specified areas pertaining to most favored nation clauses in health care contracts, and

requires the Commission to submit a final report of its findings and recommendations to the General Assembly.

- Creates the Advisory Committee on Eligibility and Real Time Claim Adjudication to study and recommend mechanisms or standards that will enable providers to send to and receive from payers sufficient information to enable a provider to determine at the time of the enrollee's visit the enrollee's eligibility for services covered by the payer as well as real time adjudication of provider claims for services and requires the Committee to submit a report of its findings and recommendations for legislative action to the General Assembly.

TABLE OF CONTENTS

Background.. 7
Overview of the bill.. 8
Definitions 8
Prohibitions applicable to contracting entities 12
Selling, renting, or giving contracting entity's rights to participating provider's services 12
Providing services for more than one product.. 13
Offering of financial incentive or other form of consideration.............................. 14
Other prohibition 14
Prohibitions regarding health care contracts 14
Termination of health care contract.. 15
Existing law 15
Operation of the bill... 15
Arbitration of disputes.. 16
Contents of health care contract and summary disclosure form 17
Other requirements for summary disclosure form 19
Information on compensation or payment terms.. 19
Disclosure of program used to review services.. 20
Disclosures under the Physician-Health Plan Partnership Law 20
Confidentiality agreement 21
Disclosures under the Physician-Health Plan Partnership Law 21
Amendment of health care contract.. 21
Existing law 21
Operation of the bill 22
Credentialing 23
Operation of the bill... 24
Remittance notices.. 26
Rules 26

Enforcement........26
Exclusions........27
Prohibited contents of health insuring corporation contract with provider or health care facility........27
Most favored nation clauses........28
Informed consent to surgical or medical procedure or course of procedures........29
Fees for providing copies of medical records........29
  Generally........29
  Patient or patient representative copies........29
  Copies for persons other than patient or patient representative........30
  Free copies to specified entities........30
Hospital Care Assurance Program--definitions........31
Nursing home license........31
Applicability........32
Department of Job and Family Services functions........32
Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts........32
  Definitions........32
  Moratorium........33
  Composition; appointment; meetings........33
  Duties; report........34

CONTENT AND OPERATION

Background

R.C. Chapter 1751. (Health Insuring Corporation Law) governs the operations of corporations to which the Superintendent of Insurance has issued a certificate of authority to establish and operate a "health insuring corporation" (see **COMMENT** 1). R.C. Chapter 3923. (Sickness and Accident Insurance Law) governs the issuance of sickness and accident insurance policies by insurers licensed and regulated by the Superintendent of Insurance (see **COMMENT** 2). R.C. 1753.01 to 1753.30 (Physician-Health Plan Partnership Law) contains provisions dealing with health insuring corporations and addressing provider contractual issues and issues relating to patient access to covered health care services, quality assurance programs, and utilization review (see **COMMENT** 3). R.C. 3901.38 and 3901.381 to 3901.3814 contain provisions for the prompt payment by third-party payers of claims submitted by providers.

R.C. 1751.08 and 1753.30 govern the relations among the laws described in the preceding paragraph. R.C. 1751.08(A) provides that, except as otherwise specifically provided in the Health Insuring Corporation Law (R.C. Chapter 1751.) or the Insurance Law (R.C. Title XXXIX), the provisions of the Insurance Law

(including the Sickness and Accident Insurance Law and new R.C. Chapter 3963. enacted by the bill) are not applicable to any health insuring corporation holding a certificate of authority under the Health Insuring Corporation Law. However, this nonapplicability provision does not apply to an insurer licensed and regulated pursuant to the Insurance Law except with respect to its health insuring corporation activities authorized and regulated pursuant to the Health Insuring Corporation Law. In other words, except as otherwise specifically provided in the Health Insuring Corporation Law or the Insurance Law, a licensed insurer is regulated under the Insurance Law with respect to its activities other than its health insuring corporation activities that are authorized and regulated under the Health Insuring Corporation.

R.C. 1753.30 provides that nothing in R.C. Chapter 1753. (Physician-Health Plan Partnership Law) prevents or otherwise affects the application to any health care plan of those provisions of R.C. Title XVII (Corporations and Partnerships) or XXXIX (Insurance) that would otherwise apply.

Overview of the bill

The bill enacts a new chapter in the Insurance Law (R.C. Chapter 3963.) that primarily regulates health care contracts entered into by certain health care providers and contracting entities. It includes specific prohibitions applicable to contracting entities and health care contracts. The bill requires specified disclosures regarding compensation or payment terms to be made by contracting entities upon presentation of a proposed health care contract to providers and additional disclosures in a summary disclosure form. It specifies that disputes concerning the enforcement of the contract rights conferred by certain provisions are subject to a mutually agreed upon and binding arbitration mechanism. The bill's standardized provider credentialing procedures replace the credentialing procedures in existing law.

Definitions

The bill defines the following terms for purposes of its provisions (R.C. 3963.01):

"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.

"Basic health care services" has the same meaning as in R.C. 1751.01(A) (see **COMMENT** 4), except that it does not include any services listed in that provision that are provided by a pharmacist or nursing home.

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

"Credentialing" means the process of assessing and validating the qualifications of a provider applying to be approved by a contracting entity to provide basic health care services, specialty health care services, or supplemental health care services to enrollees.

"Edit" means adjusting one or more procedure codes billed by a participating provider on a claim for payment or a practice that results in: (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, or (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.

"Electronic claims transport" means to accept and digitize claims or to accept claims already digitized, to place those claims into a format that complies with the electronic transaction standards issued by the United States Department of Health and Human Services pursuant to the "Health Insurance Portability and Accountability Act of 1996" (hereinafter "HIPAA"), as those electronic standards are applicable to the parties and as those electronic standards are updated from time to time, and to electronically transmit those claims to the appropriate contracting entity, payer, or third-party administrator.

"Enrollee" means any person eligible for health care benefits under a health benefit plan, including an eligible recipient of Medicaid under R.C. Chapter 5111., and includes all of the following terms: (1) "enrollee" and "subscriber" as defined by R.C. 1751.01, (2) "member" as defined by R.C. 1739.01, (3) "insured" and "plan member" pursuant to R.C. Chapter 3923., and (4) "beneficiary" as defined by R.C. 3901.38. (See **COMMENT** 5.)

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

"Health care services" means basic health care services, specialty health care services, and supplemental health care services.

"Material amendment" means an amendment to a health care contract that decreases the participating provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to

significantly increase the provider's administrative expenses, or adds a new product. A material amendment does not include any of the following:

(1) A decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the contract;

(2) A decrease in payment or compensation that was anticipated under the terms of the contract, if the amount and date of applicability of the decrease is clearly identified in the contract;

(3) An administrative change that may significantly increase the provider's administrative expense, the specific applicability of which is clearly identified in the contract;

(4) Changes to an existing prior authorization, precertification, notification, or referral program that do not substantially increase the provider's administrative expense;

(5) Changes to an edit program or to specific edits if the participating provider is provided notice of the changes pursuant to R.C. 3963.04(A)(1) and the notice includes information sufficient for the provider to determine the effect of the change;

(6) Changes to a health care contract described in R.C. 3963.04(B)).

"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.

"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.

"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.

"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.

"Product" means one of the following types of categories of coverage for which a participating provider may be obligated to provide health care services pursuant to a health care contract:

(1) A health maintenance organization or other product provided by a health insuring corporation;

(2) A preferred provider organization;

(3) Medicare;

(4) Medicaid or the children's buy-in program established under R.C. 5101.5211 to 5101.5216;

(5) Workers' Compensation.

"Provider" means a physician, podiatrist, dentist, chiropractor, optometrist, psychologist, physician assistant, advanced practice nurse, occupational therapist, massage therapist, physical therapist, professional counselor, professional clinical counselor, hearing aid dealer, orthotist, prosthetist, home health agency, hospice care program, or hospital, or a provider organization or physician-hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts. "Provider" does not mean a pharmacist, pharmacy, nursing home, or a provider organization or physician-hospital organization that leases the provider organization's or physician-hospital organization's network to a third party or contracts directly with employers or health and welfare funds.

"Specialty health care services" has the same meaning as in R.C. 1751.01, except that it does not include any services listed in R.C. 1751.01(B) that are provided by a pharmacist or a nursing home.

"Supplemental health care services" has the same meaning as in R.C. 1751.01(B) (see **COMMENT** 6), except that it does not include any services listed in that provision that are provided by a pharmacist or nursing home.

For purposes of this analysis, a defined term is enclosed in quotation marks the first time it is used.

Prohibitions applicable to contracting entities

Selling, renting, or giving contracting entity's rights to participating provider's services

The bill prohibits any "contracting entity" from selling, renting, or giving a third party the 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 (R.C. 3963.02(A)(1)):

(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 for services 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 either is an affiliate or subsidiary of the contracting entity or is 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 provider's services is any of the following: (1) a "payer" or a third party administrator or other entity responsible for administering claims on behalf of the payer, (2) 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 this paragraph (C), 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, or (3) an entity that is engaged in the business of providing "electronic claims transport" between the contracting entity and the payer or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of the contracting entity's contract with the participating provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.

The bill requires 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 described above to do both of the following (R.C. 3963.02(A)(2)):

(1) Maintain a web page that contains a listing of third parties described in paragraphs (B) and (C), above, 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;

(2) 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 is solely responsible for payment to the participating provider.

The bill provides that any information disclosed to a participating provider under R.C. 3963.02 is considered proprietary and cannot be distributed by the participating provider. Except as described above in paragraphs (A), (B), and (C), the bill prohibits any entity from selling, renting, or giving a contracting entity's rights to the participating provider's services pursuant to a health care contract. (R.C. 3963.02(A)(3) and (4).)

<u>Providing services for more than one product</u>

The bill prohibits any contracting entity from requiring, as a condition of contracting with the contracting entity, that a participating provider provide services for all of the products offered by the contracting entity (R.C. 3963.02(B)(1)). This prohibition is not to be construed to do any of the following (R.C. 3963.02(B)(2)):

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

(2) 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 all of the contracting entity's products;

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

Notwithstanding paragraphs (1), (2), and (3), above, the bill prohibits any contracting entity from requiring, as a condition of contracting with the contracting entity, that the participating provider accept any future product offering that the contracting entity makes (R.C. 3963.02(B)(3)(a)). If a participating provider refuses any future product offering that the contracting entity makes, the contracting entity may terminate the health care contract based on the participating provider's refusal upon written notice to the participating provider no sooner than 180 days after the refusal (R.C. 3963.02(B)(3)(b)).

Offering of financial incentive or other form of consideration

Once the contracting entity and the participating provider have signed the health care contract, it is presumed that the financial incentive or other form of consideration that is specified in the health care contract is the financial incentive or other form of consideration that was offered by the contracting entity to induce the participating provider to enter into the contract (R.C. 3963.02(B)(4)).

Other prohibition

The bill prohibits any contracting entity from requiring, as a condition of contracting with the contracting entity, that a participating provider waive or forego any right or benefit expressly conferred upon a participating provider by state or federal law. However, this provision does not prohibit a contracting entity from restricting a participating provider's scope of practice for the services to be provided under the contract. (R.C. 3963.02(C).)

Prohibitions regarding health care contracts

The bill prohibits any health care contract from doing any of the following (R.C. 3963.02(D)):

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

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

(3) Preclude its use or disclosure for the purpose of enforcing the bill's provisions (new R.C. Chapter 3963.) 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.

Termination of health care contract

Existing law

The Physician-Health Plan Partnership Law (R.C. 1753.09) provides generally that 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 must 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 must 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.

Notwithstanding the preceding paragraph, 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.

Nothing in R.C. 1753.09 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. Nothing in R.C. 1753.09 may 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. (R.C. 1753.09(A), (D), and (F).)

Operation of the bill

The bill provides that in addition to any other lawful reasons for terminating a health care contract, a health care contract may only be terminated under the circumstances described below in the first paragraph in "***Operation of the bill***" under "***Amendment of health care contract***." If the health care contract provides for termination for cause by either party, the contract must state the reasons that may be used for termination for cause, which terms must be reasonable. Once the contracting entity and the participating provider have signed the health care contract, it is presumed that the reasons stated in the health care contract for termination for cause by either party are reasonable. Subject to the

following paragraph, the health care contract must state the time by which the parties must provide notice of termination for cause and to whom the parties must give the notice.

The bill provides that nothing in the preceding paragraph is to be construed as prohibiting any health insuring corporation from terminating a participating provider's contract for any of the causes described in "***Existing law***," above. Notwithstanding any provision in a health care contract as described in the preceding paragraph, existing R.C. 1753.09 applies to the termination of a participating provider's contract for any of the causes described in "***Existing law***," above. The bill also provides that, subject to R.C. 3963.01 to 3963.11, nothing in R.C. 3963.02 prohibits the termination of a health care contract without cause if the health care contract otherwise provides for termination without cause. (R.C. 3963.02(E).)

The bill further provides that nothing in R.C. 1753.09 may be construed as prohibiting a health insuring corporation from terminating a participating provider's contract pursuant to any provision of the contract providing that it may be terminated for reasons specified in the contract as described in the second preceding paragraph, except that, notwithstanding any such provision of a contract, R.C. 1753.09 applies to the termination of a participating provider's contract for any of the causes described above in "***Existing law***" (R.C. 1753.09(F)(3)).

Arbitration of disputes

The bill provides that disputes among parties to a health care contract that only concern the enforcement of the contract rights conferred by R.C. 3963.02 (see "***Prohibitions applicable to contracting entities***," "***Prohibitions regarding health care contracts***," and "***Termination of health care contract***," above), R.C. 3963.03(A) and (D) (see "***Contents of health care contract and summary disclosure form***" and "***Disclosure of program used to review services***," below), and R.C. 3963.04 (see "***Amendment of health care contract***," below) 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 provision to the prevailing party.

The arbitrator must make a decision having due regard for any applicable rules, bulletins, rulings, or decisions issued by the Department of Insurance or any court concerning the enforcement of the contract rights conferred by R.C. 3963.02, 3963.03(A) and (D), and 3963.04.

A party cannot simultaneously maintain an arbitration proceeding as described in the preceding paragraph and pursue a complaint with the

Superintendent of Insurance to investigate the subject matter of the arbitration proceeding. However, if a complaint is filed with the Department of Insurance, the Superintendent may choose to investigate the complaint or, after reviewing the complaint, advise the complainant to proceed with arbitration to resolve the complaint. The Superintendent may request to receive a copy of the results of the arbitration. If the Superintendent notifies an insurer or a health insuring corporation in writing that the Superintendent has initiated a market conduct examination into the specific subject matter of the arbitration proceeding pending against that insurer or health insuring corporation, the arbitration proceeding must be stayed at the request of the insurer or health insuring corporation pending the outcome of the market conduct investigation by the Superintendent. The arbitrator must 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 R.C. 3963.02, 3963.03(A) and (D), and 3963.04. (R.C. 3963.02(F).)

Contents of health care contract and summary disclosure form

The bill requires each health care contract to include, and requires each contracting entity to include a summary disclosure form with a health care contract that includes, all of the following information (R.C. 3963.03(A) and (B)(1)):

(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 paragraph (1)(b), below:

(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 must provide a participating provider with the fee schedule for any other procedure codes requested and a written fee schedule, that cannot be required more frequently than twice per year excluding when it is provided in connection with any change to the schedule. 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.

(iii) The effect, if any, on payment or compensation if more than one procedure code applies to the service also must 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 the preceding two paragraphs, the contracting entity must 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 must 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.

(c) If the contracting entity is not the payer and is unable to include the information described in (1)(a) or (b) above, then the contracting entity must provide by telephone a readily available mechanism, such as a specific web site address, that allows the participating provider to obtain that information from the payer.

(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.

Other requirements for summary disclosure form

The information in the summary disclosure form must 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. (R.C. 3963.03(B)(1).)

The summary disclosure form must include all of the following statements (R.C. 3963.03(B)(2)):

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

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

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

(4) That the terms and conditions of the health care contract may be amended pursuant to R.C. 3963.04 and the participating provider is encouraged to carefully read any proposed amendments sent after execution of the contract;

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

The bill provides that no contracting entity that includes any information in the summary disclosure form with the reasonable belief that the information is truthful or accurate is subject to a civil action for damages or to binding arbitration based on the summary disclosure form. This provision does not impair or affect any power of the Department of Insurance to enforce any applicable law. (R.C. 3963.03(B)(3).)

The bill requires the summary disclosure form to be in substantially the form specified in R.C. 3963.03(B)(4) (see **Attachment**).

Information on compensation or payment terms

When a contracting entity presents a proposed health care contract for consideration by a provider, the bill requires the contracting entity to provide in writing or make reasonably available the information on compensation or payment terms required as described in paragraph (1) under "***Contents of health care contract and summary disclosure form***," above. (R.C. 3963.03(C).)

Disclosure of program used to review services

The bill requires a contracting entity to identify any utilization management, quality improvement, or a similar program the contracting entity uses to review, monitor, evaluate, or assess the services provided pursuant to a health care contract. The contracting entity must disclose the policies, procedures, or guidelines of such a program applicable to a participating provider upon request by the participating provider within 14 days after the date of the request. (R.C. 3963.03(D).)

Disclosures under the Physician-Health Plan Partnership Law

Prior to entering into a participation contract with a provider under the existing Physician-Health Plan Partnership Law, a health insuring corporation must disclose basic information regarding its programs and procedures to the provider, *upon the provider's request*. The information includes all of the following (R.C. 1753.07(A)):

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

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

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

The bill modifies existing law by requiring that a health insuring corporation disclose the information described in paragraph (1), above, without a provider requesting the information. It further provides that insofar as the information on compensation or payment terms described in paragraphs (1)(a) and (b) under "***Contents of health care contract and summary disclosure form***," above, applies, all of that described information that is not included in paragraph (1) in existing law, above, must be disclosed by a health insuring corporation without a provider requesting the information. (R.C. 1753.07(A)(1)(b).)

The existing Physician-Health Plan Partnership Law requires a health insuring corporation to 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, and (3) a signed and dated copy of the final participation contract (R.C. 1753.07(B)).

The bill provides that insofar as the bill's provisions on the summary disclosure form are applicable, a health insuring corporation must provide to a participating provider the summary disclosure form with the disclosures required under the bill (R.C. 1753.07(B)(3)). It further provides that nothing in R.C. 3963.03 is to be construed as preventing or affecting the application of R.C. 1753.07 that would otherwise apply to a contract with a participating provider (R.C. 3963.03(E)).

Confidentiality agreement

The bill provides that the requirements of R.C. 3963.03(C) do not prohibit a contracting entity from requiring a reasonable confidentiality agreement between the provider and the contracting entity regarding the terms of the proposed health care contract and provides that if either party violates the confidentiality agreement, a party to the confidentiality agreement may bring a civil action to enjoin the other party from continuing any act that is in violation of the confidentiality agreement, to recover damages, to terminate the contract, or to obtain any combination of relief (R.C. 3963.03(F)).

Disclosures under the Physician-Health Plan Partnership Law

The bill provides that nothing in R.C. 1753.07 requires a health insuring corporation providing specialty health care services or supplemental health care services to disclose the health insuring corporation's aggregate maximum allowable fee table used to determine other participating providers' fees or fee schedules (R.C. 1753.07(C)).

Amendment of health care contract

Existing law

The Physician-Health Plan Partnership Law requires a health insuring corporation (see **COMMENT** 1) that amends a participation contract to notify the participating provider of the amendment prior to the effective date of the amendment. A health insuring corporation must also notify a participating provider prior to the effective date of an amendment to any document incorporated by reference into such a contract if the amendment directly and materially affects the participating provider. These amendments are not to be effective with regard to the participating provider until the participating provider has had reasonable time, as defined in the contract, to exercise the participating provider's right to

terminate the provider's participation status in accordance with the terms and conditions of the contract. These provisions pertaining to the amendment of a participating provider's contract do not apply to amendments that are required by state or federal law, rule, or regulation, and they do not apply if a delay caused by compliance with the provisions could result in imminent harm to an enrollee.[1] (R.C. 1753.08.)

Operation of the bill

The bill outright repeals the above provisions in the Physician-Health Plan Partnership Law and replaces them with the following provisions. If an amendment to a health care contract is not a "material amendment," the contracting entity must provide the participating provider notice of the amendment at least 15 days prior to the effective date of the amendment, and the contracting entity must provide all other notices to the participating provider pursuant to the health care contract. A material amendment of a health care contract occurs only if the contracting entity provides to the participating provider the material amendment in writing and notice of the material amendment not later than 90 days prior to the effective date of the amendment. The notice must be conspicuously entitled "Notice of Material Amendment to Contrary." If within 15 days after receiving the material amendment and notice the participating provider objects in writing to the material 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 60 days prior to the effective date of the material amendment. If the participating provider does not object to the material amendment in the manner described above, the material amendment becomes effective as specified in the notice of the material amendment. (R.C. 3963.04(A).)

The provisions described in the preceding paragraphs do not apply if the delay caused by compliance with those provisions could result in imminent harm to an "enrollee" or if the material amendment of a health care contract is required by state or federal law, rule, or regulation, or if the provider affirmatively accepts the material amendment in writing and agrees to an earlier effective date than otherwise required by R.C. 3963.04(A)(2) (R.C. 3963.04(B)(6)).

R.C. 3963.04 does not apply under any of the following circumstances (R.C. 3963.04(B)(2)):

[1] R.C. 1753.01(B) (not in the bill), by reference to R.C. 1751.01(J), defines "enrollee" as any natural person who is entitled to receive health care benefits provided by a health insuring corporation.

(1) 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.

(2) 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 this provision: (a) "service code, procedure code, or reporting code" means the current procedural terminology (CPT), current dental terminology (CDT), the healthcare common procedure coding system (HCPCS), the international classification of diseases (ICD), or the drug topics redbook average wholesale price (AWP), and (b) "third party source" means the American Medical Association, the American Dental 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.

Notwithstanding the above provisions, a health care contract may be amended by operation of law as required by any applicable state or federal law, rule, or regulation. Nothing in R.C. 3963.04 is to be construed to require the renegotiation of a health care contract that is in existence before the effective date of that section, until the time that the contract is renewed or materially amended. (R.C. 3963.04(C).)

Credentialing

Existing law

The Physician-Health Plan Partnership Law requires the Superintendent of Insurance to prescribe a standard credentialing form to be used by all health insuring corporations when initially credentialing or recredentialing providers in connection with policies, contracts, and agreements providing basic health care services. The Director of Health may make recommendations to the Superintendent for such a standard credentialing form, and the Superintendent must consider those recommendations in prescribing a standard credentialing form. If the Director makes such recommendations, the Director is required to take into consideration the standard credentialing forms developed by the National Association of Insurance Commissioners, the American Medical Association, the American Association of Health Plans, and any other national organization that has developed such a form. The Superintendent may amend or revise the prescribed standard credentialing form as necessary, and a health insuring corporation must use the amended or revised form to credential or recredential providers. A health insuring corporation may request information from a provider, in addition to that information provided from the standard credentialing form, as

necessitated by the health insuring corporation's credentialing standards. (R.C. 1753.03 and 1753.04.)

Existing law permits a health insuring corporation to use "economic profiling" as a factor in credentialing a provider, if the economic profiling takes into consideration the case mix, severity of illness, and age of patients. "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 health care services to enrollees as a participating provider.

A health insuring corporation may request the information necessary to perform an economic profile with regard to an initial applicant. If the health insuring corporation requests information on case mix, severity of illness, and age of patients, but the information is not produced by the applicant, the health insuring corporation is not required to take these factors into consideration in its economic profile of the provider. The Law states that it does not prohibit a health insuring corporation from taking into consideration the quality and appropriateness of care given by a provider when deciding whether to employ, contract with, or terminate the provider. (R.C. 1753.01(A) and 1753.05.)

Operation of the bill

The bill outright repeals the above credentialing provisions in existing law and replaces them with the following provisions regarding "credentialing." It eliminates the definition of "economic profiling" (R.C. 1753.01(A)) and the existing provisions (R.C. 1753.05) on economic profiling as a factor in credentialing providers. The bill requires the Department of Insurance to prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format for physicians, to prepare the standard credentialing form for all other providers, and to make the standard credentialing form as simple, straightforward, and easy to use as possible, having due regard for those credentialing forms that are widely in use in the state by contracting entities and that best serve these goals. (R.C. 3963.05(A).)

The bill prohibits any contracting entity from doing either of the following (R.C. 3963.05(B) and (C)):

(1) Failing to use the applicable standard credentialing form when initially credentialing or recredentialing providers in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services;

(2) Requiring a provider to provide any information in addition to the information required by the applicable standard credentialing form in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services.

The above credentialing process does not prohibit a contracting entity from limiting the scope of any participating provider's basic health care services, specialty health care services, or supplemental health care services and provides that the requirement that the Department of Insurance prepare the standard credentialing form for all other providers does not include preparing the standard credentialing form for a hospital (R.C. 3963.05(D) and (E)).

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 must notify the provider of the deficiency electronically, by facsimile, or by certified mail, return receipt requested, not later than 21 days after the contracting entity receives the form. 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 and must send this request electronically, by facsimile, or by certified mail, return receipt requested. (R.C. 3963.06(A) and (B).)

The bill provides that, except as provided below, the credentialing process starts when a provider initially submits a credentialing form upon the oral or written request of a contracting entity and that the provider must submit the credentialing form to the contracting entity electronically, by facsimile, or by certified mail, return receipt requested. Subject to the last sentence in this paragraph a contracting entity must complete the credentialing process not later than 90 days after the contracting entity receives that credentialing form from the provider. The contracting entity must allow the provider to submit a credentialing application prior to the provider's employment. A contracting entity that does not complete the credentialing process within that 90-day period is liable for either a civil penalty payable to the provider in the amount of $500 per day, including weekend days, starting at the expiration of that 90-day period until the provider's application for the health care contract is granted or denied or retroactive reimbursement to the provider according to the terms of the contract for any basic health care services, specialty health care services, or supplemental health care services the provider provided to the enrollees starting at the expiration of that 90-day period until the provider's application for credentialing is granted or approved and provides that when the credentialing process of the contracting entity exceeds the 90-day period, the contracting entity must select the liability to which the contracting entity is subject and must inform the provider of the contracting

entity's selection. The credentialing process for a Medicaid managed care plan starts when the provider submits a credentialing form and the provider's national provider number issued by the Centers for Medicare and Medicaid Services. The requirement that the credentialing process be completed within the 90-day period specified in this paragraph does not apply to a contracting entity if a provider that submits a credentialing form to the contracting entity under that division is a hospital. (R.C. 3963.06(C).)

The bill provides that any communication between the provider and the contracting entity must be electronically, by facsimile, or by certified mail, return receipt requested (R.C. 3963.06(D)).

If the State Medical Board or its agent has primary source verified the medical education, graduate medical education, and examination history of the physician, or the status of the physician with the Educational Commission for Foreign Medical Graduates, if applicable, the contracting entity may accept the documentation of primary source verification from the State Medical Board's web site or from its agent and is not required to perform primary source verification of the medical education, graduate medical education, and examination history of the physician or the status of the physician with the Educational Commission for Foreign Medical Graduates, if applicable, as a condition for initially credentialing or recredentialing the physician (R.C. 3963.06(E)).

The bill provides that the provisions of R.C. 3963.06 take effect 90 days after the effective date of the act (Section 4).

Remittance notices

The bill requires all remittance notices sent by a payer, whether written or electronic, to include both the name of the payer issuing the payment to the participating provider and 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. This provision takes effect March 31, 2009. (R.C. 3963.07.)

Rules

The bill requires the Superintendent of Insurance to adopt any rules necessary for the implementation of R.C. Chapter 3963. (R.C. 3963.08).

Enforcement

The bill provides that a series of violations of R.C. Chapter 3963. by any person regulated by the Department of Insurance under R.C. Title XVII (Corporations and Partnerships) or R.C. Title XXXIX (Insurance) that, taken together, constitute a pattern or practice of violating R.C. Chapter 3963. may be

defined as an unfair and deceptive insurance practice under R.C. 3901.19 to 3901.26.

The bill specifically authorizes the Superintendent of Insurance to conduct a market conduct examination of any person regulated by the Department of Insurance under R.C. Title XVII or R.C. Title XXXIX to determine whether any violation of R.C. Chapter 3963. has occurred. When conducting that type of examination, the Superintendent 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 R.C. Chapter 3963. All costs, assessments, and fines collected under this provision must be deposited to the credit of the Department of Insurance Operating Fund. (R.C. 3963.09.)

Exclusions

The bill provides that R.C. Chapter 3963. does not apply with respect to any of the following (R.C. 3963.10)):

(1) A contract or provider agreement between a provider and the state or federal government, a state agency, or a federal agency for health care services provided through a program for Medicaid or Medicare;

(2) A contract for payments made to providers for rendering health care services to claimants pursuant to claims made under R.C. Chapter 4121. (Industrial Commission), 4123. (Workers' Compensation), 4127. (Public Works Relief Compensation), or 4131. (Separate Compensation Funds);

(3) 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.

Prohibited contents of health insuring corporation contract with provider or health care facility

The current Health Insuring Corporation Law precludes any health insuring corporation contract with a provider or health care facility from containing provisions that do any of the following: (1) directly or indirectly offer an inducement to the provider or health care facility to reduce or limit medically necessary health care services to a covered enrollee, (2) penalize a provider or health care facility that assists an enrollee in seeking reconsideration of a health insuring corporation's decision to deny or limit benefits, (3) limit or otherwise restrict 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, (4) penalize a provider or health care facility for principally advocating for medically necessary health care services, or (5) penalize a provider or health care facility for providing information or testimony to a legislative or regulatory body or agency if the information or testimony is not libelous or slanderous or does not disclose trade secrets that the provider or health care facility has no privilege or permission to disclose. (R.C. 1751.13(D)(1)(a) to (e).)

The bill additionally precludes any health insuring corporation contract with a provider or health care facility from containing any provision that violates the bill's provisions (R.C. 1751.13(D)(1)(f)).

Most favored nation clauses

The bill prohibits a contracting entity from doing any of the following (R.C. 3963.11(A)):

(1) Offer to a provider other than a hospital a health care contract that includes a most favored nation clause;

(2) Enter into a health care contract with a provider other than a hospital that includes a most favored nation clause;

(3) Amend an existing health care contract previously entered into with a provider other than a hospital to include a most favored nation clause.

The bill provides that the above prohibition does not go into effect until three years after the effective date of this provision (R.C. 3963.11(B)).

The bill provides that "contracting entity," "health care contract," "health care services," "participating provider," and "provider," have the same meanings as in R.C. 3963.01 (see "***Definitions***," above) (R.C. 3963.11(C)(1)).

The bill defines "most favored nation clause" as a provision in a health care contract that does any of the following (R.C. 3963.11(C)(2)):

(1) 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;

(2) 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;

(3) 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;

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

Informed consent to surgical or medical procedure or course of procedures

Existing law provides that the consent for a surgical or medical procedure or course of procedures must be signed by the patient for whom the procedure is to be performed, or, if the patient for any reason, including, but not limited to, competence, infancy, or the fact that, at the latest time that the consent is needed, the patient is under the influence of alcohol, hallucinogens, or drugs, lacks legal capacity to consent, by a person who has legal authority to consent on the behalf of such patient in such circumstances. The bill replaces "infancy" with "minority" and provides that a person who has legal authority to consent on behalf of the patient includes either of the following (R.C. 2317.54(C)):

(1) The parent, whether the parent is an adult or a minor, of the parent's minor child;

(2) An adult whom the parent of the minor child has given written authorization to consent to a surgical or medical procedure or course of procedures for the parent's minor child.

Fees for providing copies of medical records

Generally

Existing law requires health care providers and medical records companies to provide copies of medical records in accordance with R.C. 3701.741.

Patient or patient representative copies

Existing law sets forth the total costs for copies and all services related to those copies for requests made by the patient or the patient's personal representative and those copies for requests made by someone other than by the patient or the patient's personal representative.

With respect to data recorded on paper, the total costs for copies and all services related to those copies (for requests made by the patient or the patient's personal representative), may not exceed to sum of the following: (1) $2.50 per page for the first ten pages, (2) 51¢ per page for pages 11 through 50, and (3) 23¢

per page for pages 51 and higher. The bill provides that with respect to data recorded on paper or *electronically* the total costs for copies and all services related to those copies may not exceed the following amounts: (1) $2.74 per page for the first ten pages, (2) 57¢ per page for pages 11 through 50, and (3) 23¢ per page for pages 51 and higher.

With respect to data recorded other than on paper, the maximum charge is $1.70 per page. The bill includes data "resulting from an x-ray, magnetic resonance imaging (MRI), or computed axial tomography (CAT) scan that is recorded on film" in this category and provides that the sum for the copies and all services related to those copies is $1.87 per page. (R.C. 3701.741(B)(1)(a) and (b).)

<u>Copies for persons other than patient or patient representative</u>

Existing law provides that the total costs for copies and all services related to those copies for requests made other than by the patient or the patient's personal representative must not exceed the sum of the following: (1) an initial fee of $15.35, which compensates for the records search, (2) with respect to data recorded on paper, the following amounts: (a) $1.02 per page for the first ten pages, (b) 51¢ per page for pages 11 through 50, and (c) 23¢ per page for pages 51 and higher. The bill provides that with respect to data recorded on paper or *electronically* the total cost may not exceed the following amounts: (1) an initial fee of $16.84 for the records search, (2) with respect to data recorded on paper or electronically, the following amounts: (a) $1.11 per page for the first ten pages, (2) 57¢ per page for pages 11 through 50, and (3) 23¢ per page for pages 51 and higher.

With respect to data recorded other than on paper, $1.70 per page. The bill modifies this category to include data "resulting from an x-ray, magnetic resonance imaging (MRI), or computed axial tomography (CAT) scan" that is recorded on paper "or film" and provides that the sum for the copies and all services related to those copies is $1.87 per page. (R.C. 3701.741(B)(2)(a) through (c).)

<u>Free copies to specified entities</u>

The bill requires, *on request*, that a health care provider or medical records company provide one copy *of the patient's medical record and one copy of any records regarding treatment performed subsequent to the original request, not including copies of records already provided*, without charge, to the Bureau of Workers' Compensation, Industrial Commission, Department of Job and Family Services, and Attorney General and to a patient, patient's personal representative, or *authorized person* if the medical record is necessary to support a claim under

Title II or Title XVI of the "Social Security Act," and the request is accompanied by documentation that a claim has been filed (language in italics is added by the bill) (R.C. 3701.741(C)).

Hospital Care Assurance Program--definitions

Existing law, for the purposes of the law regarding the Hospital Care Assurance Program provides that "existing health care facility" means either of the following (R.C. 3702.51(L)):

(1) A health care facility that is licensed or otherwise authorized to operate in this state in accordance with applicable law, is staffed and equipped to provide health care services, and is actively providing health services;

(2) A health care facility that is licensed or has beds registered under R.C. 3701.07 as skilled nursing beds or long-term care beds and has provided services for at least 365 consecutive days within 24 months immediately preceding the date a certificate of need application is filed with the Director of Health.

The bill modifies this definition by providing that "existing health care facility" means (1) a health care facility that is licensed or otherwise authorized to operate in this state in accordance with applicable law, *including a county home or a county nursing home that is certified as of February 1, 2008, under Title XVIII or Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended*, is staffed and equipped to provide health care services, and is actively providing health services, or (2) a health care facility that is licensed *or otherwise authorized to operate in this state in accordance with applicable law, including a county home or a county nursing home that is certified as of February 1, 2008, under Title XVIII or Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended*, or *that* has beds registered under R.C. 3701.07 as skilled nursing beds or long-term care beds and has provided services for at least 365 consecutive days within the 24 months immediately preceding the date a certificate of need application is filed with the Director of Health.

The bill also provides that "county nursing home" has the same meaning as in R.C. 5515.31 (R.C. 3702.51(CC)).

Nursing home license

The bill prohibits the Director of Health from denying a nursing home license to a facility seeking a license as a nursing home on the grounds that the facility does not satisfy a requirement established in rules adopted under R.C. 3721.04 regarding the toilet rooms and dining and recreational areas of nursing homes if all of the following requirements are met (R.C. 3721.042):

(A) The facility seeks a license under R.C. Chapter 3721. because it is a county home or district home being sold under R.C. 5155.31 to a person who may not operate the facility without a nursing home license under R.C. Chapter 3721.

(B) The requirement would not have applied to the facility had the facility been a nursing home first licensed under R.C. Chapter 3721. before October 20, 2001.

(C) The facility was a nursing home, as defined in R.C. 5111.20, on the date immediately preceding the date the facility is sold to the person seeking the license.

Applicability

The bill states that its provisions (R.C. 3963.01 to 3963.11) apply only to contracts that are delivered, issued for delivery, or renewed or materially amended in Ohio on or after the effective date of the act. A health insuring corporation having fewer than 15,000 enrollees must comply with the "provisions of this section" within 12 months after the act's effective date. (Section 3.)

Department of Job and Family Services functions

Existing law authorizes the Department of Job and Family Services (ODJFS) to 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 R.C. 5111.16. The bill requires ODJFS to allow managed care plans to use providers to render care upon completion of the managed care plan's credentialing process. (R.C. 5111.17(A) and (C).)

Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts

Definitions

The bill defines the following terms for purposes of the Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts that it creates (Section 5(A)):

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

(1) 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;

(2) 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;

(3) 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;

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

"Contracting entity," "health care contract," "health care services," "participating provider," and "provider" have the same meanings as described above under "***Definitions***."

Moratorium

The bill precludes any health care contract that includes a most favored nation clause from being entered into, and precludes any health care contract from being amended or renewed at the instance of a contracting entity to include a most favored nation clause, for a period of two years after the effective date of the act, subject to extension as described below. The moratorium does not apply to and does not prohibit the continued use of a most favored nation clause in a health care contract that is between a contracting entity and a hospital and that is in existence on the effective date of the act even if the health care contract is materially amended with respect to any provision of the health care contract other than the most favored nation clause during the two-year period or during any extended period of time as provided below. (Section 5(B).)

Composition; appointment; meetings

The bill creates the Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts consisting of 17 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 R.C. Title XVII, (7) two representatives of contracting entities regulated by the Department of Insurance under R.C. Title XXXIX, (8) one representative of an employer that pays for the health insurance coverage of its employees, (9) a licensed attorney with an expertise in antitrust law who represents providers, and (10) a licensed attorney with an expertise in antitrust law who represents contracting entities that have used most favored nation clauses in their health care contracts and that are regulated by the Department of Insurance under either R.C. Title XVII or Title XXXIX. (Section 6(A).)

The members of the Commission are appointed as follows (Section 6(B)):

(1) The Speaker of the House of Representatives appoints the two members of the House specified in (2) in the preceding paragraph.

(2) The President of the Senate appoints the two members of the Senate specified in (3) in the preceding paragraph.

(3) The Speaker of the House and the President of the Senate jointly appoint the remaining members specified in (4) to (10) in the preceding paragraph.

Initial appointments to the Commission must be made within 30 days after the effective date of the act. The appointments are for the term of the Commission as described below. Vacancies are to be filled in the same manner provided for original appointments. (Section 6(C).)

The Superintendent of Insurance is the Chairperson of the Commission. Meetings of the Commission are at the call of the Chairperson and must be held pursuant to R.C. 121.22 (Open Meetings Law). All of the members of the Commission are voting members. The Department of Insurance must 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. The Chairperson must keep the records of the Commission. Upon submission of the Commission's final report to the General Assembly, the Chairperson must deliver all of the Commission's records to the General Assembly. (Section 6(D).)

Duties; report

The bill requires the Commission to study the following areas pertaining to health care contracts and authorizes the Commission to take testimony from experts or interested parties on the areas of study: (1) the procompetitive and anticompetitive aspects of most favored nation clauses, (2) the impact of most favored nation clauses on health care costs and on the availability of and

accessibility to quality health care, (3) the costs associated with the enforcement of most favored nation clauses, (4) other state laws and rules pertaining to most favored nation clauses in their health care contracts, (5) matters determined by the Department of Insurance as relevant to the study of most favored nation clauses, and (6) any other matters that the Commission considers appropriate to determine the effectiveness of most favored nation clauses. (Section 6(E).)

Not less than 90 days prior to the expiration of the two-year period described above in "***Moratorium***," the Commission must 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 must submit its final report to the General Assembly not later than three months after the expiration of the two-year period. If the General Assembly grants the extension, the extension must be for not more than one year after the expiration of the two-year period, and the Commission must submit its final report to the General Assembly not later than six months prior to the expiration of the one-year extension. The final report of the Commission must include its findings and recommendations on whether state law should prohibit or restrict most favored nation clauses in health care contracts. The Commission ceases to exist upon the submission of its final report to the General Assembly. (Section 6(F).)

The bill creates the Advisory Committee on Eligibility and Real Time Claim Adjudication to study and recommend mechanisms or standards that will enable providers to send to and receive from payers sufficient information to enable a provider to determine at the time of the enrollee's visit the enrollee's eligibility for services covered by the payer as well as real time adjudication of provider claims for services. The membership of the Advisory Committee consists of the Superintendent of Insurance or the Superintendent's designee and at least one representative from ten health care related groups or entities that are appointed by the Superintendent or the Superintendent's designee. Initial appointments to the Advisory Committee will be made 30 days after the effective date of the act and that the members of the Advisory Committee serve without compensation.

The Superintendent of Insurance is the Chairperson of the Advisory Committee, that all members of the Advisory Committee are voting members, and that the meetings must be held pursuant to the Open Meetings Law. The Department of Insurance must provide office space or other facilities, any administrative or other technical, professional, or clerical employees, and any necessary supplies for the work of the Advisory Committee.

The Advisory Committee must advise the Superintendent of Insurance on (1) the technical aspects of using the transaction standards mandated by HIPAA

and the transaction standards and rules of the CAQH Committee on Operating Rules for Information Exchange to require health benefit plan issuers and administrators to provide access to information technology that will enable physicians and other health care providers to generate a request for eligibility information at the point of service that is compliant with those transaction standards and (2) the data elements that health benefit plan issuers and administrators are required to make available, using, to the extent possible, the framework adopted by the CAQH Committee on Operating Rules for Information Exchange.

The Advisory Committee must consider including the following data elements in the information that must be made available in eligibility and real time adjudication transactions: (1) the name, date of birth, member identification number, and coverage status of the patient, (2) the identification of the payer, insurer, issuer, and administrator, as applicable, (3) the name and telephone number of the payer's contact person, (4) the payer's address, (5) the name and address of the subscriber, (6) the patient's relationship to the subscriber, (7) the type of service, (8) the type of health benefit plan or product, (9) the effective date of the health care coverage, (10) for professional services, all of the following: (a) the amount of any copayment, (b) the amount of an individual deductible, (c) the amount of a family deductible, (d) benefit limitations and maximums, (11) for facility services, all of the following: (a) the amount of any copayment or coinsurance, (b) the amount of an individual deductible, (c) the amount of a family deductible, (d) benefit limitation and maximums, (12) precertification or prior authorization requirements, (13) policy maximum limits, (14) patient liability for a proposed service, (15) the health benefit plan coverage amount for a proposed service.

The Advisory Committee must make recommendations regarding various specific types of information technologies to facilitate the generation of a request for eligibility information that is compliant with the transaction standards and rules of the CAQH Committee on Operating Rules for Information Exchange, time frames for the implementation of these recommendations, and when a provider may rely upon the eligibility information transmitted by a payer regarding a service provided to an enrollee for purposes of allocating responsibility for payment for services rendered by the provider. The Advisory Committee must recommend how disputes over enrollee eligibility for services received must be resolved taking into consideration the legal relationship between the provider, the enrollee, and the payer. The recommendations made by the Advisory Committee cannot endorse or otherwise limit the choice of products or services available to health care payers, purchasers, or providers.

The Advisory Committee must provide the General Assembly with a report of its findings and recommendations for legislative action to standardize eligibility and real time adjudication transactions between providers and payers not later than January 1, 2009. The transaction standards adopted by the General Assembly must, at a minimum, comply with standards mandated by HIPAA to the extent that HIPAA applies to the transaction. The Advisory Committee ceases to exist upon the submission of its report and recommendation to the General Assembly. (Section 7.)

COMMENT

1. R.C. 1751.01(O), not in the bill, defines "health insuring corporation" as a corporation that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an "open panel plan" or a "closed panel plan" (see below).

"Health insuring corporation" does not include a limited liability company formed pursuant to R.C. Chapter 1705., *an insurer licensed under R.C. Title XXXIX (Insurance Law) if that insurer offers only open panel plans under which all providers and health care facilities participating receive their compensation directly from the insurer*, a corporation formed by or on behalf of a political subdivision or a department, office, or institution of the state, or a public entity formed by or on behalf of a board of county commissioners, a county board of mental retardation and developmental disabilities, an alcohol and drug addiction services board, a board of alcohol, drug addiction, and mental health services, or a community mental health board, as those terms are used in R.C. Chapters 340. and 5126.

"Closed panel plan" means a health care plan that requires enrollees to use participating providers. "Open panel plan" means a health care plan that provides incentives for enrollees to use participating providers and that also allows enrollees to use providers that are not participating providers. (R.C. 1751.01(E) and (S)(1), not in the bill.) No health insuring corporation may offer an open panel plan, unless the health insuring corporation is also licensed as an insurer under the Insurance Law, the health insuring corporation, on June 4, 1997, holds a certificate of authority or license to operate under R.C. Chapter 1736. or 1740. (both chapters have been repealed), or an insurer licensed under the Insurance Law is responsible for the out-of-network risk as evidenced by both an evidence of coverage filing under R.C. 1751.11 (evidence of subscriber's coverage for health care plan under which health care benefits are provided) and a policy and

certificate filing under R.C. 3923.02 (sickness and accident insurance policy or certificate). (R.C. 1751.01(S)(2), not in the bill.)

2. "Policy of sickness and accident insurance" includes any policy, contract, or certificate of insurance against loss or expense resulting from the sickness of the insured or from bodily injury or death of the insured by accident, or both (R.C. 3923.01, not in the bill).

3. The provisions of the Physician-Health Plan Partnership Law addressing contractual issues generally: (a) require the Superintendent of Insurance to prescribe a standard credentialing form to be used by health insuring corporations in credentialing providers, (b) require a health insuring corporation to give participating providers an opportunity to take corrective action prior to terminating the provider's participation in the health insuring corporation, (c) prohibit the inclusion of certain provisions in a health insuring corporation's contract with a provider or health care facility, including "gag" clauses, and (d) require a health insuring corporation to make certain disclosures to participating providers and provider applicants.

4. R.C. 1751.01(A)(1) generally defines "basic health care services" as the following services when medically necessary: (a) physician's services, except when such services are supplemental as defined below, (b) inpatient hospital services, (c) outpatient medical services, (d) emergency health services, (e) urgent care services, (f) diagnostic laboratory services and diagnostic and therapeutic radiologic services, (g) diagnostic and treatment services, other than prescription drug services, for biologically based mental illnesses, and (h) preventive health care services, including, but not limited to, voluntary family planning services, infertility services, periodic physical examinations, prenatal obstetrical care, and well-child care. "Basic health care services" does not include experimental procedures.

5. The definition of "enrollee" in the bill includes all of the following: (a) "enrollee" and "subscriber" as defined in R.C. 1751.01(J) and (AA) ("enrollee" means any natural person who is entitled to receive health care benefits provided by a health insuring corporation; "subscriber" means a person who is responsible for making payments to a health insuring corporation 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 insuring corporation), (b) "member" as defined by R.C. 1739.01(E) ("member" means an individual or an employer that is a member of an organization sponsoring a "multiple employer welfare arrangement," defined as an employee welfare benefit plan, trust, or any other arrangement, whether such plan, trust, or arrangement is subject to the "Employee Retirement Income Security Act of 1974," 29 U.S.C.A. 1001, that is established or maintained for the purpose of offering or providing, through group insurance or

group self-insurance programs, medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, or death, to the employees, and their dependents, of two or more employers, or to two or more self-employed individuals and their dependents (R.C. 1739.01(F))), (c) insured and plan member pursuant to R.C. Chapter 3923. (Sickness and Accident Insurance), (d) "beneficiary" as defined by R.C. 3901.38(A) ("beneficiary" means any policyholder, subscriber, member, employee, or other person who is eligible for benefits under a "benefits contract," which means a sickness and accident insurance policy providing hospital, surgical, or medical expense coverage, or a health insuring corporation contract or other policy or agreement under which a third-party payer agrees to reimburse for covered health care or dental services rendered to beneficiaries, up to the limits and exclusions contained in the benefits contract), and (e) claimant pursuant to R.C. Chapter 4121. (Industrial Commission; Bureau of Workers' Compensation), 4123. (Workers' Compensation), 4127. (Public Works Relief Compensation), or 4131. (Separate Compensation Funds).

6. R.C. 1751.01(B)(1) defines "supplemental health care services" as any health care services other than basic health care services that a health insuring corporation may offer, alone or in combination with either basic health care services or other supplemental health care services, and includes: (a) services of facilities for intermediate or long-term care, or both, (b) dental care services, (c) vision care and optometric services including lenses and frames, (d) podiatric care or foot care services, (e) mental health services, excluding diagnostic and treatment services for biologically based mental illnesses, (f) short-term outpatient evaluative and crisis-intervention mental health services, (g) medical or psychological treatment and referral services for alcohol and drug abuse or addiction, (h) home health services, (i) prescription drug services, (j) nursing services, (k) services of a dietitian licensed under R.C. Chapter 4759., (l) physical therapy services, (m) chiropractic services, and (n) any other category of services approved by the Superintendent of Insurance.

7. R.C. 1751.01(C) defines "specialty health care services" as one of the supplemental health care services listed in R.C. 1751.01(B) (described in **COMMENT** 6, above), when provided by a health insuring corporation on an outpatient-only basis and not in combination with other supplemental health care services.

HISTORY

ACTION	DATE
Introduced	03-22-07
Reported, H. Civil & Commercial Law	10-09-07
Passed House (91-5)	10-09-07
Reported, S. Judiciary - Civil Justice	02-21-08

h0125-rs-127.doc/jc:kl

Attachment

SUMMARY DISCLOSURE FORM

(1) Compensation terms
(a) Manner of payment
[ ] Fee for service
[ ] Capitation
[ ] Risk
[ ] Other ________________________ See ____________________
(b) Fee schedule available at _________________________________
(c) Fee calculation schedule available at ______________________
(d) Identity of internal processing edits available at _____________
(e) Information in (c) and (d) is not required if information in (b) is provided.
(2) List of products or networks covered by this contract
[ ] ____
[ ] ____
[ ] ____
[ ] ____
[ ] ____
(3) Term of this contract ___________________________________
(4) Contracting entity or payer responsible for processing payment available at ____
(5) Internal mechanism for resolving disputes regarding contract terms available at ____
(6) Addenda to contract

	Title	Subject
(a)		
(b)		
(c)		
(d)		

(7) Telephone number to access a readily available mechanism, such as a specific web site address, to allow a participating provider to receive the information in (1) through (6) from the payer.

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.