Bill Analysis

Lisa Sandberg *Legislative Service Commission*

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(As Introduced)

Sens. Coughlin, Boccieri, Gardner, Spada, Cafaro, Clancy, Padgett, Schuring, Mumper, D. Miller, Morano, Schuler

BILL SUMMARY

- Prohibits third-party payers under a health care contract from generally selling or giving their provider network information to other persons or from requiring that a provider, as a condition of contracting with the third-party payer, provide services under more than one "product" offered by the third-party payer or waive any right or benefit under state or federal law.

- Prohibits a health care contract from including certain provisions, including a "most favored nation clause" if a third-party payer controls more than 20% of a health insurance market share in a county.

- Requires each health care contract to provide that the third-party payer or the provider may terminate the contract without cause by giving a 90-day notice and requires a health care contract to state the reasons that may be used for termination for cause if the contract provides for such termination for cause by either party.

- Specifies that disputes concerning certain provisions in the bill are subject to a mutually agreed upon arbitration mechanism that is binding on the parties and authorizes an arbitrator to award to the prevailing party reasonable attorney's fees and arbitration costs.

- Requires a third-party payer, upon presentation of a proposed health care contract for a provider's consideration and upon execution of the contract, to make available to the provider specified information regarding compensation or payment terms for health care services.

- Requires a third-party payer to include with a health care contract a summary disclosure form that discloses 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 or assess the services provided under the contract.

- Replaces existing law's procedures for amending a health care contract with new procedures.

- Specifies that the standard credentialing form for credentialing providers is the credentialing form used by the Council for Affordable Quality Healthcare (CAQH) and eliminates existing law's provisions on economic profiling of providers.

- Requires a third-party payer, upon a participating provider's submission of certain information about an enrollee, to make available electronically or by an internet portal, specified personally identifiable and other information concerning the enrollee.

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

- Generally provides that a violation of the bill's provisions is an unfair and deceptive act or practice in the business of insurance.

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

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

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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 third-party payers. It includes specific prohibitions applicable to third-party payers and health care contracts. The bill requires specified disclosures regarding compensation or payment terms to be made by third-party payers upon presentation of a proposed health care contract to providers and additional disclosures upon execution of the contract. It specifies that disputes concerning the enforcement of certain provisions are subject to a mutually agreed upon and binding arbitration mechanism. The bill requires third-party payers, upon a provider's submission of certain information regarding an enrollee, to make available electronically or through the internet personally identifiable and other information concerning the enrollee. The bill's standardized provider credentialing procedures replace the credentialing procedures in existing law.

Prohibitions applicable to third-party payers

The bill prohibits any "third-party payer" from doing either of the following (R.C. 3963.02(A)) (see "***Definitions***," below, for definitions of any terms that appear above or below in quotation marks):

(1) Selling, renting, or giving its "provider" network information to any other person, except for the purpose of providing claims processing for the third-party payer;

(2) Requiring, as a condition of contracting with the third-party payer, that a "provider" provide services under more than one "product" offered by the third-party payer or waive or forego any right or benefit to which the provider may be entitled under state or federal law.

The bill further prohibits any third-party payer, other than the third-party payer that executes a "health care contract," from enforcing against the provider

the payment or compensation terms of the health care contract unless the other third-party payer is contractually bound to all terms and conditions of the health care contract executed by the provider, and either (1) the other third-party payer is clearly identified in the health care contract executed by the provider, or (2) before health care services are provided, the health care contract is amended by a writing in which the provider agrees to provide health care services for the payment or compensation described in the health care contract to be paid by the other third-party payer. (R.C. 3963.02(B).)

Prohibitions regarding health care contracts

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

(1) Interfering with a provider's right to set the provider's payer-mix ratio in the provider's practice;

(2) Precluding its use or disclosure for the purpose of enforcing the bill's provisions 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;

(3) Including a "most favored nation clause" (defined in the following sentence) if a third-party payer controls more than 20% of a health insurance market share in a particular county. "Most favored nation clause" means a contract provision that: (a) prohibits, or grants a third-party payer an option to prohibit, the provider from contracting with another third-party payer to provide services at a lower price than the payment specified in the contract, (b) requires, or grants a third-party payer an option to require, the provider to accept a lower payment in the event the provider agrees to provide services to any other third-party payer at a lower price, (c) requires, or grants the third-party payer an option to require, termination or renegotiation of the existing health care contract in the event the provider agrees to provide services to any other third-party payer at a lower price, or (d) requires the provider to disclose the provider's contractual reimbursement rates with other third-party payers. Any health care contract provision that violates the prohibition against including a most favored nation clause if a third-party payer controls more than 20% of a health insurance market share in a particular county is null and void.

Termination of health care contract

The bill requires each health care contract to provide that the third-party payer or the provider may terminate the health care contract without cause by giving not less than 90 days written notice to the other party. If the health care

contract provides for termination for cause by either party, the health care contract must state the reasons that may be used for termination for cause and those terms must be reasonable. The health care contract is required to 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 no term for compensation or payment in a health care contract survives the termination of the contract, except with the agreement of the provider or for a continuation of coverage arrangement otherwise required by law. (R.C. 3963.02(D), (E), and (F).) (See **COMMENT** 4.)

Arbitration of disputes

The bill specifies that disputes among parties concerning the enforcement of the provisions described in "***Prohibitions applicable to third-party payers***," "***Prohibitions regarding health care contracts***," and "***Termination of health care contract***," above, and in "***Disclosure requirements***" and "***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 to the prevailing party reasonable attorney's fees and costs for arbitration relating to the enforcement of the arbitration provision. The limitation to reasonable attorney's fees and costs do not apply to disputes regarding breach of contract. (R.C. 3963.02(G).)

Disclosure requirements

The bill requires a third-party payer to make specific disclosures to a provider upon presentation of a proposed health care contract for the provider's consideration and upon execution of the contract.

Information on compensation or payment terms

When a third-party payer presents a proposed health care contract for consideration by a provider, the bill requires the third-party payer to provide in writing or make reasonably available the information sufficient for the provider to determine the compensation or payment terms for health care services, including all of the following (R.C. 3963.03(A)(1) and (B)):

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

(2) The fee schedule of codes reasonably expected to be billed by a provider's specialty for services provided pursuant to the health care contract, including, if applicable, current procedural terminology codes and the Centers for Medicare and Medicaid Services health care common procedure coding system and the associated payment or compensation for each "procedure code." A fee schedule may be provided electronically. Upon request, a third-party payer must

provide a provider with the fee schedule for any other codes requested and a written fee schedule, which cannot be required more frequently than twice per year excluding when it is provided in connection with any change to the schedule. The third-party payer also must state the effect, if any, on payment or compensation if more than one procedure code applies to the service. A third-party payer may satisfy this requirement by providing a clearly understandable, readily available mechanism, such as a web site, that allows a provider to determine the effect of service codes on payment or compensation before a service is provided or a claim is submitted.

(3) The methodology used to calculate any fee schedule, such as relative value unit system and conversion factor, percentage of Medicare payment system, or percentage of billed charges. If applicable, the methodology disclosure must include the name of any relative value 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.

(4) The identity of any internal processing "edits" used by the third-party payer, including the publisher, product name, version, and version update of any editing software used by the third-party payer.

If the above information is not disclosed in writing, it must be disclosed in a manner that allows the provider to evaluate the provider's payment or compensation for services under the health care contract. After the health care contract is executed, a third-party payer must disclose the above described information upon request by the provider. The third-party payer need not provide such information in written format more than twice a year. (R.C. 3963.03(B).)

Summary disclosure form

The bill requires each third-party payer to include a summary disclosure form with a health care contract that discloses in plain language all of the following information: (1) the information described in paragraphs (1) to (4), above, in "***Information on compensation or payment terms***," (2) any "product" for which the provider is to provide services, (3) the term of the health care contract and how it may be terminated, (4) the identity of the third-party payer responsible for the processing of the provider's compensation or payment, (5) any internal mechanism provided by the third-party payer to resolve disputes concerning the interpretation or application of the terms or conditions of the contract, (6) any provisions for the amendment of the contract, and (7) a list of addenda, if any, to the contract. (R.C. 3963.03(A).)

Disclosure of program used to review services

The bill requires a third-party payer to identify any utilization management, quality improvement, or a similar program the third-party payer uses to review, monitor, evaluate, or assess the services provided pursuant to a health care contract. The third-party payer must disclose the policies, procedures, or guidelines of such a program applicable to a provider upon request by the provider within 14 days after the date of the request. (R.C. 3962.03(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. It requires a third-party payer to notify a provider 120 days prior to the effective date of an amendment to the provider's contract with the third-party payer, and 120 days prior to the effective date of an amendment to any document incorporated by reference into the contract if the amendment of the document directly and materially affects the provider. The amendments are not effective with regard to a provider until the provider has agreed in writing to the change. These provisions

[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.

do not apply if the delay caused by compliance with them could result in imminent harm to an "enrollee" or if the amendment is required by state or federal law, rule, or regulation.

The provisions described in the preceding paragraph do not apply if the provider's payment or compensation is based on the current Medicare physician fee schedule final rule as published by the Centers for Medicaid and Medicare Services annually in the Federal Register, and the change in payment or compensation results solely from a change in the physician fee schedule.

Notwithstanding the provisions described in the two preceding paragraphs, a health care contract may be modified without the need for amendment by operation of law as required by any applicable state or federal law or rule or regulation. All of the above provisions regarding the amendment of a health care contract are not to be construed to require the renegotiation of a contract in existence before the bill's effective date until such time as the contract is renewed or modified. (R.C. 3963.04.)

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 existing provisions (R.C. 1753.05) on economic profiling as a factor in credentialing providers. The bill specifies that the standard credentialing form is the credentialing form used by the Council for Affordable Quality Healthcare (CAQH), in electronic or paper format. It prohibits any third-party payer from doing either of the following (R.C. 3963.05):

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

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

If a provider submits to a third-party payer a credentialing form that is not complete, the third-party payer that receives the form must notify the provider of the deficiency not later than 14 days after the third-party payer receives the form. A third-party payer must reimburse a provider who has submitted a complete credentialing form for entrance into a health care contract with the third-party payer when the period of review of the provider's credentialing form exceeds 45 days and until the third-party payer rejects or approves the provider for a health care contract.

If the third-party payer and the provider enter into a health care contract, the third-party payer must retroactively reimburse the provider according to the terms of the contract for any basic or supplemental health care services the provider provided to enrollees after the provider submitted to the third-party payer a complete credentialing form and until the third-party payer and the provider enter into a health care contract. A provider may keep record of in-network claims incurred while the provider's credentialing is pending and submit the claims to be paid by the third-party payer once the third-party payer and the provider enter into a health care contract. (R.C. 3963.06.)

Enrollee information

The bill requires each third-party payer, upon a "participating provider's" submission of an "enrollee's" name, the enrollee's relationship to the primary enrollee, and the enrollee's birth date, make available information maintained in the ordinary course of business that is sufficient for the provider to determine at the time of the enrollee's visit all of the following: (1) the enrollee's identification number assigned by the third-party payer, (2) the birth date and gender of the primary enrollee, (3) the names, birth dates, and gender of all covered dependents, (4) the current enrollment and eligibility status of the enrollee, (5) whether a specific type or category of service is a covered benefit for the enrollee, (6) the enrollee's excluded benefits or limitations, whether group or individual, (7) the enrollee's copayment requirements, and (8) the unmet amount of the enrollee's deductible or the enrollee's financial responsibility. A third-party payer must make available the information described in this paragraph electronically or by an internet portal. The bill prohibits any third-party payer from directly or indirectly charging a provider any fee for the above information the third-party payer makes available.

Notwithstanding the above requirement for a third-party payer to make available the described information regarding an enrollee, a third-party payer is not required to make that information available to any person except to a participating provider who is authorized under state and federal law to receive personally identifiable information concerning an enrollee or an enrollee's dependent. (R.C. 3963.07.)

Rules

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

Unfair and deceptive act or practice in the business of insurance

The bill specifies that, unless otherwise stated, a violation of its provisions is an unfair and deceptive act or practice in the business of insurance under R.C. 3901.19 to 3901.26 (R.C. 3963.09).

Definitions

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

"Edit" means adjusting one or more procedure codes billed by a provider on a claim for payment or a third-party payer's practice that results in: (1) payment for some, but not all of the procedure codes originally billed by a provider, (2) payment for a different procedure code than the procedure code originally billed by a 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.

"Health care contract" means a contract entered into or renewed between a third-party payer and a provider for the delivery of basic or supplemental health care services to enrollees.

"Procedure codes" includes the American Medical Association's current procedural terminology code, and the Centers for Medicare and Medicaid Services health care common procedure coding system.

"Product" means a product line for health services, including, but not limited to a health insuring corporation product or a Medicare or Medicaid product as established by a third-party payer and for which the provider may be obligated to provide services pursuant to a contract.

"Provider" means a physician, podiatrist, dentist, pharmacist, chiropractor, optometrist, psychologist, or other health care provider entitled to reimbursement by a third-party payer for services rendered to an enrollee under a heath care contract. "Provider" does not mean a hospital or nursing home.

"Third-party payer" means any person that has a primary business purpose of contracting with health care providers for the delivery of basic health care services.

"Credentialing" means the process of assessing and validating the qualifications of a provider applying to be approved by a third-party payer to provide basic health care services to the third-party payer's enrollees.

"Enrollee" means any person eligible for health care benefits under a health benefit plan and includes all of the following terms: (1) enrollee and subscriber as defined by R.C. 1751.01, (2) member as defined by R.C. 1739.01, (3) insured and plan member pursuant to R.C. Chapter 3923., (4) beneficiary as defined by R.C. 3901.38, and (5) claimant pursuant to R.C. Chapter 4121., 4123., 4127., or 4131. (See **COMMENT** 5.)

"Participating provider" means a provider that has a health care contract with the third-party payer.

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)).

Applicability

The bill states that its provisions apply only to contracts that are delivered, issued for delivery, or renewed or modified 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.)

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: (1) require the Superintendent of Insurance to prescribe a standard credentialing form to be used by health insuring corporations in credentialing providers, (2) 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, (3) prohibit the inclusion of certain provisions in a health insuring corporation's contract with a provider or health care facility, including "gag" clauses, and (4) require a health insuring corporation to make certain disclosures to participating providers and provider applicants.

4. The Physician-Health Plan Partnership Law contains distinct provisions regarding the termination of a provider's participation and a provider's option to take corrective action. Under R.C. 1753.30 (see the last paragraph in "***Background***," above), nothing in these termination provisions (described below) in the Physician-Health Plan Partnership Law (R.C. Chapter 1753.) prevents or affects the application to a health care plan of provisions in Title XVII (17) or XXXIX (39) that would otherwise apply. Thus, it appears that the bill's provision (R.C. 3963.02(E)) *requiring* a health care contract to provide that a third-party payer or the provider may terminate the contract *without cause* by giving the other party a 90-day written notice preempts the following provisions in R.C. 1753.09 in the Physician-Health Plan Partnership Law.

Under R.C. 1753.09, except as described in the following paragraph, 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. A participating provider whose participation has so terminated may appeal the termination to the appropriate medical director of the health insuring corporation. The medical director must give the participating provider an opportunity to discuss with the medical director the reason or reasons for the termination. If a satisfactory resolution of the appeal cannot be reached, the participating provider may appeal the termination to a panel composed of participating providers who have comparable or higher levels of education and training than the participating provider making the appeal. A representative of the participating provider's specialty must be a member of the panel, if possible. This panel must hold a hearing and render its recommendation in the appeal within 30

days after holding the hearing. The recommendation must be presented to the medical director and to the participating provider. The medical director must review and consider the panel's recommendation before making a decision. The decision rendered by the medical director is final. A provider's status as a participating provider remains in effect during the appeal process unless the termination was based on any of the reasons listed in the following paragraph. (R.C. 1753.09(A), (B), and (C).)

Notwithstanding the above provisions regarding the termination of 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 provider's participation may be immediately terminated if the participating provider's conduct presents an imminent risk of harm to an enrollee or enrollees; 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. The termination provisions described in this and the preceding paragraph apply only to providers who are natural persons. Nothing in these provisions 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. These provisions are not to 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(D), (E), and (F).)

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).

HISTORY

ACTION	DATE
Introduced	03-22-07

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