Synopsis of Senate Committee Amendments[*]

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Sub. H.B. 125

127th General Assembly
(S. Judiciary Civil Justice)

The committee amended the As Passed by the House version of the bill to do the following:

(1) Defines the terms "electronic claims transport," "material amendment," and "specialty health care services," and modifies the definitions for "credentialing," "enrollee," "health care services," "health care contract," "product," "provider," "service code," and "third party source."

(2) Modifies the prohibition against a contracting entity selling, renting, or giving the contracting entity's rights to a participating provider's services pursuant to the contracting entity's health care contract with the participating provider by providing that the prohibition does not apply if, among other things, 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 from, the contracting entity or an affiliate or subsidiary of the contracting entity or if the health care contract applies to network rental agreements and the third party accessing the participating provider's services is 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.

(3) Prohibits any contracting entity from requiring, as a condition of contracting with the contracting entity, that a participating provider provides services for all of the products (changed from "more than one product") offered by the contracting entity.

(4) Provides that if a participating provider refuses any future product offering that the contracting entity makes, the contracting entity may terminate the health care

[*] This synopsis does not address amendments that may have been adopted on the Senate floor.

contract based on the participating provider's refusal upon written notice to the participating provider no sooner than 180 days after the refusal.

(5) Provides that 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.

(6) Provides that the contracting entity cannot require, 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 (changed from "any right or benefit *to which the* participating provider *may be entitled under* state or federal law").

(7) Prohibits any health care contract from prohibiting any contracting entity from entering into a health care contract with any other provider.

(8) 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 and provides that once the parties have signed the contract it is presumed that the reasons in the contract for termination for cause by either party are reasonable.

(9) Provides that if a complaint is filed with the Department of Insurance to investigate the subject matter of an arbitration proceeding, the Superintendent may choose to investigate the complaint or, after reviewing the complaint, advise the complainant to proceed with arbitration to resolve the complaint, allows the Superintendent to request to receive a copy of the results of the arbitration, and provides that, 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.

(10) Provides that, if the contracting entity is not the payer and is unable to include the information required to be included in the contract and summary disclosure form, 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 and includes within the summary disclosure form a line for the telephone number to access that readily available mechanism.

(11) Provides that the requirements regarding the information that must be included in a health care contract 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.

(12) Removes the requirement that if the contracting entity does not disclose the information required to be in a health care contract in writing the contracting entity must disclose that information in a manner that allows the participating provider to evaluate the participating provider's payment or compensation for services under the health care contract and the provision that the contracting entity does not need to provide that information to the participating provider in written format more than twice a year.

(13) Provides that nothing in R.C. 1753.07 (requirement that a health insuring corporation disclose basic information regarding its programs and procedures to the provider) requires a health insuring corporation providing specialty health care services or supplemental health care services to disclose the health insuring corporation's maximum allowable fee table used to determine providers' fees or fee schedules.

(14) Requires 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.

(15) Provides that a *material* amendment to 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 *material* amendment and provides that the notice must be conspicuously entitled "Notice of Material *Amendment* to Contract."

(16) Provides that if within 15 days (changed from 30 days) after receiving the material amendment (changed from "proposed") and notice the participating provider objects in writing to the material amendment (changed from "proposed") 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 (changed from 30 days) prior to the effective date of the material amendment.

(17) Removes the provision that provided that if a proposed amendment is the addition of a new category of coverage under the health care contract, the participating provider objects to that proposed amendment, and there is no resolution of the objection, the amendment is not effective as to the participating provider, and the objection is not a basis upon which the contracting entity may terminate the contract.

(18) 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 used in the state by contracting entities and that best serve these goals.

(19) Includes within the definition of "service code, procedure code, or reporting code" the "current dental terminology" (CDT) and with "third party source" the "American Dental Association."

(20) Provides that the 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.

(21) Allows a contracting entity to send a notice of deficiency in a credentialing form or a request for written clarification by facsimile, requires a provider to submit a credentialing form to a contracting entity electronically, by facsimile, or by certified mail, return receipt requested, and requires that any communication between the provider and the contracting entity be electronically, by facsimile, or by certified mail, return receipt requested.

(22) Provides that a contracting entity must allow a provider to submit a credentialing application prior to the provider's employment and provides that 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.

(23) Provides that a contracting entity that does not complete the credentialing process within the 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 the 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.

(24) Provides that 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 for 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.

(25) Removes the provisions regarding web-based eligibility from the bill.

(26) Provides that the requirements regarding remittance notices sent by a payer take effect March 31, 2009.

(27) Provides that R.C. Chapter 3963. does not apply to a contract or provider agreement between a provider and the state or federal government, a state agency, or federal agency for health care services provided through a program for Medicaid or Medicare.

(28) 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 does not go into effect until three years after the effective date of this provision.

(29) Modifies current law regarding informed consent to a surgical or medical procedure or course of procedures by providing that consent for a surgical or medical procedure or course of procedures is 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, *minority* (current law says "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 behalf of such patient in such circumstances, including either the parent, whether the parent is an adult or a minor, 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.

(30) 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.

(31) 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.

(32) Provides that the two-year moratorium on most favored nation clauses 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.

(33) Adds two additional members to the Joint Legislative Study Commission on Most Favored Nation Clauses; a licensed attorney with an expertise in antitrust law who represents providers, and 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, both of whom are appointed jointly by the Speaker of the House and the President of the Senate.

(34) Creates the Advisory Committee on Eligibility and Real Time Claims 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.

(35) Provides that the requirements regarding credentialing do not go into effect until 90 days after the effective date of the bill.

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